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REPORT TO THE CONGRESS

Medicare Payment Policy

MEDpAC Medicare
Payment Advisory
Commission

MEDPAC

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Payment Advisory
Commission

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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Glenn M. Hackbarth, J.D., Chairman
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March 14, 2014

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 2014 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and to 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, including a chapter on moving forward on common patient assessment to better evaluate the cost and outcomes of the care beneficiaries receive across post-acute care settings;
- a chapter that updates the trends in enrollment, plan offerings, and payments in Medicare Advantage plans and includes two recommendations—one that reduces unnecessary spending and one that improves coordination for end-of-life care;
- 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 to increase the efficiency of Medicare—that is, to find 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 update for 2015 for five fee-for-service payment systems. In three sectors (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, the Commission has developed in the recent past 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.

For the hospital inpatient and outpatient payment systems we have developed a package of recommendations that reduces excessive payment rates for certain outpatient hospital services and aligns them with rates paid in physician offices, creates greater equity between rates paid for similar patients in acute care hospitals and long-term care hospitals, and increases hospital payment rates for fiscal year 2015 based on our assessment of payment adequacy. This package of recommendations should be considered as a whole because each of these actions affect hospital revenues in different ways and will, together, improve financial incentives in these payment systems while maintaining adequate overall payments.

The Commission opposes the sequester as applied to Medicare because it reduces payments across all settings by 2 percent without regard to payment adequacy. By law, we are required to recommend payment changes to the Congress each year, and we do so by analyzing the circumstances of each setting. In our thinking, it is not reasonable to treat settings in the same way, if their beneficiaries' access to care, the quality of care, and aggregate Medicare margins differ. Therefore, we will continue to make our recommendations for each setting year by year, so that we can give the Congress the best advice we can, taking into account the most current information available and bringing any options for savings to your attention. To make the update recommendations in this report unambiguous, they are stated relative to the 2014 base payment as defined in Medicare's authorizing statute—Title XVIII of the Social Security Act.

I clarify the Commission's position on the sequester because some argue that 2 percentage points should be added to the Commission's recommendations to "reverse" the sequester. It is inappropriate to interpret the Commission's position in this way. In fact, doing so would increase program spending much more quickly than overriding the sequester because of compounding and would, in addition, increase beneficiary cost sharing.

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 high-quality care and providing sufficient payment for efficient providers.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with the first letters of the first and last names being capitalized and prominent.

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

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

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

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

We recognize that managing updates and relative payment rates alone will not solve what has been the fundamental problem with Medicare FFS payment systems to date—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address that problem directly, two

approaches must be pursued. First, payment reforms, such as penalties for excessive hospital readmission rates, need to be implemented more broadly and coordinated across settings. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care—such as medical homes, bundling, and accountable care organizations (ACOs)—need to be monitored and successful models adopted on a broad scale.

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

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

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

Context for Medicare payment policy

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

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

The level of and growth in health care spending significantly affect federal and state budgets since public spending accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, then spending for other public priorities—like education, investment in infrastructure and scientific research—will be crowded out, and the federal government will have less flexibility to support states because of its own debt and deficit burdens. Social Security, Medicare, Medicaid, other health insurance programs, and net interest will account for about 14 percent of GDP in 10 years, whereas total federal revenues have averaged a little over 17 percent of GDP over the past 40 years.

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

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

There are indications that some share of health care dollars is not spent effectively or is simply misspent. First, health care spending varies significantly across different regions

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

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

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

As required by law, the Commission makes payment update recommendations annually for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system is changed relative to the prior year. As described in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2014) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2015). As part of the process, we examine payment adequacy for the “relatively efficient” provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

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

Commission looks at all available indicators of payment adequacy and reevaluates any prior year assumptions using the most recent data available to make sure its assessments accurately reflect current conditions. We may also consider changes that redistribute payments within a payment system to correct any biases that may result in inequity among providers, make patients with certain conditions financially undesirable, or make particular services unusually profitable. Finally, we also make recommendations to improve program integrity.

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

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

These update recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of the relatively efficient provider not only help create fiscal pressure on providers to control their costs but also help create pressure for broader reforms to address what has traditionally been the fundamental problem of FFS payment systems—that providers are paid more when they deliver more services regardless of the quality or value of those additional services. Broader reforms such as bundled payments and ACOs are meant to stimulate delivery system reform—that is, the development of more integrated and value-oriented health care systems.

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment rate on the rate in the most efficient clinically appropriate setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting. In 2012, the Commission recommended that payments for evaluation and management (E&M) office visits in the hospital outpatient and physician office settings be made equal. In this report, we extend that principle to specific services that meet the Commission’s criteria for which payment rates in the hospital outpatient prospective payment system (PPS) should be lowered to better match payment rates in the physician office setting. We also recommend consistent payment between acute care hospitals and long-term care hospitals (LTCHs) for certain types of patients. The Commission will continue to study other services that are provided in multiple settings to find additional services for which the principle of the same payment for the same service can be applied.

Hospital inpatient and outpatient services

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

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

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

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

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

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

In an effort to move toward paying the same rate for the same service across different settings, we recommend aligning the payment rates in hospital outpatient departments (HOPDs) for certain services that meet the Commission’s criteria with the rates paid in freestanding physician offices. Under current policy, Medicare usually pays more for services in HOPDs—often more than double—even when those services are frequently performed in physicians’ offices. This payment difference creates a financial incentive for hospitals to purchase

freestanding physicians’ offices and convert them to HOPDs without changing their location or patient mix. For example, from 2010 to 2012, we saw a 33 percent increase in echocardiograms in HOPDs and a 10 percent decline in echocardiograms in physicians’ offices, with a resulting increase in both beneficiary cost sharing and program spending. To remove this distortion in the payment system, the Commission recommends aligning payment rates between HOPDs and physician offices for specific services that meet the Commission’s criteria. This alignment will reduce Medicare program spending, reduce beneficiary cost sharing, and create an incentive to care for patients in the most efficient setting appropriate for their condition.

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

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

Physician and other health professional services

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

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

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

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

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

for Medicare's payments relative to providers' costs. Medicare's payments for fee schedule services relative to private insurer payments have remained constant at about 80 percent.

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

Ambulatory surgical center services

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

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

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

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

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

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

Outpatient dialysis services

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

In Chapter 6, we find that payment adequacy indicators for outpatient dialysis services are generally positive:

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis beneficiaries. Between 2010 and 2012, the number of FFS dialysis beneficiaries and dialysis treatments grew at similar rates (2 percent and 3 percent, respectively). At the same time, the per treatment use of most dialysis injectable drugs, including erythropoietin-stimulating agents (ESAs) that are used in anemia management, substantially declined. The new dialysis PPS created an incentive

for providers to be more judicious about their provision of dialysis drugs. In addition, in 2011, the Food and Drug Administration recommended more conservative ESA dosing.

- We looked at changes in quality indicators under the new PPS from 2010 through June 2013. Rates of mortality and emergency department use remained relatively constant while rates of hospitalization declined. With regard to anemia management, average hemoglobin levels declined. Under the new PPS, use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 8 percent of beneficiaries to 10 percent.
- Information from investment analysts suggests that access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.
- Under the new PPS, cost per treatment increased by 2 percent from 2011 to 2012, while Medicare payment per treatment increased by 2.3 percent. We estimate that the aggregate Medicare margin was 3.9 percent in 2012 and project that the aggregate Medicare margin will be 2.9 percent in 2014.

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

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

Post-acute care providers: Steps toward broad payment reforms

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

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

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

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

Skilled nursing facility services

SNFs furnish short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2012, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million FFS beneficiaries

during 2.4 million stays. Medicare FFS spending on SNF services was \$28.7 billion in 2012.

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

- Access to SNF services remains stable for most beneficiaries. The number of SNFs participating in the Medicare program was stable between 2011 and 2012. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly. The median occupancy rate was 87 percent, indicating some excess capacity for admissions. Days and admissions per FFS beneficiary declined between 2011 and 2012, reflecting declines in inpatient hospital admissions (a prerequisite for Medicare coverage).
- The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, readmission to a hospital for potentially avoidable conditions during a beneficiary's SNF stay, and readmission to a hospital within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. This year we also report on a measure of change in beneficiaries' functional status during their SNF stay. We found essentially no improvement on this measure between 2011 and 2012.
- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Capital will continue to be available in 2014, though uncertainties surrounding the federal budget continue to make some lenders wary. This reluctance is not a statement about the adequacy of Medicare's payments to SNFs.
- In 2012, the Medicare margin was 13.8 percent, down from 21.2 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were a result of unwarranted overpayments generated by the industry's response to Medicare policy changes. For the 13th consecutive year, Medicare margins were above 10 percent. Margins continue to vary greatly across facilities, depending on the share of intensive therapy days, facility size, and cost per day. The

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

In 2012, the Commission recommended first restructuring the SNF payment system and then rebasing payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF PPS; during the year of revision, payment rates were to be held constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics, not services provided. Second, payments for nontherapy ancillary services (such as drugs) should be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy should be added to the PPS. After the PPS is revised, in the following year, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

This multiyear recommendation to revise the PPS in the first year and rebase payments the next year was based on several facts: (1) high and sustained Medicare margins; (2) widely varying costs unrelated to case mix and wages; (3) cost growth well above the change in input prices in most years over the past decade, reflecting little fiscal pressure from the Medicare program; (4) the ability of many SNFs (almost 900) to have consistently relatively low costs and relatively high quality of care; (5) the continued ability of the industry to maintain high margins despite changing policies; and (6) in many cases, Medicare Advantage payments to SNFs are considerably lower than the program's FFS payments, suggesting that some facilities are willing to accept rates much lower than FFS payments to treat beneficiaries.

No policy changes have been made that would materially affect these findings. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the

Congress to direct the Secretary, as soon as practicable, to revise the PPS and begin a process of rebasing payments.

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare (private pay and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities decreased slightly between 2012 and 2013. In 2012, the average non-Medicare margin was -2 percent. The average total margin, reflecting all payers and all lines of business, was 1.8 percent.

Home health care services

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

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

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

care settings. According to capital market analysts, the major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, although terms were not as favorable as in prior years. The significant number of new agencies in 2012 suggests that even small agencies had access to the capital necessary for start-up.

- For over a decade, payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins for freestanding agencies averaged 14.4 percent in 2012 and 17.5 percent from 2001 through 2011. Two factors have contributed to payments exceeding costs: Fewer visits have been delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care. We project the aggregate Medicare margin for home health agencies in 2014 to be 12.6 percent.

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

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

Inpatient rehabilitation facility services

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

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

- Our measures of access to care suggest that beneficiaries generally maintained access to IRF services in 2012. The number of cases increased slightly, by about 0.5 percent in 2012. Although the number of unique patients per 10,000 FFS beneficiaries decreased slightly from 2011 to 2012, the number has remained relatively stable over recent years, suggesting relative stability in IRF use. The supply of IRFs nationwide was almost unchanged in 2012, a shift from declines in previous years. The total number of freestanding facilities continued to increase slightly, while the number of hospital-based facilities decreased slightly. Occupancy rates decreased slightly for both facility types to 62.8 percent overall. IRFs are not the sole providers of rehabilitation services in communities; skilled nursing facilities and home health agencies are both potential alternatives for beneficiaries with rehabilitation needs. The overall growth in the number of IRFs, low occupancy rates, and availability of rehabilitation alternatives suggest that capacity remains adequate to meet demand.
- Quality of care measures show improvement in recent years. From 2010 to 2012, Functional Independence Measure™ gain increased by an average of 3 percent each year. Rates of discharge to the community grew by an average of 0.5 percent each year, while rates of discharge to an acute care hospital declined by an average of 2.7 percent each year. These outcomes do not control for changes in case mix over time. Despite a small increase in case-mix severity, quality outcomes improved.
- One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF Medicare revenues and 22 percent of revenues for the entire IRF industry has very good access to capital. We were

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

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

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

Long-term care hospital services

LTCHs furnish care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals (ACHs), and its Medicare patients must have an average length of stay greater than 25 days. In 2012, Medicare spent \$5.5 billion on care provided in 420 LTCHs nationwide. About 124,000 beneficiaries had more than 140,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

In Chapter 11, we find that our indicators of payment adequacy are positive.

- Trends suggest that access to care has been maintained. Growth in the number of LTCHs slowed considerably during the five-year moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments. In the last year of the moratorium (2012), the number of LTCHs rose from 417 to 420, while the number of LTCH beds increased 0.5 percent. From 2011 to 2012, the number of beneficiaries who had LTCH stays increased by 0.7 percent. Controlling for the growth in the number of FFS beneficiaries, we found that the number of LTCH cases declined 1 percent between 2011 and 2012. This reduction in per capita admissions is consistent with (though smaller than) the reduction seen in other settings.
- LTCHs only recently began submitting quality of care data to CMS. Those data are not yet available for analysis. However, using claims data without

adjustment for case mix, we found stable or declining rates of readmission, of death in the LTCH, and of death within 30 days of discharge for almost all of the top 25 diagnoses in 2012.

- For the past few years, the availability of capital to LTCHs has reflected uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The moratorium has reduced opportunities for expansion and the need for capital. With the expiration of the moratorium at the end of 2012, LTCH companies appear to be acting with caution, likely because of the continued scrutiny of Medicare spending on LTCH care.
- Since 2007, LTCHs have held cost growth below the rate of increase in input prices. Between 2011 and 2012, Medicare payments continued to increase faster than provider costs, resulting in an aggregate 2012 Medicare margin of 7.1 percent. We project an aggregate Medicare margin of 6.5 percent in 2014.

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

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

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

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries must elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2012, more than 1.27 million Medicare beneficiaries received hospice services from over 3,700 providers, and Medicare expenditures totaled about \$15.1 billion.

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

- Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2012, hospice use increased across all demographic and beneficiary groups examined. However, hospice use rates remained lower for racial and ethnic minorities than for Whites. The supply of hospices increased nearly 4 percent in 2012, due almost entirely to growth in the number of for-profit hospices. The increase in 2012 continues a more than decade-long trend of substantial market entry by for-profit

providers. The proportion of beneficiaries using hospice services at the end of life continues to grow, and average length of stay increased in 2012. In 2012, 46.7 percent of Medicare beneficiaries who died that year used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000. Average length of stay among decedents, which increased between 2000 and 2011 from 54 days to 86 days, grew to 88 days in 2012. The median length of stay for hospice decedents was 18 days in 2012 and has remained stable at approximately 17 or 18 days since 2000.

- At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. The Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014. Beginning in 2013, hospices must report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Initially, two limited quality measures were adopted. Beginning in July 2014, seven new quality measures will be collected by means of a standardized data collection instrument. In 2015, a hospice experience-of-care survey for bereaved family members will be implemented. CMS has indicated that public reporting of quality information is unlikely before 2017.
- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 6.9 percent increase in 2012) suggests that access to capital is adequate for these providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited. Hospital-based and home health-based hospices have access to capital through their parent providers.
- The aggregate 2011 Medicare margin was 8.7 percent in 2011, up from 7.4 percent in 2010. The projected margin for 2014 is 7.8 percent. The margin estimates exclude nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 percentage points and 0.3 percentage point, respectively). Margins also do not include any adjustment for the higher indirect costs observed among hospital-based and home health-based hospices (which, if such an adjustment were made,

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

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

The Medicare Advantage program: Status report

Each year, the Commission provides a status report on the MA program. In 2013, the MA program included more than 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about \$146 billion. In Chapter 13, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide an update on current quality indicators in MA. We make two recommendations, one on employer group plans and one on including hospice in the MA benefit.

- In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries. Enrollment in HMO plans—the largest plan type—increased 10 percent to nearly 10 million enrollees. Local preferred provider organizations (PPOs) grew about 11 percent, to 3.3 million enrollees, and regional PPOs grew about 16 percent, to 1.1 million enrollees. The MA plan bids project an increase in overall enrollment for 2014 of 3 percent to 5 percent, primarily in HMOs and local PPOs.
- In 2014, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to at least one network-based coordinated care plan (CCP), which includes HMOs and PPOs. Eighty-four percent of beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). Beneficiaries are able to choose from an average of 10 MA plan options, including 8 CCPs.
- We estimate that 2014 MA benchmarks, bids, and payments (including quality bonuses) will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively. Bids and payments relative to FFS remained about the same in 2014 as they were in 2013.

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

The MA program gives Medicare beneficiaries the option to receive benefits from private plans rather than from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans, because they are paid a capitated rate rather than on an FFS basis, have greater incentives to innovate and use care management techniques.

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

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

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

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

Status report on Part D

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

- In 2013, about 68 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 6 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. Among 35 million Part D plan enrollees, 11.2 million individuals received the low-income subsidy (LIS). In 2011, the most recent year for which data are available, 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier, on average. More than half of those without Part D coverage reported they did not take enough medications to need such coverage.
- Although surveys suggest high satisfaction with Part D among enrollees, about 6 percent reported having trouble obtaining needed medications. We examined available data on Part D's exceptions and

appeals process but found insufficient data to evaluate its effectiveness. We also found that the process is complex and burdensome for many individuals. Our review suggests a need for additional data on the outcomes of the exceptions and appeals process and a need for a more transparent and streamlined process.

- In 2013, about 64 percent of Part D enrollees were in stand-alone prescription drug plans (PDPs) and the rest in Medicare Advantage–Prescription Drug plans (MA–PDs). Premiums averaged about \$30 across all plans.
- The number of plan offerings remained stable between 2013 and 2014, with a modest increase in PDP offerings and slightly fewer MA–PDs. Beneficiaries will continue to have between 28 and 39 PDPs to choose from in their region, depending on where they live, along with many MA–PDs. In 2014, a total of 1,169 PDPs are offered nationwide along with 1,615 MA–PDs. MA–PDs continue to be more likely than PDPs to offer enhanced benefits that include some coverage in the gap—the period between when Part D's initial coverage ends and when the enrollee meets the out-of-pocket threshold to enter the catastrophic phase of the benefit. For 2014, more premium-free PDPs will be available to enrollees who receive the LIS; 352 plans qualified compared with 331 in 2013.
- Between 2007 and 2012, Medicare's Part D spending increased from \$46.7 billion to \$62.5 billion (about 6 percent annual growth on average). In 2012, LIS payments continued to be the single largest component of Part D spending, while Medicare's reinsurance payments continued to be the fastest growing component, growing at an average annual rate of 14 percent between 2007 and 2012. Aggregate Part D payments to plans continued to grow at a faster rate than the growth in Part D enrollment. The "excess" growth in payments appears to be driven in large part by the growth in the average price of drugs filled, particularly among enrollees receiving the LIS.
- The average costs for basic Part D benefits are expected to grow by 4 percent between 2013 and 2014, but plan sponsors are expecting significant changes in costs for individual components: a decrease of over 10 percent for the direct subsidy and an increase of about 20 percent for the reinsurance component.

An increasing number of plans are adding a nonpreferred generic tier with substantially higher cost-sharing amounts relative to the preferred generic tier. In addition, we are seeing a trend toward the use of tiered network pharmacies that lower cost sharing if one fills medications at a designated preferred pharmacy. In 2014, over 70 percent of all PDPs have tiered pharmacy networks. Both of these strategies provide financial incentives for enrollees to use a lower cost drug (or setting), potentially reducing program costs. However, the use of such financial incentives, while potentially lowering plans' costs of providing the basic benefit, could increase Medicare's spending for the LIS

because those beneficiaries do not pay cost sharing and thus have no incentive to use drugs on preferred tiers or preferred pharmacies.

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

CHAPTER

1

**Context for Medicare
payment policy**

Context for Medicare payment policy

Chapter summary

Medicare payment policies must be considered in the broader context of the nation's health care system—including spending, delivery of care, access to and use of services—and pressure on federal and state budgets. Health care has accounted for a large and growing share of economic activity in the United States, nearly doubling as a share of gross domestic product (GDP) in the period between 1980 and 2012, from 8.9 percent to 17.2 percent. Growth in spending has slowed somewhat in recent years, dropping below growth in GDP in 2011 and 2012. Although the causes of this slowdown are debated, the decade-long period of slow economic growth from 2000 to 2011, decline in real incomes, and shift to less generous insurance coverage have all likely had an effect on the growth in health care spending.

The level of and growth in health care spending significantly affect federal and state budgets since public spending on health care accounts for nearly half of all health care spending. If this spending continues to consume an increasing share of federal and state budgets, spending for other public priorities—like education and investment in infrastructure and scientific research—will be crowded out, and the federal government will have less flexibility to support states because of its own debt and deficit burdens. Social Security, Medicare, Medicaid, other health insurance programs, and net interest will account for about 14 percent of GDP in 10 years, whereas total federal revenues have averaged a little over 17 percent of GDP over the past 40 years.

In this chapter

- Growth in health care spending
- Growth in Medicare spending
- The impact of health care spending on federal and state budgets
- Changes in the Medicare-eligible population
- Effects of growth in health care spending on individuals and families
- Patterns in health care spending that suggest inefficiencies
- Conclusion

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

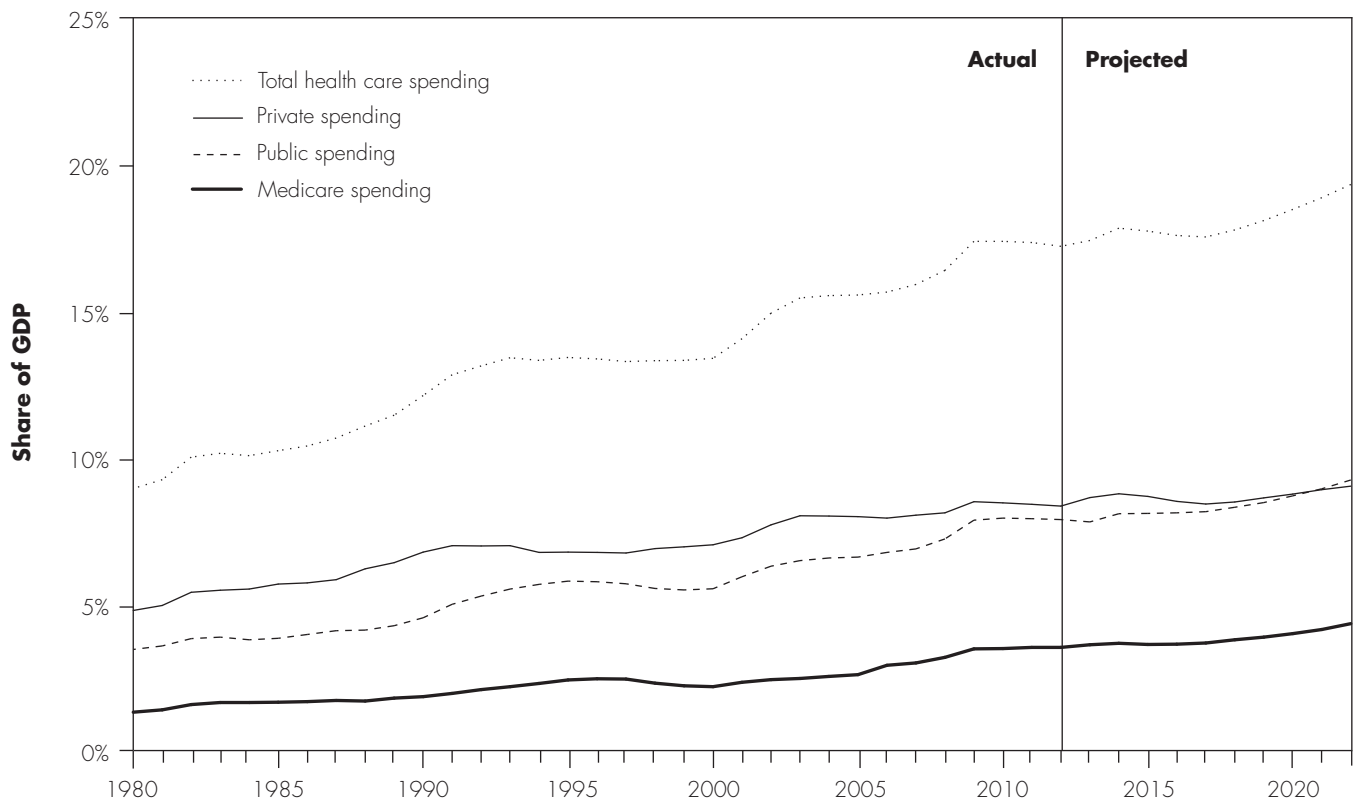
Medicare spending per beneficiary over the next 10 years is projected to grow at a slower rate than in the past 10 years (3.3 percent annually compared with 6.1 percent annually). The lower projections for growth in spending per beneficiary are due in part to reduced updates of fee-for-service Medicare and lower payments to managed care plans and in part to the recent slowdown in use of services. At the same time, the number of Medicare beneficiaries will grow notably faster as the baby-boom generation ages into the program (about 3 percent annually compared with about 2 percent annually in the past). Despite the slower growth rate in spending per beneficiary projections, total Medicare spending will continue to increase because of the sustained increase in the number of Medicare beneficiaries. As a result, the program still faces substantial deficits over the long term, and the Hospital Insurance Trust Fund is projected to be exhausted by 2026.

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

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

FIGURE 1-1

Health care spending has risen as a share of GDP



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. Medicare spending reflects current law, which includes the sustainable growth rate.

Source: MedPAC analysis of the 2012 version of the National Health Expenditures released in January 2014 and National Health Expenditure Projections 2012–2022 released in September 2013 by the Centers for Medicare & Medicaid Services Office of the Actuary. Historical GDP data is from the Bureau of Economic Analysis (BEA) downloaded in December 2013. Those data reflect BEA’s upward revisions of GDP estimates first released in July 2013. Projected GDP data are from the Congressional Budget Office (CBO) report *The 2013 Long-Term Budget Outlook* released September 2013. CBO’s projected GDP data also reflect BEA’s upward revisions.

Introduction

The following topics provide important context for the Medicare payment policies discussed in the other chapters of this report:

- the growth in health care spending and the main drivers of that growth,
- Medicare’s role in and effect on the whole of the federal budget and how growth in health care spending affects current and future federal and state budgets,
- changes in the Medicare-eligible population,
- the effect of growth in health care spending on individuals and families, and

- variation in health care spending and quality of care, indicators that suggest health care dollars may be substantially misspent or misallocated.

Taken together, these points about the levels and growth of health care spending undergird the Commission’s payment update recommendations and its call for payment reforms.

Growth in health care spending

Total health care spending consumes an increasing proportion of national economic resources, accounting for a double-digit share of gross domestic product (GDP) annually since 1982 (Figure 1-1). As a share of GDP, total

The level of health care spending and factors that influence spending growth

Factors that influence health care spending trends include technology, prices, changes in provider and insurer market power, health insurance, and changes in demographics and patient characteristics (particularly in income and wealth). Interactions among factors add an additional layer of complexity to attributing causes of spending levels, growth, and slowdowns. Since the baseline for growth is built from the level of health care spending, we include it in the discussion of some of the growth factors.

- Technology is credited as having the largest single effect on growth in health care spending (ranging across studies from 38 percent to more than 65 percent of spending growth attributed to technology) (Cutler 1995, Newhouse 1992, Smith et al. 2009). In most studies, analysts have not directly measured technology's effect on health care spending because it is difficult to do so. Instead, they have estimated the contributions of other measurable demographic and economic factors on health care spending 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. Technology can include not only new procedures and treatments but also old procedures
- and treatments applied to a different population or for a different purpose from what was originally intended (Ginsburg 2008). Some new technologies such as the application of procedures and treatments that are not proven for a given purpose and interventions that are not proven for a specific contingent of patients could increase spending growth without producing better health outcomes (Baicker and Chandra 2011, Garber et al. 2007, Redberg 2011, Welch 2012).
- Both the level and growth of prices for health care products and services have a major effect on health spending. Prices are higher in the United States than they are in other developed countries, without correspondingly higher quality or outcomes (Anderson et al. 2005, Anderson et al. 2003, Anderson and Squires 2010, Laugesen and Glied 2011). Prices vary across geographic areas, payers, and providers and are rarely transparent; however, studies consistently cite growth in prices (between 10 percent and 25 percent) as a leading cause of health spending growth (Coakley 2011, Health Care Cost Institute 2012a, Health Care Cost Institute 2012b, Laugesen and Glied 2011).
- Provider market power and insurer market power also have major effects on prices and therefore

(continued next page)

health care spending increased from about 9 percent in 1980 to a little over 17 percent in 2009 and has remained at about that share through 2012.¹ It is projected to rise to about 19 percent of GDP by 2022.² Why health care spending has increased at a faster rate than GDP is not well understood. Some analysts conclude that the factor with the greatest impact on spending growth is the advancement of medical technology (Chernew and Newhouse 2012). From this point of view, the term *technology* is interpreted broadly to mean any factor that influences spending growth but cannot be measured (see text box for a discussion).

In 2012, public spending made up 49 percent of total health care spending and private spending made up 51

percent.³ In 2021, public spending is projected to begin to exceed private spending as Medicare enrollment accelerates with the aging of the baby-boom population (individuals born between 1946 and 1964), enrollment in Medicaid expands, and subsidies for coverage purchased in the new health insurance exchanges are provided under provisions of the Patient Protection and Affordable Care Act of 2010 (PPACA).⁴ Medicare spending has also grown as a share of the economy from a little over 1 percent of GDP in 1980 to 3.5 percent in 2011. By 2022, Medicare is projected to total 4.3 percent of GDP.

National health care spending

In 2012, total U.S. health care spending reached \$2.8 trillion, or \$8,915 per person (Martin et al. 2014, Office of

The level of health care spending and factors that influence spending growth (cont.)

health care spending. Hospitals, physician groups, and health insurers alike are increasingly consolidating (Berenson et al. 2012, Cutler and Scott Morton 2013, Robinson 2004). One reason providers merge is to gain market power over insurers to negotiate higher payment rates (Berenson et al. 2012, Berenson et al. 2010, Coakley 2010). (Increased efficiency is another reason cited to explain why providers merge, although studies have not shown a strong link between the two.) Studies have found that hospital prices increased by 5 percent or more as a result of consolidation, and at the same time, quality of care declined (see Gaynor and Town (2012) and Vogt and Town (2006) for syntheses of the research). However, in the presence of provider consolidation, insurance market concentration can decrease health care spending because providers may have less leverage in negotiating prices where insurers are dominant (Moriya et al. 2010, Trish and Herring 2013).

- Health insurance coverage—while increasing access to health care and protecting beneficiaries against the risk of financial hardship when they need expensive health 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, the shifting of health care costs to insurers has slowed due to rising coinsurance, copayments, and deductibles, likely contributing to the recent slowing of the growth in health care spending (Kaiser Family Foundation and Health Research and Education Trust 2013).

- Demographics and patient characteristics (especially income and wealth) also affect spending growth. People who have more expendable income and wealth will use more of it on health care services (Newhouse 1992). National income growth, in tandem with expanding insurance coverage, can drive investment and changes in health technologies (Smith et al. 2009). Changes in the age and health status of a population also affect changes in health care spending. ■

the Actuary 2014). The bulk of that spending—accounting for about 85 percent of spending in the health care sector at \$2.4 trillion—was for personal health care spending. That category includes spending for all medical goods and services that are provided for the treatment of an individual. The remaining expenditures are for broad categories of spending that support the provision of health care, including the administrative costs of private and public insurers; the spending by public health departments; and investments in medical research, equipment, and structures.

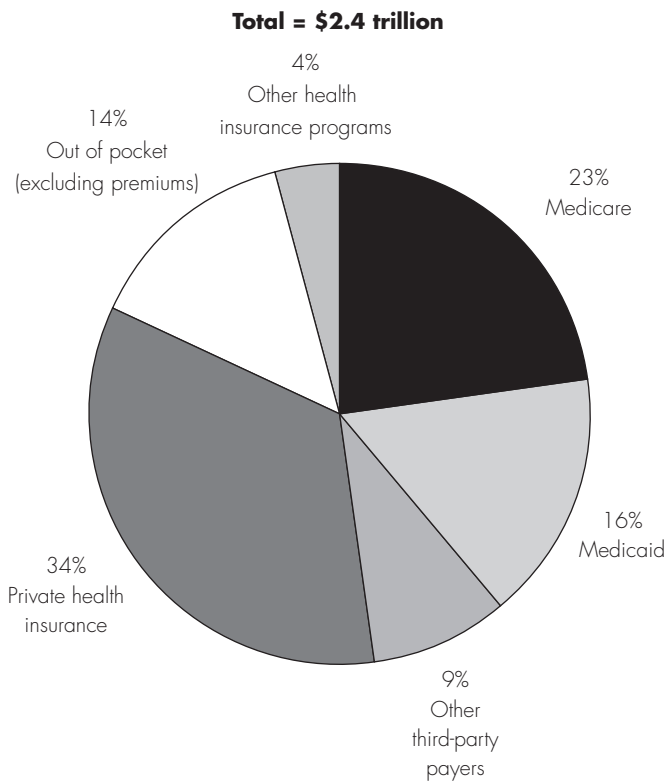
The largest share of personal health care spending for all payers was for hospital care (\$882 billion, or 37 percent) and physician and clinical services (\$565 billion, or 24 percent). A smaller share went to spending on prescription

drugs (\$263 billion, or 11 percent), nursing home care (\$152 billion, or 6 percent), and home health services (\$78 billion, or 3 percent) (Office of the Actuary 2014).

Medicare is the largest single purchaser of health care in the United States. Of the \$2.4 trillion spent on personal health care in 2012, Medicare accounted for 23 percent, or \$538 billion, and covered 49.7 million enrollees.⁵ Medicaid—a program financed by the federal and state governments that pays for health care services for low-income people—accounted for 16 percent of spending and had an average monthly enrollment of about 56 million people.⁶ Thirty-four percent of spending was financed through private health insurance payers covering 188 million people.⁷ Individuals contributed 14 percent in the form of out-of-pocket spending; in addition, they made

FIGURE 1-2

Medicare is the largest single purchaser of personal health care, 2012



Note: Personal health care is a subset of national health expenditures. It includes spending for all medical goods and services that are provided for the treatment of an individual and excludes other spending, such as government administration, the net cost of health insurance, public health, and investment. 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 share of out-of-pocket category. Other health insurance programs include the Children's Health Insurance Program, Department of Defense, and Department of Veterans' Affairs. Other third-party payers include worksite health care, other private revenues, Indian Health Service, workers' compensation, general assistance, maternal and child health, vocational rehabilitation, other federal programs, Substance Abuse and Mental Health Services Administration, other state and local programs, and school health.

Source: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Accounts, "Table 6 Personal Health Care Expenditures; Levels, Percent Change and Percent Distribution, by Source of Funds: Selected Calendar Years 1970-2012," released January 2014.

premium contributions that are included in the totals for Medicare and private health insurance spending (Figure 1-2).

Recent slowdown in health care spending

Historically, growth in health care spending has outpaced GDP growth (Figure 1-1, p. 5). In recent years, however,

national health expenditure data have shown a significant slowdown in health care spending, with growth in health care spending dropping below the growth in GDP in 2011 and 2012.⁸ From 2009 to 2012, spending grew an average of 3.7 percent per year. In contrast, from 1980 to 2012, spending grew an average of 7.8 percent per year. The slower growth rate in recent years led to a slight decrease in health care spending as a share of GDP, declining from 17.4 percent in 2009 to 17.2 percent in 2012.

Many analysts attribute the slowdown to the economic recession of 2007 to 2009 (the Great Recession) and the slow recovery in its aftermath (Cuckler et al. 2013, Fuchs 2013, Hartman et al. 2013, Kaiser Family Foundation 2013, Keehan et al. 2012, Martin et al. 2014). Under that view, health care spending growth is expected to rebound as the economy recovers, and health care spending will once again consume an ever-increasing share of economic output.

The Office of the Actuary (OACT) in CMS shares that viewpoint and attributes the slowdown to the rise in unemployment and decline in income, assets, and private health insurance coverage during the economic downturn (Hartman et al. 2013). Examining data over the last 45 to 60 years, analysts at OACT and elsewhere have found that sharp increases (and decreases) in economic output have been accompanied by similar movements in health care spending (Centers for Medicare & Medicaid Services 2013, Fuchs 2013, Kaiser Family Foundation 2013). Once economic conditions improve significantly, OACT expects health care spending growth to accelerate (Cuckler et al. 2013).

Alternatively, a second point of view attributes the slowdown to more permanent changes in health care markets and concludes that the slower growth rates may persist—somewhat alleviating budget pressure on federal and state governments, third-party payers, and individuals (Cutler and Sahni 2013, Ryu et al. 2013). That viewpoint is supported by studies that found the slowdown was too large to be explained by the recession and even predated the recession by a couple of years (Cutler and Sahni 2013, Roehrig et al. 2012, Ryu et al. 2013). The authors conclude that the slowdown was caused by structural changes in the health care system such as the slowed rate of introduction of new medical technology and, therefore, may persist after the economy fully recovers.

Finally, a third point of view maintains there are three reasons for the spending slowdown in addition to the Great Recession (Holahan and McMorro 2013):

- The decade-long period of slow economic growth from 2000 to 2011. The economy was in a recession in the early part of the decade and recovered somewhat in the middle before the Great Recession began at the end of 2007. Over the decade, real median household income declined about 10 percent.
- A shift away from employer-sponsored coverage. The proportion of the population with employer-sponsored insurance (ESI) declined 10.9 percentage points, while the Medicaid proportion increased 6.6 percentage points and the proportion of those who were uninsured increased 3.2 percentage points. Medicaid and the uninsured typically pay hospitals and physicians significantly less than ESI. The authors conclude that the real income declines and the shift to less generous coverage slowed the growth in provider revenue. Providers responded by cutting costs, which further reduced spending growth.
- A variety of structural changes contributed to slower spending growth, including payment rate cuts in Medicare, growth in beneficiary cost sharing, and state efforts to contain Medicaid costs. However, they argue that it was the decade-long period of slow economic growth, decline in real incomes, and a shift toward less generous insurance coverage that caused those structural changes.

What do those viewpoints mean for the future? If economic trends caused the slowdown, will growth in health care spending pick up as the economy recovers? If, instead, the slowdown is due to structural changes in health care markets, will growth in health care spending continue to be modest? The Commission maintains that past trends will not necessarily carry into the future—regardless of whether or not they were caused by economic fluctuations or by structural changes. As an example, in the mid-1990s, health care spending slowed dramatically, in part due to 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.

Furthermore, even if the growth rate of health care spending has slowed, there is agreement that it will still outpace the growth rate of GDP. In response to the slowdown, the Congressional Budget Office (CBO) has

substantially reduced its projections of federal health care spending for the coming decade, but federal spending is still projected to grow more than 2 percentage points faster than the growth rate of GDP (Congressional Budget Office 2013a). OACT estimates that national health spending will grow 1 percentage point faster over the next decade, and an analysis by researchers at Harvard and Dartmouth predicts that it will grow 1.2 percentage points faster over the next couple of decades (Chandra et al. 2013, Cuckler et al. 2013). While those projections are lower than the historical rate—since 1960, national health spending has grown at 2.6 percentage points above the growth rate of GDP—they are still on track to substantially impact the U.S. government, states, employers, individuals, and families.

Finally, studies have found that a significant share of health care spending in the United States is wasteful; even if the growth rate of health care spending slows, much can be done to improve quality of care while lowering cost per beneficiary (Berwick and Hackbarth 2012, Institute of Medicine 2012). The Commission maintains that future trends depend, in large part, on policy decisions made today. Accordingly, the Commission will continue to work on efforts to encourage efficient use of resources and promote coordinated, high-quality health care.

Growth in Medicare spending

Like overall health care spending, the growth in Medicare spending per beneficiary also slowed in the last few years. From 2010 to 2012, Medicare spending per beneficiary grew an average of 1.6 percent per year, or at roughly 2 percentage points below the growth rate of per capita GDP. Historically, however, Medicare spending per beneficiary has grown at roughly 2 or 3 percentage points above the growth rate of per capita GDP. The recent slowdown has been due to both modest payment rate increases and low utilization growth for some sectors (see text box, p. 10, for a description of 2012 program spending and funding).

Despite the overall slowdown, some sectors experienced robust growth. From 2010 to 2011, per beneficiary spending on hospital outpatient services grew 6.3 percent and per capita spending on physician-administered drugs grew 11.4 percent. Moreover, Medicare spending overall continues to grow faster than the growth rate of GDP as

Medicare program spending and funding

Medicare's spending covers acute and post-acute care, ambulatory care, and prescription drugs (Table 1-1). The Medicare program is funded by premiums and cost sharing, payroll taxes, general revenue, and other sources (Table 1-2). General revenue transferred to Medicare accounts for 40 percent of Medicare's revenue (and represents about 16 percent of all income taxes collected by the government) (Congressional Budget Office 2013b).

- **Part A is Medicare's Hospital Insurance benefit**, which covers hospitalizations and post-acute care. Part A is financed through a 2.9 percent payroll tax split between employers and employees and, since 2013, an additional 0.9 percent payroll tax on wages over \$200,000 for single filers and \$250,000 for married filers.
- **Part B is a part of Medicare's Supplementary Medical Insurance benefit**, which covers outpatient hospital services and ambulatory care as well as home health care under certain circumstances. Part B is financed primarily through

TABLE 1-1 Medicare program spending, 2012

	Dollars (in billions)	Percent
Total	\$574	100.0%
Inpatient hospital	140	24.4
Outpatient hospital	39	6.8
Skilled nursing facilities	28	4.9
Home health	19	3.3
Physician fee schedule*	70	12.2
Medicare Advantage	136	23.7
Prescription drugs	67	11.7
Hospice	15	2.6
Other**	52	9.1
Administration	8	1.4

Note: Individual amounts may not sum to total due to rounding.
 *Services provided by advanced practice nurses and physician assistants accounted for 3.2 percent of physician fee schedule spending in 2012.
 **"Other" includes items such as physician-administered drugs and durable medical equipment.

Source: 2013 annual report of the Boards of Trustees of the Medicare trust funds.

TABLE 1-2 Sources of Medicare revenue, 2012

	Dollars (in billions)	Percent
Total	\$537	100.0%
Payroll taxes	206	38.4
Interest from Hospital Insurance Trust Fund	13	2.4
Taxation of Social Security benefits	19	3.5
Premiums	70	13.0
General revenue	214	39.9
Transfers from states*	8	1.5
Other**	7	1.3

Note: **"Transfers from states" (often called the Part D "clawback") refers to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending.
 ***"Other" includes items such as fees on manufacturers of brand drugs and transfers from the fraud and abuse control program and the Railroad Retirement program.

Source: 2013 annual report of the Boards of Trustees of the Medicare trust funds.

beneficiary premiums and general revenue. Since 2011, Medicare also collects a fee from pharmaceutical manufacturers to fund Part B.

- **Part C is the Medicare Advantage (MA) program**, which contracts with private plans to offer Part A and Part B services. The MA program is funded through beneficiary premiums and transfers from Part A and Part B.
- **Part D is a part of Medicare's Supplementary Medical Insurance benefit**, which covers outpatient pharmaceuticals and is financed through beneficiary premiums, general revenue, and payments from the states. States make payments to Medicare since Medicare assumed primary responsibility for prescription drug benefits for enrollees who have both Medicare and Medicaid.

Nearly all parts of Medicare have some beneficiary cost sharing through deductibles and coinsurance. The Medicare program does not have a catastrophic limit on cost sharing other than a partial limit in Part D in which cost sharing is significantly reduced after total out-of-pocket expenditures reach a catastrophic threshold. ■

**TABLE
1-3**

Spending, use, and price trends for people enrolled in employer-sponsored health insurance and FFS Medicare

Percent change from 2010 to 2011¹

	Employer-sponsored health insurance			FFS Medicare		
	Spending per insured	Services per insured	Price per service	Spending per FFS beneficiary	Services per FFS beneficiary	Price per service
All categories	4.6%			1.0%		
Inpatient hospital ^{2,3}	4.9	-0.6%	5.5%	-1.0	-1.3%	0.7%
Medical		-1.2			-0.5	
Surgical		-4.2			-3.8	
Outpatient visits and services ^{2,4}	6.9	1.9	4.9	6.3	4.4	1.8
Emergency room		3.7			2.4	
Observation		3.2			5.3	
Outpatient surgery ⁵		-0.2			0.2	
Professional services ^{2,6}	3.8	1.2	2.6	3.1	0.8	2.3
Office and home visits	5.2	1.2	3.9	5.7	0.6	5.1
Radiology	-2.4	-3.8	1.5	0.5	0.6	-0.1
Prescription drugs ^{2,7}	1.0 ⁸	-0.2	1.2 ⁸	3.4 ⁸	2.3	1.7 ⁸

Note: FFS (fee-for-service).

¹ Results for other or longer time periods may differ from the results examined here.

² The estimates for inpatient hospital, outpatient visits and services, and professional services include other subcategories not shown.

³ For inpatient hospital, services per beneficiary are measured as admissions per beneficiary.

⁴ Outpatient services include radiology, lab/pathology, and other services such as physical therapy and audiology services provided in an outpatient setting.

⁵ Outpatient surgery does not include surgeries furnished at ambulatory surgical centers.

⁶ Professional services exclude physician-administered drugs.

⁷ Services per beneficiary are measured as prescriptions per beneficiary. For Medicare, this category includes only prescriptions provided under Part D. Not every FFS beneficiary enrolls in a Part D prescription drug plan. In 2010 and 2011, a little over half were enrolled. Those who are not enrolled may be receiving prescription drug benefits from a former employer.

⁸ Both employer-sponsored health insurance and FFS Medicare rely on private insurers to administer drug benefits. Private insurers negotiate drug prices with pharmacies and rebates with drug manufacturers. Also, for FFS Medicare, the Patient Protection and Affordable Care Act of 2010 required drug manufacturers to offer a 50 percent discount on brand drugs and a 7 percent discount on generic drugs filled in the coverage gap in 2011. (The coverage gap is a temporary gap in coverage after a beneficiary's total spending exceeds a certain threshold but is below a catastrophic threshold.) The spending and price growth estimates are for total spending (including beneficiary cost sharing) and do not reflect any rebates or discounts.

Source: Health Care Cost Institute 2012. *Health Care Cost and Utilization Report: 2011*. MedPAC analysis of claims data for 100 percent of Medicare FFS beneficiaries.

enrollment increases at a faster rate than in the past due to the aging of the baby-boom population.

Fee-for-service Medicare and private health insurers: A comparison of trends for spending, use, and price

An analysis of private-sector claims data shows that between 2010 and 2011 per capita spending for the privately insured grew faster than per capita spending for Medicare beneficiaries in the traditional fee-for-service (FFS) program. The Health Care Cost Institute (HCCI), which examined health care spending for people younger

than 65 covered by employer-sponsored private health insurance, found that from 2010 to 2011, per capita spending by private insurers increased by 4.6 percent; by comparison, Medicare spending during this period rose 1 percent for FFS Medicare. (Results for other or longer time periods may differ from the results examined here.)

HCCI also broke down the percentage change in per capita spending for private insurers into changes in use and price, which we compare with Medicare use and prices in Table 1-3. Overall, the growth in per capita spending by private insurers was driven largely by price growth and occurred

despite tepid or even negative growth in utilization. Medicare experienced low growth in per capita spending as a result of low growth in utilization coupled with low price growth.

Inpatient hospital use declined for both private insurers and Medicare. However, for private insurers, prices grew by 5.5 percent, driving an increase in per capita spending of 4.9 percent. In contrast, prices increased by less than 1 percent in Medicare, contributing to a decline in per capita spending of 1 percent.

Both private insurers and Medicare had high growth in per capita spending for hospital outpatient departments (6.9 percent for private insurers and 6.3 percent for Medicare). For private insurers, the increase in per capita spending was driven largely by price growth (of 4.9 percent) and to a lesser extent by growth in utilization (of 1.9 percent). The opposite was true for Medicare: growth in utilization (4.4 percent) was the primary driver of per capita spending growth, while prices grew by 1.8 percent.

Trends for professional services (services provided by physicians and other health professionals) were similar between Medicare and private insurers. Both Medicare and private insurers experienced relatively low growth in per beneficiary service use of about 1 percent. Price growth was also similar at 2.3 percent for Medicare and 2.6 percent for private insurers, resulting in per capita spending growth of 3.1 percent for Medicare versus 3.8 percent for private insurers.

Growth in per capita spending on prescription drugs was higher for Medicare (Part D) than for private insurers (3.4 percent growth for Medicare versus 1 percent growth for private insurers).⁹ Medicare's higher per capita spending was the result of both higher volume growth and higher price growth. Unlike the services discussed above, Medicare does not set prices administratively for prescription drugs and so cannot as readily control price growth for prescription drugs as it can for other services. Instead, Medicare relies on competing private plans to negotiate drug prices with pharmacies and control drug spending.¹⁰

The higher price growth may also be partly explained by Medicare beneficiaries using a higher share of brand-name drugs than the privately insured in 2011: brand-name drugs accounted for 25 percent of prescriptions dispensed in Medicare versus 21 percent for private insurers, and brand prices continued to grow faster than generic prices.¹¹

The closing of the coverage gap in Medicare Part D, which began in 2011, could also have contributed to the growth in spending and use. Beginning in 2011, PPACA requires drug manufacturers to offer a 50 percent discount on brand drugs filled in the coverage gap. The discount counts toward a beneficiary's catastrophic limit on out-of-pocket spending. That change likely contributed to the increased proportion of Part D beneficiaries reaching catastrophic coverage in 2011 compared with 2010 (8.4 percent compared with 7.9 percent). Those beneficiaries could have filled more prescriptions as their cost sharing declined on reaching catastrophic coverage.

Other factors affect the difference in rates of growth in drug spending and use, such as the availability of drugs that treat the medical conditions of the two insured populations and the different impact economic conditions may have on the two populations' demand for prescription drugs.

Medicare spending over the next 10 years

Despite the slow growth in recent years, CBO projects that total Medicare spending will grow at an average annual rate of about 6.6 percent over the next 10 years.¹² Figure 1-3 shows historical and projected spending growth broken out between growth in per beneficiary spending and growth in enrollment. While the growth in per beneficiary spending has slowed recently (averaging 1.6 percent annually from 2010 to 2012 compared with an annual average growth rate of about 7 percent since 1980), it is projected to begin to pick back up and average 3.3 percent annually over the next 10 years. Historically, Medicare enrollment has grown about 2 percent per year, but over the next decade, Medicare enrollment growth is projected to average about 3 percent annually, increasing Medicare enrollment from about 50 million beneficiaries today to about 70 million by 2022 (Boards of Trustees 2013).

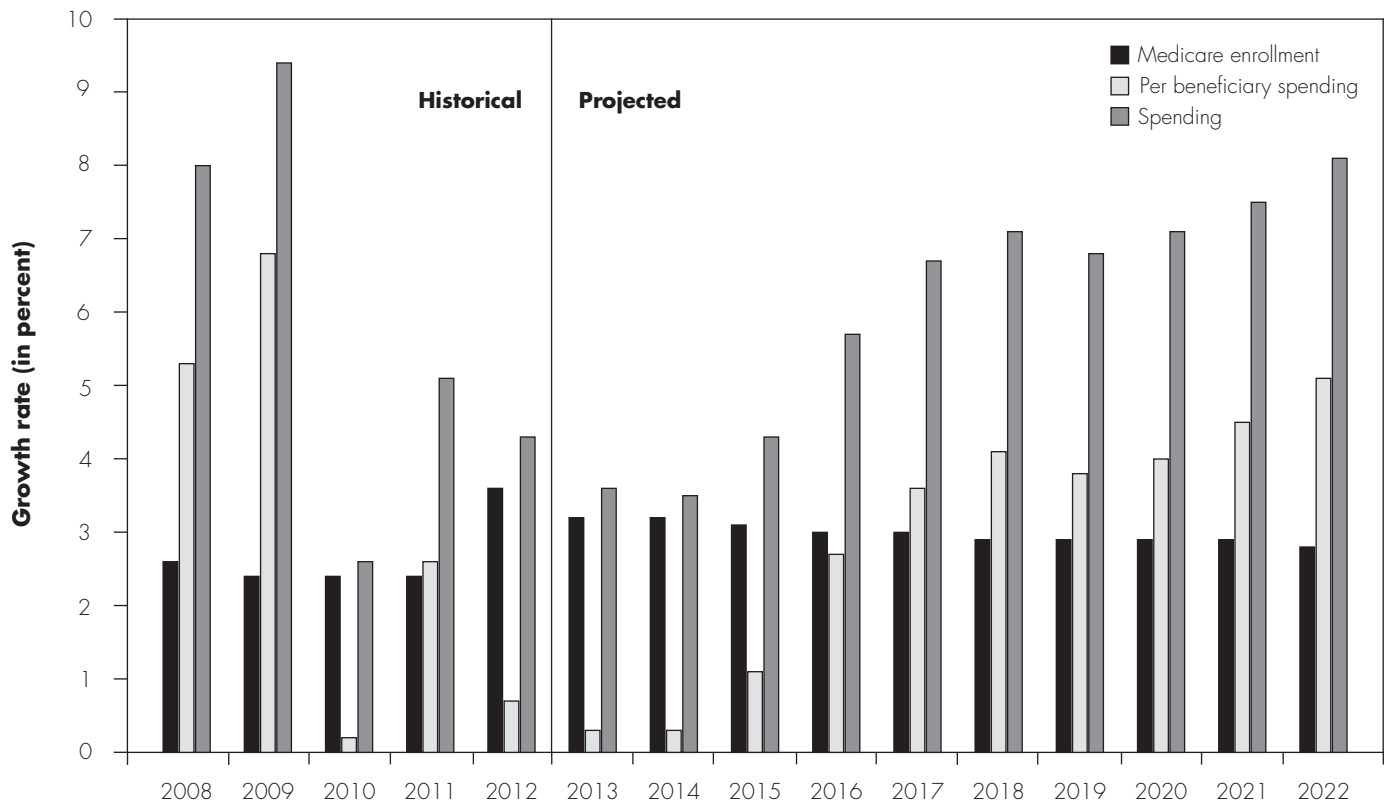
CBO projects strong growth in enrollment in Medicare Advantage (MA) plans. Payment reductions to MA plans began in 2011, but MA enrollment as a share of total Medicare enrollment continued to climb—by 3 percent in 2011 and by 6 percent in 2012. CBO projects that the share of Medicare beneficiaries enrolled in MA plans will continue to increase over the decade and reach 30 percent by 2023 (Congressional Budget Office 2013b).

Long-run Medicare projections

The Medicare Trustees project that Medicare's share of GDP will rise to 5.8 percent in 2040 and to 6.5 percent in 2085 (Figure 1-4, p. 14). Under an alternative set

FIGURE 1-3

Despite the recent slowdown, growth in Medicare spending is projected to increase



Note: Assumes the sustainable growth rate formula is replaced with a 0 percent update annually beginning in 2014.

Source: 2013 annual report of the Boards of Trustees of the Medicare trust funds, Congressional Budget Office May 2013 baseline, Congressional Budget Office May 2013 budgetary impact of alternative policies.

of assumptions—including an override of the price reductions for physician services called for by the sustainable growth rate (SGR) formula, a phase-out of productivity cuts to Medicare providers after 2020, and an override of cuts mandated by the Independent Payment Advisory Board—Medicare’s share of GDP would reach 7 percent of GDP in 2040 and 10.3 percent in 2085 (Boards of Trustees 2013).

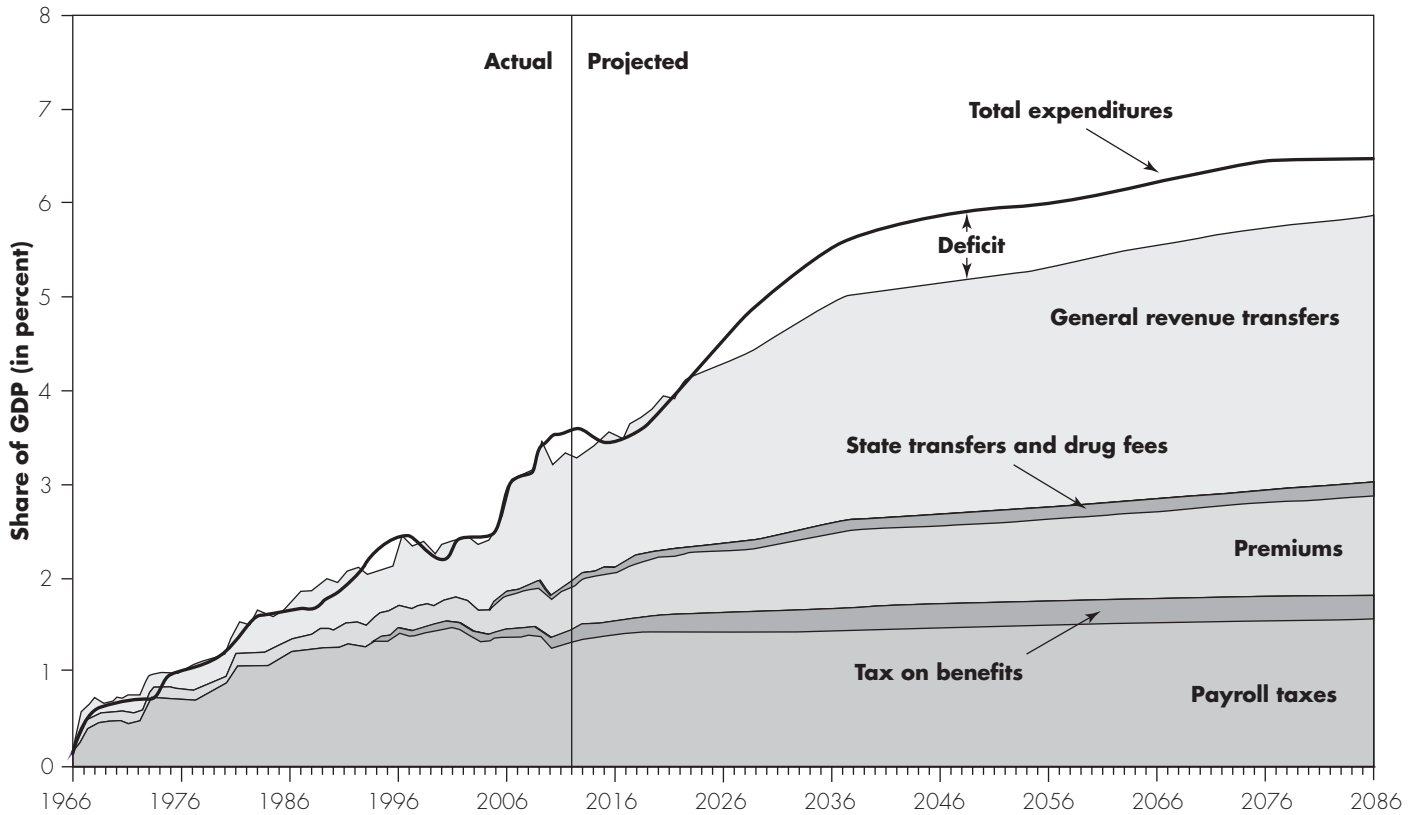
While projections about the growth rate of spending per beneficiary vary, analysts agree that Medicare spending as a share of GDP will continue to rise. Enrollment growth will be a large driver of spending growth through 2035 because of the aging of the baby-boom population (Boards of Trustees 2013). So even if Medicare spending per beneficiary grows at the same rate as GDP—an extremely slow rate by historical standards—Medicare spending will continue to rise as a share of GDP from 3.5 percent in 2012 to 5.1 percent in 2035 (Chernew 2013).

As spending grows, general revenues will grow as a share of total Medicare financing, adding significantly to federal budget pressures (Figure 1-4, p. 14). In this chapter, the term *general revenues* includes both tax revenue and borrowing since federal spending, with few exceptions, has exceeded federal revenues since the Great Depression. In 2012, the most current year for which data are available, spending exceeded revenue by 44 percent.

Under current law, 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. In contrast, payroll taxes—which fund the Hospital Insurance (Part A) trust fund—are projected to

**FIGURE
1-4**

Medicare's long-term financing challenge



Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions. "Tax on benefits" refers to a portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. "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: 2013 annual report of the Boards of Trustees of the Medicare trust funds.

grow only slightly faster than GDP because the rate of growth is based on the rates of growth in earnings and because the ratio of workers to retirees is shifting with the retirement of the baby-boom generation.

Under current law, Part A is fully financed through payroll taxes paid by current workers. However, since 2008, the Hospital Insurance Trust Fund has run an annual deficit (i.e., paid more in benefits than it collects in revenues). 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 2026, an event that could prompt a call for increasing the payroll tax on current workers, adding a beneficiary premium to Part A, or initiating general

revenue transfers to the trust fund. However, as Medicare becomes more dependent on general revenues, there will be fewer resources available to finance other priorities, such as education and investment in infrastructure and scientific research, and greater pressure to reduce spending or increase taxes.

The impact of health care spending on federal and state budgets

Because general revenues finance a large share of Medicare—and 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. Medicaid—a joint federal–state program that pays for health care services for low-income people—accounted for about one-sixth of state general fund spending in 2011, making it the second largest category of general fund spending after education (The National Association of State Budget Officers 2012).¹³

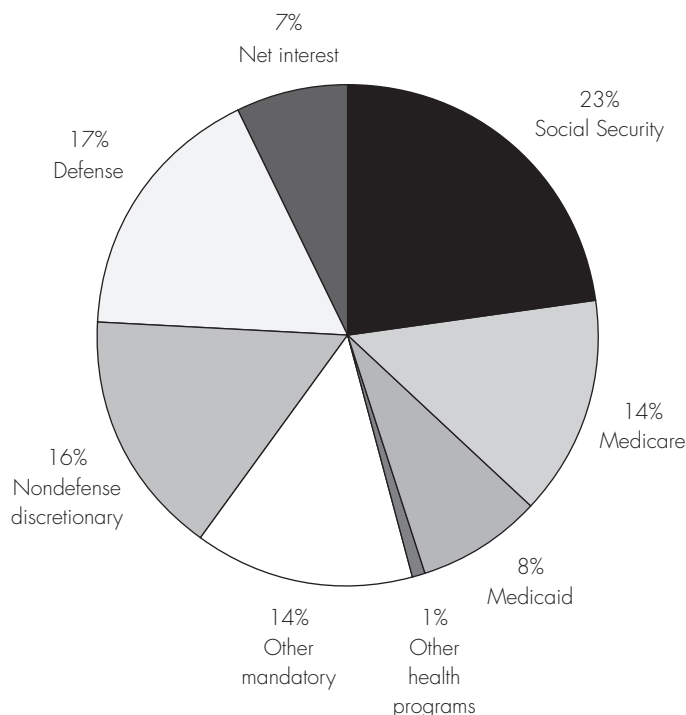
Health care and federal spending

In 2014, Medicare spending is projected to consume 14 percent of the federal budget. When combined with spending on Social Security and Medicaid, the three programs are projected to consume 45 percent of the federal budget (Figure 1-5). Spending on those three programs is projected to grow rapidly over the decade, by 6.3 percent annually, on average (Table 1-4). Spending growth in those programs is hard to change because they are entitlement programs, meaning the Congress must appropriate whatever funds are required to implement the benefits to those who are eligible. To change the spending trajectory of these programs, the Congress would need to pass new laws changing the benefit structure of the programs or changing those who are eligible.

FIGURE 1-5

Medicare, Medicaid, and Social Security are projected to consume 45 percent of the federal budget in 2014

Total = \$3.6 trillion



Source: MedPAC analysis of data from the Congressional Budget Office’s *Updated Budget Projections: Fiscal Years: 2013 to 2023*.

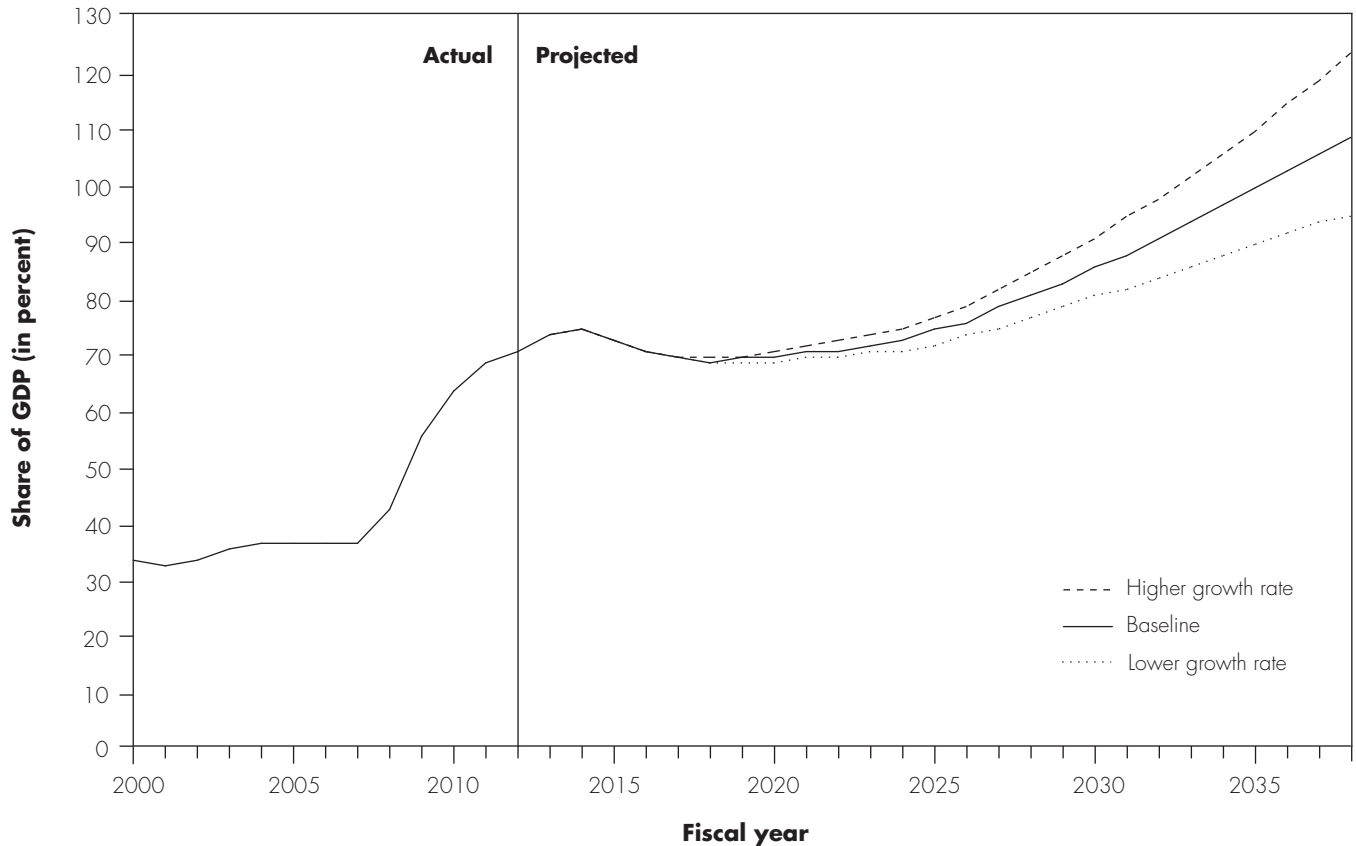
TABLE 1-4

Spending on Medicare, Medicaid, and Social Security is projected to grow rapidly over the decade

	2003–2012 actual average annual growth rates	2014–2023 projected average annual growth rates
Medicare	8.1%	6.6%
Medicaid	5.1	7.1
Social Security	5.6	5.8
Medicare, Medicaid, and Social Security	6.3	6.3
Other mandatory spending	6.6	1.9
Defense	5.8	1.9
Nondefense discretionary	4.3	2.4
Net interest	4.1	14.0
Nominal GDP	3.9	4.9
Population growth	0.9	0.8

Note: GDP (gross domestic product). All figures are nominal (i.e., not adjusted for inflation) and based on the Congressional Budget Office’s May 2013 baseline, which conforms to the statutory spending caps and sequester provisions in the Budget Control Act of 2011. Growth rates are compound annual growth rates.

Source: Congressional Budget Office May 2013 baseline, Bureau of Economic Analysis.

**FIGURE
1-6****Debt as a share of GDP under alternative assumptions
about the growth of federal spending on health care**

Note: GDP (gross domestic product). The baseline assumes that per beneficiary spending on Medicare and Medicaid will grow at average annual rates of 4.3 percent and 4.7 percent, respectively, between 2013 and 2038. The higher growth rate of per beneficiary spending on Medicare and Medicaid is 0.5 percentage points per year higher—and the lower growth rate is 0.5 percentage points per year lower—than in the baseline. The projections incorporate the effects that changes in debt and marginal tax rates have on the economy in the long run and how that economic feedback, in turn, would affect the budget. Incorporating the economic feedback, the Congressional Budget Office projects the debt to equal 108 percent of GDP by 2038 under the baseline assumptions. Without incorporating the economic feedback, the Congressional Budget Office projects the debt to equal 100 percent of GDP by 2038 under the baseline assumptions.

Source: Congressional Budget Office 2013a.

In trying to reduce deficits and the debt, Congress has passed laws to reduce spending growth in the rest of the budget. Under current law, spending for other parts of the budget—defense, nondefense discretionary, and other mandatory—is projected to grow at about 2 percent per year through 2023, much less than the actual rates of spending for those programs from 2003 through 2012, which ranged on average from 4.3 percent to 6.6 percent per year (Table 1-4, p. 15).

However, the debt is projected to remain historically high for the next decade and beyond due to growing interest payments to finance the sizable debt, the pressures of an aging population, and rising health care costs (Figure 1-6). Federal debt equaled 35 percent of GDP at the end of 2007

as the economy entered the last recession. In response to the recession, tax revenue declined and federal spending increased as more people qualified for unemployment compensation, food stamps, and Medicaid. As a result, the debt climbed, reaching 70 percent of GDP in 2012—almost twice the percentage as at the end of 2007. By 2038, the debt is projected to equal 108 percent of GDP, under CBO’s baseline assumptions, reaching levels obtained just after World War II.¹⁴

The baseline assumes that per beneficiary spending for Medicare and other health care programs will increase more slowly in the future than during the past several decades. If, however, per beneficiary spending on Medicare and Medicaid were to rise 0.5 percentage point

per year faster, on average, than in the baseline, the federal debt would be 123 percent of GDP by 2038. In contrast, if Medicare and Medicaid per beneficiary spending rose 0.5 percentage point per year more slowly, on average, the federal debt would be 94 percent of GDP by 2038.

Health care and state spending

In 2011, the Medicaid program had an average monthly enrollment of about 56 million people, with spending totaling \$432 billion, accounting for 2.8 percent of GDP (Office of the Actuary 2012). The federal portion was about \$294 billion (or 64 percent of the total) and states paid the remainder (\$138 billion, or 36 percent of the total). Historically, the federal portion has averaged 57 percent. Legislation—in response to the last economic recession—temporarily boosted the federal share.

PPACA expands Medicaid eligibility beginning in 2014 to nonelderly people with incomes at or below 133 percent of the federal poverty level in states that have chosen to adopt this option. Based on the assumption of how many states would expand eligibility, the expansion is projected to increase enrollment by 15 percent in 2014 and by 31 percent in 2021 (Office of the Actuary 2012). The federal government will pay all of the costs of covering newly eligible enrollees in 2014, with the federal government's share declining gradually to 90 percent by 2020 and remaining at 90 percent thereafter.

Some of the new enrollees are expected to be people who were previously eligible for Medicaid but were not already enrolled. States will not receive the higher federal share for that group. People who were previously eligible but not already enrolled are expected to sign up for Medicaid in response to a more streamlined enrollment process required by PPACA and an increased awareness of health insurance coverage options as the health insurance exchanges begin in 2014. Some states concerned about increased enrollment from that group have acted to contain spending now and have reduced provider payment rates and optional benefits (National Governors Association and National Association of State Budget Officers 2012).

To increase the participation of primary care providers in Medicaid to meet the needs of the expansion, PPACA also requires states to increase the payment rates of certain services furnished by primary care physicians in 2013 and 2014 to Medicare levels, with the federal government paying for the difference. Some health policy analysts have questioned how much of an effect the provision

could have on provider participation since it lasts only two years. Additionally, providers often state reasons for not participating in Medicaid other than low payment rates, such as a heavy administrative burden from program participation.

Changes in the Medicare-eligible population

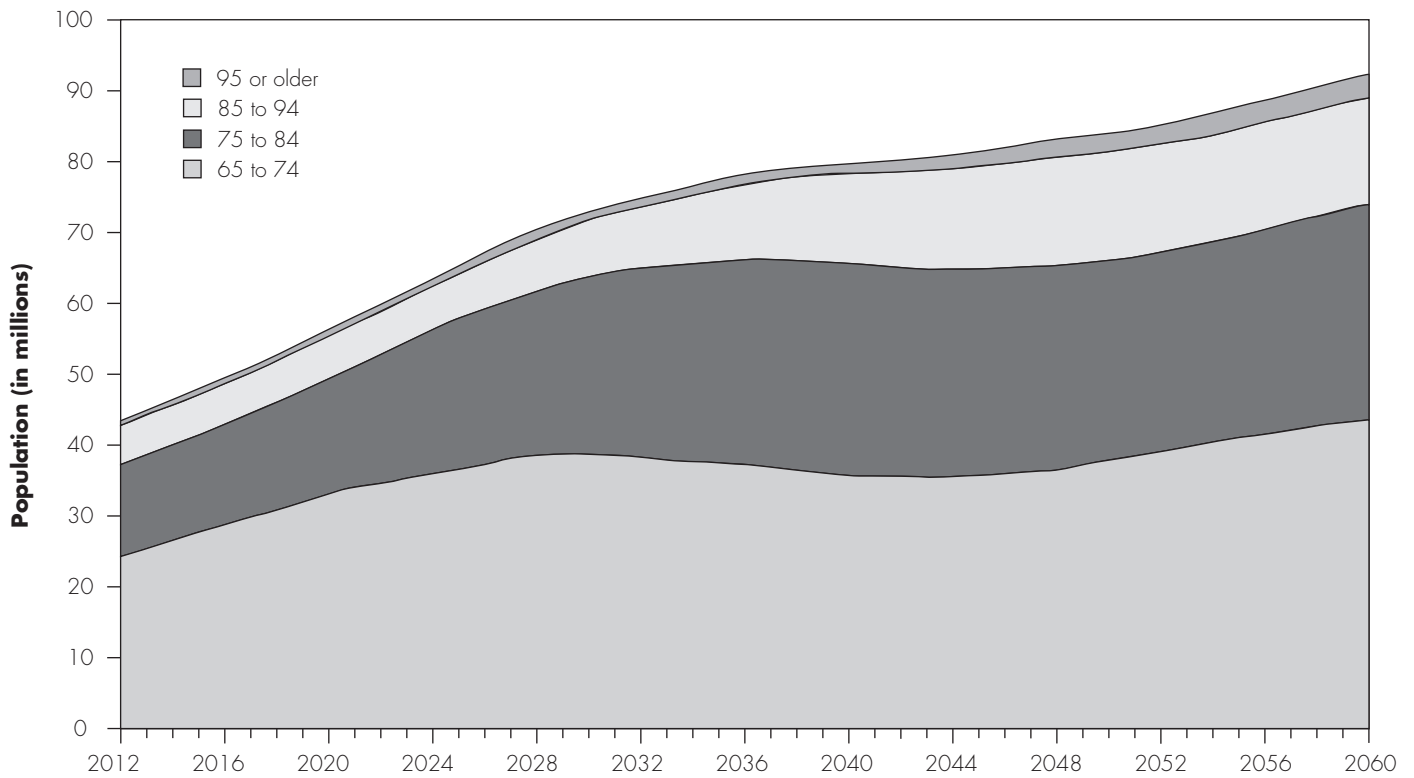
The Medicare population is projected to grow by over 70 percent over the next 20 years, as the bulk of the baby-boom generation ages into Medicare eligibility. With this expansion, the Medicare population will differ in key ways from the current one. First, the average age initially will skew younger than in the recent past, but then grow rapidly older as the number and share of beneficiaries ages 85 and older increases. Second, it will become more racially and ethnically diverse than the current population. Third, a greater number and share of beneficiaries will have multiple chronic conditions. Finally, 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, due to significant changes that have taken place and continue in the private and non-Medicare public health insurance markets.

Age and demographic changes

The Census Bureau estimates that between 2012 and 2032, the number of Americans ages 65 and older will grow from about 43 million to about 75 million—an increase of over 70 percent over the next 20 years (Figure 1-7, p. 18, and Table 1-5, p. 18).¹⁵ Over the next approximately 50 years, the number of Americans 65 years and older will more than double, reaching an estimated 92 million individuals by 2060. In the next 10 years, the average age of Medicare beneficiaries will continue to decline slightly as the large baby-boom generation (individuals born between 1946 and 1964) continues to age into Medicare eligibility. By 2022, almost 60 percent of Medicare beneficiaries ages 65 and over will be between 65 and 74 years old (Table 1-5). However, around the middle of the 2020s, the average age of Medicare beneficiaries will start to increase as a function of the continued aging of the baby boomers and expected increases in longevity. By 2042, over half of Medicare beneficiaries will be ages 75 and older, with almost one-fifth ages 85 and older (Table 1-5).

**FIGURE
1-7**

Projected U.S. population ages 65 and over, 2012-2060



Source: Census Bureau, 2012 National Population Projections.

**TABLE
1-5**

Projected U.S. population ages 65 and over, by age cohort, selected years 2012-2060

Age group	2012	2022	2032	2042	2060
Age 65-74					
Population (in millions)	24.0	34.5	38.1	35.2	43.3
Percent of total	56%	58%	51%	44%	47%
Age 75-84					
Population (in millions)	13.3	18.2	26.6	29.8	30.5
Percent of total	31%	31%	36%	37%	33%
Age 85 and over					
Population (in millions)	5.9	6.9	10.0	15.1	18.2
Percent of total	14%	12%	13%	19%	20%
Total					
Population (in millions)	43.2	59.6	74.7	80.2	92.0
Percent of total	100%	100%	100%	100%	100%

Note: Columns may not sum to total due to rounding.

Source: Census Bureau, 2012 National Population Projections.

In addition to growing rapidly in overall size, the Medicare population will become more diverse racially and ethnically over the next 50 years as increasing percentages of Americans ages 65 and over will identify as African American, Asian American, and Hispanic. The largest increase will be among the proportion of Americans age 65 and over identifying as Hispanic, which is projected to triple from 7 percent to 21 percent between 2012 and 2060 (Figure 1-8, p. 20).

At the same time, the number of Medicare beneficiaries who speak a language other than English at home, and therefore may have limited English proficiency, also is expected to grow. The number of people living in the United States who speak a language other than English at home increased from 23 million in 1980 to over 60 million in 2011 (Ryan 2013). The single largest group today, and among the fastest-growing over the past 30 years, are speakers of Spanish or Spanish Creole; there were about 17 million persons in this group in 1990 and over 37 million in 2011. Other primary (spoken at home) languages that are relatively large and/or fast growing include Chinese, Russian, Korean, Vietnamese, and Tagalog (Ryan 2013).

Of the 60.6 million people who spoke a language other than English at home in 2011, about 42 percent reported that they spoke English less than “very well” (Ryan 2013). Individuals who speak a language other than English at home and who speak English less than very well are considered to have limited English proficiency (LEP), which means that they are not able to speak, read, write, or understand the English language at a level that permits them to interact effectively with health care providers (Karliner et al. 2007). A significant body of research suggests that language barriers in health care settings may compromise access and quality of care for LEP patients and that the use of professional medical interpreters can significantly improve clinical care for these patients (Karliner et al. 2007, Wilson et al. 2005). Since the number of people in the United States, including those ages 65 years and over, who speak a language other than English at home is projected to continue to grow (Ortman and Shin 2011), health care providers—especially those in the geographic areas where LEP patients tend to be concentrated—will encounter growing demands for linguistic (and often cultural) competencies to meet the clinical care needs of a diverse Medicare patient population. Few studies have been done of the costs of providing interpreter and translation services for LEP patients as required by federal law. An estimate prepared

by the Office of Management and Budget in 2002 assessed that total national costs for health care providers to comply with the law would be about \$270 million, or about 0.02 percent of national health expenditures in 2002. The report estimated that the average increase in costs per visit by LEP persons across the four types of services examined (emergency department visits, inpatient hospital admissions, outpatient physician visits, and dental visits) would be 0.5 percent (Office of Management and Budget 2002).

Disease burden and prevalence of multiple chronic conditions

According to a study of the 2010 Medicare FFS population, chronic conditions such as high blood pressure, high cholesterol, heart disease, and diabetes were highly prevalent: almost 60 percent had high blood pressure; 45 percent had high cholesterol; and almost one-third had ischemic heart disease, arthritis, or diabetes (Figure 1-9, p. 21) (Centers for Medicare & Medicaid Services 2012). The top 15 chronic conditions and the percentage of beneficiaries with those diagnoses in 2010 are shown in Figure 1-9. The percentages add up to more than 100 percent because beneficiaries may have multiple chronic conditions.

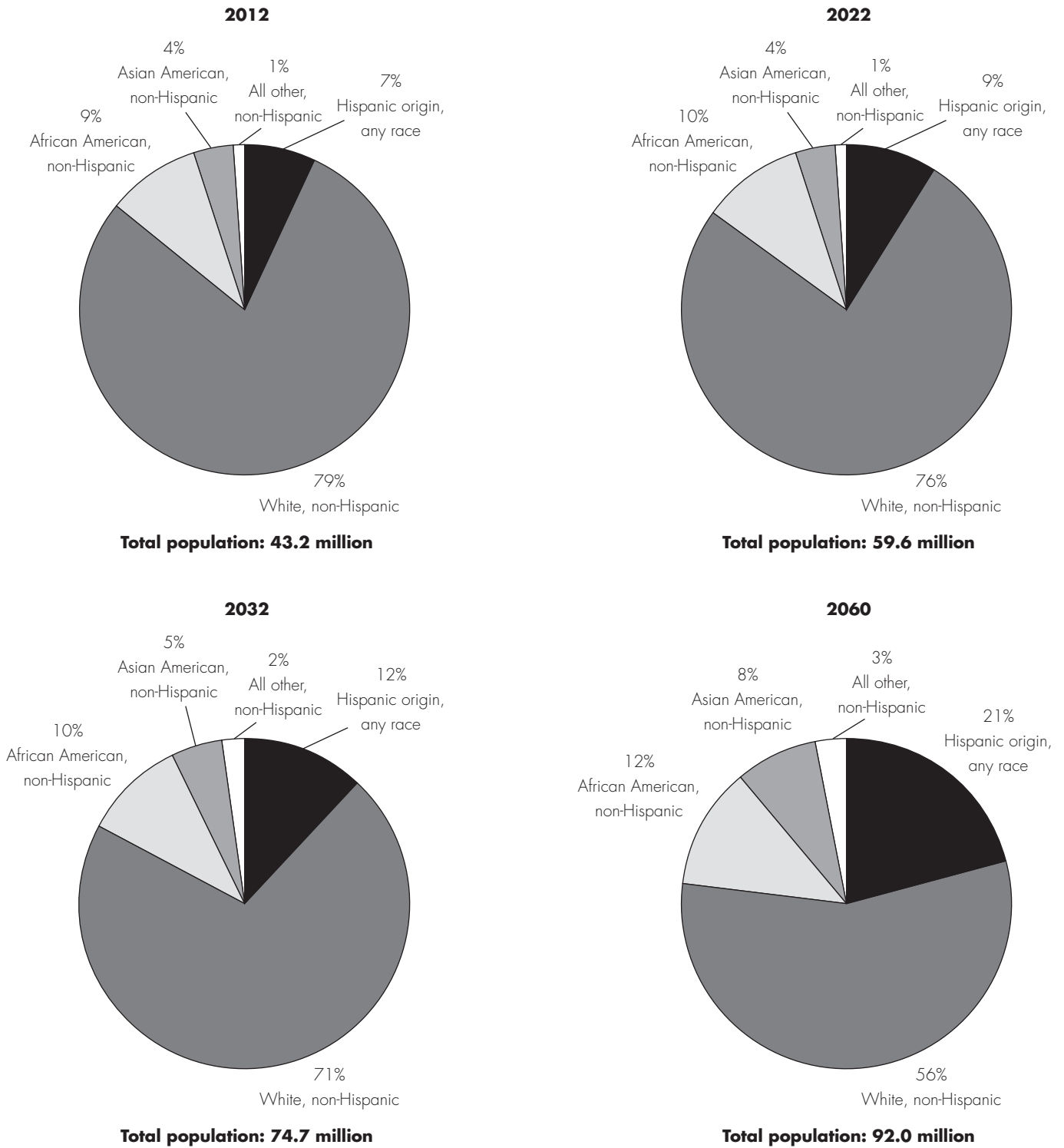
In fact, over two-thirds of Medicare beneficiaries have multiple (2 or more) of these 15 chronic conditions (Figure 1-10, p. 22). Beneficiaries with multiple chronic conditions accounted for a greater share of Medicare spending than those with a single chronic condition or none. Beneficiaries with six or more chronic conditions constituted about 14 percent of the Medicare population but accounted for over 40 percent of Medicare spending. In contrast, beneficiaries with none or one chronic condition—about a third of the population—accounted for 7 percent of total Medicare spending (Figure 1-10, p. 22).

In 2010, Medicare spent an average of \$9,738 per beneficiary across all FFS Medicare enrollees, compared with an average of \$32,658 per beneficiary for those who were diagnosed with six or more chronic conditions (Centers for Medicare & Medicaid Services 2012). Those beneficiaries were more likely than the average beneficiary to have heart failure, chronic kidney disease, chronic obstructive pulmonary disease, atrial fibrillation, and stroke.

Another recent study estimated that in 2010 nearly 15 percent of people older than age 70 years (or about 3.8 million people) had dementia—a broad category that

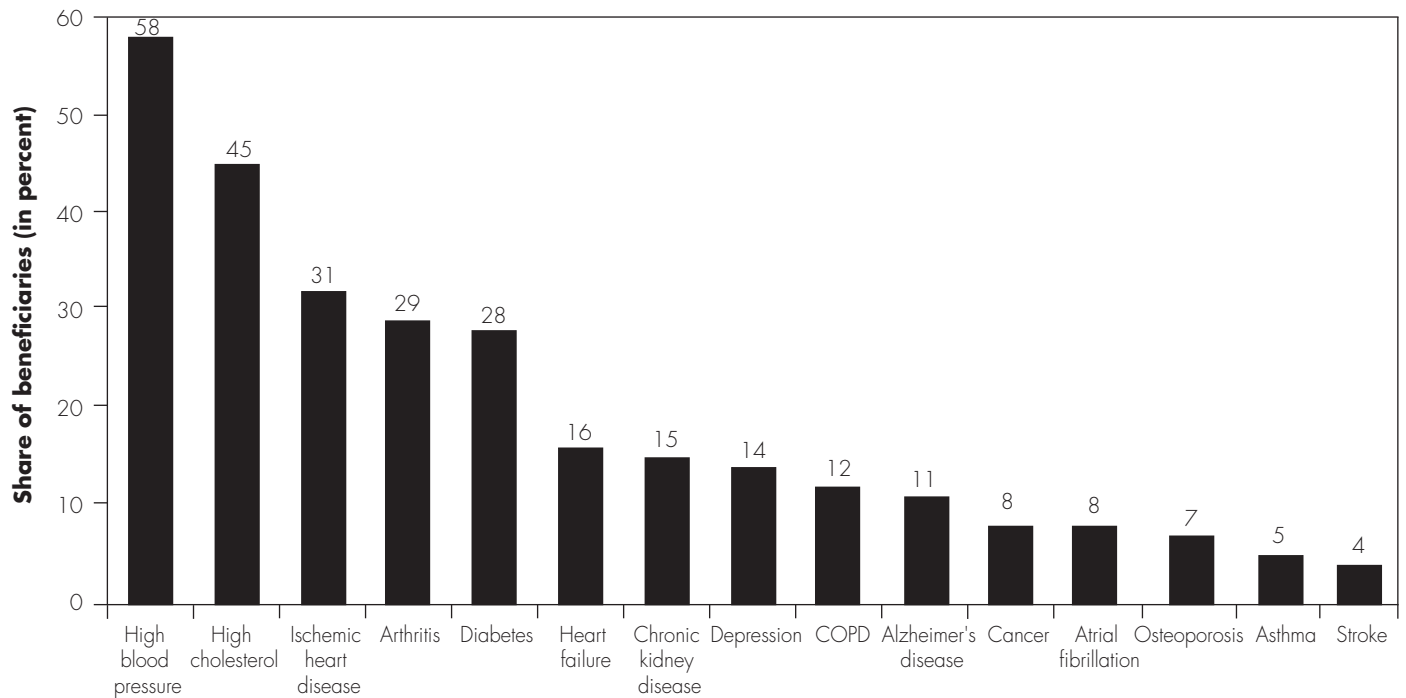
**FIGURE
1-8**

Estimated U.S. population ages 65 and over, by race and Hispanic origin, selected years, 2012-2060



Note: "Asian American" includes Native Hawaiian and all other Pacific Islander. "All other" includes American Indian and Alaska Native and multiracial.

Source: Census Bureau 2012 National Population Projections.

**FIGURE
1-9****Percentage of Medicare FFS beneficiaries with 15 selected chronic conditions, 2010**

Note: FFS (fee-for-service), COPD (chronic obstructive pulmonary disease).

Source: Centers for Medicare & Medicaid Services 2012.

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 (such as dressing and bathing).

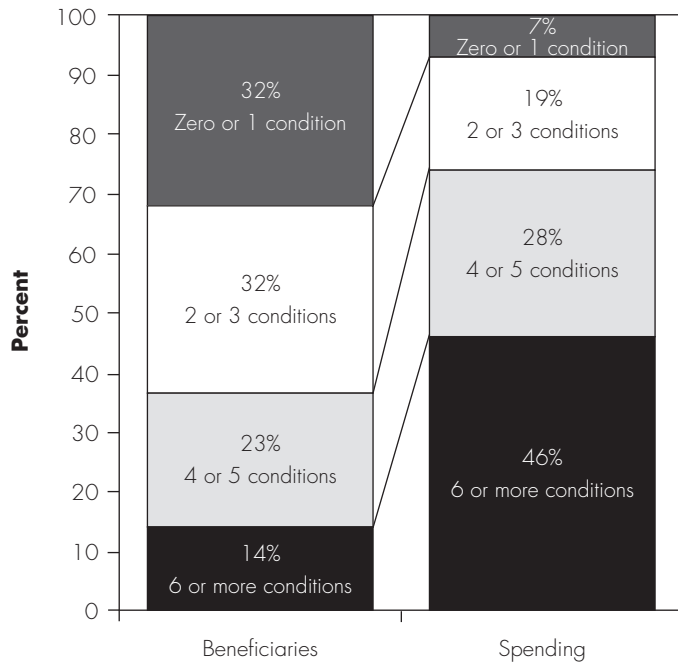
Evidence is mixed on whether the prevalence of chronic disease among the Medicare-eligible population has increased over time. For example, between 1997 and 2011, the proportion of individuals ages 65 and over who reported having heart disease remained relatively stable, at about 30 percent, and the proportion who reported having had a stroke also remained relatively constant, at about 8 percent (Centers for Disease Control and Prevention 2012). In contrast, the proportion who reported having cancer increased from 14 percent to about 19 percent over the same time period (which could reflect changes in the use of cancer diagnostic procedures over the time period), and the share reporting that they had diabetes (both physician diagnosed and undiagnosed) grew from about 22 percent to 28 percent from 1999 to 2010.

Trends have been found in the increasing prevalence of multiple chronic conditions in the population that will be aging into Medicare over the next 20 years. An analysis of 2001–2010 National Health Interview Survey data by Centers for Disease Control and Prevention researchers showed a statistically significant trend from 2007 through 2010 for increases in the number of adults ages 45 to 64 years with two to three chronic conditions, and a significant increase in the prevalence of four or more chronic conditions from 2001 through 2010 among the same age cohort (Ward and Schiller 2013). Given the evidence that health care service use and costs increase as the number of chronic conditions an individual has increases (Anderson 2010, Centers for Medicare & Medicaid Services 2012, Machlin and Soni 2013), it is reasonable to expect upward pressure on Medicare spending from these trends in the number of chronic conditions per person and the number of adults with four or more chronic conditions in the population cohort that is approaching the current Medicare eligibility age.

In addition, the overall aging of the Medicare population as the large baby-boom cohort grows older will almost

FIGURE 1-10

Medicare spending is concentrated among beneficiaries with multiple chronic conditions, 2010



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

Source: Centers for Medicare & Medicaid Services 2012.

certainly magnify trends in the prevalence of multiple chronic conditions. In general, older beneficiaries are more likely to have multiple chronic conditions (Table 1-6). As noted earlier, the age distribution of Medicare beneficiaries will begin to shift steadily upward in about 10 years. If the current relationship between age and number of chronic

conditions holds, then the number of older Medicare beneficiaries needing treatment for multiple chronic conditions also will begin to increase at that time.

Experience with private health insurance coverage

Changes in the private health insurance market may have an effect on new Medicare beneficiaries' familiarity with different types of coverage and their expectations about out-of-pocket costs. For example, workers covered by private health care insurance today are accustomed to receiving health care from a network of participating health care providers rather than from an unconstrained array of unaffiliated providers paid under a fee-for-service arrangement. Adults approaching Medicare eligibility who have worked for large employers often have been choosing coverage from among a range of plan choices during their working years, and those purchasing individual health insurance also may gain experience in choosing health insurance plans through the new state and federal health insurance exchanges commencing in 2014. Those experiences may increase the willingness of future Medicare beneficiaries to enroll in Medicare Advantage plans or other alternatives to fee-for-service Medicare.

In 2013, 20 percent of workers covered by private health insurance were enrolled in a high-deductible health plan that offered some sort of savings account to pay for the deductible, compared with just 4 percent in 2006 (Kaiser Family Foundation and Health Research and Educational Trust 2013). High-deductible health plans typically have lower premiums than traditional plans but require the enrollee to spend down a large deductible before receiving insurance benefits. In addition, premiums for all types of employer-sponsored coverage have grown rapidly over the past decade; premiums for family coverage increased 80

TABLE 1-6

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 due to rounding.

Source: Centers for Medicare & Medicaid Services 2012.

percent between 2003 and 2013 (Kaiser Family Foundation and Health Research and Educational Trust 2013).

Effects of growth in health care spending on individuals and families

For individuals and families, growth in health care spending means higher health insurance premiums, higher out-of-pocket costs, 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 decreased wages as 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.

The trends in per capita health spending, premiums, and incomes in the years preceding the most recent economic recession indicate the negative effect accelerating health care spending has on incomes. From 2001 to 2007, per capita health spending grew at an average annual rate of 6.5 percent (Figure 1-11a and Figure 1-11b, p. 24) (Office of the Actuary 2013), while the average annual rate of premiums for individuals and families grew about 9 percent (Kaiser Family Foundation and Health Research & Educational Trust 2013). In contrast, during this period, average household income grew an average annual rate of just 2.5 percent; the median household income grew an average annual rate of 2.9 percent (Census Bureau 2013).

Medicare beneficiaries are not exempt from the financial challenges of ever-growing cost-sharing liabilities under the program. Over time, growth in Medicare premiums and cost sharing has outpaced growth in Social Security benefits and is projected to continue to do so (Figure 1-12, p. 25). Social Security benefits constitute about 40 percent of income for the median Medicare beneficiary and close to 90 percent of income for Medicare beneficiaries in the bottom income quintile (Kaiser Family Foundation 2010). In 2012, Supplementary Medical Insurance (Medicare Part B and Part D) premiums and cost sharing consumed 23 percent of the average Social Security benefit (Boards of Trustees 2013). By 2032, the Medicare Trustees estimate that those costs will consume 31 percent of the average Social Security benefit.

As the Commission has noted in its work on reforming Medicare's benefit design, about 90 percent of current Medicare beneficiaries purchase or receive some form of supplemental benefits so that their actual out-of-pocket spending is much smaller than their cost-sharing liabilities (Medicare Payment Advisory Commission 2012a). Almost one-quarter of Medicare beneficiaries enrolled in Part A and Part B in 2007 had medigap policies and 31 percent had employer-sponsored retiree policies.¹⁶ However, trends in coverage for both of these forms of supplemental benefits indicate that many future Medicare beneficiaries will have higher out-of-pocket spending than current beneficiaries. Enrollment is growing rapidly in the newer standardized medigap plans, which include enrollee cost-sharing requirements (America's Health Insurance Plans 2013, Medicare Payment Advisory Commission 2012a). The number of large employers offering retiree health benefits to active workers has been steadily declining over the past 25 years, from 66 percent in 1988 to 28 percent in 2013 (Kaiser Family Foundation and Health Research and Educational Trust 2013).

Despite these challenges, Medicare beneficiaries experience greater stability from guaranteed insurance benefits than adults under the age of 65. Adults ages 65 and older are less likely to report trouble paying for health care (17 percent) compared with those ages 18 to 64 (about 30 percent). Fewer seniors report skipping care due to cost concerns (43 percent) compared with privately insured adults under 65 (60 percent) (Kaiser Family Foundation 2012). In the survey conducted annually by the Commission on access to physician services, we find that most beneficiaries have reliable access to primary and specialty care.

The recent economic downturn has made it more difficult for Medicare beneficiaries and for adults approaching Medicare eligibility (ages 45 to 64) to cope with the high growth rate of health care spending. The economic downturn has depreciated the value of their assets and caused more financial insecurity for that population. Adults ages 45 to 64 have experienced a notable increase in unemployment during the recent recession, similar to those in most other age groups (Bureau of Labor Statistics 2012). In a 2010 RAND survey, one-quarter of respondents ages 50 to 59 lost more than 35 percent of their retirement savings, and 40 percent had been affected by unemployment, declining home values, or foreclosure (Hurd and Rohwedder 2010). As a result, adults approaching Medicare eligibility could have smaller assets and income than their predecessors.

Growth in health care spending and premiums has outpaced growth in household income

Figure 11a. Cumulative change, 2001–2007

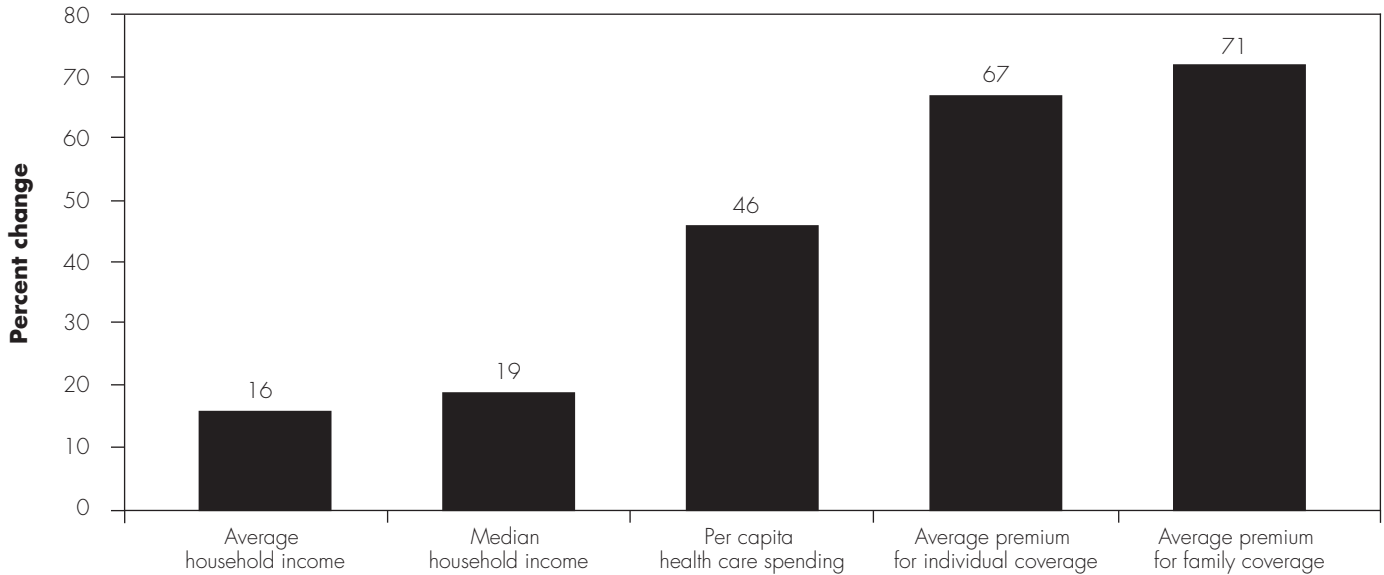
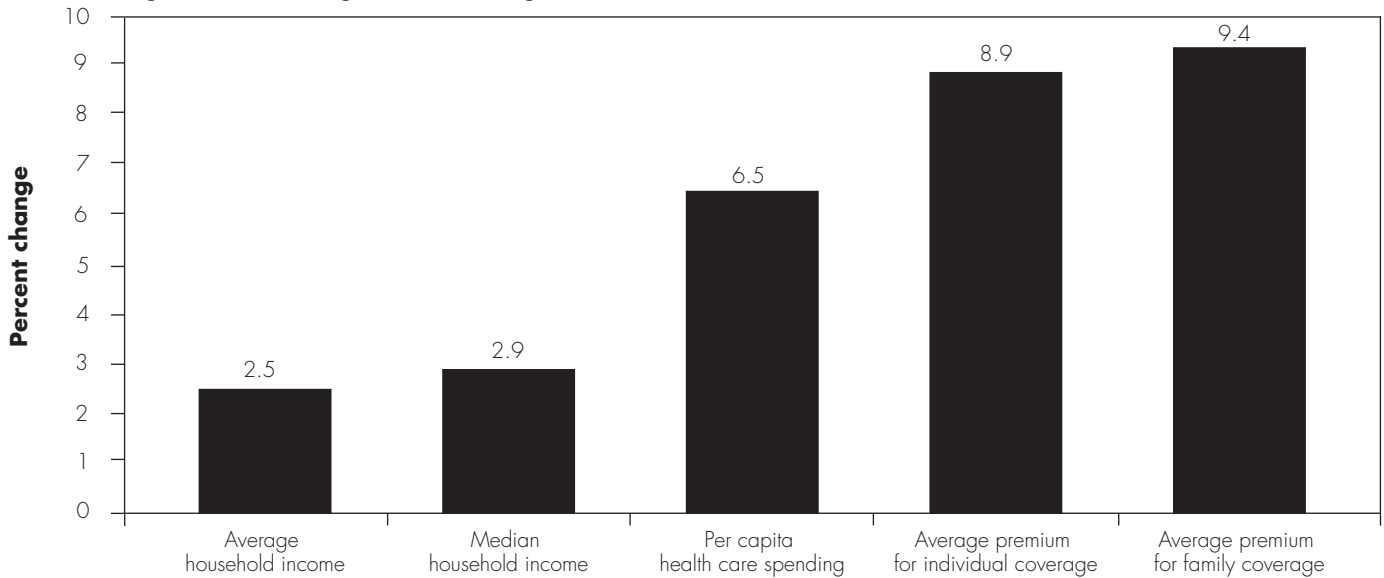


Figure 11b. Average annual change, 2001–2007



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

Source: Census Bureau 2013, National health expenditure data 2013, and Kaiser Family Foundation and Health Research & Educational Trust 2013.

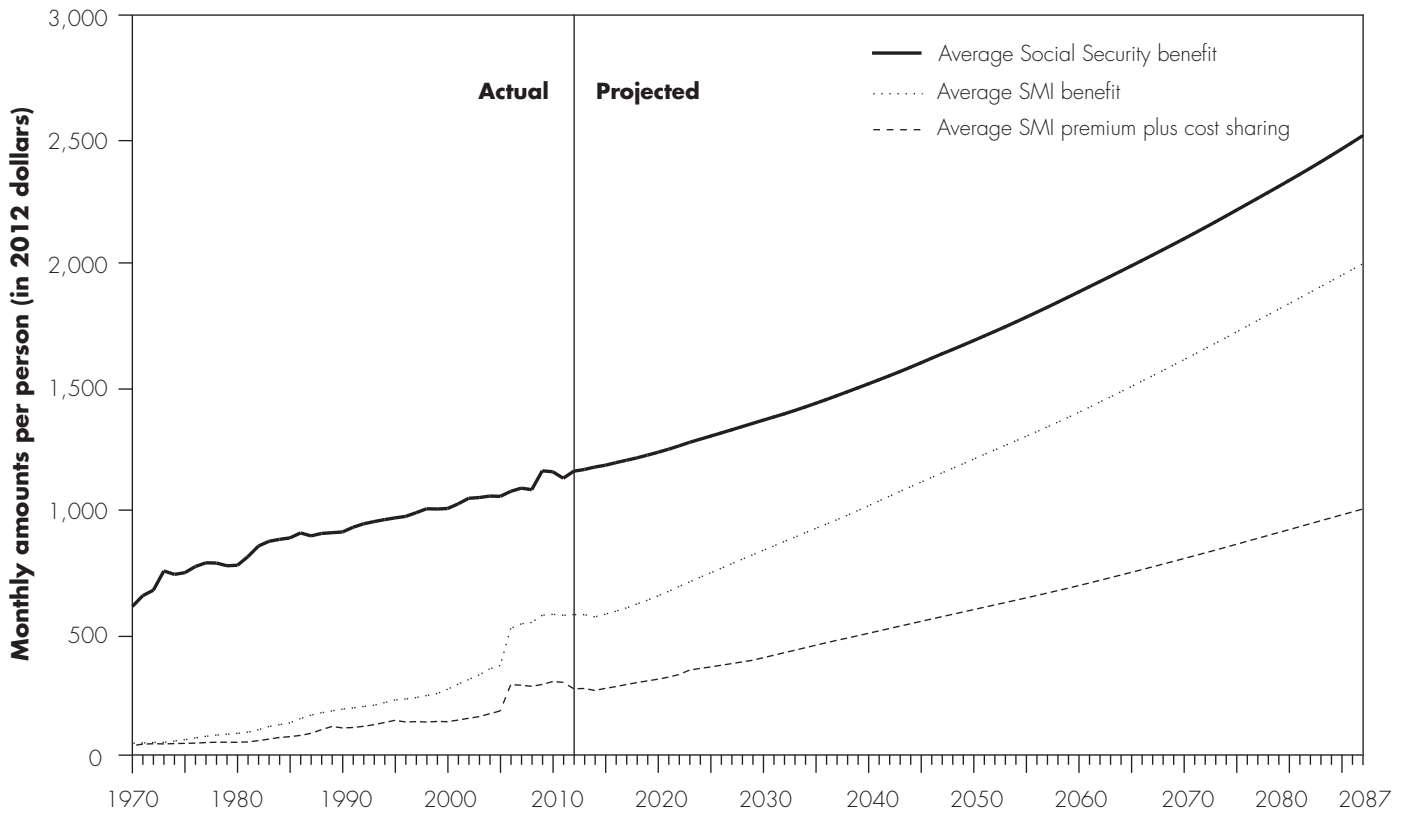
Patterns in health care spending that suggest inefficiencies

Several patterns that are evident in U.S. health care spending broadly and Medicare in particular suggest that at least some portions of current spending are inefficient and do not improve health outcomes. Researchers have

documented notable geographic variation in the use of and spending on health care that cannot be fully explained by differences in disease burden or severity or in the supply of providers. Evidence also points to a decline in the marginal value of the health care dollar, particularly for the elderly, suggesting that some health spending does not equate to better health. Medicare expenditures

**FIGURE
1-12**

Average monthly SMI premiums and cost sharing are projected to grow faster than the average monthly Social Security benefit



Note: SMI (Supplementary Medical Insurance). Average SMI benefit and average SMI premium plus cost-sharing values are for a beneficiary enrolled in Part B and (after 2006) Part D. Beneficiary spending on outpatient prescription drugs before 2006 is not included.

Source: 2013 annual report of the Boards of Trustees of the Medicare trust funds.

resulting from fraud and abuse show no signs of abating, abetted by the program’s complexity and susceptibility to improper payments as well as by statutory requirements such as “any willing provider” that prevent Medicare from deploying program integrity tools such as provider credentialing that are routinely used by private payers. Several FFS Medicare payment systems are poorly targeted and undermine efforts to design payment systems that can induce the efficient delivery of clinically appropriate and high-quality care. Finally, though some indicators of quality are improving from a national perspective, disparities persist in health care quality across communities, and racial and ethnic minorities continue to experience worse health outcomes. All of these patterns suggest opportunities for payment reforms to incentivize more efficient care delivery that improves health outcomes for all beneficiaries.

Wide variation occurs across geographic areas in health care spending and service use

Researchers have documented wide variations across geographic areas in health care service use and spending and have found no consistent relationship between the amount of spending and quality of care (i.e., more spending is not always associated with higher quality, nor vice versa). The observed variation in service use and spending is so wide that it cannot be fully explained by differences in patients’ disease burden or severity of illness, nor by the supply of care and caregivers in a region (Fisher et al. 2003a, Fisher et al. 2003b, Institute of Medicine 2013b, Medicare Payment Advisory Commission 2011b, Zhang et al. 2010, Zuckerman et al. 2010). The latest comprehensive analysis, released by the

Institute of Medicine in July 2013, found that substantial variation in spending and utilization remains at all levels of measurement, from the hospital referral region to the group practice level (Institute of Medicine 2013b).

In 2011, the Commission reported significant variation in the use of services among the Medicare population. After accounting for Medicare's explicit price adjustments and special payments, variation in Medicare service use between the 90th percentile and 10th percentile of measurement area was 44 percent. After adjusting for beneficiaries' health status, a 30 percent gap in service use remained between the 90th percentile and 10th percentile of areas. Variation in use of post-acute care services (such as home health care and durable medical equipment) was particularly high, and those services disproportionately contributed to overall variation (Medicare Payment Advisory Commission 2011b). Similarly, use of Medicare Part D for drugs was 20 percent greater for beneficiaries in higher spending areas (the 90th percentile) compared with lower spending areas (the 10th percentile).

There is little evidence to support the contention that greater amounts of health care services, measured by either service use or spending, result in better quality of care for beneficiaries. The Institute of Medicine's recently published report on geographic variation in health care found no consistent relationship, at the level of hospital referral regions, between quality and spending or service use among either Medicare beneficiaries or the commercially insured (Institute of Medicine 2013b). Similarly, older research using Medicare data found that beneficiaries in high-spending areas (in the top 20 percent) received as much as 60 percent more care than their counterparts in low-spending areas but did not realize better health outcomes (Baicker and Chandra 2004, Fisher et al. 2003a, Fisher et al. 2003b). The amount of real variation in spending and service use across the United States, with no corresponding patterns of higher quality in areas with higher spending and service use, prompts fundamental questions about the efficiency of health care spending in high-expenditure areas, as well as significant concerns about the persistence of fraud and abuse in those areas.

In addition to the variations in health care service use and spending within U.S. regions, there are also significant international differences in health care use, spending, and outcomes (see the text box on p. 28 for a discussion).

Vulnerability of FFS Medicare to fraud contributes to spending variation

Some of the geographic variation in health care spending in the United States is due to geographic variation in health care fraud (Institute of Medicine 2013b). Over the last several years, CMS and federal law enforcement agencies have initiated efforts to find and prosecute perpetrators of fraud and recover fraudulent spending, returning \$2.4 billion to the Medicare trust funds in fiscal year 2012 (Department of Health and Human Services and Department of Justice 2013). When CMS began the process of screening 1.5 million Medicare-enrolled providers in fiscal year 2012, it reported eliminating nearly 150,000 ineligible providers (about 10 percent) from its billing system by the end of the year (Department of Health and Human Services 2013). These law enforcement and administrative efforts are not insignificant, but they do not alter fundamental statutory limitations such as Medicare's current "any willing provider" policy that prevent the program from using tools such as provider credentialing requirements that are commonly deployed in private health plans. The Government Accountability Office (GAO) has found "persistent weaknesses in Medicare's enrollment standards and procedures that increased the risk of providing billing privileges to entities intent on defrauding the program," and notes that CMS has taken steps under new statutory authority in recent years to address only some of these problems (Government Accountability Office 2013). Estimates of the total amount of health care spending attributable to fraud are imprecise by definition, but one recent analysis estimated that the costs of fraud to Medicare and Medicaid ranged from about 4 percent to over 12 percent of combined federal spending on the two programs in 2011 (Berwick and Hackbarth 2012). According to GAO, Medicare reported improper payments estimated to be more than \$44 billion in 2012, and it remains on GAO's list of "high-risk" programs, where it has been since 1990 (Government Accountability Office 2013).

Some FFS Medicare payment policies may not be well targeted

The Commission has found instances in which certain Medicare payment policies that were intended to reach one kind of goal, such as ensuring beneficiaries' access to care, may have, over time, resulted in inefficiencies that can contribute to unnecessary spending. For example, in its March 2007 report to the Congress, the Commission found that the indirect medical education payment adjustment to teaching hospitals was set considerably above the

empirical level of costs for those hospitals (Medicare Payment Advisory Commission 2007). In its June 2012 report on rural payment policies, the Commission observed that some special payments to providers in rural areas are not well targeted because some providers in those areas do not need the extra financial assistance or are not the sole providers in their communities (Medicare Payment Advisory Commission 2012a). Other payment distortions that contribute to inefficiency in care delivery have occurred as the various FFS payment systems have evolved separately. For instance, the Commission has analyzed whether it undermines efficiency to continue Medicare policies that result in higher payments for certain services, such as physician evaluation and management and some ambulatory surgery services, based solely on the setting in which the service is delivered (Medicare Payment Advisory Commission 2013). In general, the Commission maintains that Medicare should base payment rates on the resources needed to treat patients in the most efficient setting, adjusting for differences in patient severity to the extent that those differences affect provider costs.

Value of health care services is not always clear

In addition to abusive payment system practices, health system analysts have questioned the comparative value of certain health care services, given the wide variation in service use and spending that does not correspond to significant differences in health outcomes. First, researchers have noted a decline in the value of health spending over time. For instance, Cutler and colleagues showed that spending from 1960 to 2000 provided reasonable value (in terms of macro-level quality indicators like mortality rates); however, after 2000, the value of health care spending seems to have decreased, particularly among the elderly (Cutler et al. 2006).

Second, health dollars are misallocated when they are spent for inappropriate or inappropriately applied services, including improper services, services delivered at an inappropriate time, services that are not proven for a given purpose, interventions that are not proven for a specific contingent of patients, and interventions disseminated beyond a population for whom they are effective or for whom the risks of screening or treatment outweigh the benefits (Baicker and Chandra 2011, Garber et al. 2007, Kale et al. 2013, Lipitz-Snyderman and Bach 2013, Redberg 2011). Spending on such services does not improve health and, indeed, may expose patients

to unnecessary medical and financial risk. A recent analysis of trends in the delivery of inappropriate care (both overuse and misuse) in ambulatory care settings (e.g., physician offices, outpatient clinics) found steady or growing rates of inappropriate care between 1999 and 2009 for 10 of 13 measures analyzed (Kale et al. 2013).

Disparities across populations persist

The Commission remains concerned about the notable differences in access to quality care for different demographic groups. First, in its 2012 annual survey of access to physician services, the Commission noted that minorities more frequently report access problems. Second, beneficiaries who are members of racial or ethnic minorities or those with low incomes are more likely to seek care from providers of poorer quality (Bach et al. 2004, Dimick et al. 2013, Jha et al. 2007). Further, though quality of care is broadly improving across racial and ethnic groups, age groups, and income groups, minorities continue to experience worse quality of care compared with their nonminority counterparts (Agency for Healthcare Research and Quality 2013).

These discrepancies are also of concern because racial and ethnic minority beneficiaries have disproportionately high rates of chronic disease with multiple comorbid conditions and so are disproportionately likely to incur high Medicare spending (Centers for Medicare & Medicaid Services 2012). For example, African Americans and Hispanics are overrepresented among those beneficiaries in the top decile of Medicare spending (Medicare Payment Advisory Commission 2012a). For individuals with diabetes, which is one of the most prevalent conditions among Medicare beneficiaries with multiple chronic conditions, the rate of hospital admissions for uncontrolled diabetes is significantly higher for African Americans (the highest) and Hispanics (next highest) than the rate for non-Hispanic Whites; all non-White racial and ethnic groups have higher rates of end-stage renal disease due to diabetes than non-Hispanic Whites (Agency for Healthcare Research and Quality 2013).

Differences in medical literacy (the individual's ability to understand medical instructions and communicate with doctors and other staff members) further compound disparities in the prevalence of chronic disease. The proportion of individuals having below-basic medical literacy is significantly higher for Hispanics (41 percent), African Americans (24 percent), and Native Americans/Alaskan Natives (25 percent) than for Whites (9 percent) and Asian/Pacific Islander groups (13 percent) (Kutner et

The United States spends more on health care than other countries but achieves poorer health outcomes

The United States spends more on health care, both per capita and as a share of gross domestic product (GDP), than any of the 34 countries that are members of the Organisation for Economic Co-operation and Development (OECD) (Figure 1-13a) (Organisation for Economic Co-operation and Development 2013). At the same time, the United States ranks 26th in life expectancy and 31st on infant survival rates of the 34 OECD countries (Figure 1-13b) (Organisation for Economic Co-operation and Development 2013). Since 1990, life expectancy at birth in the United States and the health of the population more generally have increased, but at a slower rate than in the other OECD countries (Organisation for Economic Co-operation and Development 2013, U.S. Burden of Disease Collaborators 2013). Researchers have explored several possible explanations for the relatively poor health outcomes in the United States, including the fragmented nature of the health care delivery system and large segment of the population without health insurance; higher rates of chronic diseases such as obesity, ischemic heart disease, and diabetes; socioeconomic factors such as a higher relative poverty rate; and behavior-related factors such as higher calorie consumption per capita, higher prevalence of unsafe sex practices and drug abuse, and higher rates of deaths from motor vehicle accidents and homicides (National Research Council and Institute of Medicine 2013a, Organisation for Economic Co-operation and Development 2013). Moreover, countries with substantially lower GDPs and health expenditures per capita, such as Chile, Portugal, Slovenia, and South Korea, have lower mortality rates than those in the United States (U.S. Burden of Disease Collaborators 2013). According to the Institute of Medicine, the superior health outcomes in other countries demonstrate that people in the United States are dying and suffering from illness and injury at rates that are unnecessary (Institute of Medicine 2013a). Moreover, ever-higher health care spending with poorer health outcomes for its workforce puts the United States at an economic

disadvantage with respect to other countries (Institute of Medicine 2013a).

Other evidence indicates that the higher U.S. spending levels are attributable to the nation's significantly higher prices for health care services and not to greater utilization of hospital and physician services (Anderson et al. 2003, Laugesen and Glied 2011, Squires 2012, White 2007). The United States has shorter lengths of stay per hospital visit than most other countries and has a comparatively lower number of hospital beds and hospital visits per capita (Anderson and Squires 2010, Organisation for Economic Co-operation and Development 2013). At the same time, spending per hospital discharge is higher in the United States than any other OECD country (Anderson et al. 2003). Per capita, the United States also has relatively fewer physicians and physician visits compared with the other OECD countries (Anderson and Squires 2010, Organisation for Economic Co-operation and Development 2013). Physicians generally receive higher payment rates for office visits and hip replacements in the United States than in Australia, Canada, France, Germany, and the United Kingdom (Laugesen and Glied 2011).

However, the use and cost of sophisticated imaging technology—computerized tomography scanners, magnetic resonance imaging, and positron emission tomography scanners—are higher in the United States than most other OECD countries (Anderson and Squires 2010, Organisation for Economic Co-operation and Development 2013, Squires 2012).

One key driver of higher prices in the United States is provider market power (Berenson et al. 2012, Berenson et al. 2010, Coakley 2010). Hospitals merge and physician groups consolidate to gain market power over insurers to negotiate higher payment rates (see text box on pp. 6–7 for a discussion of market power and prices). In OECD countries, prices are typically set administratively. ■

(continued next page)

The United States spends more on health care than other countries but achieves poorer health outcomes (cont.)

FIGURE 1-13

Out of 34 OECD countries, the United States ranks first on health care spending but 26th on life expectancy

Figure 13a. Health care spending as a share of GDP, selected OECD countries, 2011

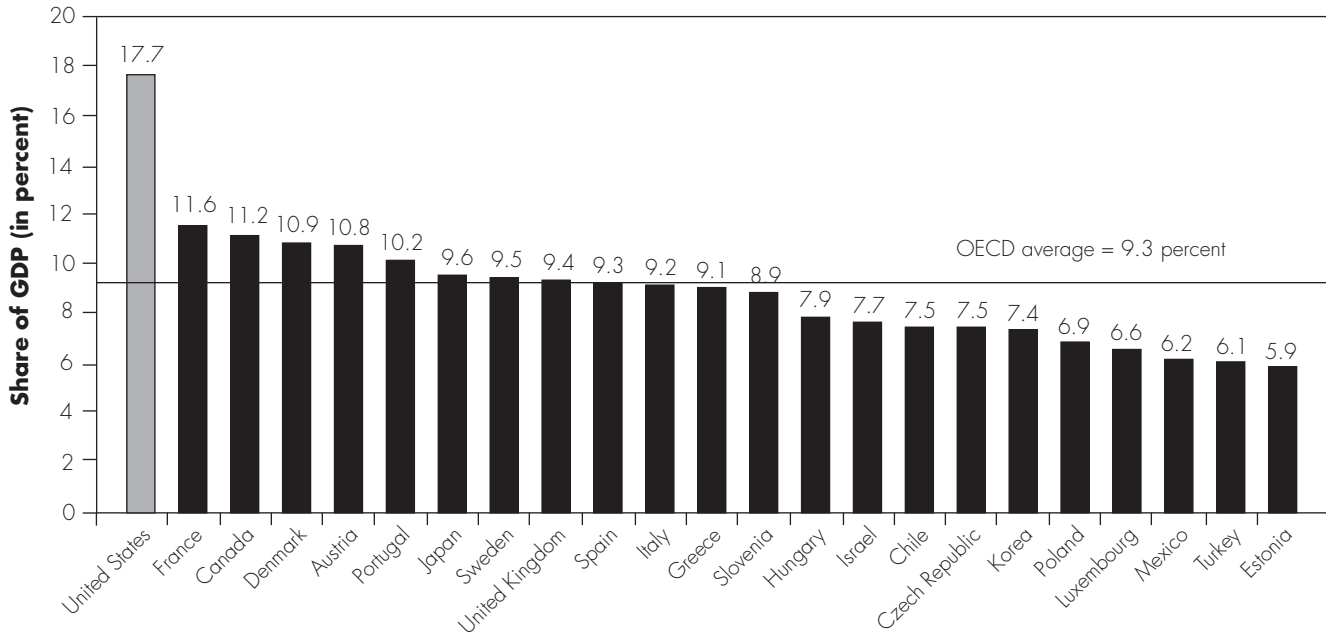
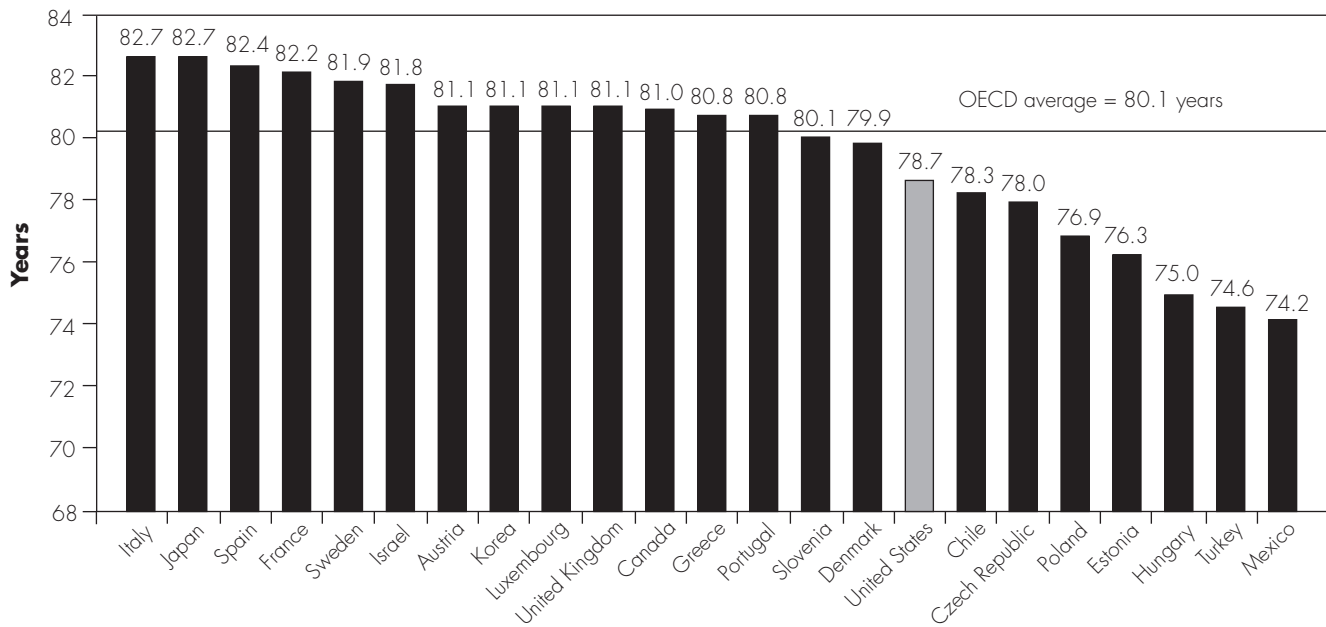


Figure 13b. Life expectancy at birth, selected OECD countries, 2011



Note: OECD (Organisation for Economic Co-operation and Development), GDP (gross domestic product).

Source: Organisation for Economic Co-operation and Development 2013.

al. 2006). Noting that minorities tend to seek care from poorer quality providers, the Commission recommended that the Secretary make low-performing providers and community-level initiatives a high priority in allocating resources for technical assistance for quality improvement. If effective, such a policy could lead to improved outcomes for racial and ethnic minority beneficiaries (Medicare Payment Advisory Commission 2011a).

Conclusion

The level and growth of health spending as a share of the economy will require that an ever-increasing amount of the country's economic activity and gain be dedicated to purchasing health care. Medicare, as the single largest payer in the health care sector, will expand, and its eligible population will grow more diverse with the aging of the baby-boom generation, with major implications for program spending and the delivery of care. Significant variation in use and spending, which does not correspond to better quality, raises flags 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 privately insured health care 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. All payers will face continued pressure to decrease growth in health care spending.

Despite the relatively lower spending growth rates 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 budgets and the downward trend in income, the Medicare program must be vigilant in pursuing reforms that decrease spending and improve quality. ■

Endnotes

- 1 MedPAC analysis of the 2012 version of the National Health Expenditures released in January 2014 by the Office of the Actuary, Centers for Medicare & Medicaid Services.
- 2 MedPAC analysis of National Health Expenditures Projections released September 2013, and projected GDP data from the Congressional Budget Office's *The 2013 Long-Term Budget Outlook*, released September 2013.
- 3 MedPAC analysis of the 2012 version of the National Health Expenditures released in January 2014 by Office of the Actuary, Centers for Medicare & Medicaid Services.
- 4 MedPAC analysis of National Health Expenditure Projections 2012–2022 released in September 2013 by the Office of the Actuary, Centers for Medicare & Medicaid Services.
- 5 While Medicare's spending on personal health care in 2012 was \$538 billion, Medicare's total spending in that year was \$574 billion. Total spending includes items such as investment and administration costs that are not included in personal health care.
- 6 In 2012, 10.6 million people were enrolled in both Medicare and Medicaid (Boards of Trustees 2013). 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.
- 7 Enrollees in private health insurance may also be enrolled in other third-party health insurance programs. For example, Medicare FFS beneficiaries may also have supplemental insurance sold by private companies.
- 8 Statements in this paragraph are based on the Commission's analysis of the 2012 version of the National Health Expenditures released in January 2014 by the Office of the Actuary, CMS, and historical GDP data from the Bureau of Economic Analysis (BEA), downloaded in December 2013. The historical GDP data reflect BEA's upward revisions to GDP estimates first released in July 2013.
- 9 Not every FFS beneficiary enrolls in a Part D prescription drug plan. In 2010 and 2011, a little over half were enrolled. Those who are not enrolled may be receiving prescription drug benefits from a former employer.
- 10 Both employer-sponsored health insurance and FFS Medicare rely on private insurers to administer drug benefits. Private insurers negotiate drug prices with pharmacies and rebates with drug manufacturers. As well, for FFS Medicare, PPACA required drug manufacturers to offer a 50 percent discount on brand drugs and a 7 percent discount on generic drugs filled in the coverage gap in 2011. The spending and price growth estimates are for total spending (including beneficiary cost sharing) and do not reflect any rebates or discounts.
- 11 To be comparable with the other Medicare data in Table 1-3, the 2011 brand-name drug dispensing rate of 25 percent is the rate for Medicare's prescription drug plans only (plans that service FFS beneficiaries) and does not reflect the experience of Medicare Advantage prescription drug plans.
- 12 This projection assumes that the reductions to the payment rates for physicians and other health professionals mandated by the sustainable growth rate (SGR) formula are replaced with a payment rate freeze beginning in 2014.
- 13 That estimate of Medicaid's share of state general fund spending is based on state Medicaid funds and excludes federal matching funds in the calculation.
- 14 The projections incorporate the effects that changes in debt and marginal tax rates have on the economy in the long run and how that economic feedback, in turn, would affect the budget. Without incorporating the economic feedback, CBO projects the debt to equal 100 percent of GDP by 2038 under the baseline assumptions.
- 15 This discussion of the impact on Medicare of rapid enrollment growth, aging, and demographic changes is focused on Medicare beneficiaries age 65 and over because the program's actuaries project that enrollment of beneficiaries under age 65 who are eligible on the basis of disability will grow much more slowly over at least the next 10 years than enrollment of those age 65 and over. Enrollment of beneficiaries under age 65 who are eligible on the basis of disability is projected to grow at an average annual rate of 0.7 percent from 2012 through 2022 compared with 3.8 percent annually for those age 65 and over (Boards of Trustees 2013).
- 16 The other sources of supplemental benefits that cover some or all Medicare cost-sharing liabilities are Medicaid programs and Medicare Advantage plans.

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CHAPTER

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 (2014) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2015). As part of the process, we examine payment adequacy for the “efficient” provider to the extent possible. 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, 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 reevaluates any prior year assumptions using the most

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- Are Medicare payments adequate in 2014?
- What cost changes are expected in 2015?
- How should Medicare payments change in 2015?
- Payment adequacy in context

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 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 quality or 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 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. 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 and physicians' offices (Medicare Payment Advisory Commission 2012). In this report, we extend that recommendation to additional services provided in those two settings and recommend consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients (see Chapter 3). The Commission will continue to analyze opportunities for applying this principle to other services and settings, such as those that provide post-acute care. ■

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 2015, we first consider whether payments are adequate for relatively efficient providers in 2014. 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 2014. We then consider how providers' costs will change in 2015. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2015.

Within a given level of funding, 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 medically complex patients.

We also make recommendations to improve program integrity when needed. In some cases, our data analysis reveals problematic variation across geographic regions or providers in service utilization. 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 2015 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 2014?

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:

- beneficiaries' access to care
- the quality of care
- providers' access to capital
- Medicare payments and providers' costs for 2014

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 their 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 (HOPD) 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. Medicare's payment systems are not generally based on quality; payment is usually the same regardless of the quality of care. For many years, the Commission has recommended creating incentives in Medicare FFS payment systems to reward better quality, and the Medicare program has recently begun to carry out

quality-based payment policies in a number of sectors. The Commission continues to look for ways to further improve quality-based payment policies, including delivery system reform that rewards care coordination and makes possible more comprehensive measures of population health.

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 2014

For most payment sectors, we estimate Medicare payments and providers' costs for 2014 to inform our update recommendations for 2015. 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 2013, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2010). 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 identified relatively efficient home health agencies (HHAs) last year (Medicare Payment Advisory Commission 2013). We plan to extend our efficient-provider analysis to other sectors as data and resources permit.

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, less 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 2013 and 2014 to our base data (2012 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2014. To estimate 2014 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 relation 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 (Berenson et al. 2010, Gaskin and Hadley 1997, Medicare Payment Advisory Commission 2005, Robinson 2011). 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 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 2015?

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 2015?

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 this year relative to the 2014 base payment as defined in Medicare's authorizing statute—Title XVIII of the Social Security Act. The Commission's recommendations may call for an increase, a decrease, or no change from the 2014 base payment. For example, if the statutory base payment for a sector were \$100 in 2014, an update recommendation of 1 percent for a sector means that we are recommending that the base payment in 2015 for that sector should be 1 percent greater, or \$101. If the current sequester (which reduces the amount providers receive from Medicare by 2 percent) remains in effect in 2015 and makes payments in that sector different from our recommended \$101 base payment rate in 2015, that policy would not be 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. By law, we are required to recommend payment changes to the Congress each year, and we do so by analyzing the circumstances of each sector. 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 aggregate Medicare margins differ. The Commission's approach is to evaluate the adequacy of Medicare's payments for each FFS sector, an assessment that includes both the level and distribution of payments. If in the course of this work the Commission finds savings that can be obtained without harming beneficiary access to and quality of care, the Commission will bring those options to the attention of the Congress. We will also continue to make our update recommendations year by year so we can give the Congress the best advice we can, taking into account the most current information available on payment adequacy. Our recommendations are referenced to the base rate in

statute, so they are unambiguous and are meant to stand regardless of any reductions required by the sequester.

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

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 will affect providers differentially based on their patients' characteristics.

The Commission, as it makes its update recommendations, may in some cases take payment differentials across sectors into consideration 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, as well as 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, upon leaving the hospital, patients with joint replacements requiring physical therapy might be discharged with home health care or outpatient therapy or be discharged to a SNF or IRF, and Medicare payments (and beneficiary cost sharing) can differ widely as a result. (See Chapter 7 on the challenges of aligning payments in post-acute care.)

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). In this report, we extend 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. We also recommend consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients (see Chapter 3). 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 baby boomers' aging, 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 accountable care organizations 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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CHAPTER

3

**Hospital inpatient and
outpatient services**

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

- 3** 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 2015 to 2017.
 - increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

COMMISSIONER VOTES: YES 16 • NO 0 • NOT VOTING 1 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

The 4,700 acute care hospitals paid under the Medicare prospective payment systems and the critical access hospital payment system received \$166 billion for 10.4 million Medicare inpatient admissions and 190 million outpatient services in 2012. These amounts compare with \$163 billion for 10.8 million inpatient admissions and 181 million outpatient services in 2011. Net payments per beneficiary were essentially constant from 2011 to 2012 due to roughly equal growth in total payments and the number of fee-for-service beneficiaries with Part A and Part B Medicare coverage.

This year, we recommend a package of changes to Medicare's hospital payment systems. The recommendation 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 long-term care hospitals (LTCHs), and changing inpatient and outpatient payment rates for fiscal year 2015 based on our assessment of payment adequacy and the impact of the outpatient and LTCH changes. This package of changes is designed to improve financial incentives in these payment systems while maintaining adequate overall payments.

Assessment of payment adequacy

To evaluate whether aggregate payments are adequate, we consider beneficiaries' access to care, changes in the volume of services provided,

In this chapter

- Are Medicare payments adequate in 2014?
- Joint recommendation on how to change hospital payment policies and payment rates in 2015

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, on average, overall Medicare margins continue to be negative, and under current law they are expected to fall further in 2015.

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

- ***Capacity and supply of providers***—We expect Medicare beneficiaries' access to hospital services to remain strong due to excess hospital capacity in most markets. The excess capacity stems from a decline in admissions per capita coupled with few hospital closures. While we eventually expect bed supply to more closely meet demand, there have been only modest reductions in bed supply in recent years.
- ***Volume of services***—Medicare inpatient volume declined by 4.5 percent and outpatient service volume grew by 4.3 percent. When inpatient and outpatient volumes are combined into a measure of adjusted admissions (which converts outpatient services to inpatient equivalents), overall service use shows a decline of over 2 percent per capita. Because there is excess capacity (occupancy rates averaged 61 percent in 2012), the decline in service volume appears to reflect a decline in demand for services.

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

Providers' access to capital—Most hospitals continue to have adequate access to capital markets. However, in 2013, some hospitals have faced downgrades by credit rating agencies associated with weak demand for inpatient care.

Medicare payments and providers' costs—From 2007 through 2012, Medicare IPPS hospital payments were 5 percent to 7 percent below allowable Medicare costs, with an industry-wide Medicare margin of –5.4 percent in 2012. 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 2011 and 2012. Their margins are expected to remain at 2 percent through 2014. However, under current law, payments are

projected to decline in 2015; this decline would result in lower margins for all hospitals, including the relatively efficient providers.

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, we recommend adjusting the rates paid 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 performed safely in physician offices. For example, Medicare pays more than twice as much for a level II echocardiogram in an outpatient facility (\$453) as it does in a freestanding physician office (\$189). This payment difference creates a financial incentive for hospitals to purchase freestanding physicians' offices and convert them to HOPDs without changing their location or patient mix. For example, from 2010 to 2012, echocardiograms provided in HOPDs increased 33 percent, while those in physician offices declined 10 percent. When echocardiograms shifted from being billed as physician services to being billed as HOPD services, the higher Medicare rates resulted in beneficiary cost sharing increasing from \$38 to \$91 for level II echocardiograms, and program cost increasing from \$151 to \$362. To remove this distortion in the payment system, the Commission recommends aligning outpatient prospective payment rates with physician office rates for certain services that meet the Commission's criteria. This approach will 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 LTCHs. As explained in greater detail in Chapter 11, 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 propose a new criterion for admissions to receive higher level LTCH payments. Chronically critically ill (CCI) patients would still qualify for the relatively high LTCH standard diagnosis related group (DRG) payment rates because they often need LTCH type care. LTCHs' average standard DRG rate for CCI patients would remain at roughly \$50,000. In contrast, most non-CCI patients at LTCHs (who often do not need LTCH type care) 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

To improve financial incentives in the Medicare hospital payment systems while maintaining adequate payments, the Commission recommends adjusting the relative payment rates in the outpatient prospective payment system, the long-term care hospital payment system, and the acute care inpatient outlier payment system. Specifically, the Congress should direct the Secretary of Health and Human Services to:

- 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 payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

This package of changes should be considered as a whole; together the 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 system is adequate to provide high-quality care for Medicare beneficiaries. These changes can be accomplished by reducing payment rates for services that can safely be provided in lower cost settings and, concurrently, increasing base payment 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	2011	2012	Average annual change 2006-2011	Change 2011-2012
Inpatient services					
Total FFS payments (in billions)	\$110	\$121	\$120	1.8%	-0.8%
Payments per FFS beneficiary	3,084	3,341	3,263	1.6	-2.3
Outpatient services					
Total FFS payments (in billions)	29	42	46	7.8	8.0
Payments per FFS beneficiary	845	1,305	1,397	8.1	7.0
Inpatient and outpatient services					
Total FFS payments (in billions)	140	163	166	3.2	1.5
Payments per FFS beneficiary	3,967	4,646	4,660	3.2	0.3

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 2012 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. Although the number of Medicare beneficiaries grew significantly from 2006 to 2011, the number of Part A FFS beneficiaries only increased slightly and Part B beneficiaries declined slightly due to the shift of beneficiaries to the Medicare Advantage program. From 2011 to 2012, the number of Part A beneficiaries grew by 1.6 percent, while the number of Part B enrollees grew by 0.9 percent, presumably because many 65-year-olds declined Part B because they continued to have employer-based insurance. For the purposes of calculating payments per beneficiary, we identified populations of beneficiaries eligible for inpatient (Part A) and outpatient (Part B) coverage. The combined inpatient and outpatient services per capita are based on a weighted average of the Part A and Part B beneficiaries.

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

Background

Acute care hospitals provide Medicare beneficiaries with inpatient care for the treatment of acute conditions and manifestations of chronic conditions. They also provide ambulatory care through hospital outpatient departments (HOPDs) and emergency rooms. In addition, many hospitals provide home health, skilled nursing facility, psychiatric, and rehabilitation services. To be eligible for Medicare payment, short-term general and specialty hospitals must meet the program’s conditions of participation and agree to accept Medicare rates as payment in full.

Medicare spending on hospitals

In 2012, Medicare paid acute care hospitals nearly \$120 billion for fee-for-service (FFS) inpatient care and nearly \$46 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 2011 to 2012, Medicare inpatient spending per FFS beneficiary decreased by 2.3 percent, and outpatient spending per FFS beneficiary grew by 7 percent.¹ The 2.3 percent decline in inpatient payments reflects a 4.5 percent drop in admissions per capita, which was partially offset

by increases in case complexity and Medicare payment rates. The 7 percent outpatient increase in spending reflects a 4.3 percent increase in service volume and an increase in Medicare payment rates. On a combined basis, total payments per beneficiary were roughly flat (a 0.3 percent increase) due to decreases in payments for inpatient care offsetting increases in outpatient payments.

Medicare’s payment systems for inpatient and outpatient services

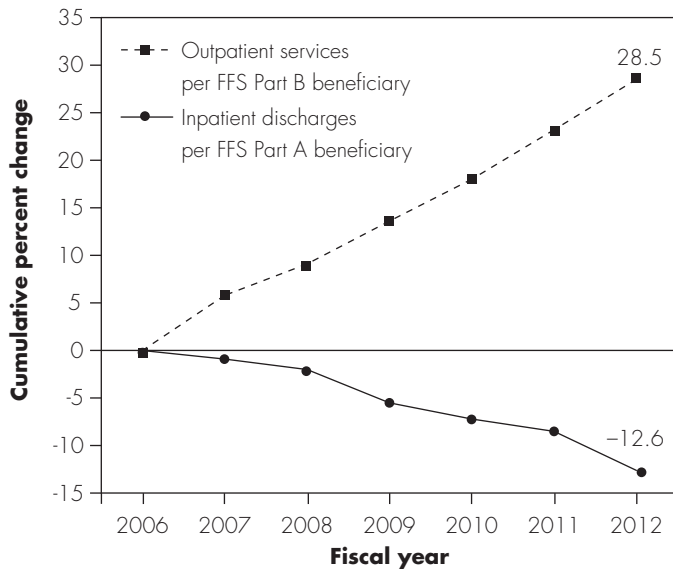
Medicare’s inpatient and outpatient prospective payment systems (PPSs) have a similar basic structure. Each has a base rate modified for the differences in type of case or service as well as geographic differences in input prices. However, each PPS has different units of service and a different set of payment adjustments.

Acute inpatient 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 payment 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

**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: Medicare hospital cost reports and Medicare outpatient claims data.

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 patient cases in 1 of 749 groups, which reflect 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 (no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPSS, including payment adjustments, can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_hospital.pdf.

Hospital outpatient 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 relative weight based on its geometric mean cost of service compared with the geometric mean cost of a clinic visit. A conversion factor translates relative weights into dollar payment amounts. A more detailed description

of the OPPS can be found at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_OPD.pdf.

Are Medicare payments adequate in 2014?

To judge whether payments for 2014 are adequate to cover the costs relatively efficient hospitals incur, 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 of 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 for treating Medicare patients remain negative for most hospitals.

Beneficiaries' access to care: Access remains positive, while excess inpatient capacity increased

We expect Medicare beneficiaries' access to hospital services to remain strong because of excess hospital capacity in most markets. The excess stems from a decline in admissions per capita coupled with few hospital closures. While we would expect bed supply to more closely meet demand eventually, hospitals have reduced bed supply only modestly in recent years.

Volume of services: Inpatient volume declines as outpatient volume grows

Medicare inpatient discharge volume declined 4.5 percent per Medicare FFS Part A beneficiary between 2011 and 2012 and by a total of 12.6 percent over the past six years (Figure 3-1). The decline is only partially explained by the shift to outpatient care. From 2011 to 2012, outpatient services increased 4.3 percent per Medicare Part B beneficiary; from 2006 to 2012, service volume increased by 28.5 percent. On a weighted average basis (where outpatient services are converted to inpatient equivalents), the total volume of Medicare hospital services per beneficiary declined from 2011 to 2012 by over 2 percent.

Declines in admissions are widespread across groups of patients. From 2011 to 2012, the volume of inpatient services declined approximately 4 percent to 6 percent across all Medicare age groups. Among privately insured individuals under age 65, inpatient admissions per capita declined by 1.5 percent in 2011 and then by another 3.1 percent in 2012 (Health Care Cost Institute 2013). This

**TABLE
3-2**

Growth in observation stays only partially explains decrease in admissions

	Number of discharges/visits per 1,000 beneficiaries			Change in volume per 1,000 beneficiaries			
	2006	2011	2012	2006-2012		2011-2012	
				Number	Percent	Number	Percent
Inpatient and observation stays per 1,000 beneficiaries							
Inpatient discharges	334	306	289	-45		-17	
Outpatient observation visits	28	47	53	25		6	
Total	362	353	342	-20	-6%	-11	-3%
Inpatient and observation days per 1,000 beneficiaries							
Inpatient days	2,218	2,136	2,063	-155		-73	
Outpatient observation days	30	56	65	35		9	
Total	2,248	2,192	2,128	-120	-5%	-64	-3%

Source: MedPAC analysis of claims data.

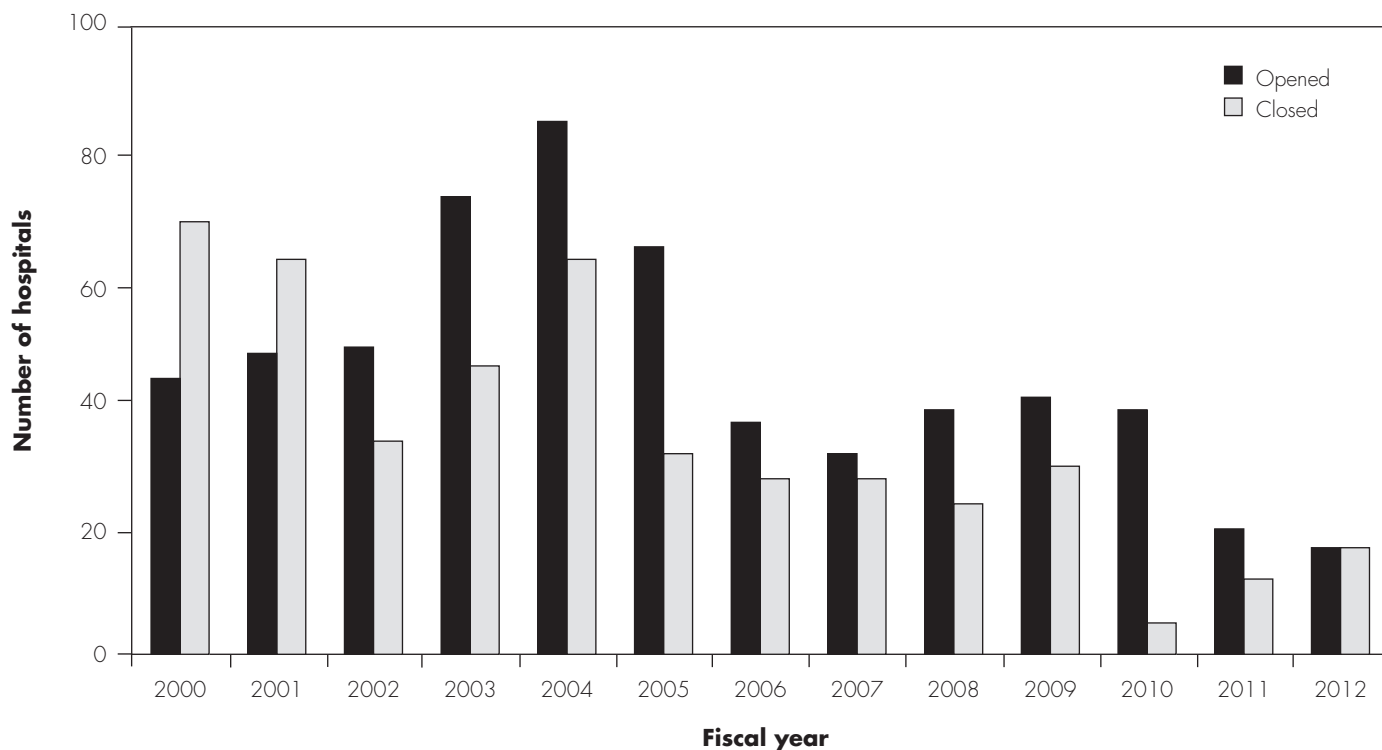
decline suggests that care patterns are changing for all insured patients, not just Medicare beneficiaries.

In 2012, there were slightly more than 10 million Medicare FFS inpatient discharges, and the rate of decline in discharges differed depending on the type, geographic location, and size of the hospital. For the same cohort of hospitals from 2006 to 2012, inpatient discharges declined 8 percent in urban hospitals and 21 percent in rural hospitals. The drop in inpatient discharges was most pronounced for the smallest rural hospitals (those with fewer than 100 beds), declining approximately 25 percent. This more rapid decline in discharges at the smallest rural hospitals is attributable in part to the movement of patient care from relatively isolated rural facilities to more centralized facilities. For example, large shifts in market share from rural hospitals to urban hospitals occurred for cardiac diagnosis related groups (DRGs) and nervous system DRGs (including stroke), which could reflect cases being directed to more specialized facilities that offer cardiac catheterization facilities and specialized stroke care centers (Jauch et al. 2013). Use of hospital inpatient care also varies among states and regions. In 2012, for example, approximately 15 percent of Medicare beneficiaries in Oregon and Vermont had an inpatient stay, compared with 21 percent in Ohio and Kentucky.

Observation stays are growing but only partially explain the decline in inpatient stays If a Medicare patient does not initially meet the criteria for inpatient admission but

the attending physician concludes the patient should be observed in the hospital for a period of time before being sent home, the patient can remain in the hospital in observation status.² Observation stays are billed as outpatient services rather than inpatient admissions. Over the last several years, outpatient observation claims have risen rapidly, but these stays alone do not account for the decline in inpatient discharges. From 2006 to 2012, the number of outpatient observation claims per 1,000 Part B beneficiaries increased from approximately 28 to 53 visits (Table 3-2). Inpatient discharges declined by 45 discharges per 1,000 beneficiaries (from 334 to 289). The net result is that the combined number of inpatient and observation stays declined by 20 stays from 2006 to 2012 (a 6 percent decline) and by 11 stays from 2011 to 2012 (a 3 percent decline). When we used days spent in the hospital as the unit of analysis, we similarly found a 3 percent reduction in combined observation and inpatient days, indicating that the growth in observation days does not fully explain the decline in inpatient days and occupancy.

Hospitals increased their use of observation status in 2012. CMS processed 1.8 million outpatient observation claims in 2012; another 700,000 observation stays did not result in observation claims because the patient was admitted for inpatient care and the observation care was bundled into the inpatient stay. From 2006 to 2012, the number of outpatient observation claims increased 88 percent and the

**FIGURE
3-2****Hospital openings and closures were equal in 2012**

Note: "Hospital" refers to general short-term acute care hospitals. MedPAC's reported number of open and closed hospitals can change from year to year based on hospitals that enter Medicare as an acute care facility and later convert to a more specialized type of facility, such as a long-term care hospital or critical access hospital.

Source: MedPAC analysis of Medicare Provider of Service file, inpatient prospective payment system final rule impact file, and hospital cost reports.

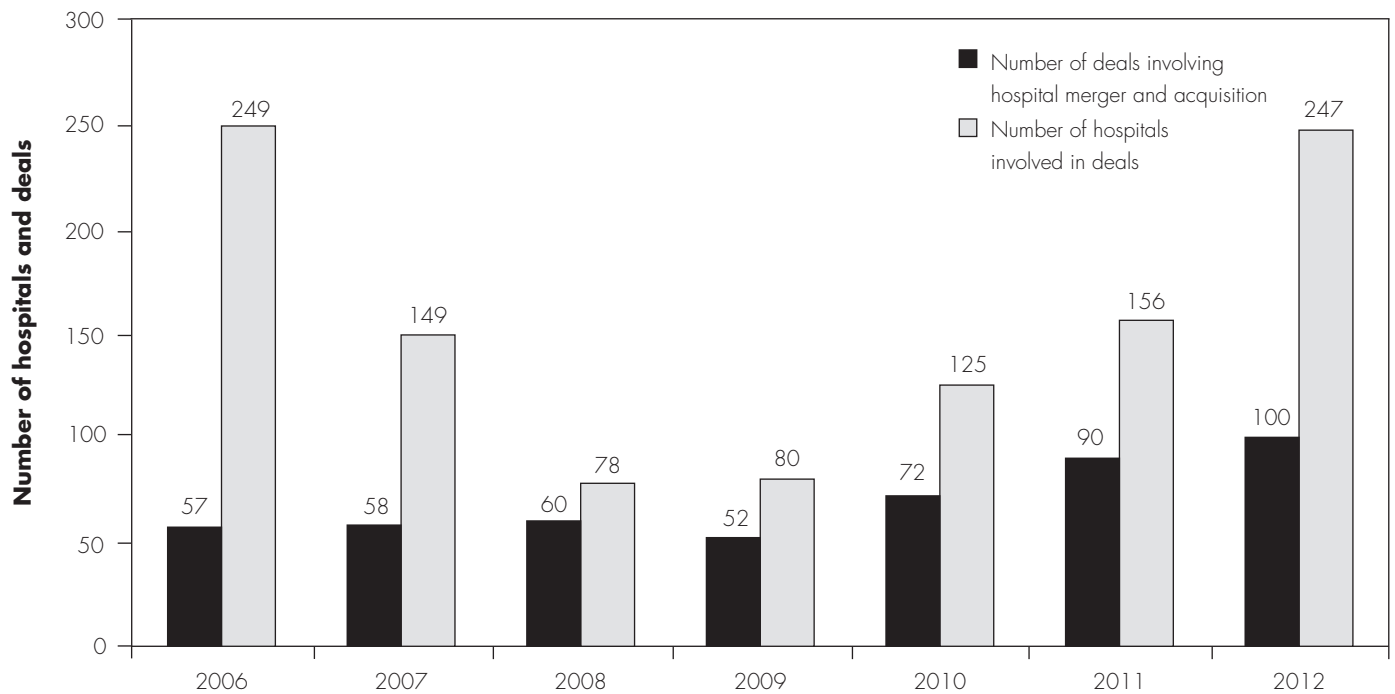
average length of observation stays also increased from 26 hours per stay to 29 hours per stay.

In 2012, Medicare paid \$2.5 billion for outpatient observation visits. The average payment per visit that included packaged outpatient observation care was about \$1,400, and the average out-of-pocket cost for Medicare beneficiaries was about \$360. Both volume and spending associated with outpatient observation visits in 2012 were concentrated among a small group of diagnoses. Six diagnoses accounted for about one-third of volume and one-third of spending: two different chest pain diagnoses, syncope, coronary atherosclerosis, dizziness, and dehydration. Chest pain alone accounted for 23 percent of observation stays.

Excess capacity varies by region From 2006 to 2012, the national average hospital bed occupancy rate for beds that were available to be staffed declined from 64 percent

to 61 percent, despite a decrease during this period in the number of available beds, from 2.8 beds to 2.6 beds per 1,000 people. Occupancy rates for urban hospitals declined from 67 percent to 64 percent on average. Occupancy rates for rural hospitals declined from 48 percent to 43 percent on average. Inpatient capacity is expected to remain in excess in most markets even after accounting for increases in demand expected from the 2014 expansion of Medicaid and introduction of the new mandate to purchase insurance.³

On a market level, the extent of excess inpatient capacity varied widely in 2012. Among the 382 metropolitan statistical areas with available data, 17 markets had average hospital occupancy rates of more than 75 percent, 243 markets had rates between 50 and 74 percent, 121 markets had rates between 25 and 49 percent, and 1 market had an average occupancy rate below 25 percent.⁴

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

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

Despite declining demand for inpatient services, few hospitals closed in 2012

In 2012, approximately 4,700 short-term acute care hospitals participated in the Medicare program, of which approximately 1,300 were critical access hospitals (CAHs) (Flex Monitoring Team 2012). In that year, 17 acute care hospitals closed and 17 new hospitals opened (Figure 3-2).⁵ In light of changes in the practice of medicine, reductions in inpatient discharges, and declining occupancy rates, we may see more than 17 closures per year in the future.

The 17 hospital openings added 1,200 new acute care beds and the closures eliminated about 2,000 beds, a net reduction of 800 beds. This amount represents a 0.1 percent reduction in existing bed capacity. The majority of closures occurred in urban locations, with only four occurring in rural locations. Among the 17 closed facilities, most appear to have closed completely, but 5 were converted to outpatient care facilities.

Closed hospitals had low occupancy and lower average quality scores

Hospitals that closed in 2012 had an average occupancy rate of 27 percent in 2011, considerably lower than the 57

percent average occupancy rate of the competing nearby hospitals.⁶ For most of the closed facilities, low occupancy was associated with poor financial performance. (Poor performers are discussed in the text box, pp. 60–61.) The average all-payer 2011 profit margin for the hospitals that closed in 2012 was –10.5 percent, considerably lower than the average of 6 percent for all hospitals. On average, closed hospitals had slightly higher readmission and mortality rates, but the differences were not statistically significant. In terms of patient satisfaction, 6 of the 17 hospitals had among the lowest scores in the nation, based on the share of their patients who would “definitely not recommend” their hospital to others. The 17 hospitals also had lower average quality scores on three process measures for cardiac care.⁷

Hospital industry consolidation increased

In 2012, at least 247 individual hospitals were acquired in over 100 transactions (Irving Levin Associates Inc. 2013).⁸ Both the number of merger and acquisition deals in 2012 and the number of hospitals involved in the deals represent a marked increase from 2009 to 2012 (Figure 3-3).

Large acquisitions continued in 2013, with the Tenet system’s acquisition of Vanguard Health Systems and Community Health Systems’ (CHS’s) acquisition of

Characteristics of poorly performing hospitals

As discussed, inpatient volume and occupancy rates have been declining for the past several years. Eventually, these trends may result in hospitals closing or merging to reduce unneeded capacity. Some recently closed hospitals had low occupancy and low patient satisfaction. If more such hospitals closed, that could improve the quality of care as long as neighboring hospitals have excess capacity. We analyzed the characteristics of low-occupancy, low-performing hospitals to understand what role they play in their markets and whether other hospitals (with better quality metrics) could absorb some or all of these hospitals' patients.

We defined hospitals as low occupancy, high readmission, and poor satisfaction if they met all three of the following criteria:

- an occupancy rate for beds available to be staffed of under 50 percent
- risk-adjusted hospital-wide readmissions rates in the worst decile
- patient experience survey (Hospital Consumer Assessment of Healthcare Providers and Systems®) scores in the worst decile as indicated by either:
 - a high (worst decile) share of patients rating the hospital 6 or lower on a 10-point scale
 - a high share of patients who would not recommend the hospital
 - a low share of patients who would recommend the hospital

We identified 112 hospitals with this combination of low occupancy, high readmission rates, and low patient satisfaction. Of these, about half were urban hospitals and half were rural hospitals.

- *Urban poor-performing hospitals.* Most of the poor-performing hospitals are near another hospital—half have another hospital less than five miles away. However, a quarter of these urban hospitals are more than 15 miles away from the nearest hospital, so they do not have a direct competitor in their immediate vicinity. On average, urban low-performing hospitals have an average of 138 beds, an average daily census of 50 patients, and are disproportionately for profit (70 percent compared with 27 percent of all urban hospitals). Chicago, Los Angeles, and Miami all have multiple hospitals identified as low performing and low occupancy.
- *Rural poor-performing hospitals.* In most cases, these hospitals are the only hospital in the immediate market; median distance to the next nearest hospital is almost 25 miles. However, 8 of these rural hospitals have a neighboring hospital within 15 miles and 3 have a competing hospital of similar size in the same town. The low-occupancy, low-quality rural hospitals have an average of 78 beds and an average daily census of 23 patients. Alabama, Arkansas, Louisiana, Mississippi, Oklahoma, Tennessee, and Texas all have at least four rural hospitals classified as low performing and low occupancy.

The financial situation of many of these hospitals is tenuous. In general, these hospitals have falling

(continued next page)

Health Management Associates. These two deals made CHS 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. These three chains now collectively own nearly 450 hospitals (Moody's Investors Service 2013a). Los Angeles-based Prime Healthcare Services also

expanded its portfolio by acquiring six additional hospitals in New Jersey, Rhode Island, and Texas.

There has also been an increase in vertical integration—hospital systems merging with insurers or other hospital systems that have an insurance product. We have been told by some hospital executives that they are pursuing this strategy to prepare for taking on greater risk-based contracts. Some recent acquisitions include Pittsburgh's

Characteristics of poorly performing hospitals (cont.)

occupancy rates and lower than average total all-payer margins in 2011 as compared with other hospitals, with 43 percent facing negative total margins. Moreover, their non-Medicare margins were much lower than average, with the median at only 2.2 percent, 5 percentage points below the median for all hospitals. In contrast, these hospitals have higher Medicare inpatient and overall Medicare margins relative to other facilities. This situation is likely due to Medicare disproportionate share payments since most of these hospitals have above average shares of low-income Medicare patients.

In addition to poor readmission rates, most of these hospitals also perform poorly on mortality metrics. Their median all-condition mortality rate (as measured by an Agency for Healthcare Research and Quality metric) was 20 percentage points higher than average.

To better understand what might be happening to this set of hospitals, we examined whether the hospital was still operating in 2013 or may have merged or had other major organizational changes. Our analysis found that:

- 8 of the 112 hospitals closed.
- 3 hospitals were involved in bankruptcy proceedings.
- 22 hospitals were or are undergoing a change in ownership.
- 8 were undergoing substantial renovations of their facilities; 2 were replacing their entire facility.

- 10 were either eliminating specific services such as the emergency department, intensive care unit, or pediatrics department, or were making substantial cuts in staffing without any specific departments targeted.
- 6 had a specialty focus, generally a surgical specialty, which may also explain their low occupancy rates. (The services of these specialty hospitals may not be crucial for access.)
- 3 were likely unavailable to the general public since 2 were hospitals located within retirement communities that provide all levels of care to their residents and the other was a state hospital that provides surgical and medical care to residents of state mental health facilities.

Poor performance on patient surveys and other quality metrics may signal a hospital that is in trouble; in fact, five of the urban hospitals we identified closed, and competing hospitals absorbed their patient loads. In situations where a low-performing hospital is the only facility in the immediate market, other interventions may be necessary if that facility is to remain open. In some cases, larger systems purchase these poor-performing providers. In other cases, the hospitals or communities have committed resources to improving the facilities, through either major renovations or curtailing underperforming services. ■

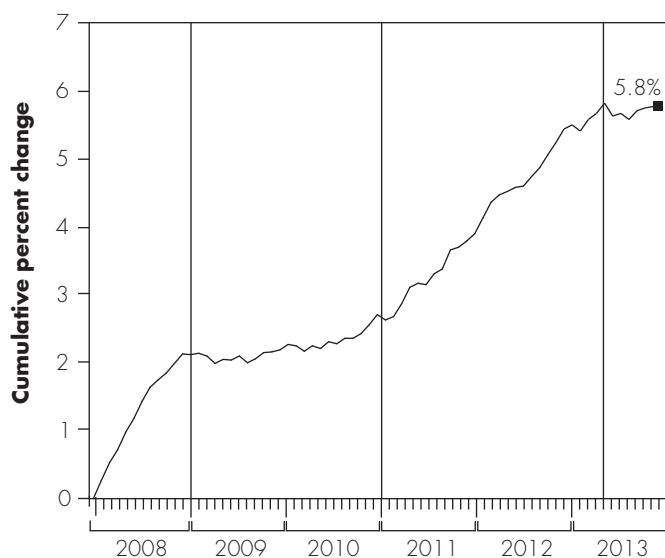
health insurer, Highmark Inc., recently acquiring Saint Vincent Health System in Erie, Pennsylvania. HealthPartners, a nonprofit insurer in Minnesota with an existing network of hospitals and clinics, merged with Park Nicollet, a nonprofit physician group practice with a hospital of its own. Both of 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. In addition, Baylor Health Care System of northern Texas merged with Scott & White Healthcare of central Texas to form the state's largest nonprofit health system. The merger will not only create a system encompassing 43 hospitals, 500 patient care sites,

and more than 6,000 affiliated physicians, but also will include a health plan originating from Scott & White.

The presence of accountable care organizations (ACOs) in a particular market does not appear to be directly correlated with hospital merger and acquisition activity since half of mergers and acquisitions occur in markets with an ACO and half in markets without a significant ACO presence. This observation is not surprising since hospitals can benefit from enhanced market power through consolidation in markets with and without ACOs. Greater provider consolidation can lead to higher prices for commercially insured patients (Gaynor and Town 2012). The additional commercial revenue can reduce financial

**FIGURE
3-4**

Hospital employment growth since 2008



Source: Bureau of Labor Statistics.

pressure to constrain costs, resulting in higher costs for Medicare and privately insured patients, as well as reduced Medicare margins. The result could be an increase in the discrepancy between Medicare and private payer payment rates.

Access to capital and employment remains steady

Overall, hospitals maintained reasonable access to capital markets in 2012 and 2013. Hospital construction spending has been consistent over the last three years, with more construction now focused on building outpatient capacity than inpatient capacity. Hospital employment grew significantly in 2012 but remained flat in 2013.

Hospital borrowing

Overall, the hospital industry maintains reasonable access to capital markets. Through the end of 2012, hospital tax-exempt municipal bond offerings amounted to \$27 billion, including refinancing. Bonds involving only new financing remained relatively flat at \$18 billion in 2012. We expect refinancing to decline since interest rates increased between November 2012 and November 2013 from 3.5 percent to 5.13 percent for the average double-A tax-exempt 30-year hospital bond (Brothers 2013). While most hospitals continue to have access to bond markets,

some hospitals have had their credit ratings downgraded. Moody's cites the decline in hospitals' volumes as one reason why the number of downgrades (30) exceeded upgrades (18) through the first three quarters of 2013 (Moody's Investors Service 2013b). In addition to the traditional capital bond markets and use of cash flows from operations, hospitals have increasingly sought out alternative sources of capital, for instance, by partnering with real estate entities that possess both capital and expertise in developing health care facilities (Zismer 2013).

Hospital construction

The dollar value of hospital construction projects in the United States remained steady in 2012 and the first half of 2013. Hospital construction spending was consistently in the \$26 billion to \$28 billion range in 2010, 2011, and 2012 (Census Bureau 2013). Based on data from the first half of the year, the Census Bureau projects that 2013 hospital construction spending also exceeded \$26 billion. These findings are consistent with Moody's Investment Service's observation concerning a steady median capital-spending ratio—1.2 times annual depreciation in 2011 and 2012—and hospitals spending more than necessary to replace existing facilities (Moody's Investors Service 2013c). Additionally, in *Modern Healthcare's* 2013 Construction & Design Survey, respondents indicated that the balance of hospital construction spending has tilted away from inpatient- and toward outpatient-based projects, such as building new medical office buildings (Robeznieks 2013).

Hospital employment

Over the past six years, hospital employment has grown by a total of 5.8 percent, but employment has alternated between periods of growth and stability (Figure 3-4). Before the recession of 2009, employment grew by 2 percent per year. But during the recession (January 2009 to January 2011), hospital employment growth slowed to less than 0.5 percent per year. As the economy started to recover, hospital employment increased more than 1 percent per year (January 2011 to August 2012). Finally, in the most recent 12 months (November 2012 to November 2013), hospital employment was flat, reflecting a lack of growth in patient volume. Over the same six-year period, employment for the rest of the health care sector grew by 14.8 percent.⁹ Employment trends appear strong in the health care sector and the hospital industry compared with the rest of the economy, which declined 2.6 percent over the same period. While the hospital industry has added jobs in recent years, an increase in the number of individuals employed by a given industry may not indicate

Hospital Readmissions Reduction Program: Options for refinement

In its June 2013 report to the Congress, the Commission included a chapter on options for refining the Hospital Readmissions Reduction Program. The chapter focused on three primary changes:

- provide a fixed target for readmission rates so penalties disappear if a hospital reduces its readmission rates below the target,
- use an all-condition readmission measure to increase the number of observations and reduce the random variation compared with single readmission measures, and
- evaluate each hospital's readmission rate against the rate for a group of its peers with similar shares of low-income Medicare beneficiaries as a way to

adjust the readmission penalties for socioeconomic status.

These refinements would help overcome issues with current policy, maintain or increase the average hospital's incentive to reduce readmissions, and increase the share of hospitals that has an incentive to reduce readmissions. The changes could be structured so that the Medicare program savings from either future reductions in readmissions or future penalties are equal to the expected savings under current law. The three readmission program changes would require new legislation because the current formula to compute the readmission penalty is set in current law. The goal of the refinements would be a decline in readmissions, a decline in penalties paid by hospitals, and a decline in Medicare spending on readmissions. ■

an improvement in economic efficiency (Baicker and Chandra 2012).

Quality of care: Overall, indicators show improvement

We use mortality rates and patient safety indicators (PSIs) developed by the Agency for Healthcare Research and Quality (AHRQ) to evaluate trends in the quality of inpatient care. Our analysis for the period 2009 to 2012 shows generally positive trends in quality. We observed statistically significant improvements in 8 out of 10 risk-adjusted mortality rates, including in-hospital and 30-day postdischarge, for 5 prevalent clinical conditions.¹⁰ We also found statistically significant improvements from 2009 to 2012 in seven out of the eight risk-adjusted PSIs analyzed.¹¹

Readmission rates have improved, but refinements in the Medicare Hospital Readmissions Reduction Program are warranted

The Congress enacted a Medicare Hospital Readmissions Reduction Program in 2010. Starting in fiscal year 2013, hospitals face a penalty if they have above-average readmission rates (from a prior three-year period) in one of three clinical conditions (heart failure, acute myocardial infarction, or pneumonia). The penalty is capped at 1 percent of base inpatient payments in 2013, 2 percent

in 2014, and 3 percent in 2015 and after. CMS plans to add two more sets of conditions (acute exacerbation of chronic obstructive pulmonary disease and hip and knee replacements) to the measure in 2015.

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 Readmissions Reduction Program (Medicare Payment Advisory Commission 2013c). From 2009 through 2011, all-cause readmission rates for the three conditions covered by the current readmissions reduction program dropped between 0.5 and 0.7 percentage point, with a slightly larger drop if we focused only on potentially preventable readmissions. In 2012, readmission rates continued to decline for these conditions, with the average rate dropping an additional 0.5 percentage point across all conditions. Analysis from CMS also shows a decline in all-cause 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 readmissions reduction payment policy and other efforts such as the Partnership for Patients have encouraged hospitals to look beyond their walls and improve care coordination across providers to reduce readmissions (Naylor et al. 2012). The Commission finds that the policy should be refined and continued (see text box).

Value-based purchasing program

The Congress mandated a value-based purchasing (VBP) program for IPPS hospitals beginning in fiscal year 2013. For fiscal year 2014, CMS reduced all IPPS hospitals' base operating DRG payment amounts by 1.25 percent to create a pool of funds from which the performance-based incentive payments will be distributed. As required by law, the total amount of withheld payments, which CMS projected at \$1.1 billion for fiscal year 2014, must be redistributed to hospitals participating in the VBP program.

The Commission has expressed concerns regarding the relatively large number of clinical process measures and low weight (25 percent) given to the outcome measures in the first year of the program (Medicare Payment Advisory Commission 2012a). CMS is moving to address this concern. By 2016, CMS will use an almost equal number of outcome and process measures and will increase the outcome measures' weight (to 40 percent) in the calculation of a hospital's total performance score, while reducing the weight for process measures (to 10 percent).

Hospital-Acquired Condition Reduction Program

In 2010, the Congress enacted a Hospital-Acquired Condition (HAC) Reduction Program that will take effect in fiscal year 2015. Medicare will reduce payments by 1 percent to IPPS hospitals that rank in the lowest national quartile on a set of hospital-acquired conditions defined by CMS. For fiscal year 2015, CMS has decided to use a composite of AHRQ PSIs and two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention (CDC).

The Commission has expressed its concerns 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 with the current readmissions penalty program, it may be more effective to use a fixed performance target, to create an incentive for all hospitals to decrease HACs at least to 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 Medicare patients as one of the five key indicators of payment adequacy. We assess the adequacy of Medicare payments for the hospital as a whole (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 services, plus graduate medical education payments and costs.

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.

To measure the pressure 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.

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 2012, the base inpatient payment rate increased by approximately 1 percent.¹² Our analysis also shows that inpatient case mix increased approximately 1.4 percent between 2011 and 2012, which is larger than the 0.5 percent increase in 2011. The 2012 case-mix growth may be the result of real changes in the mix of patients rather than continued documentation and coding changes that we observed for several years after the implementation of the MS-DRGs in 2008.¹³ The additional payments hospitals receive for health information technology (HIT) significantly affected payments. Between 2011 and 2012, Medicare HIT payments rose from \$0.8 billion to \$2.4 billion.¹⁴ These payments increased hospitals' FFS Medicare revenue by more than 1 percent.

**TABLE
3-3**

Cost growth close to input price inflation since 2009

Cost measure	Annual cost growth				Average annual cost growth 2009-2012
	2009	2010	2011	2012	
Inpatient costs per discharge	3.5%	1.6%	2.5%	3.1%	2.7%
Outpatient costs per service	4.8	0.1*	2.7	3.2	2.7
Weighted average	3.9	1.1	2.5	3.1	2.7
Input price inflation	2.6	2.1	2.7	2.2	2.4

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 adjusted for complexity of services provided. Input price inflation reflects a weighted average of changes in the hospital operating and capital market basket indexes.

Source: MedPAC analysis of Medicare cost reports and claims files from CMS.

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

From 2009 through 2012, hospitals’ Medicare inpatient and outpatient costs per case grew an average of 2.7 percent, only about 0.3 percent faster than input price inflation (the hospital market basket index) (Table 3-3). This growth is much slower than that experienced through most of the 2000s, when costs increased one or more percentage points faster than input price inflation.

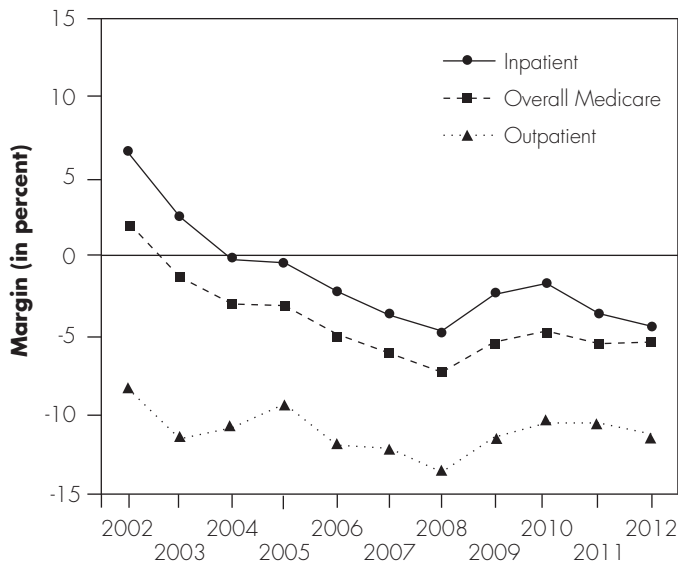
The lower cost growth from 2009 through 2012 was partly due to lower input price inflation facing hospitals, reflecting lower economy-wide inflation for goods and services and slower wage growth. Compensation costs for hospital workers, for example, grew by less than 2.5 percent in each year from 2009 through 2012. These increases are the smallest in hospital compensation costs in more than a decade (Bureau of Labor Statistics 2013b). Hospitals may also have worked to control cost growth in response to the recession and difficult year they had financially in 2008, when the industry experienced historically low total all-payer margins (1.8 percent) and had declines in hospitals’ investment portfolios, including those that fund hospital workers’ retirement plans.

Lower cost growth, however, was not uniform across provider groups. We see higher cost growth for smaller rural hospitals in 2011 and 2012, which could be due to higher revenues associated with the low-volume adjustment. Rural hospitals with less than 50 beds, for example, saw Medicare inpatient payments per case

increase by 8.8 percent in 2011, but they also had much higher growth in cost per case, at 6.5 percent in 2011 and 5.1 percent in 2012. This trend compares with an average cost increase of 2.7 percent for hospitals that did not receive this adjustment. For-profit hospitals’ Medicare costs per case rose by just 1.6 percent in 2012, the lowest of any hospital group. For-profit hospitals tend to control their costs to increase profits, even when they are not under financial pressure to do so. Nonprofit hospitals’ costs tend to be more related to financial pressure.

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, which are 1,300 rural hospitals paid 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, p. 66).¹⁵ However, from 2008 to 2010, the overall Medicare margin went up from -7.3 percent to -4.7 percent, largely due to documentation and coding changes and lower cost growth. In 2011, it declined to -5.5 percent as CMS started to recover past coding-related overpayments. In 2012, it 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.

**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 system. Overall Medicare margin covers acute inpatient, outpatient, hospital-based home health and skilled nursing facility (including swing bed), inpatient psychiatric and rehabilitation services, plus graduate medical education and health information technology payments.

Source: MedPAC analysis of Medicare cost reports from CMS.

2012 Medicare margins by hospital type

We further examined overall aggregate Medicare margins by hospital type. In 2012, the -1.9 percent overall Medicare margin for rural PPS hospitals was higher than the -5.8 percent margin for urban hospitals (Table 3-4). Smaller rural hospitals saw the greatest improvement in their overall Medicare margins. Between 2010 and 2012, rural hospitals in the bottom quintile of inpatient volume saw their overall margins increase from -2.1 percent to 7.1 percent (not shown in Table 3-4). This improvement is likely temporary, however, because many of these hospitals received a combination of low-volume and other temporary payments that are scheduled to expire before 2015.

In 2012, the overall Medicare margin was -2.6 percent for major teaching hospitals, which is 2.8 percentage points higher than the average for all hospitals. Major

teaching hospitals have higher overall Medicare margins than the average IPPS hospital in large part due to the extra inpatient payments they receive through the indirect medical education (IME) and disproportionate share (DSH) adjustments in the IPPS. Past Commission analysis has shown that the IME and DSH adjustments have provided payments that substantially exceed the estimated effects that teaching intensity and service to low-income patients have on hospitals' average costs per discharge. In June 2010, the Commission made recommendations to use teaching hospital payments as incentives to train physicians for 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 on average (-7.2 percent in 2012).

In aggregate, overall Medicare margins at for-profit hospitals were positive in 2012, well above aggregate margins for nonprofit hospitals. In 2012, the aggregate overall Medicare margin for for-profit hospitals was 1.5 percent compared with -7.1 percent for nonprofit hospitals, an 8.6 percentage point differential. In aggregate, for-profit hospitals have higher inpatient margins (6.4 points higher) and higher outpatient margins (11.2 points higher) than nonprofits. Our analysis of data in recent years shows that most of the differential in margins can be explained by lower cost structures for inpatient and outpatient care at for-profit hospitals. However, 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 (see text box, p. 68)

Total (all-payer) profitability reaches a 20-year high in 2012

Hospitals' total (all-payer) profit margins are an indicator of how much financial pressure hospitals are under to control costs. In 2012, total margins for hospitals increased to 6.5 percent, the highest level recorded since we started tracking all-payer margins (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 due to strong average increases in private-payer prices. The Health Care Cost Institute and the Bureau of Labor Statistics report that payment

**TABLE
3-4**

Overall Medicare margins by hospital group

Hospital group	2007	2008	2009	2010	2011	2012
All hospitals	-6.1%	-7.3%	-5.4%	-4.7%	-5.5%	-5.4%
Urban	-6.3	-7.5	-5.5	-4.9	-5.8	-5.8
Rural						
Excluding CAHs	-5.2	-6.1	-4.6	-2.8	-2.9	-1.9
Including CAHs	-3.7	-4.3	-3.2	-1.8	-1.6	-0.3
Nonprofit	-7.0	-8.5	-6.7	-6.0	-6.8	-7.1
For profit	-3.5	-2.9	-0.3	0.0	-0.3	1.5
Government*	N/A	N/A	N/A	N/A	N/A	N/A
Major teaching	-0.5	-2.4	-1.1	-0.5	-2.0	-2.6
Other teaching	-6.5	-7.3	-5.3	-4.8	-5.1	-5.2
Nonteaching	-9.4	-10.2	-8.2	-7.3	-7.9	-7.2

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.

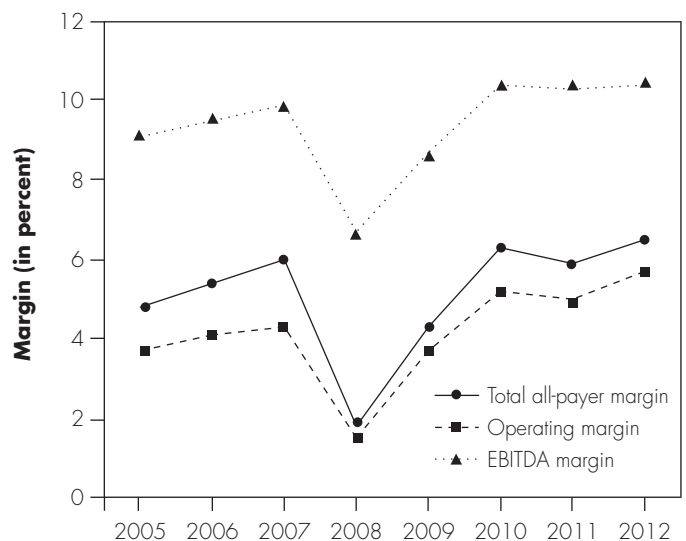
Source: MedPAC analysis of Medicare cost reports, Medicare Provider Analysis and Review files, and impact files from CMS.

rates from private insurers have grown at rates averaging 5 percent to 6 percent annually from 2011 through 2013 (Bureau of Labor Statistics 2013a, 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 the strong total all-payer margin (Figure 3-6). In addition, cash flow, as measured by earnings before interest, taxes, depreciation, and amortization (EBITDA), held steady at 10.4 percent in 2012, showing hospitals maintained a relatively strong cash flow position. It is unclear whether cost growth will remain at current levels or rebound to levels above input price inflation due to 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 2012). In general, in periods when the hospitals were under pressure due to managed care cost constraints or contractions in the economy, costs per discharge grew slowly. In periods when profit margins were high, costs per discharge grew more rapidly.

**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.

For-profit outpatient hospital margins

To examine the degree to which service mix contributes to better outpatient margins among for-profit hospitals, we examined 2009 Medicare data, which was the most recent available detailed data at the time this study was conducted. As was also the case in 2012, 2009 outpatient margins varied widely among hospitals and hospital groups. The average outpatient margin was –2.5 percent among for-profit hospitals and –12.6 percent among nonprofit hospitals on average, while major teaching hospitals had an outpatient margin of –21 percent.

It is possible that these discrepancies among hospital categories are due to the most profitable hospitals focusing on services that have the lowest cost relative to payment (most profitable) in the outpatient prospective payment system (OPPS), while the least profitable hospitals disproportionately provide services that are less profitable. Alternatively, it could be that the more profitable hospitals use fewer inputs per service than less profitable hospitals, meaning that their cost per unit of outpatient service is lower, after adjusting for differences in their mix of services.

We examined hospitals' 2009 outpatient cost and service mix data to determine which of these factors contributes

more to the differences in outpatient margins among hospital groups. We found that differences in hospitals' basic cost structures have a larger effect on hospitals' outpatient Medicare margins than differences in service mix. In particular, underlying cost-structure differences increase the outpatient cost per unit of service in major teaching hospitals by 10.4 percent above the national average and decrease the cost per unit in for-profit hospitals by 5.2 percent below the national average. In contrast, service mix differences increase cost per unit for major teaching hospitals by 1.2 percent and decrease cost per unit in for-profit hospitals by 0.8 percent (Table 3-5). This finding suggests that differences in average relative profitability among services under the OPPS are small, while cost differences across hospital categories are large among services grouped together in each ambulatory payment classification.

We suspect that a part of the higher outpatient costs for major teaching hospitals is due to the teaching costs they incur. Medicare makes extra payments for teaching costs under the inpatient prospective payment system but not under the OPPS. However, for-profit hospitals still have roughly a 6 percent lower cost structure on average than other hospitals after controlling for the effect of teaching status (not shown). ■

**TABLE
3-5**

Cost structure has larger effect than service mix on outpatient costs

Hospital group	Effect on cost relative to national average		
	Medicare margin	Effect of cost structure	Effect of service mix
Urban	-12.6%	0.4%	0.1%
Rural	-7.2	-2.5	-0.5
Major teaching	-21.0	10.4	1.2
Other teaching	-8.4	-0.5	-0.4
Nonteaching	-7.8	-3.9	-0.7
Nonprofit	-12.6	1.0	0.0
For profit	-2.5	-5.2	-0.8
Government	-14.2	2.1	0.8

Note: This analysis examines how hospital cost structure and service mix affect cost per unit in hospital outpatient departments for the hospital groups listed in this table. The second column indicates how much hospital cost structure causes per unit cost in a hospital group to be above or below the national average per unit cost. The third column indicates how much service mix causes per unit cost in a hospital group to be above or below national average per unit cost. The difference in Medicare margins is not completely explained by cost structure and service mix given that we have excluded outliers and separately payable drugs in this analysis. Major teaching hospitals have resident-to-bed ratios above 0.25. This analysis excludes critical access hospitals.

Source: MedPAC analysis 2009 hospital claims from their outpatient departments.

Profit margins and financial pressure to constrain costs vary by hospital

The effect of financial pressure on hospitals' costs is not only evident over time; it is also evident when comparing hospitals facing different levels of financial pressure to constrain costs. Some hospitals have strong profits on non-Medicare services and investments and are under relatively little pressure to constrain their costs. Other hospitals, with thin profits 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 2007 to 2011. 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 2007 to 2011 ended up with lower standardized Medicare costs per discharge in 2012 than hospitals under low levels of financial pressure during the same five-year period. For more details on our analytic methods, see our prior year's analysis of payment adequacy (Medicare Payment Advisory Commission 2011).

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

- **High pressure = low cost:** The 26 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 2,822 IPPS hospitals with available data. Because of their lower Medicare costs, hospitals under pressure generated a median overall Medicare profit margin of 2 percent, which is 7 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 -10 percent, which is 4 percentage points below the national median.
- While the high-pressure hospitals' costs are significantly lower than low-pressure hospitals' costs, the cost differential between these groups remained

constant in recent years. Both low-pressure and high-pressure hospitals have constrained cost growth to about 2 percent per year from 2011 to 2012, which is roughly the rate of input price inflation. The similar rate of cost growth for the two groups suggests that financial pressure may cause a one-time shift in cost structure rather than allowing perpetually lower cost growth.

- **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.

The overarching conclusion is that costs are at least partially under hospitals' control, and those hospitals with the strongest cost control can generate profits treating Medicare patients. The next question is whether some set of hospitals can have both low costs and high-quality outcomes.

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), standardized inpatient Medicare costs per case, providers' payer mix, and the annual level of total FFS Medicare service use per beneficiary in the county where the hospital is located. As data and risk-adjustment methodologies improve, our measures of efficiency will continue to evolve. Our assessment of efficiency is not in absolute terms but rather is relative to other IPPS hospitals.

Ideally, we would limit our set of efficient hospitals to those that not only had high in-hospital quality and low unit costs but also low overall costs to the Medicare program during the year. To avoid having hospitals from high-use areas in our analysis, we removed hospitals from the population studied if they were in counties in the top 10 percent of annual Medicare FFS service use per FFS beneficiary. This method reduces the chance that a hospital

will appear to have low unit costs of service simply because it is in an area with a high volume of low-cost admissions that could have been treated on an outpatient basis.

We further restricted the population of hospitals that we evaluated for efficiency by removing the 10 percent of hospitals with the smallest shares of Medicaid patients. This process reduces the likelihood that hospitals in our efficient group got there simply because they had a favorable selection of patients. Our goal in this screening process is to improve our ability to identify hospitals that can provide good outcomes at a reasonable cost while serving a broad spectrum of patients (including Medicaid) without driving up the overall volume of hospital and nonhospital services provided.

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 2009 to 2011.¹⁶ We then examined the performance of the two hospital groups in fiscal year 2012.

Hospitals were identified as relatively efficient if they met four criteria every year of the 2009 to 2011 period:

- 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.

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).

Examining performance of relatively efficient and other hospitals from 2009 to 2011 Of the 2,133 hospitals that met our screening criteria, 302 (14 percent) were found to be relatively efficient during the 2009 to 2011 period.¹⁷ The set of relatively efficient providers was 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 2009 to 2011 by reporting the group's median performance divided by the median for the set of hospitals in our analysis (Table 3-6). The median efficient hospital's relative risk-adjusted 30-day mortality rate from 2009 through 2011 was 83 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 17 percent below the national median. The median readmission rate for the efficient group was 6 percent below the national median. Standardized Medicare cost per discharge for the efficient group was 11 percent below the national median. Relatively efficient hospitals tended to be larger than average but otherwise had diverse characteristics. For a more complete description of the methodology and other characteristics of relatively efficient providers, see our March 2011 report (Medicare Payment Advisory Commission 2011).

Historically strong performers had lower mortality rates and readmissions in 2012 The composite mortality rate for the efficient group was 13 percent below the national median in 2012, and the readmission rate was 4 percent below the national median. The share of patients who gave the median hospital a top rating in 2012 was similar for the efficient group, with 69 percent of patients treated at hospitals in the efficient group being highly satisfied and 68 percent in the comparison group being highly satisfied.

Historically strong performers continue to have lower costs in 2012 Hospitals that were low-cost and low-mortality providers from 2009 through 2011 continued to have lower costs in 2012. The median standardized Medicare cost per discharge in the efficient group was 10 percent lower than the national median, compared with 2 percent higher for the other group. 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 -5 percent. Among the relatively efficient hospitals, 59 percent had positive Medicare margins compared with 37 percent for the comparison hospitals. The distribution for the efficient hospitals ranged from -5 percent to 9 percent at the 25th and 75th percentiles, respectively. For the comparison group, the distribution of Medicare margins was -15 percent and 4 percent at the 25th and 75th percentiles,

**TABLE
3-6**

Performance of relatively efficient hospitals

Relative performance measure	Type of hospital	
	Relatively efficient during 2009-2011	Other hospitals
Number of hospitals	302	1,831
Share of hospitals	14%	86%
Historical performance, 2009-2011 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	83%	103%
Readmission rates (3M™)	94	101
Standardized Medicare costs per discharge	89	102
Performance metrics, 2012 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	87%	103%
Composite 30-day readmission (3M)	96	101
Standardized Medicare costs per discharge	90	102
Percent of patients highly satisfied, 2012 (H-CAHPS®)	69	68
Median:		
Overall Medicare margin, 2012	2%	-5%
Non-Medicare margin, 2012	5	8
Total (all payer) margin, 2012	5	5

Note: AHRQ (Agency for Healthcare Research and Quality), H-CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems). 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) due to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and outcomes. H-CAHPS scores are the most recently available scores.

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

respectively. Among the relatively efficient hospitals, 47 percent were under high or medium financial pressure to constrain their costs, compared with 38 percent for the other hospitals. This result suggests that some of the efficient hospitals may have been pressured to constrain their inpatient costs, while those who were not under pressure still restrained their unit costs in order to expand services or build financial reserves.

How would current law changes for 2014 and 2015 affect hospitals' Medicare payments and access?

Certain changes to Medicare payment policy have increased payments to hospitals in 2014 and are expected to decrease payments to hospitals in 2015. The largest change stems

from changes to Medicare DSH/uncompensated care payments, which are expected to increase slightly in 2014 because of the expansion of the Medicaid program, but they are projected to decline in 2015 and future years because of reductions in the number of uninsured people. The Patient Protection and Affordable Care Act of 2010 (PPACA) mandated that uncompensated care payments would decline as the rate of uninsurance declines. Given Congressional Budget Office estimates of annual changes in rates of uninsurance, we project that DSH/uncompensated care payments will increase from roughly \$11 billion in 2013 to \$12 billion in 2014 (a 0.7 percent increase in overall Medicare payments) and then decline to \$9 billion by 2015. Hospitals are expected to offset these losses in DSH/uncompensated care payments with increases in payments

from Medicaid and private insurers as rates of uninsurance decline. (A further discussion of the changes to Medicare DSH/uncompensated care policy is available in the online Appendix 3-A, available at <http://www.medpac.gov>).

A group of smaller payment rate changes will reduce Medicare payments by 0.9 percent from 2012 to 2014, and another set of changes will reduce rates by another 1.5 percent in 2015. The two sets of changes are discussed below.

Expected changes in payments from 2012 to 2014

In addition to changes in DSH payments and payment updates, a group of smaller payment rate changes are expected, on net, to reduce Medicare payments by 0.9 percent from 2012 to 2014. The group of other permanent policy changes includes:

Policies designed to address or change hospital practice patterns

- Most hospitals receive additional Medicare bonus payments for adopting electronic health records (EHRs). As more hospitals adopt EHRs between 2012 and 2014, these bonus payments will increase overall Medicare payments by roughly 0.5 percent.
- The American Taxpayer Relief Act of 2012 requires that CMS recover \$11 billion of past overpayments with temporary adjustments from 2014 through 2017. The \$11 billion in recoveries is equivalent to reducing inpatient payments by roughly 0.8 percent for four straight years. In the context of overall Medicare hospital payments, this reduction is equivalent to a 0.6 percent reduction in 2014.
- Penalties for high readmission rates in 2013 and 2014 have reduced payments by 0.2 percent.
- Medicare program payments for bad debts associated with beneficiary cost sharing were reduced in 2013, thereby reducing payments by approximately 0.1 percent.

Expiration of special add-on payments

- The expiration of the temporary Medicare low-volume payment adjustment in 2014 reduced payments by approximately 0.2 percent.
- The expiration of outpatient hold-harmless payments at the end of 2012, eliminating additional payments to some sole-community hospitals and rural hospitals

with 100 or fewer beds, on net reduced payments by approximately 0.1 percent.

- The expiration of a temporary add-on adjustment for hospitals in counties with low overall Medicare spending at the end of 2012 reduced payments by roughly 0.1 percent.
- The expiration of a temporary wage index add-on payment (called the Section 508 adjustment) at the end of 2013 reduced payments by less than 0.1 percent.
- The expiration of the Medicare Dependent Hospital Program in 2014 will reduce payments by less than 0.1 percent.

(See the text box about further regulatory changes).

Medicare margins are expected to decline slightly in 2014

We expect that the overall Medicare margin will decline slightly to –6 percent in 2014. The slight margin decline from 2012 is projected as a result of hospitals' costs increasing faster than payment rates under current law. From 2012 to 2014, we expect hospitals' Medicare revenues will increase a little over 4 percent due to payment rate updates and other policy changes. We also expect a small increase in payments from a continued rise in inpatient case mix as measured by the MS–DRGs. At the same time, we expect that hospital costs will increase about 6 percent—roughly 3 percent per year. This cost increase is similar to what we observed from 2011 to 2012 and what also has been reported by for-profit hospitals through the first nine months of 2013 (Community Health Systems 2013, Hospital Corporation of America 2013, LifePoint Hospitals 2013, Tenet Health 2013, Universal Health Services 2013). Finally, we expect that Medicare payments for hospitals' purchase of HIT will increase from about \$2.4 billion in cost reporting year 2012 for FFS enrollees to \$3 billion in the 2014 cost reporting year. We also expect some case-mix growth. Together these changes will offset much of the 2 percentage point difference between the growth in costs and payment rates we expect to see between 2012 and 2014.

The projection of a –6 percent overall Medicare margin is dependent on hospitals maintaining their rate of cost growth at around 3 percent. There is uncertainty, however, as to whether hospitals will be under sufficient pressure to maintain that level of cost growth given the strong growth in all-payer profitability that has occurred in recent years. In the past, we have seen cost growth accelerate when

Regulatory policy changes in 2014

Several regulatory changes that took place in 2014 affect Medicare payments to hospitals. These changes are as follows:

- **Changes in inpatient admission and medical review criteria (“2-midnight policy”)**—In the fiscal year 2014 inpatient prospective payment system final rule, CMS finalized the 2-midnight policy. This regulation clarifies for Medicare’s external reviewers that they must presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than one Medicare utilization day (defined by encounters crossing two midnights) in the hospital receiving medically necessary services.¹⁸ If a patient does not stay two days, they are presumed to be appropriately served on an outpatient basis unless a physician documents the need for a one-day inpatient stay. CMS estimates that the 2-midnight policy will result in changes in hospital admitting practices that will amount to a \$220 million increase in inpatient payments in fiscal year 2014. As a result, CMS reduced the fiscal year 2014 inpatient update by 0.2 percent to keep this change budget neutral.
 - **Changes to Part B inpatient payment policy (“rebilling policy”)**—An increasing number of successful appeals of decisions made by administrative law judges and the Medicare Appeals Council required Medicare, under Part B, to pay for inpatient services attached to denied Part A inpatient claims. In response, CMS issued regulations that permit hospitals to rebill the Medicare program for these inpatient services, which would have been payable under Part B if the beneficiary initially had been treated as an outpatient rather than admitted as an inpatient and subsequently had the inpatient claim denied by a Medicare external contractor. Rebilling for these services must be done within 12 months of the original date of service. CMS estimates that this policy will increase Part B inpatient payments by \$850 million in fiscal year 2013 and by \$120 million or less in each year from fiscal year 2014 to fiscal year 2017. CMS’s estimated impact for
- fiscal year 2013 is considerably higher because the 12-month rebilling restriction was added midyear. In subsequent years, the 12-month timeliness restriction blunts the extent of hospital rebilling (Centers for Medicare & Medicaid Services 2013).
- **Changes to outpatient payment weights:**
 - CMS substantially increased the items that can be packaged with a primary service to create a single payment unit. This change will increase the size of payment units in the outpatient prospective payment system (OPPS). Items in this category include certain drugs, biologics, and laboratory tests.
 - CMS will use new standard cost centers for computed tomography (CT), MRI, and cardiac catheterization in setting OPPS payment rates for those services. This change will result in lower rates for CT, MRI, and cardiac catheterization and higher rates for other imaging services. Lower OPPS payment rates for CT and MRI services will affect the Medicare physician fee schedule (PFS). The PFS payment rate for the technical component of CT and MRI services is the lesser of the standard PFS method for setting those rates or the OPPS payment rate.
 - CMS created a single ambulatory payment classification (APC) (and payment rate) for clinic visits. There had been five APCs and five payment rates for clinic visits. This change will result in higher payment rates for some of these services and lower rates for others.
 - **Separately paid drugs**—For 2014, CMS has decided to pay for drugs and biologics separately at a rate equal to each drug’s average sales price (ASP) plus 6 percent. In 2012, CMS had paid for such drugs at a rate of ASP plus 4 percent. To maintain budget neutrality in the OPPS, the increased rates for separately paid drugs will be offset by lower rates for all other services. ■

**TABLE
3-7**

Medicare payment growth slows from 2012 to 2015

**Approximate change in payments
under current law**

Payment change	2012-2014	2014-2015
DSH/uncompensated care payment changes	+0.7%	-2.0%*
Other permanent policy changes	-0.9	-1.5
Projected weighted average of inpatient and outpatient updates to payment rates	+4.2	+2.2**
Approximate change in projected payments, not including any case-mix change	+4.0 (2 years)	-1.3*

Note: DSH (disproportionate share). These projections are preliminary and subject to change and are presented as changes in overall hospital Medicare fee-for-service revenue (not just inpatient revenue), which is roughly \$170 billion per year. The projections do not factor in the 2 percent sequester, and they do not factor in a 0.4 percent permanent documentation and coding adjustment that will eventually have to be made. Projected updates are net of adjustments for productivity, budget adjustments, and certain other factors.

* The impact of the DSH/uncompensated care changes could be less to the extent that expansion of insurance coverage through the exchanges and Medicaid expansion is less than the Congressional Budget Office forecast.

** The 2015 update is projected to be approximately 2.2 percent, but this update could change as CMS changes its forecasts of the market basket between now and the start of fiscal year 2015.

Source: MedPAC analysis of CMS claims data and scheduled legislative changes.

hospitals are under less pressure to constrain costs. The -6 percent margin also does not factor in the effect of the sequester, which is currently reducing Medicare program payments to hospitals by 2 percent. Therefore, if the sequester remains in place, margins would be expected to be almost 2 percentage points lower. The reduction in payments is slightly less than 2 percent because the sequester affects Medicare program payments but not beneficiary cost sharing.

Medicare margins are expected to fall further in 2015 if current law holds

A series of policy changes in current law will decrease payments to hospitals in 2015. Under current law, the base payment rate update is projected to be 2.2 percent; however, because of a scheduled reduction in DSH payments and other policy changes, we expect payments to decline by roughly 1.3 percent in 2015 (Table 3-7). These changes may cause Medicare revenues to fall below the costs of relatively efficient providers in 2015.¹⁹

The other policy changes that will affect payments in 2015 are the following:

- Readmission penalties are expected to increase when additional conditions are added. This increase is expected to reduce payments by an additional 0.1 percent in 2015.
- The 25 percent of hospitals with the lowest performance on hospital-acquired conditions 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 EHRs will start phasing out, causing a decline in EHR payments equivalent to 0.7 percent of overall Medicare payments from 2014 to 2015.
- Mandated recoveries of \$11 billion will continue, resulting in an expected 0.8 percent adjustment to inpatient rates, 0.5 percent of overall 2015 payments.

Despite the potential for declining margins, access is expected to remain strong

After PPACA was passed, some argued that the slow growth of Medicare payments and continued rapid growth in private-payer rates would create a large divergence that could put pressure on Medicare patients' access to care (Foster 2010, Newhouse 2010, Shatto and Clemens 2011). They suggested 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, private insurer payment rates were 47 percent above costs, and Medicare rates were 6 percent below costs; we expect this gap to grow. Despite the gap in payer rates, 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 61 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.
- 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.
- Medicare's share of hospitals' revenue (excluding critical access hospitals) is rarely more than 50 percent, and hospitals' overall financial condition is expected to remain strong because of the expansion of profits from private payers' patients.

Given these considerations, the current law reductions in Medicare payments in 2015 are not expected to be large enough to induce hospitals to restrict access for Medicare patients.

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 is to recommend an appropriate aggregate level of payments using the update. The second objective is to make adjustments in payment policies when necessary to have 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, HOPD rates are not aligned with rates paid for the same services in a physicians' office, which gives hospitals an incentive to acquire physician practices and start billing for the same services as outpatient services. To remove this incentive, we are proposing to move outpatient rates closer to physician office rates for services that are often performed in both locations.

A similar problem exists for hospital inpatient services. Long-term care hospitals (LTCHs) are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require the specialized services of an LTCH. To correct this problem, we propose a new criterion for patients receiving standard LTCH payments. Chronically critically ill (CCI) patients would still qualify

for the relatively high LTCH standard DRG payment rates because they often need LTCH-type care. LTCHs' average standard DRG rate for CCI patients would remain at roughly \$50,000.²⁰ In contrast, non-CCI patients (other than patients who receive prolonged mechanical ventilation) would receive IPPS standard DRG payment rates. Equalizing rates for non-CCI patients would reduce the average standard DRG rate for LTCHs' non-CCI cases from roughly \$40,000 to about \$12,000 (the IPPS average standard DRG rate for the same LTCH non-CCI cases). The reduction in LTCH standard 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 acute care hospitals. 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 the patients' needs and less dependent on the payment system under which the provider operates.

Aligning payment rates across hospital outpatient departments and physician offices

Medicare payment rates often differ for the same (or similar) ambulatory services provided in physicians' offices and HOPDs. CMS sets payment rates for physician and other practitioner services in the fee schedule for physicians and other health professionals, also known as the PFS. Payment rates for most HOPD services are set by the OPDS. For services provided in physicians' offices, Medicare makes a single payment under the PFS. For services provided in HOPDs, Medicare makes two payments: one for the physician's professional fee under the PFS and one for the HOPD under the OPDS. For most services, the combined OPDS and PFS payments for services provided in HOPDs are higher than the single PFS payment for services provided in freestanding offices.

The Commission's position is that Medicare should ensure that patients have access to settings that provide the appropriate level of care. From this perspective, if the same service can be safely provided in different settings, a prudent purchaser should not pay more for that service in one setting than another. These payment differences between settings may cause Medicare and beneficiaries to pay more than necessary. Therefore, Medicare should strive to base payment rates on the resources needed to treat patients in the most efficient (i.e., highest quality, lowest cost) setting, adjusting for differences in patient severity to the extent that severity differences affect costs.

**TABLE
3-8**

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

Type of service	Share of ambulatory services performed in HOPDs, 2012	Per beneficiary volume growth, 2010-2012	
		Freestanding office	HOPD
E&M office visits (CPT codes 99201-99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), HOPD (hospital outpatient department), CPT (Current Procedural Terminology), APC (ambulatory payment classification).

Source: MedPAC analysis of standard analytic claims files from 2010, 2011, and 2012.

In previous work, the Commission recommended that Medicare reduce payment rates for evaluation and management (E&M) office visits provided in HOPDs so that total payment rates would be equal whether these visits were provided in an HOPD or in a freestanding physician’s office (Medicare Payment Advisory Commission 2012). We also identified groups of services provided in HOPDs and physicians’ offices that meet the Commission’s principles for aligning payment rates across settings (Medicare Payment Advisory Commission 2013b). In this chapter, we recommend that the Congress direct the Secretary to adjust HOPD rates so that they align more closely with physician office rates for all service groups that meet these five principles (discussed on p. 77).

Payment variations across settings should be addressed because the billing of many ambulatory services has been shifting from physicians’ offices to the usually higher paid HOPD setting. Among E&M office visits, echocardiograms, and nuclear cardiology services, for example, the volume of services decreased in freestanding offices and increased in HOPDs from 2010 to 2012 (Table 3-8). As billing of services shifts from physicians’ offices to HOPDs, program spending and beneficiary cost sharing increase without significant changes in patient care (Dutton 2012, Kowalczyk 2013, Mathews 2012, Schulte 2012). To limit the incentive to shift cases to higher cost sites of care, there is a need to align HOPD rates with physician office rates.

Some stakeholders have argued that Medicare should pay HOPDs higher rates purely because hospitals could use the higher payments to subsidize standby capacity, access to care for low-income patients, efforts to improve care coordination, and community outreach (Medicare Payment

Advisory Commission 2013b). However, building indirect subsidies for these activities into the payment rates for all services does not directly target resources to these activities and can distort prices, which could have unintended consequences. For example, paying much more for cardiac tests in HOPDs than freestanding offices may encourage hospitals to purchase cardiology practices and bill for cardiac testing as a hospital outpatient service. In addition, paying higher rates for services provided in HOPDs is an inefficient way to reward hospitals for improving care (such as reducing readmissions) because it does not distinguish between hospitals that improve care and those that do not.

Higher rates for HOPD services should be limited to a select set of services. For example, some services have costs associated with maintaining standby emergency capacity. HOPDs on the main campus of a hospital with an emergency department are subject to the Emergency Medical Treatment and Active Labor Act of 1986, which requires them to screen and stabilize (or transfer) patients who believe they are experiencing a medical emergency, regardless of their ability to pay. Medicare payments for emergency department services include these standby costs, and therefore they will not be equal to freestanding office rates for similar services. For certain other services, patients treated in HOPDs are often more medically complex than patients receiving those services in a freestanding office. The higher complexity patients in HOPDs may require more resources than the lower complexity patients in freestanding offices.

Stakeholders have further argued that Medicare should not align any HOPD rates with physician office rates because hospitals incur higher overhead costs than freestanding

physician offices. For example, hospitals must comply with more stringent building codes, life-safety codes, and hospital-level staffing requirements. In addition, hospitals must incur the cost of financially integrating the HOPD into the hospital and billing patients a separate facility fee (in addition to the physician's fee). However, we believe that if patient severity is similar and a service can be provided in a lower cost setting without a reduction in quality or safety, Medicare should pay a rate based on the cost of the more efficient setting. If Medicare paid a higher rate to the less efficient setting, services would shift to being billed by the higher cost site of care, the cost of care could increase, and beneficiary costs would increase without any evidence that care would improve.

Aligning HOPD payment rates with physician office rates for some ambulatory services

We evaluated about 450 APCs that represent service categories and found 66 that do not require emergency standby capacity, do not have extra costs associated with higher patient complexity in the hospital, and do not need the additional overhead associated with services that must be provided in a hospital setting. These are candidates for having their HOPD payment rates aligned with the PFS rates. We classify these services into two categories:

- Group 1 includes services for which HOPD payment rates could equal physician office payment rates.
- Group 2 includes services for which the HOPD rate could be higher than the physician office rate but the difference should be reduced from the current level (see online Appendix 2-A to the Commission's June 2013 report for the list of services in Group 1 and Group 2, available at <http://www.medpac.gov>) (Medicare Payment Advisory Commission 2013b). The additional cost in HOPDs would reflect the cost of ancillary items that are packaged into the unit of payment in the OPSS but are paid separately in the PFS.²¹

We organized the services in Group 1 and Group 2 into APCs because that is how the OPSS classifies services for the purpose of payment. APCs comprise Current Procedural Terminology (CPT) codes that are similar both clinically and in terms of resource costs, and all CPT codes in the same APC have the same payment rate.

Services that meet the following five criteria are good candidates for adjusting HOPD payment rates so that payment rates are the same in HOPDs and freestanding offices:

- Services are frequently performed in physicians' offices (more than 50 percent of the time). This fact indicates these services are likely safe and appropriate to provide in a freestanding physician's office. Also, the PFS payment rates for these services are sufficient to ensure access to care.
- Services entail minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services).
- The services are infrequently provided with an emergency department (ED) visit when furnished in an HOPD (such services are unlikely to have costs that are directly associated with operating an ED).
- Patient severity is no greater in HOPDs than freestanding offices.
- The services do not have a 90-day global surgical code (CMS assumes that physicians' costs for these codes are higher when performed in a hospital than a freestanding office).²²

Each of the criteria must be met at the APC level rather than at the level of each CPT code. For more details on how we applied the criteria, see online Appendix 2-B to the Commission's June 2013 report, available at <http://www.medpac.gov> (Medicare Payment Advisory Commission 2013b).

We identified 24 APCs that met the five criteria for adjusting HOPD payment rates so that payment rates are equal in HOPDs and freestanding offices. Group 1 includes these 24 APCs. We also identified 42 APCs that meet four of the five criteria for equal payments across settings, but they have greater packaging of ancillary items in the OPSS than the PFS (the cost of packaged ancillaries was more than 5 percent of their total cost). These 42 APCs make up Group 2. OPSS payment rates for these services should be allowed to exceed the PFS rates by an amount equal to the cost of the additional packaging in the OPSS.²³

Effects of aligning payment rates between physicians' offices and HOPDs

For APCs in Group 1, we estimated OPSS payment rates that would produce equal payment rates in offices and HOPDs. For APCs in Group 2, we estimated OPSS payment rates that account for the cost of additional packaged services in the OPSS but would otherwise produce equal payment rates across settings. We modeled

the effect of these changes on program spending and beneficiary cost sharing for each of the 66 APCs in Group 1 and Group 2. Changing OPSS payment rates for APCs in the two groups would, on net, reduce program spending and beneficiary cost sharing by a total of \$1.1 billion in one year.²⁴ Assuming current law, beneficiaries would save about \$180 million in cost sharing.²⁵ (See the text box on pp. 80–81 for an example of how beneficiary cost sharing and Medicare program spending decline when we adjust OPSS payment rates so that payment rates are equal in offices and HOPDs.²⁶)

Impact on hospitals' Medicare revenue

For all OPSS hospitals (excluding CAHs), changing the OPSS payment rates for the 66 APCs in Group 1 and Group 2 would reduce overall Medicare revenue by 0.6 percent and aggregate Medicare HOPD revenue by 2.7 percent. Although the effect of this policy would vary widely among individual hospitals, the effect on overall Medicare revenue for most hospital categories is about equal to the overall average of 0.6 percent (see the Commission's June 2013 report for more details on the impact by hospital category). Exceptions are rural hospitals, which would lose 0.9 percent of aggregate Medicare revenue, and hospitals that have 100 or fewer beds, which would lose 1.2 percent. Rural and small hospitals would lose more revenue than urban hospitals because they receive a larger share of their overall Medicare revenue from outpatient care than do urban and larger hospitals.

We also examined the characteristics of the 100 hospitals that would have the largest percentage reductions in overall Medicare revenue from changing OPSS payment rates for APCs in Group 1 and Group 2. We found the following differences between the 100 hospitals that would be most affected and all other hospitals:

- On average, the 100 most affected hospitals are smaller, with an average of 44 beds, compared with an average 198 beds at all other hospitals.
- The 100 most affected hospitals are less likely to serve low-income patients—the median DSH percentage is 14 percent for these hospitals versus 25.8 percent among all other hospitals.
- The 100 most affected hospitals are less likely to have major teaching status than all other hospitals.
- Over half of the 100 most affected hospitals are specialty hospitals.

Some hospitals that are primary sources of access to ambulatory services for low-income patients might experience significant reductions in Medicare revenue as a result of the policies discussed, which could reduce access for these patients. Therefore, policymakers may wish to consider a stop-loss policy that would limit the loss of Medicare revenue for these hospitals.

We evaluated the effects of the same illustrative stop-loss policy that we examined in our June 2012 report (Medicare Payment Advisory Commission 2012). In this case, we estimate that the stop-loss would return only \$10 million to the hospitals that qualify. The effect would be small because many of the hospitals with the highest revenue losses under this policy serve a relatively small percentage of low-income patients, and the hospitals that would qualify for the stop-loss are relatively small, on average.

Addressing differences in payment rates across sites of care for inpatient care in LTCHs and acute care hospitals

The Commission has been considering for some time whether Medicare is paying accurately for services furnished in LTCHs (Medicare Payment Advisory Commission 2013c, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2008, Medicare Payment Advisory Commission 2004). LTCHs have positioned themselves as providers of hospital-level care for long-stay CCI patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care—but nationwide most CCI patients are cared for in acute care hospitals, and most LTCH patients are not CCI (Medicare Payment Advisory Commission 2013c).

As described in Chapter 11, Medicare pays LTCHs under a separate PPS, with higher payment rates—for both CCI and non-CCI cases—than those made for similar patients in other settings (Gage et al. 2007, Kahn et al. 2013, Kandilov and Dalton 2011, Koenig et al. 2013, Medicare Payment Advisory Commission 2004). There are 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 not CCI (Medicare Payment Advisory Commission 2013c).

The effect of the disparity in Medicare's payments across settings for the most medically complex patients is exacerbated because such cases often are unprofitable in acute care hospitals paid under the IPPS (Gage et al. 2007). Further, the relative profitability of more complex cases—whether CCI or non-CCI—may differ across acute care hospitals due to the uneven geographic distribution of LTCHs. In areas with LTCHs, acute care hospitals may be able to reduce the costs of caring for some types of cases by transferring them earlier in the course of illness.²⁷ In areas without LTCHs, acute care hospitals may have to keep these cases longer—and therefore accrue additional costs—until the patients are stable enough to be transferred to a lower level of post-acute care.

As discussed in Chapter 11, what Medicare is purchasing with its higher LTCH payments remains unclear. Studies comparing LTCH care with that provided in acute care hospitals have failed to find a clear advantage in outcomes for LTCH users (Gage et al. 2011, Kahn et al. 2013, Kennell and Associates Inc. 2010, Koenig et al. 2013, Medicare Payment Advisory Commission 2013c, Medicare Payment Advisory Commission 2004, Morley et al. 2011). At the same time, some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. In addition, some studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill (Kahn et al. 2013, Kandilov and Dalton 2011, Kennell and Associates Inc. 2010, Medicare Payment Advisory Commission 2004).

As a prudent payer, Medicare must ensure that its payments to providers are properly aligned with the resource needs of beneficiaries. In addition, the Commission has held that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

The Commission's approach to reforming the LTCH PPS and aligning payment for CCI cases across settings is based on the premise that the most medically complex patients have always been a small share of the total population of hospital inpatients (Medicare Payment Advisory Commission 2013c). As discussed in Chapter 11, although hospital case mix has increased over time, the explosive growth in the number of LTCHs that followed

implementation of the IPPS was not driven by a need for these services but rather by payment policies that created opportunities for financial gain.

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 recommends that standard LTCH payment rates be paid only for LTCH patients who meet the CCI profile at the point of transfer from an acute care hospital. LTCH cases that are not CCI (non-CCI) should be paid IPPS rates approximately the same as MS-DRG payment rates they would have been paid if the patient had been treated in an IPPS hospital in the same local market.²⁸ The Commission recommends 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 the IPPS outlier pool to help alleviate the cost of caring for extraordinarily costly CCI cases in acute care hospitals. 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.

As discussed in Chapter 11, the Commission recommends that—in the absence of data on the metabolic, endocrine, physiologic, and immunological abnormalities that characterize the CCI condition—Medicare should define LTCH CCI cases as those who spent eight or more days in an intensive care unit (ICU) during an immediately preceding acute care hospital stay. This definition is more restrictive than the three-day ICU stay threshold that is mandated by the Pathway for SGR Reform Act of 2013, scheduled to be implemented in 2016 (see text box, p. 82). The Commission also recommends 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. These types of cases are generally considered appropriate for admission to LTCHs and generally viewed as warranting higher, LTCH-level payment rates.

Similarly, the Commission recommends 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.

How to adjust the outpatient prospective payment system payment rates to produce equal rates across settings

When a physician provides a service in a freestanding office or a hospital outpatient department (HOPD), the physician's payment under the fee schedule for physicians and other health professionals, also known as the physician fee schedule (PFS), has three components: physician work, practice expense (PE), and professional liability insurance (PLI). The work and PLI payments are the same regardless of setting. However, the PE payment for a service provided in an office (the nonfacility PE) is usually higher than the PE payment for a service provided in an HOPD (the facility PE). The higher nonfacility PE payment reflects the cost of the clinical staff, medical equipment, medical supplies, and additional overhead incurred by physicians. Therefore, the PFS payment is higher in a freestanding office than in an HOPD for most services. However, when a service is provided in an HOPD, Medicare makes an additional payment to the hospital under the outpatient prospective payment system (OPPS). In most cases,

the PFS payment for a service that is provided in a freestanding office is lower than the combined OPPS and PFS payments for a service delivered in an HOPD.

For example, in 2014, when a level II echocardiogram without contrast is provided in a freestanding office, the payment to the physician (the combined physician work, PLI, and nonfacility PE) totals \$228.02 (Table 3-9). If the service is provided in an HOPD, the total payment equals the sum of the work, PLI, facility PE, and OPPS payment for a total of \$492.22.

In our analysis, we adjust the OPPS payment rate for a service to create an equal payment rate across sites of care by setting the OPPS rate equal to the difference between the nonfacility PE rate and facility PE rate. For level II echocardiograms, the nonfacility PE is \$179.56 and the facility PE is \$16.48. Taking the difference produces an adjusted OPPS rate of \$163.07. The total payment for level II echocardiograms

(continued next page)

**TABLE
3-9**

Differences in payment rates for level II echocardiogram without contrast provided in physicians' offices and HOPDs, 2014

	Payment amount	Calculation
2014 payment rates		
<i>Service in physician's office</i>		
Payment to physician	\$228.02	Work (\$) + PLI (\$) + nonfacility PE (\$)
<i>Service in HOPD</i>		
Payment to physician	\$64.95	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	<u>\$427.27</u>	HOPD rate (\$)
Total payment	\$492.22	
Policy that aligns rates across settings		
<i>Service in HOPD</i>		
Payment to physician	\$64.95	Work (\$) + PLI (\$) + facility PE (\$)
Payment to hospital	<u>\$163.07</u>	Nonfacility PE (\$) – facility PE (\$)
Total payment	\$228.02	

Note: HOPD (hospital outpatient department), PLI (professional liability insurance), PE (practice expense). Payments include both program spending and beneficiary cost sharing. The services in this table are in ambulatory payment classification (APC) group 269. When the services in this APC are provided in a physician's office, the average physician work amount is \$46.65, the PLI amount is \$1.81, and the nonfacility PE amount is \$179.56. When the services in this APC are provided in an HOPD, the average physician work amount is \$44.31, the PLI amount is \$1.72, and the facility PE amount is \$16.48.

Source: MedPAC analysis of physician fee schedule and outpatient prospective payment system payment rates for 2014.

How to adjust the outpatient prospective payment system payment rates to produce equal rates across settings (cont.)

provided in HOPDs would fall to \$228.02, which is the same rate that is paid in a freestanding office.

The lower OPSS rates that would result from aligning OPSS payment rates to PFS rates would also produce lower beneficiary copayments in most ambulatory payment classifications (APCs). For level II echocardiograms, the copayment is \$45.60 if they are provided in freestanding offices and \$98.45 if they are provided in HOPDs. Adjusting the OPSS rate so the total payment rate is the same in HOPDs as freestanding offices would reduce the total copayment in HOPDs to \$45.60 (Table 3-10).

However, reducing payment rates in the OPSS would lower beneficiaries' copayments only for APCs where the copayment is currently 20 percent of the payment rate. Current law requires that in APCs where the copayment is more than 20 percent of the payment rate, the copayment must stay at a constant dollar amount over time until the payment rate has risen high enough that the copayment is 20 percent of the payment rate. Because the copayment for level II echocardiograms is currently 20 percent of the payment rate, reducing the payment rate for that service category reduces the copayment amount. However, other service categories—such as level II extended electroencephalography, sleep, and cardiovascular studies—have copayments that exceed 20 percent of the payment rate. For those services, current law does not allow the copayment amount

**TABLE
3-10**

Differences in beneficiary copayments for level II echocardiograms without contrast provided in physicians' offices and HOPDs, 2014

	Copayment amount
Copayments in 2014	
<i>Service in physician's office</i>	
Payment to physician	\$45.60
<i>Service in HOPD</i>	
Payment to physician	\$12.99
Payment to hospital	<u>\$85.46</u>
Total payment	\$98.45
Policy that aligns rates across settings	
<i>Service in HOPD</i>	
Payment to physician	\$12.99
Payment to hospital	<u>\$32.61</u>
Total payment	\$45.60

Note: HOPD (hospital outpatient department). The services in this table are in ambulatory payment classification group 269.

Source: MedPAC analysis of physician fee schedule and outpatient prospective payment system payment rates for 2014.

to decrease when the payment rate decreases. We discussed three options for allowing beneficiary coinsurance to decline along with rates for these services in our June 2013 report to the Congress (Medicare Payment Advisory Commission 2013b). ■

In concert with the payment changes for LTCHs, the Congress should 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 IPSS-based rates, this requirement would only apply 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. However, due to the expected efficiency gains described above, the net effect on LTCH profits is expected to be far less than \$2 billion. Chapter 11 discusses these effects in detail.

Fully implementing these recommendations would shift approximately \$2 billion from LTCH PPS payments for non-CCI cases to an expanded IPSS outlier pool. IPSS hospitals would receive roughly \$2 billion in additional outlier payments. As described more fully in Chapter 11, the Commission recommends using these additional outlier funds to make higher outlier payments for IPSS CCI cases, which generally are substantially more costly

Current-law chronically critically ill definition

As discussed in Chapter 11 of this report, 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 stay. The research literature consistently describes CCI patients as having long acute care hospital 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 acute care hospital 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 Pathway to SGR Reform Act of 2013 mandated changes to the LTCH prospective payment system (PPS), including limiting standard LTCH payments to cases that spent at least three days in an ICU during an immediately preceding acute care hospital stay. The Commission’s analysis of IPPS claims data from 2012 found that 22.8 percent of inpatient prospective payment system (IPPS) discharges spent three or more days in an ICU. The Commission is concerned that this threshold 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 maintains that CCI cases are a small share of Medicare acute care hospital cases and that the ICU length-of-stay threshold identifying CCI cases should be set accordingly. The Commission therefore recommends that the Congress limit standard LTCH payments to cases that spent eight or more days in an ICU during an immediately preceding acute care hospital stay. Our analysis of 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 as large as other IPPS cases. Further, these cases were concentrated in a small number of MS–DRGs that correspond with the “ideal” LTCH patients 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).

Setting the ICU length-of-stay threshold for CCI cases at eight days captures a large share of LTCH cases requiring prolonged mechanical ventilation. The Commission’s analysis of 2012 LTCH claims data found that 69.7 percent of discharges receiving mechanical ventilation for more than 96 hours had had an immediately preceding acute care hospital stay that included at least eight days in the ICU.²⁹ Nevertheless, to ensure that patients requiring prolonged mechanical ventilation have appropriate access to the specialty weaning services offered by many LTCHs, the Commission recommends an exception to the eight-day ICU threshold for LTCH cases that receive mechanical ventilation for 96 hours or more during an immediately preceding acute care hospital stay. ■

than IPPS non-CCI cases in the same MS–DRG. To accomplish this goal, the Congress should give CMS the authority to hold the IPPS outlier policy—both the national fixed loss amount and the marginal cost factor (80 percent)—unchanged for IPPS non-CCI cases, while using the LTCH savings to set a separate national fixed loss amount and marginal cost factor (e.g., 90 percent)

for IPPS CCI cases. The Commission’s estimates suggest that adding approximately \$2 billion to the IPPS outlier pool while keeping the outlier policy unchanged for non-CCI cases would produce a much lower national fixed loss amount for CCI cases (about \$13,300 compared with about \$21,500 under current policy). Therefore, if an IPPS hospital treats a CCI patient, the Medicare program

could cover 90 percent of the additional losses after the hospital's loss once the case reaches \$13,300. The lower fixed loss amount (\$13,300) and the higher share of losses paid (90 percent rather than 80 percent) would reduce the large disparities in payments for similar CCI patients between those treated in IPPS hospitals and those treated in LTCHs.

In 2011, about 600,000 cases in IPPS hospitals met our CCI definition because they had eight or more days in the ICU. Under the proposed policy, these cases in acute care hospitals would qualify for higher outlier payments (than under current Medicare law) if the hospital incurred a loss greater than \$13,300 (the estimated fixed loss amount). The higher outlier payments would increase payments for high-cost CCI cases in acute care hospitals by almost 11 percent, causing a significant reduction in hospital losses on these cases and an overall increase in inpatient payments of almost 2 percent. The hospitals benefiting from these patients will be those that take the most CCI cases, which are disproportionately major teaching hospitals and hospitals with below-average Medicare margins.

About 20 percent of IPPS CCI cases were treated in the 1,051 IPPS hospitals located in market areas that have no LTCHs. On average, outlier payments under the current outlier policy accounted for a higher share of total DRG payments for CCI cases in hospitals in these markets compared with hospitals in markets that have LTCHs. These IPPS hospitals may be keeping their CCI patients for longer stays in the ICU or a step-down unit because of a lack of local LTCHs. The higher outlier payments under the proposed policy for IPPS hospitals taking CCI cases will make Medicare payments more equitable between markets with and without LTCHs.

Joint recommendation on how to change hospital payment policies and payment rates in 2015

This year, we are presenting a joint recommendation (covering acute care and LTCH non-CCI rates) that is designed to improve the incentives in the hospital payment systems and provide an adequate aggregate level of payments. The recommendation will improve alignment of acute hospital and physician office payment rates, improve alignment of acute care hospital and long-term care hospital rates, and increase acute care hospital rates through an update. The update portion of

the recommendation will apply to services paid under the acute care inpatient and outpatient payment systems, including non-CCI patients in LTCHs. Updates for other services provided in hospital-owned rehabilitation, home health, and skilled nursing units are based on separate recommendations for those types of Medicare services.

Current law: Projected update of 2.2 percent in 2015

For both the acute IPPS and the OPSS, the update in current law for fiscal year 2015 equals the projected increase in the hospital operating market basket index minus an adjustment equal to the Secretary's forecast of the 10-year average productivity growth nationwide, and a -0.2 percent budgetary adjustment. The operating market basket index is a projection of input price inflation for the goods and services hospitals use in producing inpatient and outpatient services. CMS's latest forecast of the market basket for October 2014 when the inpatient update takes place is 2.7 percent, and the productivity forecast is 0.3 percent. The resulting projected statutory inpatient update on October 2014 is 2.2 percent (2.7 percent - 0.3 percent - 0.2 percent). The final update may differ because input prices and productivity estimates will change twice before the final updates are published in August 2014. Given the payment adequacy indicators discussed and given the proposals to better align acute care hospital payments with payments in physician offices and long-term care hospitals, a base payment update larger than current law is warranted.

RECOMMENDATION 3

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 2015 to 2017.**
- **increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.**

The Commission balanced several factors in reaching its recommendation. First, incentives must be reduced to shift care to higher cost sites. 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 eliminate the incentive to direct non-CCI patients to LTCHs when LTCH-level care is not needed. The savings from this policy would be used to increase payments for 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 IPSS 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. The update recommendation reflects the assumption that the Congress will not override these reductions. Given the changes in current Medicare law that are expected to reduce payments in 2015, and given 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 2014 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 to base payment rates 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.

Spending

- If the reform of LTCH 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 \$1.1 billion, and increasing the update over current law would increase payments by approximately \$1.6 billion over current law. The three factors together would increase acute care hospital payments by roughly \$1.2 billion in 2015, or about 0.7 percent. After including the reductions in LTCH payments and other factors, the net effect on Medicare program spending is an increase of between \$250 million and \$750 million in 2015 and between \$5 billion and \$10 billion over five years. The annual cost of the Commission's recommendation—relative to current law—increases materially from 2015 to 2016 because the law governing LTCH payments is scheduled to change. Starting in 2016, a recently enacted reform of the LTCH system is scheduled to generate budgetary savings. Our proposal is to replace this scheduled LTCH reform (see text box, p. 82). Because we are replacing an LTCH policy that is scheduled to generate savings with one that transfers any savings to acute care hospitals, the net cost of our policy increases in 2016.

Beneficiaries and providers

- Beneficiaries would see roughly \$200 million in lower cost sharing due to the alignment of selected outpatient payment rates with the physician fee schedule and an increase in cost sharing of roughly \$100 million due to the higher update. Thus the net reduction in cost sharing is expected to be \$100 million per year. The recommendation may also slow or stop the shift of services from freestanding practices to HOPDs. Payments to LTCHs would decline for the non-CCI cases, and payments to acute care hospitals would increase for high-cost 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 post-acute services in swing beds. While PPS payments per beneficiary were roughly flat in 2013, critical access hospital payments per beneficiary grew by 4 percent, primarily because of growth in payments for outpatient care and post-acute care in swing beds.
- 2 As a condition of payment for hospital inpatient services under Medicare Part A, Section 1814(a) of the Social Security Act requires physician certification of the medical necessity that such services be provided on an inpatient basis (42 CFR Part 424 subpart B and 42 CFR 412.3).
- 3 Some evidence suggests 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; even if their chance of being admitted increased by 2 percentage points, that would only yield roughly 600,000 more admissions or less than a 2 percent increase in admissions.
- 4 Nonmetropolitan markets generally have lower average hospital occupancy rates, and had they been included in this market-level analysis, we would have seen far more markets with occupancy below 50 percent.
- 5 From 2002 to 2012, 497 hospitals entered the Medicare program and 319 closed as inpatient facilities. These numbers reflect the raw count of hospitals beginning or ending participation in the Medicare program. Changes in hospital ownership, Medicare provider number, or conversion to a different type of hospital are not considered openings or closures.
- 6 Hospitals that closed were located an average of eight miles from the nearest competitor.
- 7 Seventy-five percent of patients at closed hospitals received percutaneous coronary intervention within 90 minutes of arrival, compared with a national average of 87 percent. Seventy-six percent of heart failure patients at closed hospitals received discharge instructions, compared with a national average of 84 percent. Chest pain patients received an electrocardiogram within an average of 50 minutes of arrival at closed hospitals, compared with an average of 11 minutes nationally.
- 8 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. These data are likely to underestimate the total volume in M&A deals that occur each year because of the decentralized nature of market activity in this field. We also believe that Irving Levin's dataset is somewhat biased toward larger deals. Therefore, deals involving entities with a smaller net worth, such as the acquisition of physician group practices, are less likely to be captured by Irving Levin's data collection.
- 9 Within the health sector, employment increases were among the fastest in home health care services and outpatient care centers, which grew approximately 38 percent and 34 percent, respectively, from 2008 to 2013. The employer category "home health care services" includes home health providers, visiting nurse associations, hospital agencies, and other providers specializing in the delivery of health care services in the patient's home. In addition, the count of individuals employed within the category of home health care services includes home health aides as well as higher skilled employees such as registered nurses. The employer category outpatient care centers includes mental health centers, dialysis facilities, freestanding surgical and emergency centers, family planning centers, and other outpatient care facilities.
- 10 Inpatient mortality for all five conditions (acute myocardial infarction, congestive heart failure (CHF), hip fracture, stroke, and pneumonia) improved. Thirty-day mortality improved for CHF, stroke, and pneumonia but was unchanged for the other two conditions.
- 11 The seven PSIs are death in low-mortality DRGs, iatrogenic pneumothorax, central venous catheter-related bloodstream infections, postoperative respiratory failure, postoperative pulmonary embolism / deep-vein thrombosis, postoperative wound dehiscence, and accidental puncture or laceration.
- 12 This increase consists of a legislated update of 1.9 percent (market basket forecast of 3 percent, a multifactor productivity adjustment of -1 percentage point, and a statutory budget adjustment of -0.1 percentage point in accordance with Section 3404 of the Patient Protection and Affordable Care Act of 2010), plus a 1.1 percent increase related to settlement of a lawsuit (*Cape Cod v. Sebelius*), minus a 2 percent prospective case-mix coding adjustment, for a net increase of 1 percent.
- 13 It is plausible that the 4.5 percent reduction in discharges in 2012 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 from 2008 through 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 2010a).
- 14 The \$2.4 billion amount comprises payments to hospitals for FFS patients; it does not include payments for managed care patients or benefits 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 and temporary extra payments to hospitals located in low-spending counties.
 - 16 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
 - 17 Roughly 75 percent of the relatively efficient hospitals also met our criteria for being relatively efficient in the prior year. Combining this year's findings with prior years, we find that roughly 40 percent of the hospitals that were deemed relatively efficient in 2011 were also deemed relatively efficient in 2013, and roughly 6 percent of those that were not deemed relatively efficient three years ago have moved into the relatively efficient category. Thus there is a moderate level of consistency among the hospitals deemed relatively efficient each year. The share of hospitals meeting our criteria for being relatively efficient has remained between 9 percent and 14 percent in recent years.
 - 18 Medicare's external reviewers include Medicare administrative contractors and recovery audit contractors.
 - 19 Under current law, for hospitals to avoid a decline in Medicare overall margins, they have to reduce the number of inputs used per unit of output. Reducing prices paid for inputs (e.g., a wage freeze) would not halt the decline in margins because wages are linked to the market basket index, which governs updates under current law. A reduction in wages would cause a reduction in the update. In contrast, the Commission's update recommendations have not been directly tied to input price inflation in recent years. A fixed update (set independent of the market basket forecast) would allow the hospital industry to benefit from lower input prices (e.g., lower wage growth), and it would avoid the procyclical problem of Medicare payment rates increasing at times when hospitals can afford to increase wages and Medicare payment rates decreasing in times when hospitals constrain wages because of financial pressure.
 - 20 The standard DRG rate includes all adjustments except for high-cost outlier patients.
 - 21 There are a few services in Group 2 for which the office rate is currently higher than the HOPD rate. In these cases, the HOPD rate could be increased to the level of the office rate.
 - 22 The physician fee schedule payment for 90-day global surgical codes includes the surgical procedure itself and office visits that occur in a 90-day period after the procedure. CMS assumes that the physician's clinical staff spends additional time scheduling the procedure and coordinating presurgical services when the procedure is performed in an HOPD than in a physician's office. Therefore, these services are assumed to have a higher cost when delivered in an HOPD. However, we are unable to estimate the amount of this additional cost. Consequently, we excluded these procedures from the group of services that are candidates for equal payment rates across settings.
 - 23 For 2014, CMS has substantially expanded the extent to which ancillary items are packaged with primary services into single payment units in the OPPIs. For some APCs in Group 1, this additional packaging may cause them to be reclassified into Group 2. However, it would not change the total number of APCs in Group 1 and Group 2, nor do we think it would have a large effect on our estimate of the reduction in program spending and cost sharing that would result from adjusting the OPPI payment rates for the APCs in Group 1 and Group 2.
 - 24 The \$1.1 billion estimated impact on program spending and beneficiary cost sharing is greater than the \$900 million estimate reported in our June 2013 report to the Congress. Our current estimate is greater because the billing of services has continued to shift from freestanding offices to HOPDs, especially echocardiograms and nuclear cardiology. As this shift continues, the effect of aligning HOPD payment rates with the rates in freestanding offices will continue to increase.
 - 25 Current law requires that in APCs where the OPPI copayment amount is currently more than 20 percent of the payment rate, the copayment must stay at a constant dollar amount over time until the payment rate has risen enough that the copayment is 20 percent of the payment rate. In APCs where the copayment amount currently is 20 percent of the payment rate, any change to the payment rate must be accompanied by a change to the copayment amount so that the copayment amount remains at 20 percent of the payment rate.

- 26 For 2014, CMS reduced the practice expense portion of physician payment for all services in the physician fee schedule. Such adjustments have an effect on how much Medicare spending and beneficiary cost sharing would change by adjusting OPPS rates so that they more closely align with rates paid in freestanding offices.
- 27 The Commission and other researchers have found that patients who use LTCHs tend to have shorter acute care hospital stays than similar patients who do not use these facilities, suggesting that LTCHs substitute for at least part of the acute hospital stay (Kahn et al. 2013, Medicare Payment Advisory Commission 2004). Early transfers may distort the acute inpatient PPS relative weights by reducing the costs of acute care hospitals that routinely transfer patients to LTCHs. To the extent that such distortion occurs, even after recalibration acute care hospital payments may be too low for some patients in areas without LTCHs.
- 28 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.
- 29 Of the remaining 30.3 percent of cases, almost half had no acute care hospital discharge within three days of admission to the LTCH.

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CHAPTER

4

**Physician and other health
professional services**

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

(The Commission reiterates its standing position on improving Medicare's payments to physicians and other health professionals. See pp. 112–114.)

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 2012, Medicare paid \$69.6 billion for physician and other health professional services, accounting for 12 percent of total Medicare fee-for-service spending. About 850,000 clinicians billed Medicare—550,000 physicians and 300,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

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

Assessment of payment adequacy

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

In this chapter

- Are Medicare fee schedule payments adequate in 2014?
- How should Medicare payments change in 2015?

Beneficiaries' access to care—Overall, beneficiary access to physician and other health professional services is stable. We generally find results similar to prior years—beneficiaries' access to physician services is stable and similar to (or better than) access among privately insured individuals ages 50 to 64. Most beneficiaries report they are able to obtain timely appointments for routine care and illness or injury, and most beneficiaries are able to find a new doctor without a problem (although beneficiaries seeking a primary care doctor were more likely to report that they had a problem than beneficiaries seeking a specialist). The survey does not find statistically significant differences in access between urban and rural beneficiaries, similar to prior years.

- ***Capacity and supply of providers***—The number of physicians and other health professionals providing services to Medicare beneficiaries from 2010 through 2012 kept pace with growth in the beneficiary population.
- ***Volume of services***—Across all services, volume per beneficiary remained essentially unchanged, with a growth rate of –0.2 percent in 2012. Among broad categories of service, growth rates were 0.1 percent for evaluation and management services, 0.2 percent for major procedures, 0.4 percent for other procedures, and –0.5 percent for tests. Imaging had a negative growth rate of –3.2 percent. However, the imaging decrease does not raise concerns about access to these services. The decrease occurred amid concerns about overuse of the services. Further, the decrease includes a shift in billing for cardiovascular imaging from professionals' offices to hospitals.

Quality of care—Most measures of ambulatory care quality between the periods of 2009 to 2010 and 2011 to 2012 improved slightly or did not change; a few worsened slightly.

Medicare payments and providers' costs—Because physicians and other health professionals do not report their costs to Medicare, we use proxies for Medicare's payments relative to providers' costs. Medicare's payments for fee schedule services relative to private insurer payments have remained constant at 81 percent. CMS currently projects that the percentage change in the Medicare Economic Index, a measure of the change in providers' costs, will be 2.2 percent in 2015.

Repeal of the SGR

In light of this information regarding payment adequacy for and beneficiary access to physician and other health professional services, the Commission reiterates its longstanding recommendation to repeal the SGR formula. The Commission's 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.

The Commission sees SGR repeal as urgent because, after a decade of year-end legislative overrides, the policy is causing uncertainty for physician and other clinician practices and has the potential to create instability for beneficiaries. The SGR also bogs down the policy process by focusing all efforts on the yearly need to override negative fee schedule updates. ■

Background

Physicians and other health professionals deliver a wide range of services to Medicare beneficiaries in all settings—including physicians’ offices, hospitals, ambulatory surgical centers, skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries’ homes. Of the roughly 850,000 clinicians billing Medicare, 550,000 are physicians and 300,000 are other health professionals, such as advanced practice nurses, physical and occupational therapists, and chiropractors. Part B of Medicare pays for physician and other health professional services; in 2012, total payments were \$69.6 billion, about 12 percent of Medicare fee-for-service (FFS) spending. Nearly all Medicare beneficiaries receive at least one physician service in a year—98 percent in 2011 (Centers for Medicare & Medicaid Services 2012c).

Medicare pays for physicians’ and other health professionals’ services using a fee schedule, which includes payment rates for around 7,000 separate billing codes. For each service, CMS assigns three weights: the amount of clinician work required to provide a service, the expenses of running a practice, and the cost of malpractice insurance. Each weight is adjusted by the relative geographic cost of input prices. In total, these weights are designed to reflect the resources needed to provide the typical service. The sum of the weights is multiplied by a dollar amount called the conversion factor, which produces the total payment amount.¹

Under current law, the conversion factor is governed by the sustainable growth rate (SGR) formula. The SGR formula, established in the Balanced Budget Act of 1997, is designed to limit the aggregate growth in payments to physicians and other health professionals. It allows for growth in input prices, enrollment, changes in law and regulation, and volume, with the allowance for volume growth equal to the rate of growth in per capita gross domestic product (GDP). As a result, the differential between GDP and volume growth is an important factor. A rationale for setting GDP as the volume target is that national output—or GDP—reflects a measure of affordability because government tax collections have generally remained a constant share of national output. Medicare Part B, which funds physician and other health professional services, receives the bulk of its financing from tax collections.

The resulting formula produced negative payment updates every year starting in 2002—and continuing through

2012—due to increases in volume and intensity beyond those permitted by the formula. However, legislatively the Congress overrode the negative updates every year starting in 2003. On December 26, 2013, the estimated 24 percent payment cut to physician fees under the SGR was overridden until April 2014.

Are Medicare fee schedule payments adequate in 2014?

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: Generally stable

We review a range of beneficiary access measures, including our own beneficiary survey, other surveys, physicians’ willingness to accept Medicare beneficiaries, and results from beneficiary and physician focus groups. We find that the share of beneficiaries in 2013 reporting that they have good access to care and that they are satisfied with their care is consistent with prior years.

Beneficiary survey finds stable access to physician services

Every year, the Commission sponsors a telephone survey of 4,000 Medicare beneficiaries and 4,000 privately insured individuals ages 50 to 64. The goal in surveying these two populations is to assess whether 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 2013.

Overall, we find that beneficiaries’ access to physician services is stable and similar to or better than access among privately insured individuals. Higher shares of Medicare beneficiaries reported that they were very or somewhat satisfied with their care (88 percent) compared with those who have private insurance (83 percent) (Table 4-1, p. 98).

Most beneficiaries reported they were able to obtain timely appointments for routine care and illness or injury, and

**TABLE
4-1**

Satisfaction with the overall quality of health care received in the past 12 months, 2013

	Medicare (age 65 or older)	Private insurance (age 50-64)
Very satisfied	70%	60%
Somewhat satisfied	18	23
Somewhat dissatisfied	3	4
Very dissatisfied	1	1

Note: Table excludes the following responses: "Did not receive health care in past 12 months," "Don't know," and "Refused."

Source: MedPAC-sponsored telephone survey conducted in 2013.

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). These findings are consistent with prior years' survey results as well as with access reported among the privately insured.

Most beneficiaries are able to see their doctors when they want to The results from the 2013 survey are consistent with prior years in finding that most Medicare beneficiaries are able to see their doctors in a timely manner. The share of beneficiaries seeking a routine care appointment who reported that they never had to wait longer than they wanted was 73 percent; 82 percent of beneficiaries seeking an illness or injury appointment said they never had to wait longer than they wanted. These shares are significantly higher than the shares of the privately insured population who never had to wait longer than they wanted for a routine appointment (69 percent) or illness appointment (77 percent) (Table 4-2).

In 2013, 10 percent of beneficiaries responded that they see a nurse practitioner (NP) or physician assistant (PA) for all or most of their primary care, and 24 percent said that they see an NP or PA for some of their primary care. Rural beneficiaries were more likely than urban beneficiaries to report that they see an NP or PA for all or most of their care (13 percent for rural beneficiaries vs. 9 percent for urban beneficiaries).

Beneficiaries are generally able to find a new physician, but those seeking a new primary care provider encounter more trouble than those seeking a specialist Our survey also asks whether beneficiaries seeking a new doctor

face problems finding one. Overall, 1.3 percent of all Medicare beneficiaries reported that they had a big problem finding a new primary care doctor, higher than the share of Medicare beneficiaries reporting that they had a big problem finding a new specialist (0.7 percent). The rates of individuals with private insurance who reported a big problem finding a doctor or specialist were similar, at 1.4 percent and 1.1 percent, respectively.

Overall, we do not find significant problems with beneficiary access to physicians or other health professional services, but beneficiaries in certain areas or populations may face problems with access to care, and beneficiaries may have difficulty finding physicians in certain specialties. However, even though the share of beneficiaries with access issues is small, the problems faced by these beneficiaries can be personally distressing and are often featured in local and national media reports.

Reports of not getting needed care are higher among privately insured individuals and some groups of beneficiaries A lesser share of Medicare beneficiaries (8 percent) than 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).

Among Medicare beneficiaries, a greater share of minority beneficiaries reported that they always had to wait longer than they wanted for routine care (4 percent vs. 2 percent of White beneficiaries) and for an illness or injury appointment (3 percent vs. 1 percent). Similarly, minority beneficiaries were more likely than White beneficiaries to report that they had a medical concern about which they should have seen, but did not see, a doctor (10 percent for minority beneficiaries, 8 percent for White beneficiaries). Other differences by race in the share of beneficiaries reporting difficulties in access to primary or specialty care services were not significant (Table 4-3, p. 100).

Urban and rural beneficiaries report similar access Overall, the survey found no major differences in access between urban and rural beneficiaries. Most urban and rural beneficiaries (73 percent of both) never had to wait longer than they want for routine care; the shares were greater for illness or injury appointments (81 percent for urban, 82 percent for rural beneficiaries; see online Appendix 4-A, available at <http://www.medpac.gov>). There were no significant differences in the rates of urban and rural beneficiaries reporting that they did not have a problem finding a primary care physician or a specialist.

**TABLE
4-2**

Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2009–2013

Survey question	Medicare (age 65 or older)					Private insurance (age 50–64)				
	2009	2010	2011	2012	2013	2009	2010	2011	2012	2013
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	77% ^{ab}	75% ^{ab}	74% ^a	77% ^{ab}	73% ^a	71% ^{ab}	72% ^{ab}	71% ^a	72% ^{ab}	69% ^a
Sometimes	17 ^{ab}	17 ^{ab}	18 ^a	17 ^{ab}	20 ^a	22 ^a	21 ^{ab}	21 ^a	21 ^{ab}	23 ^a
Usually	2 ^{ab}	3 ^a	3	3	3 ^a	3 ^a	4 ^a	4	3 ^b	4 ^a
Always	2	2	2 ^a	2 ^{ab}	3	3	3	3 ^a	3 ^a	3
For illness or injury										
Never	85 ^{ab}	83 ^a	82	84 ^a	82 ^a	79 ^a	80 ^{ab}	79	80 ^a	77 ^a
Sometimes	11 ^{ab}	13 ^a	14 ^a	12 ^a	14 ^a	17 ^{ab}	15 ^a	17 ^a	16 ^{ab}	17 ^a
Usually	2	2	2	2	2 ^a	2	2	2	2	3 ^a
Always	1	1 ^a	1	1 ^a	1	2	2 ^a	1	2 ^a	2
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”	7 ^a	8 ^a	8 ^a	8 ^a	8 ^a	11 ^a	12 ^a	11 ^a	11 ^a	11 ^a
Looking for a new doctor: “In the past 12 months, have you tried to get a new...?” (Percent answering “Yes”)										
Primary care doctor	6	7	6 ^b	7	7	8	7	7	7	8
Specialist	14 ^a	13 ^{ab}	14 ^a	13 ^a	14	19 ^a	15 ^a	16 ^a	18 ^a	16
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	78	79 ^a	65	72	70	71	69 ^a	68	75	67
Percent of total insurance group	5.0	5.2	3.6	4.7	5.2	5.4	4.8	4.5	5.0	5.2
Small problem	10	8	12	14	11	8 ^b	12	16	9	15 ^b
Percent of total insurance group	0.6	0.5	0.7	0.9	0.8	0.6	0.8	1.1	0.6	1.2
Big problem	12 ^a	12	23 ^a	14	17	21 ^a	19	14 ^a	15	18
Percent of total insurance group	0.8	0.8	1.3	0.9	1.3	1.6	1.3	0.9	1.0	1.4
Specialist										
No problem	88	87 ^a	84	87	86	84	82 ^{ab}	86	86	87 ^b
Percent of total insurance group	12.5	11.0	12.1	11.7	12.4	16.1	12.6	13.9	15.6	13.9
Small problem	7	6 ^a	8	6	8	9	11 ^{ab}	8	7	6 ^b
Percent of total insurance group	1.0	0.8	1.1	0.7	1.2	1.7	1.8	1.3	1.2	0.9
Big problem	5	5	7	7	5	7	6	6	7	7
Percent of total insurance group	0.7	0.7	1.0	0.9	0.7	1.3	1.0	1.0	1.2	1.1

Note: Numbers may not sum to 100 percent because missing responses (“Don’t know” or “Refused”) are not presented. Sample sizes for each group (Medicare and privately insured) are 4,000 from 2009 to 2013. 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 from 2013 within the same insurance coverage category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted in 2009, 2010, 2011, 2012, and 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, 2013

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	73% ^a	74% ^a	71% ^a	69% ^a	70% ^{ab}	65% ^{ab}
Sometimes	20 ^a	20 ^a	19 ^a	23 ^a	23 ^a	25 ^a
Usually	3 ^a	3 ^a	4	4 ^a	5 ^a	4
Always	3	2 ^b	4 ^b	3	3 ^b	5 ^b
For illness or injury						
Never	82 ^a	83 ^{ab}	77 ^b	77 ^a	77 ^a	76
Sometimes	14 ^a	13 ^a	16	17 ^a	18 ^a	17
Usually	2 ^a	2 ^{ab}	3 ^b	3 ^a	3 ^a	2
Always	1	1 ^b	3 ^b	2	1	2
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 ^a	8 ^{ab}	10 ^b	11 ^a	11 ^a	11
Looking for a new doctor: "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	7	7	7	8	8	7
Specialist	14	15 ^b	12 ^b	16	17 ^b	12 ^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	70	72	65	67	67	66
<i>Percent of total insurance group, by race</i>	5.2	5.4	4.5	5.2	5.4	4.7
Small problem	11	9 ^a	19 ^a	15	15 ^a	16 ^a
<i>Percent of total insurance group, by race</i>	0.8	0.7	1.3	1.2	1.2	1.1
Big problem	17	18	14	18	19	16
<i>Percent of total insurance group, by race</i>	1.3	1.4	1.0	1.4	1.5	1.1
Specialist						
No problem	86	87	80	87	88	86
<i>Percent of total insurance group, by race</i>	12.4	13.1	9.4	13.9	14.9	10.6
Small problem	8	7	12 ^a	6	6	4 ^a
<i>Percent of total insurance group, by race</i>	1.2	1.1	1.4	0.9	1.0	0.6
Big problem	5	5	7	7	6	9
<i>Percent of total insurance group, by race</i>	0.7	0.7	0.8	1.1	1.0	1.1

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 presented and due to rounding. Sample sizes for each group (Medicare and privately insured) were 4,000 in 2013. 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 2013.

Beneficiary focus groups

For a number of years, the Commission has contracted to conduct beneficiary and physician focus groups to supplement our survey. This year, the focus groups included Medicare beneficiaries, dual-eligible Medicare and Medicaid beneficiaries, and primary care physicians. Groups were conducted in four areas: the Bronx, NY; Greenville, SC; Chicago, IL/Gary, IN; and Richmond, VA. These focus groups were supplemented by visits to providers in different locations—27 facilities and agencies, including hospitals and health systems, private practices, and mental health providers, among others.

With respect to access, the Commission’s findings from beneficiary focus groups have shown considerable consistency over time. Beneficiaries reported that, overall, they generally had a regular source of care and could get in to see their primary care provider in a reasonable amount of time. Some reported that they could see their provider the same day or the next day, while others reported that the wait could be more like a few days to a few weeks. Beneficiaries who see practitioners in large group practices were more likely to report that they could see another provider in their practice that day even if their usual physician was not available.

Dual-eligible beneficiaries were more likely to report that they had trouble finding a new doctor or provider, which is consistent with both the reports from prior years’ focus groups as well as beneficiary surveys. Some Medicare beneficiaries reported that while their physicians did not accept new Medicare patients, they were able to continue being seen because they were patients of the practitioner before attaining Medicare eligibility. Some beneficiaries reported problems finding access to certain specialists— notably dermatologists and psychiatrists, which is also consistent with reports from prior years’ focus groups.

Most providers interviewed stated that they continued to take new Medicare patients, at least in some capacity. A few reported that they had either dropped all insurance or that they were considering dropping Medicare in the future. Providers were more likely to report that they did not take certain types of Medicare Advantage plans (such as health maintenance organizations, or HMOs), even though they continued to take Medicare FFS. For example, one provider was having trouble keeping up with the changes in coverage in one Medicare Advantage plan and no longer participated in that plan. A few providers also reported that they did not take Medicare because of the complexity of patients in the disabled and aging populations.

This year, interviewers probed beneficiaries and providers about the concept of retainer-based, or “concierge,” physician practices. A few beneficiaries reported that they had sought care from retainer-based practices, and a few physicians reported that they had joined retainer-based practices because they felt that it allowed them to simplify administration of their practice.

Finally, participants in the physician focus groups and at the site visits were asked about working in a solo practice compared with working in a large practice or for a hospital or other organization. Many physicians reported that it was becoming more difficult to operate as a solo physician practice; interviewers got this response from both practitioners who had a solo practice as well as those in large organizations. Younger physicians were generally more likely to see a benefit to working in a large organization than were older physicians. Some also said that working for a larger organization made it easier to adopt technologies and new innovations because the organization could cover the cost of the investment, but they felt that the trade-off was some loss of autonomy.

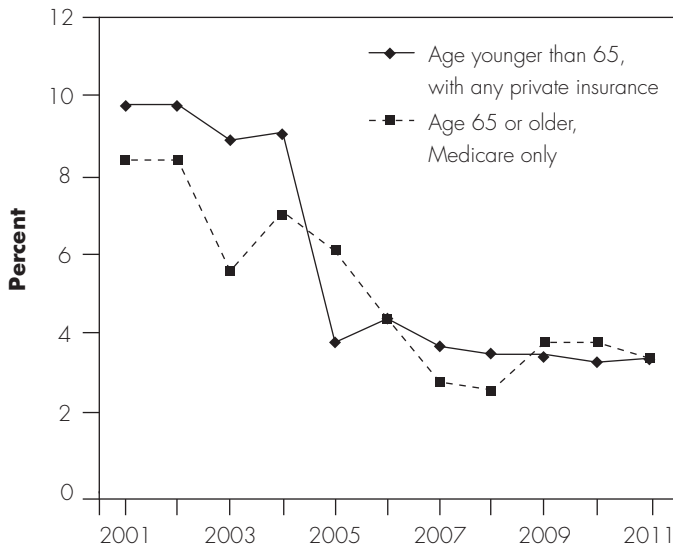
Other national patient surveys show results comparable with the Commission survey regarding beneficiaries’ access to services

The findings of other surveys assessing access for Medicare beneficiaries are similar to our beneficiary survey:

- An analysis of the 2011 Medicare Current Beneficiary Survey (MCBS) finds that 96 percent of noninstitutionalized Medicare beneficiaries had a usual source of medical care (74 percent cited a doctor’s office and 12 percent cited a clinic). About 5 percent of beneficiaries reported that they had difficulty obtaining care, and 10 percent of beneficiaries reported that they delayed care because of cost. By comparison, higher rates of the under-65 Medicare population (generally entitled to Medicare based on a disability) had access problems: 15 percent reported trouble obtaining care and 25 percent reported delaying care because of cost (Centers for Medicare & Medicaid Services 2013a).
- The 2010 Health Tracking Household Survey, administered by the Center for Studying Health System Change, found that access to health care was similar between Medicare beneficiaries and individuals ages 55–64 with private insurance. Specifically, Medicare seniors reported levels of

FIGURE 4-1

Percentage of persons unable to obtain needed care or delayed in receiving needed medical care, 2001-2011



Source: Center for Financing, Access and Cost Trends, Agency for Healthcare Research and Quality analysis of the Medical Expenditure Panel Survey, 2001-2011.

unmet need or delaying care similar to those of individuals ages 55-64 with private insurance (Yee et al. 2012).

- The 2011 Medical Expenditure Panel Survey (MEPS) found that Medicare beneficiaries, both with and without supplemental insurance, reported that they delayed or did not receive needed care at about the same rates as those under 65 with private insurance (Figure 4-1). These figures have been relatively stable since the middle of the 2000s, after declining in the early part of the last decade.

While the Commission survey is currently unable to assess whether beneficiaries have supplemental coverage or are enrolled in Medicare Advantage plans, other surveys are able to identify beneficiaries' type of coverage either from a detailed questionnaire covering insurance status (such as the MEPS) or by matching survey responses to Medicare administrative data (such as the MCBS). From those surveys, we can see whether the Medicare population's access to care varies by the type of coverage they have.

Overall, the MCBS found that beneficiaries with supplemental private insurance reported that they were slightly more likely to be satisfied with the ease of access to their doctor and less likely to report being very unsatisfied (Table 4-4). As with other surveys and beneficiary focus groups, the MCBS information on access also shows that dually eligible beneficiaries were more likely to report that they were unsatisfied with the ease of access to their doctor.

The MEPS, in addition to providing detail on the presence of Medicare supplemental insurance, also allows us to compare access among Medicare beneficiaries with under-65 individuals with private insurance. Specifically, 65 percent of beneficiaries with Medicare FFS only, 72 percent of beneficiaries with Medicare and private insurance, and 63 percent of beneficiaries with Medicare and public insurance reported that they always got an appointment for illness or injury as soon as they wanted, compared with 61 percent of nonelderly individuals with private insurance (Agency for Healthcare Research and Quality 2013).

Finally, the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey, administered by health plans and CMS, can be used to compare patient access

TABLE 4-4

Ease of access to doctor, 2011

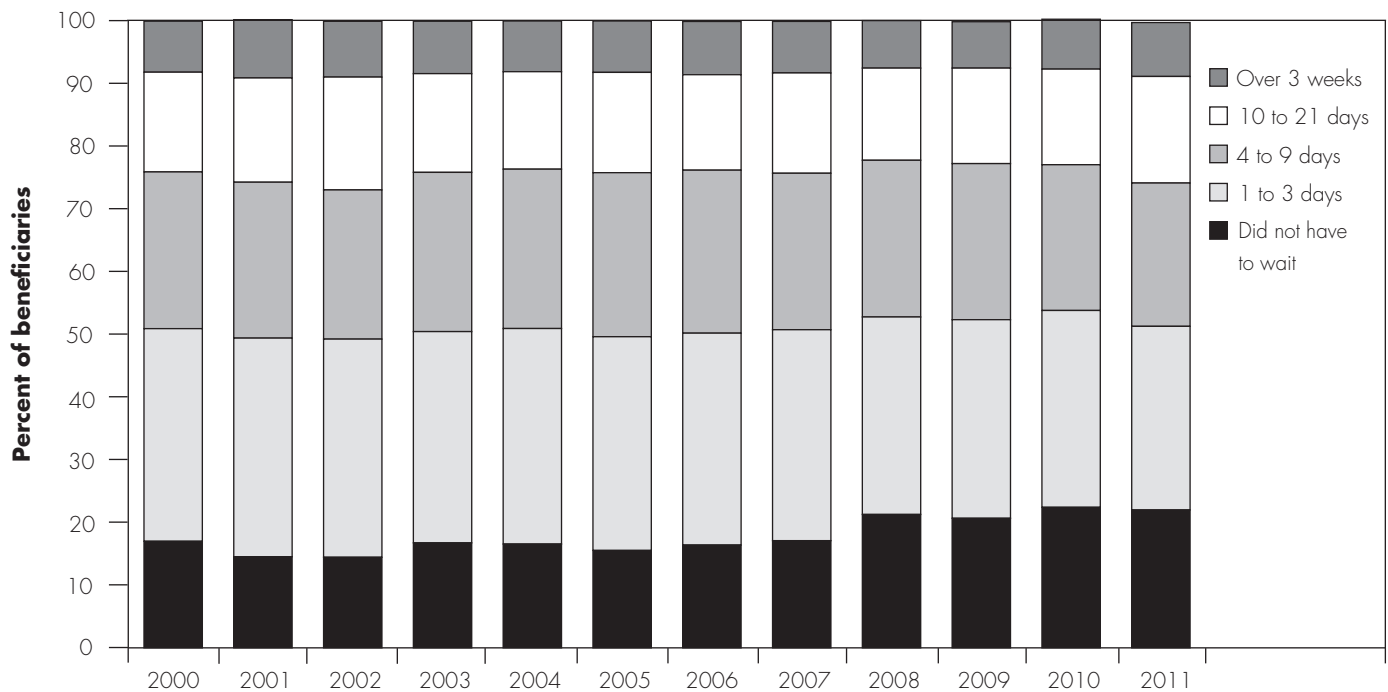
	Medicare and supplemental coverage					
	All Medicare respondents	Medicare HMO	Medicaid	Individually purchased private insurance	Employer-sponsored private insurance	Medicare FFS only
Very satisfied	30%	30%	17%	34%	36%	25%
Very unsatisfied	5	4	10	4	3	7

Note: FFS (fee-for-service).

Source: CMS analysis of the Medicare Current Beneficiary Survey Access to Care file 2011.

**FIGURE
4-2**

Half of all beneficiaries report that they can see their physician within three days



Source: Medicare Current Beneficiary Survey Access to Care file 2000–2011.

to physician and other health professional services between beneficiaries in Medicare Advantage (MA) and beneficiaries in FFS Medicare. The Kaiser Family Foundation did such an analysis and reported that beneficiaries in Medicare FFS and beneficiaries in MA were generally able to get an appointment for routine care as soon as needed at the same rate—62 percent (Boccuti et al. 2013). We are not currently able to compare access to care between beneficiaries served by an accountable care organization (ACO) and those in FFS or MA using the beneficiary telephone survey, although we may be able to do so in the future.

Some beneficiary surveys, in assessing whether individuals could get a timely appointment with their doctor, pose general questions regarding whether beneficiaries were able to see their doctor as soon as they wanted. The MEPS and the Commission’s surveys use such a framework, which helps allay concerns that beneficiaries may not be able to recall how long they waited for doctors’ appointments over the prior year with sufficient specificity.

The MCBS does ask interviewees how long they waited for their last physician appointment. In 2011, half of Medicare beneficiaries reported that they could see their doctor within three days—20 percent report that they could see their physician without waiting, and 30 percent report that they have to wait one to three days. These figures have remained relatively constant over the past decade (Figure 4-2).

Physician surveys show that providers were generally willing to accept Medicare beneficiaries

Another measure of beneficiary access to physician services is the willingness of providers to accept new Medicare patients. A study from the Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation (ASPE) reported that initial findings from the 2011 and 2012 National Ambulatory Medical Care Survey (NAMCS) showed that physician acceptance of new Medicare patients was similar to prior years, with about 85 percent of primary care physicians accepting new Medicare patients (when pediatricians

**TABLE
4-5**

Physicians and other health professionals billing Medicare, 2010–2012

Year	Physicians				Advanced practice 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					
2010	165,565	3.8	372,269	8.5	113,232	2.6	135,584	3.1
2011	169,640	3.8	379,411	8.5	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

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

Source: Medicare claims data for 100 percent of beneficiaries and the 2013 annual report of the Boards of Trustees of the Medicare trust funds.

are excluded) and 90 percent of specialist physicians accepting new Medicare patients (Shartz et al. 2013).²

The American Medical Association 2013 National Health Insurer Report Card, which assesses payment accuracy, timeliness, and transparency, found that Medicare was comparable with other large payers (American Medical Association 2013).

Supply of physicians and other 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, the share of physicians and other health professionals who 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 kept pace with enrollment growth

Our analysis of Medicare FFS claims data for 2010 to 2012 shows that the number of physicians and other health professionals providing services to Medicare beneficiaries kept pace with growth in the beneficiary population. For physicians in specialties eligible for the Primary Care Incentive Payment Program, the ratio of these physicians per 1,000 beneficiaries remained constant at 3.8 per 1,000. Between 2011 and 2012, the ratio of physicians in other

specialties fell slightly from 8.5 per 1,000 to 8.4 per 1,000. Meanwhile, the number of advanced practice nurses and physician assistants billing Medicare grew from 2.8 per 1,000 to 3.0 per 1,000 (Table 4-5).

Most physicians and other professionals are part of Medicare’s participating provider program, and most claims are taken on assignment

Nearly all physicians and other health professionals billing Medicare sign an agreement with Medicare to be part of the participating provider program—96 percent in 2011 (Centers for Medicare & Medicaid Services 2012b). 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—99.3 percent in 2011). 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, 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 2012c). Some provider specialties are more likely to balance bill than others. For example, chiropractors are more likely than other specialties or provider types to balance bill—90 percent of their claims were taken on assignment, and average balance billing amounts were about \$20 per patient. Other specialties were less likely to balance bill; when they do, because their services are more expensive, the beneficiary's liability is higher. For example, thoracic and cardiac surgery patients who were subject to balance billing had average liabilities of \$87 and \$164, respectively, and patients of radiation oncologists who were subject to balance billing had average liabilities of \$434 (Centers for Medicare & Medicaid Services 2012c).

Practitioners who opt out of Medicare are rare but the number 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 in order to care for 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). These two specialties alone accounted for over half of the opt-out providers. Providers who opted out are concentrated in California, New York, and Texas. Opt-out providers were more likely to be older—more than a third were over the age of 60.

Use of services is essentially unchanged

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 evidence indicates that volume decreases are more likely to be due to non-payment-related factors,

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 changes in population, disease prevalence, Medicare benefits, 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 2007, 2011, and 2012 to identify the services provided by physicians and other professionals billing under Medicare's fee schedule and calculate two measures of changes in service use. First, we calculated the change in the units of service per beneficiary. Second, we calculated the change in the volume of services per beneficiary. Volume is calculated as units of service multiplied by each service's relative value unit (RVU) from the fee schedule. The result is that volume growth 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, such as when providers substitute computed tomography (CT) scans for less complex X-rays. We used RVUs for 2012 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.³ Physicians and other health professionals now use office visit codes and codes for hospital and nursing facility visits. 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 inaccuracy, when considering changes in service use before 2010 we focus the discussion below 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.

Across all services, volume per beneficiary remained essentially unchanged, with a growth rate of -0.2 percent in 2012 (Table 4-6, p. 106). Among broad categories of service, growth rates were 0.1 percent for evaluation and management (E&M), 0.2 percent for major procedures,

**TABLE
4-6**
Use of services furnished by physicians and other health professionals, per fee-for-service beneficiary

Type of service	Change in units of service per beneficiary		Change in volume per beneficiary		Percent of 2012 allowed charges
	Average annual 2007-2011	2011-2012	Average annual 2007-2011	2011-2012	
All services	1.4%	-0.4%	N/A	-0.2%	100.0%
Evaluation and management	0.8	-0.4	N/A	0.1	45.8
Office visit—new and established	0.8	0.2	N/A	0.6	25.3
Inpatient visit—hospital and nursing facility	0.4	-1.8	N/A	-1.3	15.5
Emergency room visit	2.4	1.7	4.0%	2.5	3.2
Hospital visit—critical care	6.9	1.7	7.0	1.7	1.4
Home visit	4.4	0.1	5.2	0.4	0.4
Imaging	0.6	-1.9	0.2	-3.2	11.9
Advanced—CT: other	2.6	1.7	1.7	-1.1	1.7
Advanced—MRI: other	0.3	-0.4	-1.3	-3.4	1.2
Echography—heart	0.6	-2.0	0.0	-5.1	1.2
Standard—nuclear medicine	-5.4	-8.0	-6.9	-13.6	1.0
Echography—other	5.3	2.6	6.7	5.8	1.0
Standard—musculoskeletal	0.4	-1.2	0.0	-2.0	0.9
Standard—breast	2.8	-0.3	3.5	-1.6	0.7
Imaging/procedure—other	0.0	-8.2	5.1	-4.7	0.6
Advanced—MRI: brain	-0.6	-1.3	-3.6	-5.3	0.6
Advanced—CT: head	2.4	0.1	0.8	-2.4	0.5
Standard—chest	-0.8	-3.4	-1.3	-3.8	0.5
Echography—abdomen and pelvis	2.3	0.1	2.7	0.3	0.5
Major procedures	0.5	-0.9	1.8	0.2	7.5
Cardiovascular—other	-0.8	-1.7	2.6	-0.1	1.8
Orthopedic—other	4.7	-4.7	6.5	-5.3	1.1
Knee replacement	0.7	2.5	1.3	2.6	0.5
Coronary angioplasty	-1.8	-6.0	-1.7	-5.8	0.3
Hip replacement	2.4	4.7	3.0	4.9	0.3
Explore, decompress, or excise disc	3.0	2.9	5.0	3.8	0.3
Hip fracture repair	-1.7	-2.8	-1.5	-2.7	0.2
Coronary artery bypass graft	-6.8	-6.8	-7.0	-6.6	0.2
Other procedures	3.2	0.1	2.6	0.4	22.5
Skin—minor and ambulatory	1.1	1.9	2.5	1.9	4.7
Outpatient rehabilitation	6.4	-0.5	7.2	0.0	3.5
Radiation therapy	-1.6	-5.0	1.4	-6.3	2.1
Minor—other	1.9	-0.8	2.4	0.3	2.0
Cataract removal/lens insertion	-0.8	1.1	-0.4	1.3	1.6
Minor—musculoskeletal	2.2	2.2	2.8	2.0	1.4
Eye—other	10.4	8.4	4.2	5.5	1.0
Colonoscopy	-2.3	-0.6	-2.2	-0.5	0.9
Upper gastrointestinal endoscopy	1.0	-0.4	1.5	0.1	0.5
Cystoscopy	-0.2	1.0	-0.3	0.6	0.4
Tests	1.1	0.2	3.0	-0.5	5.2
Other tests	0.6	1.6	1.9	-1.1	2.0
Laboratory tests—other	4.4	1.8	6.3	1.9	1.8
Electrocardiograms	0.4	-1.9	0.8	-1.8	0.5

Note: N/A (not available), CT (computed tomography). 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 2012. For billing codes not used in 2012, 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 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 2007, units of service for office visits and inpatient visits include, respectively, office and inpatient consultations. Laboratory tests include tests billable under the fee schedule for physicians and other health professionals and excludes services billable under the laboratory fee schedule. Numbers may not sum to totals due to rounding.

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

0.4 percent for other procedures, and -0.5 percent for tests. Use of imaging services declined by 3.2 percent.

Imaging decreases amid concerns about appropriateness

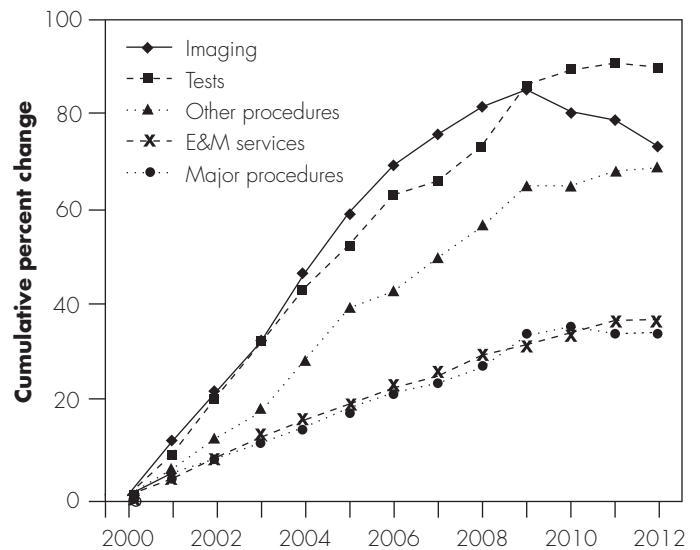
Despite decreases after 2009, use of imaging services has remained much higher than it was a decade ago (Figure 4-3). Cumulative growth in the volume of imaging from 2000 to 2009 totaled 85 percent, compared with a cumulative decrease in imaging volume since then of about 7 percent. The growth in imaging volume from 2000 to 2009 was exceeded only by the 86 percent growth in 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.

Meanwhile, physicians and others continue to raise concerns about overuse of imaging, including the exposure to radiation that can accompany that overuse. Some physician organizations have responded to these concerns. For example, the American Board of Internal Medicine (ABIM) Foundation has a Choosing Wisely initiative underway to help physicians and patients have conversations about the overuse of imaging and other services such as CT or MRI scans for common headaches or imaging studies for those with nonspecific low back pain. The initiative is also intended to support physician efforts to help patients make smart and effective choices about their care (ABIM Foundation 2012).

- Data on trends in management and treatment of uncomplicated back pain in the general population for the years 1999 to 2000 and 2009 to 2010 show that orders for CT or MRI, as a proportion of visits for the condition, went from 7.2 percent to 11.3 percent (Mafi et al. 2013). Imaging is generally not indicated for uncomplicated low back pain. The study’s authors concluded that use of advanced diagnostic imaging for low back pain has experienced an inappropriate increase.
- Physicians have voiced concerns about diagnostic tests that are ordered without an understanding of how the results could change patient treatment (Hoffman and Cooper 2012, Redberg et al. 2011). The concern is that sophisticated technology, while able to detect disease, can also have costs, including exposure to radiation, adverse effects of treatment, and proliferation of false-positive results. One radiologist

FIGURE 4-3

Growth in the volume of practitioner services, 2000–2012



Note: E&M (evaluation and management). Volume growth for E&M from 2009 to 2010 is not directly observable due to a change in payment policy for consultations. To compute cumulative volume growth for E&M through 2011, we used a growth rate for 2009 to 2010 of 1.85 percent, which is the average of the 2008 to 2009 growth rate of 1.70 percent and the 2010 to 2011 growth rate of 2.00 percent.

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

called on his colleagues in the specialty to become “effective gatekeepers” who develop clinical imaging conferences, act as imaging consultants, and conduct imaging rounds (Jha 2013).

- In a study for the Commission documenting trends in the services provided to Medicare beneficiaries by cardiologists from 1999 to 2008, physician researchers found that the bulk of the growth occurred in two established technologies: echocardiograms and stress tests with nuclear imaging (Andrus and Welch 2012). They concluded that it is unlikely that these services were underused in 1999 and expressed doubt that there was a clinical justification for a threefold increase in nuclear stress testing and a twofold increase in echocardiography. They noted further that excessive use of such services poses a number of potential harms, including cancer risk due to radiation exposure (from nuclear imaging), anxiety related to false-positive results, and complications of invasive procedures pursued in response to those false-positive results.

**TABLE
4-7**

Billing for cardiovascular imaging has shifted from professionals' offices to hospitals, 2011-2012

	Share of services performed in HOPDs, 2012	Per beneficiary growth in units of service	
		HOPD	Professional office
Echocardiography	34.6%	13.5%	-9.0%
Nuclear cardiology	39.0	9.4	-15.9

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.

- Another study for the Commission considered the extent to which certain diagnostic services are repeated when provided to Medicare beneficiaries (Welch et al. 2012). The list included three imaging services: echocardiography, imaging stress tests, and chest CT. The study showed that some clinicians routinely repeat services, even though standards for doing so are lacking. In addition, the study showed that—when comparing testing in the 50 largest metropolitan statistical areas—there is a high positive correlation between the proportion of beneficiaries who are tested and the proportion of tests repeated. This finding suggests that—in the absence of external standards—local practice style determines testing thresholds. A tendency to repeat services routinely can reduce the capacity of physicians and other health professionals to serve new patients, raise practice costs as more equipment and personnel are used to serve a given population, and increase spending.
- As reported in the press, physicians and others have expressed concerns about overuse of services, including imaging (Elton 2009, Holohan 2011, Johnson 2008, Kolata 2011, Palfrey 2011). For example, in an essay for the *New York Times*, a physician wrote that “Overconsultation and overtesting have now become facts of the medical profession. The culture in practice is to grab patients and generate volume. ‘Medicine has become like everything else,’ a doctor told me recently. ‘Everything moves because of money.’” (Juahar 2008). In a commentary for the *New England Journal*

of Medicine, a physician and another author wrote that “the goal should be to redirect nascent physicians from a shotgun approach toward the critical use of imaging in thoughtful and elegant diagnosis” (Hillman and Goldsmith 2010).

- As discussed in the Commission’s June 2011 report, there is evidence that some diagnostic imaging services ordered by physicians are not clinically appropriate and that inappropriate use occurs in multiple settings. The American College of Cardiology Foundation (ACCF) and UnitedHealthcare assessed the appropriateness of nuclear cardiology procedures performed by six nonhospital practices using criteria developed by the ACCF and the American Society of Nuclear Cardiology (Hendel et al. 2010). The researchers found that 14 percent of the studies performed at these sites were inappropriate and 15 percent were of uncertain appropriateness.

Much of imaging decrease is due to shift in billing for cardiovascular imaging from professionals' offices to hospitals

Physicians and other health professionals can bill for fee schedule services as provided in either a nonfacility setting, such as a professional office, or a facility setting, such as a hospital. As discussed in this report’s chapter on hospital inpatient and outpatient services (Chapter 3), there has been a trend toward billing for some services in hospitals instead of professionals’ offices. For instance, in 2012 compared with 2011, the number of echocardiograms per beneficiary provided in hospital outpatient departments went up by 13.5 percent, but the number provided in professional offices went down by 9 percent (Table 4-7). Similarly, from 2011 to 2012, the number of cardiac nuclear medicine studies per beneficiary provided in hospital outpatient departments went up by 9.4 percent, while the number provided in professional offices went down by 15.9 percent. These changes in billing patterns are consistent with reports of an increase in hospital-owned cardiologist practices (American College of Cardiology 2012).

This shift has implications for changes in the volume of services. Practice expense RVUs used in measuring volume are higher for services provided in a nonfacility setting, such as a professional office, than in a facility setting, such as a hospital.⁴ The difference is intended to account for higher practice costs. Therefore, measures of service volume decrease when there is a shift in billing

patterns from higher RVU nonfacility settings to lower RVU facility settings.

Some of the 3.2 percent decrease in the volume of imaging services results from decreases in units of service for nuclear medicine and echocardiography. However, the more important factor is the movement of these services from the nonfacility setting to the facility setting. If these two types of services are excluded from the calculations, the volume of all other imaging services from 2011 to 2012 would show a decrease of 1.9 percent instead of 3.2 percent.

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

For all services billable under the fee schedule, Medicare spending per beneficiary has increased faster than both the Medicare Economic Index (MEI) and updates to the fee schedule's conversion factor (Figure 4-4). From 2000 to 2012, Medicare spending per beneficiary increased by 72 percent despite an increase in updates of 9 percent, while the MEI rose at a cumulative rate of 27 percent. Since growth in payments to physicians is a function of volume growth and fee schedule updates, volume growth is an important factor accounting for the difference between the fee schedule updates and spending growth. Medicare's payment adjustments for incentive programs are another source of changes in payments. For example, the Physician Quality Reporting System bonus for 2012 was 0.5 percent.⁵

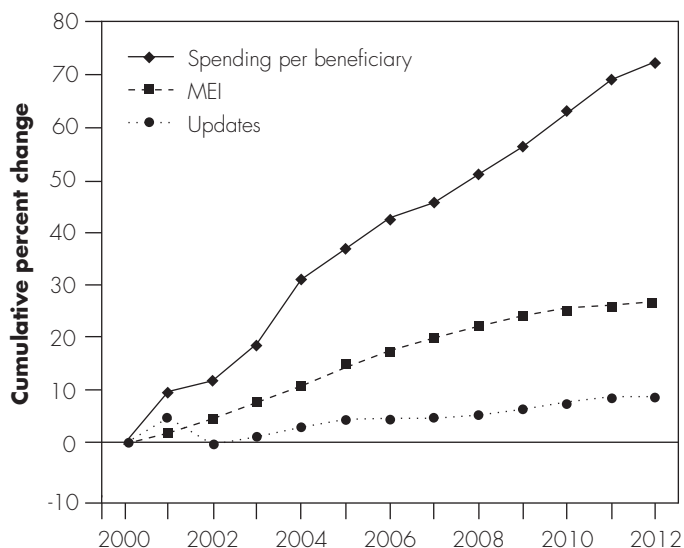
From 2011 to 2012, per beneficiary spending for the services of physicians and other health professionals grew at a rate of 2 percent. By contrast, the average annual growth rate from 2000 to 2011 was 4.9 percent.

Quality of care: Most ambulatory care indicators were stable or improved, although some measures declined

The Commission developed a set of quality indicators, called the Medicare Ambulatory Care Indicators for the Elderly (MACIEs), with input from a group of clinicians, to assess the quality of care delivered by physicians and other health professionals. The MACIEs consist of 32 measures of clinically indicated acute and follow-up care for beneficiaries diagnosed with certain chronic or acute conditions, as well as 6 measures of potentially avoidable hospitalizations and emergency department visits for beneficiaries with 5 chronic diseases (for a complete list of the MACIEs, see online Appendix 4-B, available at <http://www.medpac.gov>). For this year's analysis, we calculated

FIGURE 4-4

Volume growth has caused spending to increase faster than input prices and updates, 2000-2012



Note: MEI (Medicare Economic Index).

Source: 2013 annual report of the Boards of Trustees of the Medicare trust funds and Office of the Actuary 2013.

these measures for FFS beneficiaries based on changes in rates between two time periods, 2009 to 2010 and 2011 to 2012. Between these periods, 18 indicators improved, 15 indicators were statistically unchanged, and 5 indicators worsened. All of the statistically significant changes in the rates were modest.

Two indicators that worsened slightly were the rate of beneficiaries with a breast cancer diagnosis who received a chest X-ray at initial diagnosis and the rate of mammography surveillance following diagnosis. In both cases, it is possible that physicians used other diagnostic imaging modalities such as MRI or CT that were not included in these measures—a separate indicator of breast imaging after diagnosis increased slightly (though not enough to be statistically significant). In contrast to recent years' analyses, the indicator of breast cancer screening rates was stable rather than decreased. The trend in breast cancer screening rates was similar for Medicare Advantage and commercially insured private health plan enrollees, as measured in the National Committee for Quality Assurance's Healthcare Effectiveness Data and Information Set[®] (HEDIS[®]). In the HEDIS measures, the rates of breast cancer screening also stabilized for those enrolled in Medicare HMOs and preferred provider

organization (PPOs) as well as commercially insured individuals under age 65, after decreasing from their peaks in 2005 and 2009, respectively (National Committee for Quality Assurance 2013). This trend may be due to ongoing discussions regarding the frequency and efficacy of breast cancer screening (Bleyer and Welch 2012).

Among the six measures of potentially avoidable hospitalizations for chronic conditions, four improved (hospitalization for short-term complications of diabetes, emergency department visits for unstable angina with coronary artery disease, hospitalization for heart failure, and hospitalization for chronic obstructive pulmonary disease), one worsened (hospitalization for hypertension), and the other (hospitalization for long-term complications of diabetes) was statistically unchanged.

Medicare payments and providers' costs

Because physicians and other health professionals do not report their costs to the Medicare program, we use indirect measures to assess the adequacy of Medicare payments relative to physicians' 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 encourages differences in physician compensation across specialties, even after accounting for the cost of running a practice. The third is a measure of input prices for physicians and other health professionals—the MEI.

Ratio of Medicare payments to private insurer payments is steady

Since 1999, the ratio of Medicare's allowed physician and other health professional fees (including cost sharing) to private insurer allowed fees has been around 80 percent. Results for 2012 showed little change from the results reported for 2011. In 2012, Medicare's payments for physician and other health professional services were 81 percent of commercial rates for PPOs; the rate for 2011 was 82 percent. This analysis is based on a data set of paid claims for PPO members of a large national insurer. We are unable to include additional private insurer payments or penalties that may occur outside of the claims payment process. In contrast, Medicare fees include bonuses or penalties as part of the claim.

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 can cause an income disparity between primary care and specialty physicians. Second, FFS payment allows some specialties to increase the volume of services they provide more easily (and therefore increase 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. This difference in ability to increase volume can also lead to the compensation differences between primary care and specialty care.

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 physician fee schedule.⁶ Private payers often use a conversion factor—or multiple conversion factors, depending on the type of service—that differs from Medicare's.

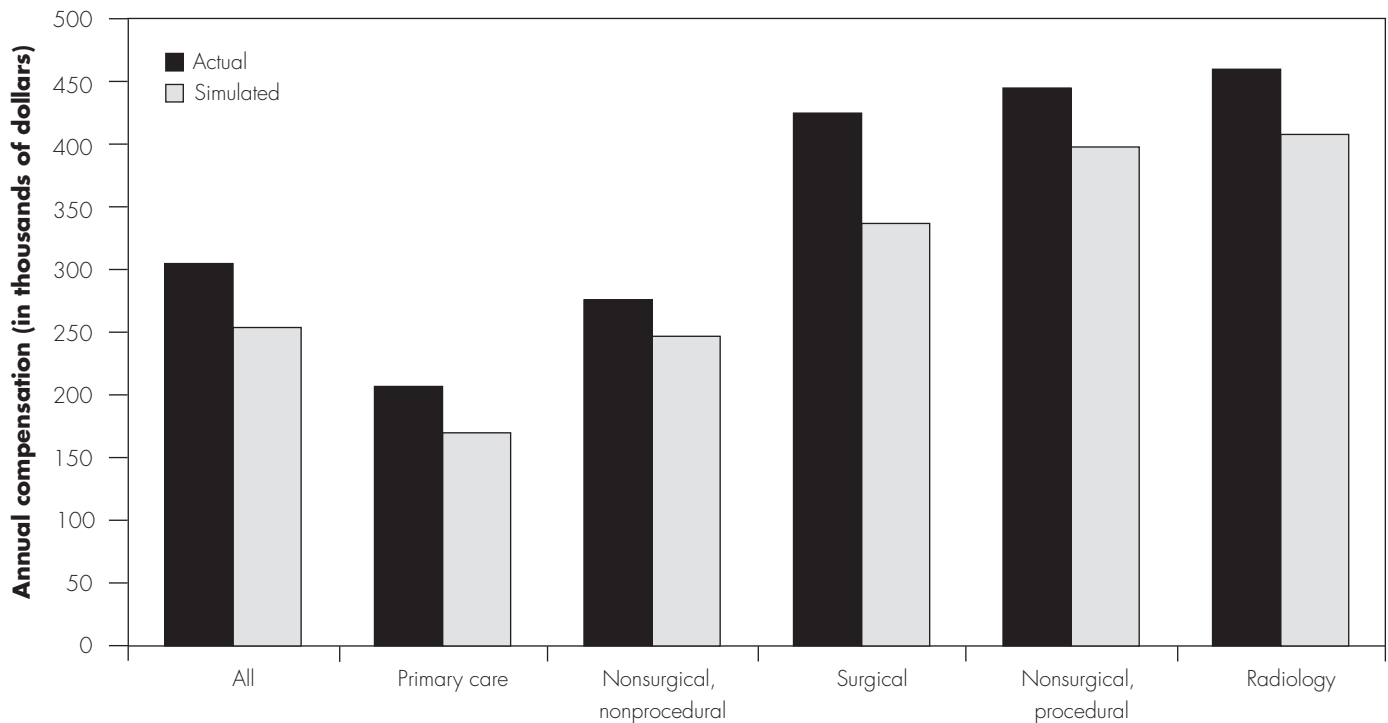
In an update of the initial analysis, the contractor used data from MGMA's Physician Compensation and Production Survey to analyze physician compensation in 2010.⁷ The analysis showed that—averaged across all specialties—actual physician compensation was about \$305,000 per year. Simulated annual compensation for all specialties was about \$254,000—17 percent lower.⁸

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 4-5).⁹ Their actual compensations were about \$445,000 and \$460,000, respectively. Compensation at these levels was more than double that of the \$207,000 average for primary care specialties.^{10,11}

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 \$408,000, or 2.4 times the

**FIGURE
4-5**

Disparities in physician compensation are widest when primary care is compared with nonsurgical proceduralists and radiologists, 2010



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

Source: Urban Institute 2011.

\$170,000 compensation for primary care physicians. For nonsurgical, procedural physicians, the average simulated compensation was about \$398,000, or 2.3 times the \$170,000 compensation for primary care physicians.

Input costs for physicians and other professionals are projected to increase in 2014

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.¹² CMS's current forecast is that the percentage change in the MEI will be 2.2 percent in 2015, and without the productivity adjustment, the MEI is projected to be 2.5 percent (Centers for Medicare & Medicaid Services 2012a).

In addition to payment updates, some of the growth in payments to physicians is due to adjustments to the fee schedule amount. Physicians and other health professionals receive bonuses and other types of positive adjustments for participating in such programs as the

Physician Quality Reporting System and the Electronic Health Record Incentive Program (Table 4-8, p. 112). Because of those positive adjustments, the payment rate for physicians has increased by more than the annual updates to the conversion factor.

How should Medicare payments change in 2015?

Informing the Commission's deliberations on payment adequacy for physicians and other health professionals are beneficiary access to services, volume growth, quality, and input prices for physicians and other health professionals. When looking across multiple measures, we find that 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—

**TABLE
4-8**

Medicare’s payment adjustments for incentive programs

Incentive program	Payment adjustment
Physician Quality Reporting System	<ul style="list-style-type: none"> • 2012–2014: 0.5% bonus for participants • 2015: 1.5% penalty for nonparticipants • 2016 and after: 2% penalty for nonparticipants
Value-based payment modifier	<ul style="list-style-type: none"> • 2015 and after: Groups (100 physicians or more) that do not satisfactorily report under the Physician Quality Reporting System receive a 1% penalty under the modifier; groups can elect cost and quality tiering.*
EHR Incentive Program	<ul style="list-style-type: none"> • Through 2014: Up to \$44,000 over five years is available per physician • 2015 and after: 1% penalty for physicians who do not satisfy the EHR criteria
eRx Incentive Program	<ul style="list-style-type: none"> • 2014: 2% penalty for physicians who did not have a qualified electronic prescribing system

Note: EHR (electronic health record), eRx (electronic prescribing).

*Under the law, the value-based payment modifier must be expanded to cover all physicians by 2017.

that beneficiary access to care is stable. Medicare beneficiaries generally have better overall access to care than privately insured individuals ages 50 to 64. Other beneficiary access surveys have findings consistent with ours. 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 reported a significant 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 was essentially unchanged, declining by 0.2 percent in 2012, and growth rates varied across services (0.1 percent for evaluation and management, 0.2 percent for major procedures, 0.4 percent for other procedures, –0.5 percent for tests, and –3.2 percent for imaging). Despite decreases after 2009, use of imaging services remained much higher than it was a decade ago.

Most measures of ambulatory care quality between the periods of 2009 to 2010 and 2011 to 2012 improved slightly or did not change, and a few worsened slightly. Input prices for physicians and other health professionals are projected to increase by 2.2 percent in 2015 (including a productivity adjustment).

SGR repeal is urgent

MedPAC’s highest policy priority with respect to Medicare’s payments to physicians and other health professionals is repeal of the SGR. Given the Commission’s findings regarding access to care, the Commission reiterates its principles for repeal and specific recommendations, as outlined in prior Commission documents.¹³

The Commission’s principles for addressing the SGR are:

- **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 physicians, other health professionals, and beneficiaries, and the short-term overrides of the SGR have created an administrative burden on providers and CMS.
- **Beneficiary access must be preserved.** Although our latest access survey does not show significant deterioration at the national level, growing “SGR fatigue” among physicians, resulting from annual crises prompted by pending Medicare payment cuts, can only exacerbate any nascent access problems.
- **The physician fee schedule must be rebalanced to achieve greater equity of payments between primary care and other specialties.** Given the important role primary care will play in delivery system reform, the Commission believes that the imbalance in payment

Policies to address ongoing management of patients with chronic conditions and to support primary care

The ability of practitioners in Medicare fee-for-service (FFS) to increase volume more easily in procedural specialties has led to compensation differentials between primary care practitioners and other specialties. It is the Commission's perspective that a robust, well-supported primary care system is crucial to the type of delivery system reform that produces high-value, coordinated care. The Primary Care Incentive Payment Program (PCIP), designed largely in accordance with the Commission's 2008 recommendation for a primary care bonus, pays a 10 percent bonus for certain services for physicians and other clinicians who specialize in delivering primary care and meet other criteria.

While FFS payment has typically focused on face-to-face activities, CMS has recently created FFS billing codes for some non-face-to-face activities—transitional care management and complex care management.

Primary Care Incentive Program

The PCIP, created in the Patient Protection and Affordable Care Act of 2010, establishes a 10 percent bonus for certain services to clinicians who have a primary Medicare specialty designation of family practice, internal medicine, pediatrics, geriatrics, nurse practitioner and clinical nurse specialist, and physician assistant—provided they meet a certain threshold for the share of visits that are in primary care. In 2012, Medicare made \$664 million in payments under the PCIP. The payment adjustment is made automatically based on the provider's specialty and claims history. Half of all payments were made to internal medicine physicians, around 40 percent to family physicians, and

10 percent to nurse practitioners and physician assistants (Centers for Medicare & Medicaid Services 2012d).

Transitional care management codes

CMS established two new transitional care management billing codes in the 2013 physician and other health professionals fee schedule final rule. Starting January 1, 2013, the Medicare program pays for 30 days of transitional care provided to beneficiaries recently discharged from a hospital, skilled nursing facility, or other facility to a community setting. The two codes correspond to higher and lower intensity medical decision making. The payment is designed to cover activities required to provide comprehensive transitional care management as beneficiaries return home.¹⁴ Use of the new codes has been relatively low due to claims processing issues and because there is often a lag for clinicians to adopt new billing conventions. CMS has released new guidance for billing and has modified its payment processes to clarify when providers should bill for the service, which should increase the number of paid claims (Centers for Medicare & Medicaid Services 2013c).

Chronic care management codes

CMS, in its 2014 physician and other health professionals fee schedule final rule, stated that it plans to pay for a new set of care management codes that would cover a 30-day period of care-management activities for beneficiaries with two or more chronic conditions. Beneficiaries would elect which physician or other eligible practitioner would deliver the services (Centers for Medicare & Medicaid Services 2013b). CMS plans to pay for these codes starting in 2015 and establish practice standards through further rulemaking. ■

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.

- **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 payment, offer an opportunity to

correct some of the undesirable incentives to increase volume without penalty 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 aim to preserve or enhance beneficiary access to quality care while minimizing the financial burden on beneficiaries and taxpayers.

Based on these principles, the Commission made four distinct recommendations:

Repeal the SGR and replace it with a 10-year path of legislated updates with higher updates for primary care services than updates for other services

Under the Commission’s approach, the SGR would be repealed and a new set of statutory updates would be created for 10 years for 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 by less than 3 percent 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 other health professionals would shoulder about one-third of the cost of repealing the SGR.

While such a sequence of legislated updates would establish a new budgetary baseline, it would not be immutable. Each year, the Commission will continue to review whether payments to physicians and other health professionals are adequate. If it is determined that a change in payment rates or a delay in a conversion factor adjustment is needed to ensure adequate access, the Commission would make such a recommendation to the Congress. The cost of a one-year delay or change in payment rates would be cheaper than the current practice of overriding the negative updates under the SGR. If necessary, it would be possible to vary the amounts of the primary care and non–primary care updates and to phase in a sequence of those updates at different rates.

Collect data to improve the relative valuation of services

In addition to a conversion factor, the physician and other health professionals fee schedule includes RVUs. These RVUs account for the amount of work required to provide each service, the expenses that practitioners incur related to maintaining a practice, and malpractice insurance costs. The Secretary lacks current, objective data needed to set the fee schedule’s RVUs for practitioner work and practice expenses. The Commission has recommended that the Secretary regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense values.

Identify overpriced services and rebalance payments

The Commission also previously recommended a change in the process for identifying overpriced services in the physician 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. The Commission’s recommendation would also give the Secretary a numeric target for the amount of overpriced services to be adjusted.

Encourage ACOs by creating greater opportunities for shared savings

The Commission recommends 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. The greater opportunity for shared savings would come through a performance standard that does not reflect lower updates.

These four recommendations constitute the Commission’s approach to moving forward from the SGR. ■

Endnotes

- 1 For further information, see the Commission's *Payment basics: Physician and other health professionals payment system* at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_Physician.pdf.
- 2 ASPE notes that their results come from the 2011 data from the NAMCS Electronic Records Supplement and 2012 data from the NAMCS Electronic Health Records Survey, which are both conducted by mail.
- 3 CMS changed the policy on billing for consultations with the rationale that relaxing requirements for consultation documentation had, over time, brought the effort involved in consultations to levels appropriate for those of visits.
- 4 When a service is provided in a facility setting, Medicare makes a separate facility payment to account for its cost.
- 5 See Table 4-8 (p. 112) for further discussion.
- 6 In simple terms, simulated compensation was calculated in two steps. Step 1 was annual total RVUs for the services provided 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 collections (revenues) from the physician's professional services and collections from other sources attributable to the physician, such as laboratory services and injectable drugs.
- 7 The 2010 data predate payment of a 10 percent bonus for eligible primary care practitioners and general surgeons (general surgeons practicing in health professional shortage areas) started on January 1, 2011.
- 8 The 17 percent difference between simulated compensation and actual compensation does not mean that Medicare's payments for physician services are 17 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, where actual compensation includes not just private payers' payments but also some Medicare payments.
- 9 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, and pulmonary medicine.
- 10 The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 11 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 2010 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 2010 data because the newer MGMA survey did not include questions about hours worked.
- 12 The MEI measures the weighted average annual price change for various inputs used by physicians and other health professionals to provide services.
- 13 See, for example, the Commission's letters to the Congress (October 2011 and April 2013), testimony to the Congress (February 2013 and May 2013), the March 2012 report to the Congress, and the March 2013 report to the Congress.
- 14 The transitional care management code requires one face-to-face visit (not paid separately) as well as the non-face-to-face time required to deliver the transitional care.

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CHAPTER

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 2015. 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 procedures to patients who do not require an overnight stay after the procedure. In 2012, 5,357 ASCs treated 3.4 million fee-for-service (FFS) Medicare beneficiaries, and combined Medicare program and beneficiary spending on ASC services was \$3.6 billion.

Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is at least adequate because the available indicators of payment adequacy for ASC services, discussed below, are positive. However, our results also indicate slower growth in the number of ASCs and volume of services in 2012 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 2007 through 2011, the number of Medicare-certified ASCs grew by an average annual rate of 2.5 percent; in 2012, the number increased by 1.2 percent. The relatively slow growth may be related to the higher Medicare payment rates for most ambulatory procedures in hospital outpatient departments (HOPDs)

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?

than in ASCs; for 2014, the Medicare rates are 81 percent higher in HOPDs than in ASCs. This payment difference may have led some ASC owners to sell their facilities to hospitals. In addition, physicians have increasingly been selling their practices to hospitals and becoming hospital employees. Physicians who are hospital employees may be more inclined to provide surgical services at hospitals than at ASCs.

- ***Volume of services***—From 2007 through 2011, the volume of services per beneficiary grew by an average annual rate of 4.6 percent; in 2012, volume increased by 1.7 percent.

Quality of care—ASCs began submitting quality data to CMS in October 2012, but CMS has not yet publicly released complete quality information. Consequently, we do not have sufficient information to assess ASCs' quality of care.

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—Medicare payments per FFS beneficiary increased by an average of 4.3 percent per year from 2007 through 2011 and increased by 4.3 percent in 2012. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin like we do for other provider types to assist in assessing payment adequacy. ■

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. Most ASCs are freestanding facilities rather than part of a larger facility, such as a hospital. 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 3,700 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 2009).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, nursing services, and other areas.

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://www.medpac.gov/documents/MedPAC_Payment_Basics_13_ASC.pdf). The ASC payment system is also partly 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/chapters/Mar10_Ch02C_APPENDIX.pdf). The most significant changes included a substantial increase in the number of ASC-covered surgical procedures, 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 (the standard ASC method). This link to the OPPS is consistent with a previous Commission recommendation to align the relative weights in the OPPS with the ASC payment system (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 the ASC system for two reasons. First, the relative weights are lower in the ASC system because CMS makes proportional adjustments to the relative weights from the OPPS to maintain budget neutrality in the ASC system. In 2014, this adjustment reduced the ASC relative weights by 7.7 percent below the relative weights in the OPPS. 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 \$43.47 in 2014, which is lower than the OPPS conversion factor (\$72.67 in 2014).

The ASC conversion factor is lower for two reasons. First, CMS set the initial ASC conversion factor for 2008 such that total ASC payments under the revised payment system would equal what they would have been under the previous payment system. 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. The Commission has recommended that CMS collect ASC cost data and use these data to examine whether an alternative input price index would be an appropriate proxy for ASC costs or an ASC-specific market basket should be developed (Medicare Payment Advisory Commission 2010b).

CMS uses a method different from the standard ASC method 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 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.² The Commission has been investigating payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2013a, Medicare Payment Advisory Commission 2012).

The ASC payment system generally parallels the OPSS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. Starting in 2008, ASCs receive separate payment 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 OPSS;
- brachytherapy sources implanted during a surgical procedure;
- all pass-through and non-pass-through drugs that are paid for separately under the OPSS when provided as part of a covered surgical procedure; and
- devices with pass-through status under the OPSS.

Because Medicare pays ASCs less than HOPDs for procedures, movement of surgical services from HOPDs to ASCs can reduce aggregate program spending and beneficiary cost sharing. If, however, the growth of ASCs results in an increase in the overall number of surgical services, this growth could partially offset reduced spending and cost sharing. Although we do not have recent ASC cost data that would allow us to quantify cost differences between settings, some evidence suggests that ASCs are a lower cost setting than HOPDs. The Government Accountability Office (GAO) compared ASC cost data from 2004 with HOPD costs and found that costs are, on average, lower in ASCs than in HOPDs (Government Accountability Office 2006).³ In addition, data from the National Survey of Ambulatory Surgery indicate that the average time for ambulatory surgical visits was 50 percent higher in HOPDs than ASCs (147 minutes vs. 98 minutes) (Cullen et al. 2009).⁴ Average times were also higher in HOPDs than ASCs for specific diagnoses such as cataract, benign neoplasm of the colon, and intervertebral disc disorders. ASCs may have lower costs because they treat a healthier mix of patients than HOPDs or because they are more efficient.

Are Medicare payments adequate in 2014?

To address whether payments for the current year (2014) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2015), 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. Unlike our assessments of other provider types, we could not use quality data in our analysis. Although ASCs began submitting information on quality measures to CMS in 2012, complete quality data are not yet publicly available (Centers for Medicare & Medicaid Services 2013b). Moreover, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.⁵ 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 2009).⁶ This share may vary regionally; for example, Medicare accounted for 24 percent of revenue for ASCs in Pennsylvania in 2012 (Pennsylvania Health Care Cost Containment Council 2013).

Beneficiaries have at least adequate access to care in ASCs, although there is some variation among subgroups of beneficiaries (see text box). In addition, ASCs have adequate access to capital, and Medicare payments to ASCs have continued to grow. Together, these measures suggest that Medicare's payment rates for ASCs were at least adequate through 2012.

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 growing access to ASCs. This growth may be beneficial to patients and providers because ASCs can offer them greater convenience and efficiency than HOPDs, the type of provider with the greatest similarity to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians, ASCs may offer more

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 2012 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 ages 85 or older (Table 5-1).⁷ 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 as their usual source of care (Centers for Medicare & Medicaid Services 2013a).

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

(continued next page)

TABLE 5-1

Medicare patients treated in ASCs differ from patients treated in HOPDs, 2012

Characteristic	Percent of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	86.0%	76.6%
Medicaid	14.0	23.4
Race/ethnicity		
White	87.7	83.8
African American	6.9	10.3
Other	5.3	5.9
Age		
Under 65	15.2	22.4
65 to 84	78.0	66.8
85 or older	6.8	10.8
Sex		
Male	42.1	44.0
Female	57.9	56.0

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 5 percent carrier and outpatient standard analytic files, 2012.

control over their work environment and specialized staff. In addition, Medicare has lower payment rates, and beneficiaries generally pay lower coinsurance in ASCs than in HOPDs. However, the growth in ASCs may lead to an increase in the overall volume of surgical procedures (see discussion on p. 130).

Capacity and supply of providers: Number of ASCs has increased, but growth has slowed

The number of Medicare-certified ASCs increased significantly in 2007 and 2008 but has grown more slowly since then. The number of ASCs increased by 5.9 percent

in 2007 and 4.2 percent in 2008. However, the growth rate decelerated to 2.2 percent in 2009 and reached 1.2 percent in 2012 (Table 5-2, p. 127). This slower growth continued into 2013, as the number of ASCs increased by 0.4 percent to 5,377 during the first three quarters of 2013 (an annual growth rate of 0.5 percent).

Several factors might explain the relatively slow growth from 2009 through 2012:

- Health care spending at the national level has experienced a significant slowdown, which many analysts attribute to the sluggish economic recovery

Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments (cont.)

risk scores from the CMS–hierarchical condition category (CMS–HCC) risk adjustment model used in Medicare Advantage to measure patient severity.⁸ 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 around 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.

Other data sources also suggest that ASCs treat patients who are different from those treated by 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 2013). In Pennsylvania in 2012, Medicaid patients accounted for 5.1 percent of ASCs’ diagnostic and surgical procedures, compared with 12 percent of HOPDs’ procedures.⁹ Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.2 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, also show that ASCs treat a smaller share of Medicaid

patients than hospitals. According to the NSAS data, ambulatory surgery visits by Medicaid patients in 2006 accounted for 3.9 percent of total visits to freestanding ASCs, compared with 8.1 percent of total visits to hospital-based surgery centers.¹⁰

Several factors could explain why ASCs treat a smaller share of Medicaid patients (including dual eligibles) than HOPDs. 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 examined referral patterns for physicians in Pennsylvania who sent most of their patients to physician-owned ASCs rather than HOPDs. These physicians were much more likely to refer their commercially insured and Medicare patients than their Medicaid patients to a physician-owned ASC. They sent more than 90 percent of their commercial and Medicare patients—but only 55 percent of their Medicaid patients—to an ASC instead of a hospital.

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 hospital emergency department (ED) than are Medicare beneficiaries who have other types of supplemental coverage (Centers for Medicare & Medicaid Services 2013a). If a patient has an HOPD or ED as his or her usual source of care, physicians may be more likely to refer the patient to an HOPD for surgical care than another setting. The relatively low rate of ASC use among dual-eligible beneficiaries may partially explain the relatively low rate of ASC use among African Americans because African Americans are more likely to be dual eligibles (Table 5-1, p. 125). ■

**TABLE
5-2****Number of Medicare-certified ASCs grew by 12 percent, 2007-2012**

	2007	2008	2009	2010	2011	2012
Number of centers	4,798	5,001	5,111	5,203	5,291	5,357
New centers	345	282	219	192	190	113
Exiting centers	77	79	109	100	102	47
Net percent growth in number of centers from previous year	5.9%	4.2%	2.2%	1.8%	1.7%	1.2%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2012.

from the recession that began in the fall of 2008 (Cuckler et al. 2013, Deutsche Bank 2012, Kaiser Family Foundation 2013).

- The ASC payment system underwent a substantial revision in 2008, and investors may be responding to the large changes in payment rates that occurred under that revision.
- Payment rates for most ambulatory surgical services are 81 percent higher in the OPPS than in the ASC payment system, which has influenced some ASC owners to sell their facilities to hospitals and caused some health care systems to expand their HOPDs rather than establish new ASCs (North Carolina Department of Health and Human Services 2008, State of Connecticut 2011).
- 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). Physicians employed by hospitals are more likely to provide ambulatory surgical services in their hospitals' HOPDs than in a freestanding ASC.

To provide a more complete picture of capacity in ASCs, we also examined the change in the number of ASC operating rooms. From 2007 through 2012, the number of ASC operating rooms increased at about the same rate as the number of ASCs (2.3 percent per year vs. 2.2 percent per year). The mean number of operating rooms per ASC (2.8) and the median number of operating rooms (2.0) did not change during this period.

ASCs are concentrated geographically. As of 2012, Maryland had the most ASCs per fee-for-service (FFS) beneficiary, followed by Idaho, Washington, and Georgia;

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 Kentucky; each state had fewer than 6 per 100,000 FFS beneficiaries.¹¹ In addition, in 2012, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-3). 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.

Continued growth in the number of Medicare-certified ASCs suggests that Medicare's payment rates have been at least adequate. Other factors have also likely influenced the long-term growth in the number of Medicare-certified ASCs:

**TABLE
5-3****Most Medicare-certified ASCs are urban and for profit**

ASC type	2007	2012
Urban	91%	91%
Rural	9	9
For profit	96	97
Nonprofit	4	3

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2012.

**TABLE
5-4**

Volume of ASC services per FFS beneficiary has continued to grow

Time period	Average annual volume growth per FFS beneficiary
2007 to 2011	4.6%
2011 to 2012	1.7
Services covered in both 2007 and 2012	1.7
Services newly covered after 2007	2.4

Note: ASC (ambulatory surgical center), FFS (fee-for-service).

Source: MedPAC analysis of 5 percent carrier standard analytic files, 2007, 2011, and 2012.

- 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., better locations and 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.¹²
- 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 surgical services in ASCs.
- Because physicians can probably perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees.

Number of beneficiaries treated and volume of services grew from 2007 to 2012

We examined growth in the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary.¹³ Because ASC services are covered under Part B, we limited our analysis to FFS beneficiaries

who have Part B. From 2007 through 2011, the number of FFS beneficiaries who received ASC services grew by an average of 1.5 percent per year and by 1.9 percent in 2012. From 2007 through 2011, the volume of surgical services per FFS beneficiary increased by an average of 4.6 percent per year and by 1.7 percent in 2012 (Table 5-4).

The 2008 revision of the ASC payment system substantially increased the number of covered services. We divided the growth in service volume from 2011 through 2012 into two parts: the portion due to surgical services newly covered after 2007 and the portion due to surgical services covered in both 2007 and 2012. Our analysis indicates that services newly covered after 2007 grew by 2.4 percent in 2012, and services covered in both 2007 and 2012 grew by 1.7 percent in 2012 (Table 5-4).¹⁴ The most commonly provided services that were newly covered after 2007—which also showed strong growth in other ambulatory settings—include two laser eye surgeries (trabeculectomy by laser eye surgery and iridotomy) and an orthopedic procedure (arthrocentesis by aspiration and/or injection of a major joint or bursa).

Although newly covered services had strong growth in 2012, they accounted for only 5.5 percent of total ASC volume. The services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2012. For example, cataract removal with intraocular lens insertion had the highest volume in both 2007 and 2012, accounting for 20 percent of volume in 2007 and 17 percent in 2012. Moreover, 19 of the 20 most frequently provided services in 2007 were among the 20 most frequently provided in 2012 (Table 5-5). For these 20 services, volume per FFS beneficiary increased by an average of 1.7 percent per year from 2007 through 2012. However, these 20 services accounted for a smaller share of total ASC volume in 2012 than in 2007 (69 percent vs. 74.6 percent), which indicates that ASCs are providing an increasingly diverse set of procedures.

Surgical services migrated from HOPDs to ASCs between 2007 and 2010, but trend has slowed

Although the growth of services provided in ASCs from 2007 to 2010 may reflect the migration of procedures from HOPDs to ASCs, this trend appears to have slowed. We compared volume growth from 2007 through 2012 for services provided in ASCs with the growth of ASC-covered services provided in HOPDs. We limited this analysis to services that were covered in the ASC payment system in 2007 because the inclusion of services covered

**TABLE
5-5**

Most frequently provided ASC services in 2012 were similar to those provided in 2007

Surgical service	2007		2012	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.9%	1	16.9%	1
Upper GI endoscopy, biopsy	7.9	2	8.1	2
Diagnostic colonoscopy	5.9	3	3.0	9
Colonoscopy and biopsy	5.5	4	5.8	3
After cataract laser surgery	5.4	5	3.9	6
Lesion removal colonoscopy	4.8	6	4.5	4
Injection spine: lumbar, sacral (caudal)	4.3	7	3.4	7
Injection foramen epidural: lumbar, sacral	3.1	8	4.1	5
Injection paravertebral: lumbar, sacral add on*	2.9	9	3.4	8
Injection paravertebral: lumbar, sacral*	1.9	10	2.4	10
Lesion removal colonoscopy	1.7	11	0.9	20
Colon cancer screen, not high-risk individual	1.7	12	1.6	13
Injection foramen epidural add on	1.6	13	2.1	11
Upper GI endoscopy, diagnosis	1.5	14	1.1	16
Colorectal screen, high-risk individual	1.4	15	1.9	12
Cystoscopy	1.3	16	1.1	17
Destruction paravertebral nerve, add on**	1.1	17	1.5	14
Revision of upper eyelid	0.9	18	0.9	18
Cataract surgery, complex	0.9	19	1.3	15
Injection spine: cervical or thoracic	0.9	20	0.9	20
Total	74.6		69.0	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal).
 *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 5 percent carrier standard analytic files, 2007 and 2012.

in the OPSS in 2007 that became covered in the ASC payment system after 2007 would have biased the results.

From 2007 through 2010, the number of ASC-covered surgical services per FFS beneficiary grew by 3 percent per year in ASCs and by 0.3 percent in HOPDs, which suggests that at least some services migrated from HOPDs to ASCs during that period. In 2011, however, surgical services increased at a lower rate in ASCs than in HOPDs (1.7 percent vs. 3.7 percent). In 2012, surgical services increased by 1.7 percent in ASCs and decreased by 1.3 percent in HOPDs. However, the decline in HOPD volume in 2012 was largely driven by a strong decrease of 10.5 percent in the volume of pain management services. Excluding the decline in pain management services, the volume of HOPD surgical services increased by 0.5 percent in 2012.

Other data also suggest that the migration of services from HOPDs to ASCs has stalled. 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 32.5 percent, but remained about the same in 2010 and 2011 and decreased to 31.5 percent in 2012 (Pennsylvania Health Care Cost Containment Council 2013).

We believe it is desirable to maintain beneficiaries' access to ASCs because services provided there are less costly to Medicare and beneficiaries than services delivered 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 2007 through 2012, the proportion of these

procedures provided in ASCs increased from 67 percent to 71 percent. Meanwhile, the payment rate for these procedures in 2012 was \$964 in ASCs compared with \$1,672 in HOPDs. Medicare's portion of this payment was \$771 in ASCs and \$1,182 in HOPDs, while the beneficiary's coinsurance was \$193 in ASCs and \$490 in HOPDs. Moreover, ASCs offer patients additional advantages over HOPDs, such as more convenient locations and shorter waiting times.

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 partially offset the effect of lower payment rates in ASCs on Medicare spending. Recent 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). One study compared practice patterns of physician-owners of ASCs in Florida, before and after they acquired an ASC, with physicians who did not own an ASC. The authors found that ASC owners increased their volume of four common surgical procedures more rapidly than non-ASC owners during the same period of time (Hollingsworth et al. 2010).¹⁵ Although this study had limitations (it was based on a single state, used a proxy measure of physician ownership, and did not examine whether the additional procedures were inappropriate), it suggests that physician ownership of ASCs is associated with greater overall volume of surgical procedures.

Two studies found that the growth of ASCs in a market is associated with higher overall volume of certain endoscopic procedures (Hollingsworth et al. 2011, Koenig and Gu 2013). The first study, which was limited to Florida, found that the volume of colonoscopies and upper gastrointestinal endoscopies in ambulatory settings increased at a faster rate in health care markets after ASCs entered the markets compared with markets that had no ASC entry (Hollingsworth et al. 2011). The authors found no significant relationship between ASC entry and the growth of cataract surgery or cancer-directed breast surgery. The second study examined national Medicare data and found that an increase in the number of ASC operating rooms in a state was associated with additional colonoscopy procedures in all outpatient settings (Koenig and Gu 2013). However, there was no significant relationship between growth in the number of ASC operating rooms and the volume of cataract surgery, upper

gastrointestinal procedures, or arthroscopy. Based on the results of these studies, it is plausible that reductions in Medicare spending due to lower payment rates for ASCs could be partially offset by a higher overall number of certain procedures.

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 2012 and the first three quarters of 2013, although at a slower rate than in previous years (Table 5-2, p. 127). This slowing growth may reflect the sluggish pace of recovery from the downturn in the economy that began in the fall of 2008, the widening difference between payment rates in the ASC payment system and the OPDS, and the increase in physician employment by hospitals. In 2008, the average payment rate for most services provided in ASCs was 65 percent of what would have been paid in HOPDs; this ratio fell to 55 percent in 2014. However, Medicare accounts for a relatively small share of ASCs' overall revenue on average, so factors other than Medicare payments may have a larger effect on access to capital for this sector.

In addition, the company that operates the largest number of ASCs in the country—Amsurg—continues to acquire new ASCs, which indicates that it has sufficient access to capital. Through the third quarter of 2013, Amsurg had acquired 5 new facilities in 2013 (it currently has 243 ASCs). The earnings per share (EPS) of stock for Amsurg is projected to increase by 12 percent in 2013 and 16 percent in 2014 (Deutsche Bank 2013). Greater EPS will provide more capital for Amsurg to acquire new ASCs and expand its existing ASCs. We caution, however, that this company includes only 5 percent of all Medicare-certified ASCs, so its experience may not represent the entire ASC sector.

Medicare payments: Payments have increased rapidly

In 2012, ASCs received about \$3.6 billion in Medicare payments and beneficiaries' cost sharing (Table 5-6). Spending per FFS beneficiary increased by an average of 4.3 percent per year from 2007 through 2011 and by 4.3 percent in 2012. The 4.3 percent increase in 2012 reflects a 1.6 percent increase in the ASC conversion factor, a 1.7 percent increase in volume per beneficiary, a 0.7 percent

**TABLE
5-6****Medicare payments to ASCs have grown, 2007-2012**

	2007	2008	2009	2010	2011	2012
Medicare payments (billions of dollars)	\$2.9	\$3.1	\$3.2	\$3.3	\$3.4	\$3.6
Medicare payments per FFS beneficiary	\$89	\$97	\$102	\$104	\$106	\$110
Percent change per FFS beneficiary from previous year	5.0%	8.1%	5.3%	2.0%	2.1%	4.3%

Note: ASC (ambulatory surgical center), FFS (fee-for-service). Medicare payments include program spending and beneficiary cost sharing for ASC facility services. Payments include new technology intraocular lenses.

Source: MedPAC analysis of data from the Office of the Actuary at CMS.

increase in the average relative weight, and a 0.2 percent increase in revenue from drugs. We examined how much of the ASC revenue growth in 2012 was from surgical services newly covered after 2007 and how much was from surgical services covered in both 2007 and 2012. In 2012, per capita spending on surgical services newly covered after 2007 (which accounted for 3.6 percent of ASC revenue from surgical services) increased 8.5 percent, and spending on surgical services covered in both 2007 and 2012 increased 4.4 percent. The increased spending on surgical services in ASCs was slightly offset by a decrease in spending on new technology intraocular lenses (NTIOLs). Spending on NTIOLs declined by \$7.4 million in 2012 because no NTIOLs were eligible for separate payment in 2012 (some NTIOLs were eligible for separate payment in 2011).

How should Medicare payments change in 2015?

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. However, our information for assessing payment adequacy is limited because, unlike other types of facilities, Medicare does not require ASCs to submit cost data. We also do not have information on the quality of care in ASCs. Although ASCs began submitting quality data to CMS in 2012, CMS has not yet publicly released complete quality information (Centers for Medicare & Medicaid Services 2013b). The Commission has recommended that CMS develop a value-based purchasing program that would use ASC quality data to reward high-performing and penalize low-performing providers, but

CMS does not have the statutory authority to implement such a program (see text box, pp. 132-133).

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. 134-135), 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).

Although CMS and ASCs have expressed concern that requiring ASCs to submit cost data may impose a burden on these facilities, we believe it is feasible for ASCs to provide a limited amount of cost information (Centers for Medicare & Medicaid Services 2011). 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.

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).¹⁶ 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 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 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.

Under the ASC Quality Reporting Program, ASCs began submitting data in 2012 and 2013 on four patient safety indicators, one process measure, and two structural measures. In 2014, ASCs began reporting data on influenza vaccination coverage among health care personnel. In 2015, they will begin reporting data on three chart-abstracted measures that relate to appropriate follow-up intervals for colonoscopy and improvement in visual function following cataract surgery (Centers for Medicare & Medicaid Services 2013b). Although CMS has not yet announced a time frame for publicly releasing the data collected under the Quality Reporting Program, this program could lay the foundation for a VBP program.

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 reduce the administrative burden on ASCs and CMS. These measures should focus on clinical outcomes because Medicare's central concern should be improving outcomes across all ASCs. Several of the indicators that are reported through the ASC Quality Reporting Program could be used for an ASC VBP program. However, a measure on surgical site infections (SSIs) should be developed. 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

(continued next page)

To enable the Commission and other analysts to determine the relationship between Medicare payments and the costs of efficient ASCs, ASCs would likely need to submit the following information:

- total costs for the facility;
- Medicare unallowable costs (e.g., entertainment, promotion, and bad debt);
- the costs of clinical staff that 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 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.

Creating a value-based purchasing program for ambulatory surgical centers (cont.)

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; and
- SSI rate.

The first three measures listed 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 (hospital transfer or admission after an ASC procedure and SSI rate) may occur at low rates 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. ■

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 1.6 percent in 2012, 0.6 percent in 2013, and 1.2 percent in 2014. The update for 2014 was based on a projected 1.7 percent increase in the CPI-U minus a 0.5 percent deduction for multifactor productivity growth, as mandated by the Patient Protection and Affordable Care Act of 2010 (PPACA).¹⁷

Update recommendation

In recommending an update to ASC payment rates for 2015, 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.

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) payments. Because of our concern that the CPI-U may not reflect ASCs' cost structure, the Commission examined in 2010 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 (Government Accountability Office 2006). 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

(continued next page)

In balancing these goals, the Commission concludes that the ASC update for 2015 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 2015. 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 2015. That is, the 2015 base payment rate under the ASC payment system should

be the same as the base rate in 2014. 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. Therefore, although we do not have cost and quality data, the indicators we 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 an efficient provider, which would help inform decisions about the ASC update. Such data are also needed to analyze whether

Revisiting the ambulatory surgical center market basket (cont.)

(Medicare Payment Advisory Commission 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. ASCs' larger share of costs for medical supplies and drugs could be related to their high volume of cataract removal and lens insertion procedures. These procedures use intraocular lenses, which are included in the medical supplies category and are relatively expensive. Another factor could be that ASCs primarily perform surgical procedures, whereas hospitals and physician offices provide a significant number of imaging and evaluation and management services, which probably have lower supply costs than surgical procedures.

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 ASC 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 10 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 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. ■

an alternative input price index would be an appropriate proxy for ASC costs.

IMPLICATIONS 5

Spending

- CMS has decided to increase ASC payment rates based on the change in the CPI-U (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 2015 is 1.8 percent, and the forecast of productivity growth for 2015 is 0.4 percent, resulting in a projected update of 1.4 percent to the base payment rates for 2015 (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 physician–hospital joint ventures in 2008 (Medical Group Management Association 2009).
- 2 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).
- 3 GAO surveyed a random sample of 600 ASCs to obtain cost data from 2004; they received reliable cost data from 290 facilities.
- 4 The average time includes time spent by the patient in the operating room and postoperative recovery room.
- 5 The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 eliminated a requirement that the Secretary collect cost data from ASCs every five years.
- 6 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 2009).
- 7 Because some states have a disproportionately high number of ASCs per beneficiary (Maryland, Washington, 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.
- 8 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.
- 9 These data are based on 269 ASCs and 171 hospitals.
- 10 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).
- 11 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 have CON laws for ASCs. Each of the 13 states with the fewest ASCs per FFS beneficiary has a CON law, while only 4 of the 10 states that have the most ASCs per beneficiary have CON laws. Among these four states, Maryland and Georgia have exceptions in their CON requirements that make it easier to establish new ASCs.
- 12 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,216 in 2014). 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.
- 13 Our analysis excluded radiology services provided in ASCs because the ASC payment system did not pay separately for radiology services before 2008.
- 14 Our analysis of service volume in 2012 included only surgical procedures (Current Procedural Terminology codes in the range of 10000–69999). Our analysis did not include nonsurgical services, such as radiology services, brachytherapy sources, drugs, and pass-through devices. In addition, it did not include services that were packaged in 2012.
- 15 This study assumed that physicians who performed at least 30 percent of their outpatient surgeries at a given ASC within a year were ASC owners. The four procedures for which there was a significant relationship between ASC ownership and volume were carpal tunnel release, cataract excision, colonoscopy, and knee arthroscopy. There was no significant relationship for myringotomy with tube placement.
- 16 The Commission also described its principles for a value-based purchasing (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).
- 17 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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CHAPTER

6

Outpatient dialysis services

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

6-1 The Congress should not increase the outpatient dialysis payment rate for calendar year 2015.

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

.....

6-2 The Congress should direct the Secretary to:

- include a measure that assesses poor outcomes related to anemia in the End-Stage Renal Disease Quality Incentive Program.
- redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility.
- audit dialysis facilities' cost report data.

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

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Outpatient dialysis services

Chapter summary

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

Assessment of payment adequacy

Our payment adequacy indicators for outpatient dialysis services are generally positive.

Beneficiaries' access to care—Measures of 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 2014?
- How should Medicare payments change in 2015?
- Regulatory improvements to the new dialysis PPS

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

- **Volume of services**—Between 2010 and 2012, the number of FFS dialysis beneficiaries and dialysis treatments grew at similar rates (2 percent and 3 percent, respectively). At the same time, the per treatment use of most dialysis injectable drugs, including erythropoiesis-stimulating agents (ESAs) that are used in anemia management, substantially declined. The new dialysis PPS created an incentive for providers to be more judicious about their provision of dialysis drugs. In addition, in 2011, the Food and Drug Administration recommended more conservative ESA dosing.

Quality of care—Using CMS data, we look at changes in quality indicators for the period from 2010 through June 2013. Rates of mortality and emergency department use remained relatively constant, while rates of hospitalization declined. With regard to anemia management, average hemoglobin levels decreased from 11.4 g/dL in 2010 to 10.6 g/dL. Under the new PPS, use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 8 percent of beneficiaries to 10 percent.

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 2011 and 2012 claims and cost report data submitted by freestanding dialysis facilities to CMS. Under the new PPS, cost per treatment increased by 2 percent between 2011 and 2012, while Medicare payment per treatment increased by 2.3 percent. We estimate that the aggregate Medicare margin was 3.9 percent in 2012 and project that the aggregate Medicare margin will be 2.9 percent in 2014. This projection reflects statutory payment updates and positive regulatory changes that will increase total payments in 2013 and 2014, a reduction in total payments in 2014 due to the statutory drug utilization adjustment, and a small payment reduction in 2013 and 2014 due to the ESRD Quality Incentive Program (QIP). This projection does not consider the impact of the sequester, which would lower the margin by about 2 percentage points.

Regulatory improvements to the new PPS

To improve the ESRD PPS, the Commission recommends that the Congress direct the Secretary to include a measure that assesses poor outcomes related to anemia in the ESRD QIP, redesign the low-volume payment adjustment to consider a low-volume facility's proximity to other dialysis facilities, and audit dialysis

facilities' cost report data. This recommendation addresses three concerns: (1) like any PPS, bundled payments create an incentive for providers to furnish fewer services (covered in the bundled payment) than medically necessary, but the ESRD QIP in 2013 and beyond does not assess the outcomes associated with poorer anemia management that might occur when fewer services are provided; (2) the low-volume payment adjustment is not targeting facilities that might be critical to beneficiary access; and (3) CMS has not yet examined the appropriateness of the costs that facilities include on their cost reports. ■

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 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. Recent clinical findings have 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. The dialysate pulls the waste and extra fluid from the patient's blood into the peritoneal cavity, and when the dialysate is drained, the wastes and extra fluids are drained with it. This filling and draining 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. Some patients switch methods when their conditions or needs change. Although most patients undergo in-center dialysis, home dialysis remains a viable option because of advantages such as increased patient satisfaction, better health-related quality of life, and fewer transportation challenges compared with in-center thrice-weekly dialysis. ■

Background

End-stage renal disease (ESRD) is the last stage of chronic kidney disease and is characterized by permanent irreversible kidney failure. ESRD patients 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 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 2012, about 370,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from about 5,800 dialysis facilities.² Since 2011, Medicare has been paying facilities using a

new 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. In 2012, Medicare expenditures for all outpatient dialysis services included in the payment bundle were \$10.7 billion.

Characteristics of fee-for-service dialysis beneficiaries, 2012

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, individuals must be fully or currently insured under the Social Security or Railroad Retirement program, entitled to benefits under the Social Security or Railroad Retirement program, or be the spouse or dependent child of an eligible beneficiary. Because of this statutory provision, most of the estimated 445,000

**TABLE
6-1**

FFS dialysis beneficiaries are disproportionately young, male, and African American compared with all Medicare FFS beneficiaries, 2012

	Percent of FFS:	
	Dialysis beneficiaries	All beneficiaries
Age		
Under 45 years	12%	4%
45–64 years	38	14
65–74 years	25	45
75–84 years	18	24
85+ years	7	12
Sex		
Male	54	46
Female	46	54
Race		
White	49	82
African American	36	10
All others	15	8
Residence, by type of county		
Urban	82	77
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 2012 claims submitted by dialysis facilities to CMS and the 2012 CMS denominator file.

individuals on maintenance dialysis in 2012 were enrolled in Medicare.³ According to CMS’s renal facility survey, about 96 percent of dialysis patients are covered by Medicare.⁴

Most (87 percent) Medicare dialysis beneficiaries have FFS coverage.⁵ 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 2012, about 13 percent of dialysis beneficiaries were enrolled in MA

plans; by comparison, about 26 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 2012, a majority of dialysis FFS beneficiaries were enrolled in Part D or had other sources of creditable drug coverage: 77 percent of dialysis FFS beneficiaries were enrolled in Medicare’s Part D program, and 12 percent received drug coverage through a retiree drug plan or other source of creditable coverage. By comparison, 53 percent of all FFS beneficiaries were enrolled in the Part D program, and 28 percent received drug coverage through a retiree drug plan or other source of creditable coverage. About three-quarters of dialysis beneficiaries with Part D coverage received the low-income subsidy. About 11 percent of dialysis FFS beneficiaries in 2012 either had no Part D coverage or had 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, and they are more likely to reside in urban areas (Table 6-1). In 2012, 75 percent of FFS dialysis beneficiaries were less than 75 years old, 54 percent were male, and 36 percent were African American. By comparison, of all FFS Medicare beneficiaries, 63 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. 77 percent, respectively).

Between 2001 and 2011, the rate (or incidence) of new ESRD cases decreased by 0.5 percent per year, from 374 per million people to 357 per million people (United States Renal Data System 2013).⁶ Since 2009, the rate of new ESRD cases has declined by 3 percent per year. This decline is seen across all races and ethnicities (White, African American, Asian, Native American, and Hispanic) and age groups, with the exception of young individuals (19 years or younger).⁷ In 2012, we estimate that approximately 83,000 FFS dialysis beneficiaries were new to dialysis, and nearly half (47 percent) of them were under age 65 and thus entitled to Medicare based on ESRD (with or without disability).⁸

Data from the mid-1990s through 2010 suggest a trend toward initiating dialysis earlier in the course of chronic kidney disease (United States Renal Data System 2013). The proportion of patients with higher levels of residual kidney function steadily increased between 2000 and 2010,

from 7 percent to 16 percent.⁹ In 2011, the share of those patients decreased modestly to 15 percent. Researchers have questioned this early initiation of dialysis in those with late-stage chronic kidney disease, concluding that it was not associated with improved survival or clinical outcomes (Cooper et al. 2010, Evans et al. 2011, Kazmi et al. 2005, Stel et al. 2009, Traynor et al. 2002).

To help pay for Part A and Part B cost sharing, some FFS beneficiaries have private or other public coverage that supplements the Medicare benefit package. Compared with all FFS beneficiaries, FFS dialysis beneficiaries are more likely to be dually eligible for Medicare and Medicaid (17 percent vs. 47 percent, respectively) and less likely to receive coverage from private sources (70 percent vs. 50 percent, respectively) (these coverage categories are not mutually exclusive). According to the Medicare Current Beneficiary Survey, in 2011, about 15 percent of dialysis FFS beneficiaries lacked any public or private supplemental coverage. Since 1997, the American Kidney Fund has maintained a Health Insurance Premium Program that helps pay dialysis patients' health insurance premiums, including Medicare Part B premiums.¹⁰

According to data from Medicare's denominator file, in 2012, Medicare was the secondary payer (for Part A and Part B) for 9 percent of FFS dialysis beneficiaries insured by an employer group health plan (EGHP) at the time they were diagnosed with ESRD. Under these circumstances, the EGHP is the primary payer for the first 33 months of care (as long as the individual maintains the EGHP coverage). EGHPs include health plans in which beneficiaries are enrolled through their own employment or through a spouse's or parent's employment before becoming eligible for Medicare through an ESRD diagnosis.

Since 2011, CMS has paid most dialysis facilities under the new dialysis PPS

To treat ESRD, dialysis beneficiaries receive care from two principal providers: (1) the physicians (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 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.

To improve the efficiency of dialysis facilities, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) mandated that CMS implement a new PPS in 2011 for dialysis facilities that includes in the payment bundle dialysis drugs, laboratory tests, and other ESRD-related items and services that were previously separately billable. MIPPA also mandated that in 2012 CMS implement a pay-for-performance program. MIPPA's provisions are consistent with the Commission's recommendation to modernize the outpatient dialysis payment system (Medicare Payment Advisory Commission 2001). We contended that Medicare could provide incentives for controlling costs and promoting quality care by broadening the payment bundle (to include drugs, laboratory services, and other commonly furnished items 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 previous incentives inherent in the former payment method to overutilize drugs. In 2011, most dialysis facilities (about 93 percent) elected to be paid under the new PPS instead of the four-year transition rate.¹¹

Under both the prior and current payment methods, Medicare pays facilities for a single dialysis treatment by using a prospective payment. However, the current payment method differs from the former one in the following ways: it (1) uses a broader payment bundle that includes injectable drugs and clinical laboratory services that were previously billable separately, (2) sets payment using a greater number of patient-level payment adjusters, (3) provides an outlier payment for high-cost beneficiaries, (4) increases the base rate by a low-volume adjustment for certain low-volume facilities, and (5) links facilities' payments to the quality of care they provide. The Commission's *Payment Basics* provides more information about Medicare's methods for paying for outpatient dialysis services (available at http://medpac.gov/documents/MedPAC_Payment_Basics_13_dialysis.pdf).

In 2014, the last year of the four-year transition to the new payment method, 100 percent of Medicare payment for all dialysis facilities is based on the new payment method. The 2014 base prospective payment is \$239.02 per treatment, a difference of 0.5 percent compared with the 2013 base rate of \$240.36 per treatment. This rate change between 2013 and 2014 primarily reflects two statutory

Section 632 of the American Taxpayer Relief Act of 2012

The American Taxpayer Relief Act of 2012 mandates that for dialysis services furnished on or after January 1, 2014, the Secretary must reduce the end-stage renal disease (ESRD) prospective payment system (PPS) base rate to reflect the change in per patient use of ESRD drugs and biologics between 2007 and 2012. The law requires that the Secretary, in making this reduction, take into account the most recently available data on average sales prices and changes in prices for drugs and biologics reflected in the ESRD market basket.

CMS calculated the change in drug use between 2007 and 2012 and the total drug utilization adjustment (reduction) per treatment by:

- determining 2012 per treatment use of ESRD drugs using 2012 claims included in the National Claims History file as of June 30, 2013.
- determining 2007 per treatment use of ESRD drugs as established in the 2011 ESRD PPS final rule.
- applying 2014 ESRD drug prices to the 2007 and 2012 per treatment use of ESRD drugs. To derive 2014 prices, the agency inflated 2011 drug prices by 7.64 percent. This inflation factor is based on the 2013 and 2014 ESRD market basket (net of

the productivity adjustment) and the wage index budget-neutrality and home dialysis training add-on factors.

- determining the per treatment difference (in 2014 prices) between the per treatment amounts for 2012 (\$51.17) and 2007 (\$83.96).
- adjusting the net difference between the 2007 and 2012 per treatment use of ESRD drugs (\$32.79) by the same factors that were used to establish the 2011 ESRD PPS rate: the 5.93 percent standardization factor, the 1 percent outlier adjustment factor, and the 2 percent adjustment factor mandated by the Medicare Improvements for Patients and Providers Act of 2008. This calculation results in a total drug reduction of \$29.93 per treatment.

CMS will phase in the drug utilization adjustment over a three- to four-year transition period. For 2014 and 2015, CMS will implement the adjustment by offsetting the payment update and other effects by a portion of the drug utilization reduction amount necessary to create an overall impact of zero percent compared with the previous year's total payments. For 2014, the drug use reduction is \$8.16 per treatment. ■

provisions: (1) MIPPA requires the Secretary to increase the dialysis PPS rate by the rate of increase in the ESRD market basket, reduced by a productivity adjustment; and (2) the American Taxpayer Relief Act (ATRA) of 2012 requires, for services furnished on or after January 1, 2014, the Secretary to reduce the ESRD PPS base rate to reflect the change between 2007 and 2012 in the per patient utilization of dialysis drugs and biologics (see text box summarizing the ATRA provision and the Secretary's calculations).

Are Medicare payments adequate in 2014?

To address whether payments for 2014 are adequate to cover the costs that efficient providers incur and how much

providers' costs should change in the update year (2015), we examine several indicators of payment adequacy.¹² We assess beneficiaries' access by examining the 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.
- Provider access to capital is sufficient.

**TABLE
6-2**

Increasing number and capacity of freestanding, for-profit, and chain organizations

	2012				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	
					2007-2012	2011-2012	2007-2012	2011-2012
All	43.3	5,800	103,100	18	3%	2%	4%	2%
	Percent of total							
Freestanding	93%	91%	93%	18	4	3	4	3
Hospital based	7	9	7	14	-4	-10	-3	-8
Location, by type of county								
Urban	84	79	83	19	4	2	4	2
Rural micropolitan	11	13	12	16	2	0	3	1
Rural, adjacent to urban	3	5	4	13	3	1	4	2
Rural, not adjacent to urban	2	3	2	12	3	2	3	1
Frontier	0.2	0.6	0.4	10	-1	0	2	8
For profit	89	85	86	18	4	3	5	3
Nonprofit	11	15	14	17	-2	-7	-1	-5
Two largest dialysis organizations	75	70	72	18	7	10	7	10
All others	25	30	28	17	-3	-13	-2	-14

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: Compiled by MedPAC from the 2007, 2011, and 2012 Dialysis Compare database from CMS and 2012 claims submitted by freestanding and hospital-based dialysis facilities to CMS.

- The 2012 aggregate Medicare margin is estimated at nearly 4 percent, and the projected 2014 Medicare margin is nearly 3 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

From 2007 to 2012, the total number of facilities increased annually by 3 percent, and their capacity to provide care—as measured by dialysis treatment stations—grew 4 percent annually (Table 6-2). During this period, the capacity of facilities that were freestanding and for

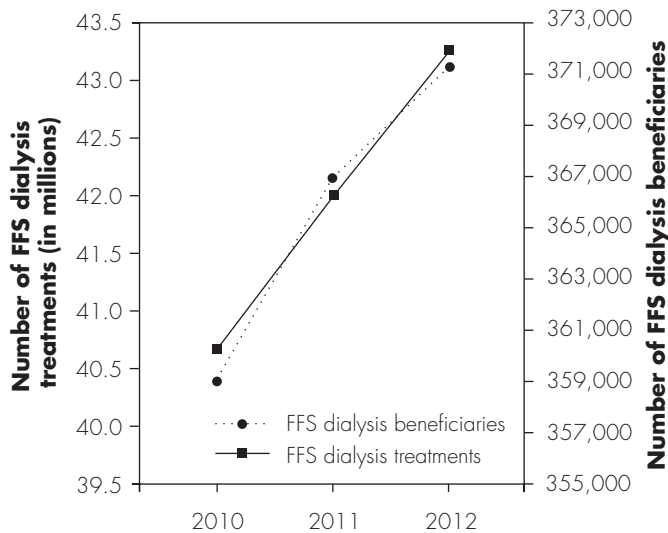
profit each grew by 4 percent and 5 percent per year, respectively. By contrast, annual growth in the capacity of facilities that were hospital based and nonprofit decreased (-3 percent and -1 percent, respectively). Between 2007 and 2012, the capacities of urban and rural facilities grew at similar rates.

Trends in supply between 2011 and 2012 are generally similar to those between 2007 and 2012, except for the growth in facilities and stations associated with the two largest dialysis organizations. As a consequence of recent acquisitions, their average annual growth rate between 2011 and 2012 exceeded their average annual growth between 2007 and 2012.¹³

Growth in the number of dialysis stations and dialysis beneficiaries suggests that provider capacity kept up with demand for care between 2007 and 2012. During

FIGURE 6-1

Similar growth rates for dialysis treatments and beneficiaries between 2010 and 2012



Note: FFS (fee-for-service).

Source: MedPAC analysis of 2010–2012 claims submitted by dialysis facilities to CMS.

this period, the 4 percent annual growth in the number of treatment stations was faster than the 2 percent average annual growth in the number of FFS dialysis beneficiaries.

Providers of outpatient dialysis services

In 2012, there were about 5,800 dialysis facilities in the United States (Table 6-2, p. 149). Since the late 1980s, for-profit, freestanding facilities have provided the majority of dialysis treatments (Rettig and Levinsky 1991). In 2012, freestanding facilities furnished 93 percent of FFS treatments and for-profit facilities furnished about 89 percent. Between 1997 and 2012, the share of facilities that is for profit and freestanding increased from 66 percent to 85 percent. In 2012, the distribution of facilities located in urban and rural areas was generally consistent with where FFS dialysis beneficiaries lived.

Chain organizations dominate this sector, which has seen significant industry consolidation.¹⁴ In 2005 and 2006, the four largest dialysis chains merged into two chains (here referred to as the two largest dialysis organizations). By 2012, they accounted for about 70 percent of all facilities.

In 2012, the two largest dialysis organizations accounted for the majority of facilities in both rural and urban areas.

In rural areas, 68 percent of facilities were affiliated with the two largest dialysis organizations, 20 percent were affiliated with other freestanding facilities, and 12 percent were hospital based. In urban areas, about 71 percent of facilities were affiliated with the two largest dialysis organizations, 22 percent were affiliated other freestanding facilities, and 8 percent were hospital-based.

In addition to operating most dialysis facilities, the two organizations are each vertically integrated. One is the leading supplier of dialysis products, such as hemodialysis machines and dialyzers, and develops and distributes renal-related pharmaceutical products (e.g., phosphate binders) (Fresenius Medical Care AG & Co. KGaA 2006). 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.

Type of facilities that closed and their effect on beneficiaries’ access to care

Each year, we assess the type of facilities that closed and whether certain groups of Medicare dialysis beneficiaries are disproportionately affected by facility closures. Using claims submitted by facilities to CMS and CMS’s Dialysis Compare database, the Provider of Service file, and the ESRD facility survey, we compare the characteristics of beneficiaries treated by facilities that closed in 2011 with those in facilities that furnished dialysis in 2011 and 2012.

On net, between 2011 and 2012, the number of dialysis treatment stations—a measure of providers’ capacity—increased by 2 percent. Compared with facilities that treated beneficiaries in both years, facilities that closed in 2011 (about 65 units) were more likely to be hospital based and nonprofit, which is consistent with long-term trends in supply (Table 6-2, p. 149). As measured by the number of dialysis treatment stations, closed facilities were smaller than facilities in 2011 and 2012 (14 stations vs. 18 stations, respectively). Compared with the distribution of facilities in business both years, a greater proportion of facilities that closed were in rural areas. However, closed rural facilities accounted for only 2 percent of all rural facilities in both years.

About 3,300 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

**TABLE
6-3**

Use per treatment of most dialysis drugs declined between 2010 and 2012

Dialysis drug	Mean units per treatment*						Aggregate percent change	
	2007	2008	2009	2010	2011	2012	2007-2012	2010-2012
ESAs								
Erythropoietin	5,532	5,099	5,243	5,214	4,033	3,106	-44%	-40%
Darbepoetin alfa	1.52	1.42	1.41	1.26	0.93	0.67	-56	-47
Iron agents								
Sodium ferric gluconate	0.39	0.39	0.30	0.15	0.16	0.17	-57	15
Iron sucrose	12.3	13.0	14.7	16.0	15.8	12.7	3	-21
Ferumoxytol**	N/A	N/A	N/A	0.8	0.9	0.02	N/A	-97
Vitamin D agents								
Paricalcitol	2.3	2.7	2.7	2.3	1.6	1.4	-39	-38
Doxercalciferol	0.8	0.7	0.7	0.9	1.1	1.2	50	38
Calcitriol	0.16	0.10	0.12	0.13	0.10	0.06	-63	-55
Antibiotics								
Daptomycin	0.097	0.163	0.216	0.217	0.183	0.171	76	-21
Vancomycin	0.029	0.021	0.024	0.024	0.024	0.022	-27	-11
Other drugs								
Levocarnitine	0.017	0.015	0.013	0.010	0.005	0.004	-78	-61
Alteplase	0.023	0.022	0.023	0.020	0.012	0.008	-67	-62

Note: 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 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 Medicare claims submitted by dialysis facilities to CMS between 2007 and 2012.

closures. Beneficiary groups who were disproportionately affected included patients who were White, older, and residing in rural areas. Our analysis of 2011 and 2012 claims data suggests that affected beneficiaries were able to obtain care at other facilities.

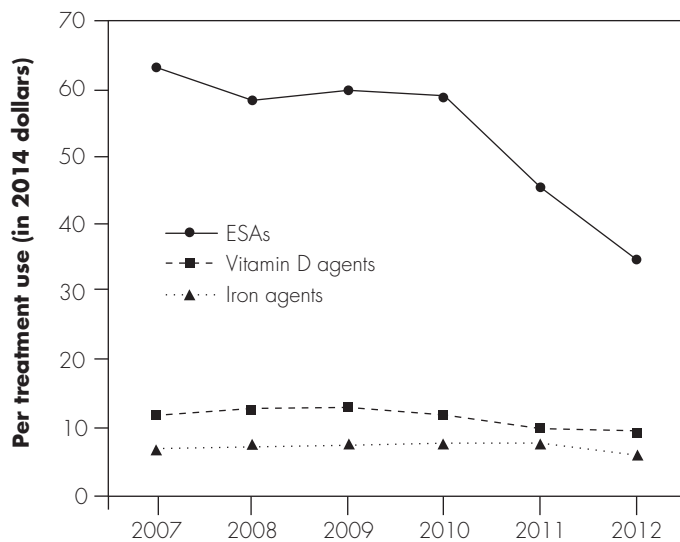
Volume of services

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.

Similar growth rates for dialysis treatments and beneficiaries between 2010 and 2012 Between 2010 and 2012, dialysis treatments grew at an average annual rate that kept pace with growth in the number of FFS dialysis beneficiaries (Figure 6-1). During this period, the number of dialysis treatments grew at an average rate of 3 percent per year, while the number of dialysis beneficiaries grew at an average rate of 2 percent per year.

Use of most dialysis drugs declined between 2010 and 2012 Because CMS based the bundled payment rate in the new PPS on a per treatment basis and based the rate on 2007 use data, we examined changes between 2007 and 2012 (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.¹⁵ We also examined changes in the use of drugs between 2010, the year before the start of the new PPS, and 2012.

Between 2007 and 2012, 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 (the leading dialysis drug class in use under the prior payment method) declined—erythropoietin by 44 percent and darbepoetin alfa by 56 percent.¹⁶ The Food and Drug Administration (FDA) changed the ESA label in

FIGURE 6-2**Reduction in drug use by drug class, 2007–2012**

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 CMS's estimated 2014 prices published in CMS's proposed rule for the end-stage renal disease prospective payment system for 2014. ESAs include erythropoietin and darbepoetin; vitamin D agents include calcitriol, doxercalciferol, and paricalcitol; iron agents include iron sucrose, sodium ferric gluconate, and ferumoxytol.

Source: MedPAC and Acumen analysis of 2007–2012 Part B claims submitted by freestanding and hospital-based facilities and the 2014 CMS proposed rule.

March 2007, which contributed to the decline in ESA units per treatment between 2007 and 2008.¹⁷

However, most of the decline in the use of dialysis drugs has occurred since 2010. For example, between 2010 and 2012, the mean per treatment units of both ESAs declined—erythropoietin by 40 percent and darbepoetin alfa by 47 percent (Table 6-3, p. 151). In 2011 and 2012, the first two years of the new PPS, per treatment use declined for all drugs except two—sodium ferric gluconate and doxercalciferol. The new PPS increased the incentive for providers to be more judicious in providing dialysis drugs since they are included in the payment bundle (and thus are a cost center). Under the prior payment method, dialysis drugs were paid according to the number of units of the drug administered (and thus were a profit center); in other words, the more units of a drug provided, the higher the Medicare payment. For ESAs, some of this decline may also have stemmed from clinical evidence that found that higher doses of these drugs led to increased risk of

morbidity and mortality, which resulted in the FDA's changing the ESA label in June 2011.

To measure use by drug class, we took the number of units of a drug provided and multiplied it by the 2014 Medicare price estimated by CMS. On a per treatment basis, use of ESAs, iron and vitamin D agents, and antibiotics was 38 percent lower in 2012 than in 2007. By drug class, on a per treatment basis, between 2007 and 2012 the use of ESAs, injectable iron agents, and vitamin D agents declined by 45 percent, 14 percent, and 19 percent, respectively (Figure 6-2). Use of antibiotics during this period increased by 5 percent (not shown in Figure 6-2). Our results are similar to those that CMS published in the proposed ESRD payment rule for 2014.

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 uses CMS's monthly monitoring data (Centers for Medicare & Medicaid Services 2013a). From 2010 through June 2013, rates of mortality and emergency department use have remained relatively unchanged, while hospitalization rates have modestly declined. Regarding anemia management, average hemoglobin levels declined. Under the new PPS, use of home dialysis, which is associated with improved patient satisfaction and quality of life, has increased modestly from 8 percent of beneficiaries to 10 percent.

In this section and the online Appendix 6-A (available at <http://www.medpac.gov>), we examine the multiple factors that affect access to kidney transplantation. The 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. Our conclusion remains unchanged from last year regarding trends in key dialysis quality measures for the most recent five-year period that data are available: While some quality measures show progress, such as vascular access management, others need improvement.

Quality under the new PPS

Compared with 2010, the proportion of dialysis beneficiaries between January 2011 and June 2013 who died or used emergency department services has remained constant, while the proportion of beneficiaries hospitalized has declined (Figure 6-3). Specifically, the monthly proportion of beneficiaries who:

- died averaged 1.7 percent per month in 2010 and 1.6 percent per month in the following years.
- used the emergency department averaged 10.7 percent per month in 2010, 10.5 percent in 2011, and 10.7 percent in the following years.
- were hospitalized steadily declined each year between January 2010 and June 2013 from an average of 14.3 percent per month to 14 percent, 13.4 percent, and 13.1 percent, respectively. This finding is not unexpected given the trend of declining inpatient admissions for all Medicare FFS beneficiaries during this period.

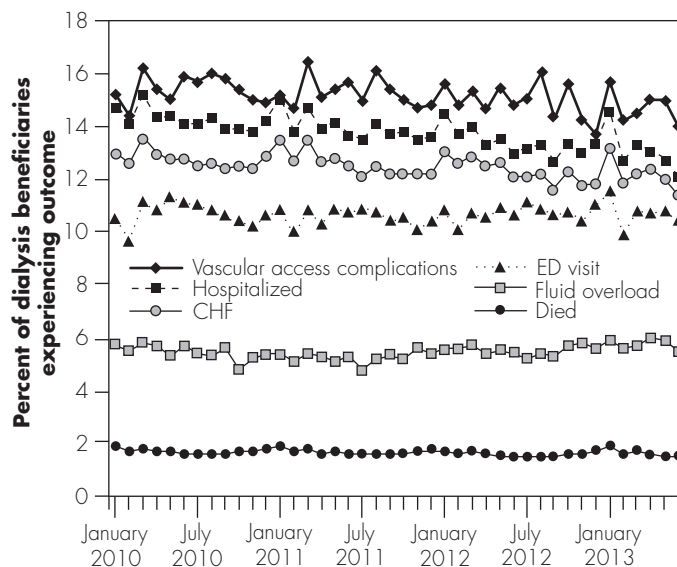
Between January 2010 and June 2013, the percent of hemodialysis beneficiaries who experienced a vascular access complication declined, from an average 15.4 percent per month to 15.3 percent in 2011, 15 percent in 2012, and 14.7 percent in 2013 (Figure 6-3). This trend is consistent with the long-term trend in increased use of the recommended type of vascular access (reported in online Appendix 6-B, available at <http://www.medpac.gov>).

CMS also gathered data on the monthly incidence of common ESRD-related comorbidities including congestive heart failure (CHF) and fluid overload (Figure 6-3). Between 2010 and the first six months of 2013, the share of beneficiaries with a CHF diagnosis modestly declined. The share of beneficiaries with a fluid overload diagnosis remained steady between 2010 and 2012 and increased in the first six months of 2013 (Figure 6-3).

Under the new PPS, management of anemia, as assessed by the declining use of ESAs per treatment, changed (Figure 6-1, p. 150). The indicators that CMS uses to monitor the outcomes associated with anemia management include median hemoglobin levels, incidence of cardiovascular events, and blood transfusions (Centers for Medicare & Medicaid Services 2013a). From January 2010 through June 2013, average monthly hemoglobin levels fell from 11.4 g/dl to 10.6 g/dL.¹⁸ Lower hemoglobin levels are generally associated with lower use of ESAs, while higher hemoglobin levels are associated with higher use of ESAs. The cumulative share of beneficiaries experiencing negative cardiovascular outcomes—stroke, acute myocardial infarction, and heart failure—associated with higher ESA use generally declined from 2007 through June 2013. According to CMS, these declines were gradual, began before implementation of the new PPS, and generally continued under the new PPS. CMS reports that the proportion

FIGURE 6-3

Changes in key outcomes for dialysis beneficiaries, 2010–2013



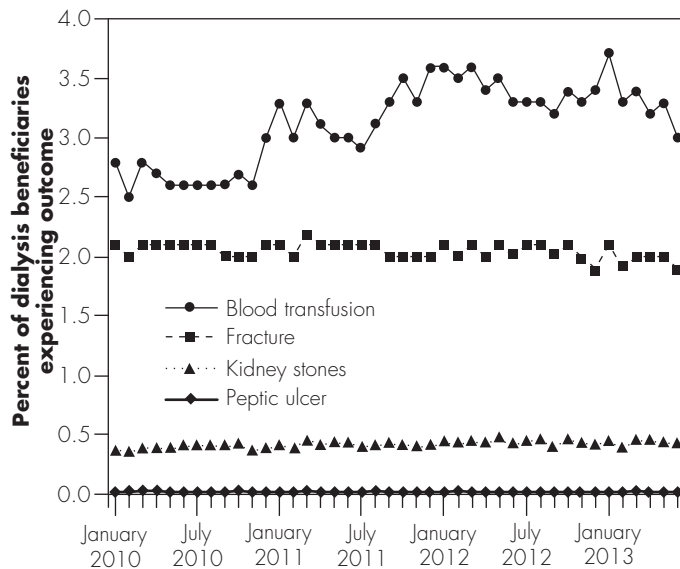
Note: ED (emergency department), CHF (congestive heart failure). Data are compiled on a monthly basis by CMS.

Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

of dialysis beneficiaries receiving blood transfusions increased in 2011.¹⁹ Each year from January 2010 through June 2013, the proportion of beneficiaries (in a given month) receiving a blood transfusion averaged 2.7 percent, 3.2 percent, 3.4 percent, and 3.3 percent, respectively (Figure 6-4, p. 154).²⁰

CMS also gathered indicators to assess the management of bone and mineral disease disorders, including fractures, kidney stones, and peptic ulcers. Between January 2010 and June 2013, outcomes for these disorders remained at about the same level (Figure 6-4, p. 154).

Regarding home dialysis, each year from January 2010 through June 2013, CMS reports that the share of beneficiaries dialyzing at home steadily increased from a monthly average of 8.3 percent to 8.9 percent, 9.5 percent, and 9.9 percent, respectively (Figure 6-5, p. 155). Between 2000 and 2009, United States Renal Data System (USRDS) data show that use of home dialysis among all dialysis patients remained relatively constant, ranging from 8 percent to 9 percent. Between 2010 and 2011, USRDS data, like CMS's findings, show that home dialysis use increased (United States Renal Data System 2013).

FIGURE 6-4**Changes in anemia and bone and mineral disease management, 2010–2013**

Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

While we are encouraged by this modest increase in use of home dialysis under the PPS, we are concerned that the differences by race remain unchanged. Our analysis suggests that between 2009 and 2012, the proportion of home dialysis beneficiaries who were African American remained at 26 percent each year, while African Americans comprised about 36 percent of all dialysis beneficiaries in those years.

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 (see online Appendix 6-A, available at <http://www.medpac.gov>). However, demand for kidney transplantation exceeds supply. Researchers have shown that kidney transplantation rates differ by patients' demographic and socioeconomic characteristics. Several patient, physician, and system factors affect access to kidney transplantation, including the clinical allocation process and donation rates; patients' health literacy, clinical characteristics, lifestyle, preferences, and beliefs; educational efforts provided by facility staff and clinicians who treat dialysis patients;

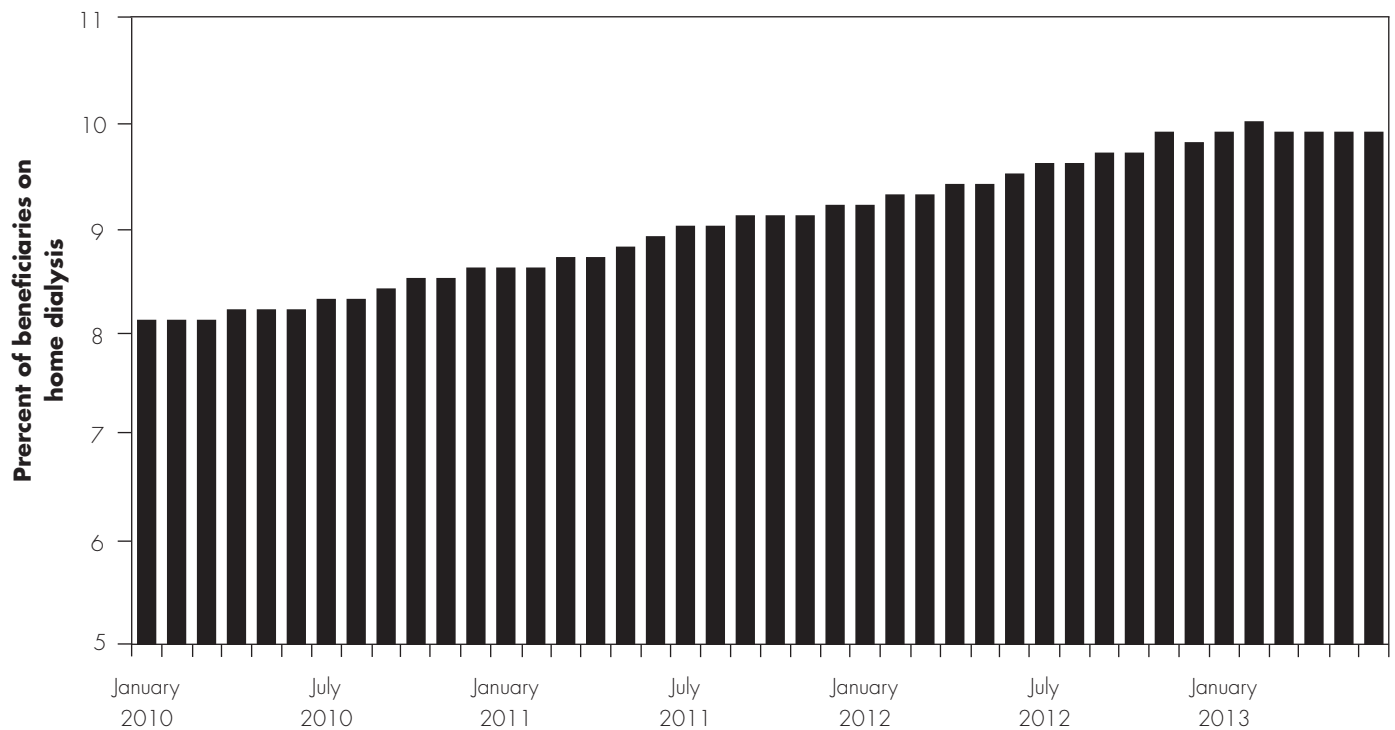
clinician referral for transplant evaluation at a transplant center; and transplant center policies.

There is particular concern about access to kidney transplantation for African Americans because they 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; less access to health care; and lack of knowledge and suboptimal discussions about kidney transplantation among recipients, their families, and health care providers (Ephraim et al. 2012).

There is a growing focus on the importance of educating patients about their treatment options. MIPPA added kidney disease education (KDE) services as a Medicare Part B–covered benefit for beneficiaries diagnosed with stage IV chronic kidney disease (the stage before end-stage renal disease) who have a referral from the physician managing their kidney condition. Beginning in 2010, CMS began to pay for a lifetime maximum of six education sessions per beneficiary. Few beneficiaries were provided KDE services in 2011 and 2012. We found that about 4,200 beneficiaries received this service in each year, and Medicare KDE spending in 2011 and 2012 was nearly \$645,000 and \$675,000, respectively. KDE services were most frequently provided by nephrologists, nurse practitioners, or physician assistants in an office setting.²¹ This analysis used 100 percent of 2011 and 2012 carrier and outpatient claims submitted for KDE services.

The use of shared decision making has the potential to help patients weigh their options—including whether to initiate dialysis, undergo in-center or home dialysis, and be considered for kidney transplantation. In situations with multiple clinically appropriate options, shared decision making is a process in which clinicians share relevant information about all the options, patients share their preferences and values, and the two parties arrive at a decision that incorporates the expertise of both parties.

Expanding CMS's Dialysis Compare public website to include performance measures on kidney transplantation might be another opportunity to enhance beneficiary awareness. The website permits beneficiaries and their families to find and compare information about dialysis facilities but does not provide facility-level performance

**FIGURE
6-5****Changes in the use of home dialysis, 2010–2013**

Source: CMS's end-stage renal disease prospective payment system overview of 2011–2013 claims-based monitoring program.

measures on access to kidney transplantation. CMS, through its contractor, has developed such a measure—a standardized transplantation ratio—which assesses the ratio of the actual number of transplants at a facility to the expected number, adjusted for patient age.²²

Five-year trends in dialysis quality

For the period from 2007 to 2011, we found the following trends in key quality measures:

- The proportion of patients receiving adequate dialysis remained high, and improvements were made in the use of the recommended type of vascular access for hemodialysis patients and in the management of patients' nutritional status.
- In anemia management, the proportion of patients with high hemoglobin levels has decreased with the decreased use of ESAs beginning in 2010.
- The proportion of dialysis patients accepted on the kidney transplant waiting list has modestly increased, but the rate of kidney transplantation among dialysis patients has declined (see on-line Appendix 6-B, available at <http://www.medpac.gov>).

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 2012 and 2013. For example:

- In 2012, DaVita completed its acquisition of HealthCare Partners for roughly \$4.4 billion. HealthCare Partners runs medical groups and physician networks in California, Florida, and Nevada; has 700 employed physicians and a network of 8,300 independent doctors; is one of the Pioneer Accountable Care Organizations; and is part of the accountable care organization (ACO) pilot project for people covered by Anthem Blue Cross.
- In 2013, Fresenius Medical Care NA acquired Shiel Medical Laboratory Inc., expanding services to the New York City area.
- In 2013, Fresenius announced that it is partnering with the ApolloMed ACO to provide integrated health care management for patients with ESRD.

- In 2013, DaVita HealthCare and Berkshire Hathaway entered into an agreement under which Berkshire would not increase its stake in the company above 25 percent. Berkshire is DaVita's largest shareholder with a stake of about 17 percent (Associated Press 2013). Such an investment suggests the financial attractiveness of the company and the positive economics associated with provision of dialysis services.
- In October 2013, Satellite Healthcare, a midsized dialysis chain, announced plans to launch a new subsidiary called Satellite Health Plan Inc., a Medicare Advantage plan. Begun in January 2014, this plan offers benefits geared toward dialysis patients.
- In October 2013, NxStage Medical Inc., a manufacturer of home hemodialysis equipment, opened its first dialysis treatment center. The new center is certified to provide both home and in-center dialysis.
- In August 2013, U.S. Renal Care, a midsized dialysis chain, completed its acquisition of Ambulatory Services of America, also a midsized dialysis chain. The acquisition will operate more than 200 facilities and nearly double the number of dialysis patients that U.S. Renal Care will serve. U.S. Renal Care also operates 17 radiation oncology centers.

In public financial filings, the two largest dialysis organizations reported positive financial performance for 2012, including strong treatment (volume) growth, productivity improvements, and cost control initiatives.

These current trends in the profit status 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. According to one midsized dialysis chain, new clinics become “EBITDA [earnings before interest, taxes, depreciation, and amortization] positive” within an average of 12 months of opening (American Renal Holdings 2011).

Medicare payments and providers' costs

Each year, we assess the relationship between Medicare's provider payments and freestanding providers' costs by considering whether current costs approximate what efficient providers are expected to spend on delivering high-quality care. To make this assessment, we reviewed Medicare expenditures for outpatient dialysis services in

2012 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 under the new PPS

Between 2011 and 2012, the first two years of the new PPS, Medicare spending increased by 6 percent, from \$10.1 billion to \$10.7 billion. During this period, per capita spending increased by 4 percent, from about \$27,700 to nearly \$29,000. The change in total and per capita spending partly reflects (1) the statutory update to the payment rate (2.1 percent for 2012), (2) the growth in the number of beneficiaries (by 2 percent between 2011 and 2012), and (3) the growth in the number of treatments (by 3 percent between 2011 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 costs provide a reasonable representation of costs that efficient providers would incur in furnishing high-quality care. For this analysis, we use cost reports for 2011 and 2012, the first two years of the new PPS, submitted 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 2011 and 2012, the cost per treatment rose by 2 percent, from about \$234 per treatment to \$238 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 2011 and 2012, per treatment costs decreased by 4 percent for facilities in the 25th percentile of cost growth and increased by 6 percent for facilities in the 75th percentile.

For the two-year period, the 2 percent cost growth stems partly from rising costs for general and administrative services, which increased by nearly 13 percent and accounted for about one-quarter of the total cost per treatment in both years. General and administrative costs include expenses associated with legal and accounting services, record-keeping and data-processing tasks, telephone and other utilities, home office costs, and malpractice premiums. Between 2011 and 2012, the cost per treatment for general and administrative services rose faster than the other cost categories that increased—labor and supplies. During this period, the cost per treatment

for laboratory services and dialysis drugs, including ESAs and other dialysis drugs that used to be separately billable, declined while capital costs remained relatively unchanged.

Regarding this cost analysis, we do not know whether the costs that facilities include on their cost reports are overstated because CMS has not yet examined the appropriateness of the costs that facilities included (if providers' costs are overstated, the Medicare margin is understated, demonstrating the need for auditing cost reports). The Commission's analysis of the Medicare margin and providers' costs uses only Medicare-allowable costs.

Total volume is correlated with cost per treatment

Cost per treatment is correlated with the total number of treatments a facility provides. The adjusted cost per treatment is inversely related to the total number of treatments a facility provides (Figure 6-6). For this analysis, we adjusted the cost per treatment to remove differences in the cost of labor among areas and included all treatments regardless of payer. Our analysis showed a statistically significant relationship between total treatments and cost per treatment (correlation coefficient equals -0.5 for 2011 and 2012).

Medicare margin for freestanding facilities in 2012

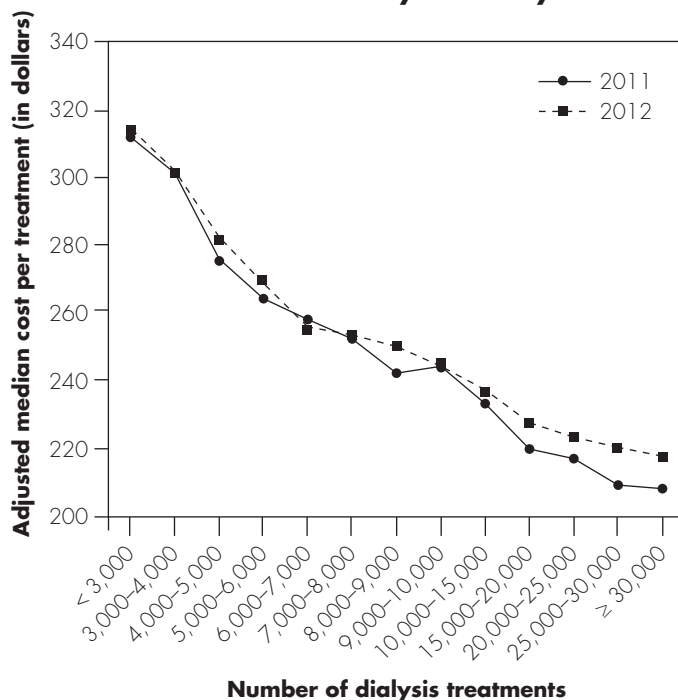
The Commission assesses current payments and costs for dialysis services for freestanding dialysis facilities by comparing Medicare's payments with providers' Medicare-allowable costs. The latest and most complete data available on payments and costs are from 2012. Our analysis includes only facilities that elected to be paid under the new PPS.

For 2012, we estimate that the aggregate Medicare margin was 3.9 percent. The distribution of margins shows wide variation in performance among freestanding facilities (Table 6-4, p. 158). In 2012, one-quarter of facilities had margins at or below -7.9 percent, but half the facilities had margins of at least 2.6 percent, and one-quarter of facilities had margins of at least 11 percent.

Generally, freestanding dialysis facilities' margins vary by the size of the facility; facilities with greater treatment volume have higher margins on average. Urban facilities in 2012 had higher margins than rural facilities (4.7 percent and -0.08 percent, respectively); differences in capacity and treatment volume explain some of the differences observed between urban and rural facilities. Urban dialysis facilities are larger on average than rural facilities with

FIGURE 6-6

Cost per treatment is inversely related to the total treatments a dialysis facility furnishes



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 and 2012 cost reports submitted by freestanding facilities to CMS.

respect to number of treatment stations and Medicare treatments provided. In 2012, urban facilities averaged 19 stations, compared with rural facilities' average of 15 treatment stations, and they averaged 8,000 Medicare treatments, compared with rural facilities' average of 5,700 Medicare treatments.

Facilities affiliated with the two largest dialysis organizations tended to have higher margins than other freestanding facilities (4.2 percent and 3.5 percent, respectively). This difference stems from differences in average cost per treatment rather than from provider size. Compared with their counterparts, the average cost per treatment for the two largest dialysis organizations was about 1 percent lower. Provider capacity, as measured by the number of treatment stations, was similar between the two largest dialysis organizations and other freestanding facilities. In 2012, both groups averaged 18 treatment stations.

**TABLE
6-4****Medicare margin in 2012 varies
by type of freestanding provider**

Provider type	Medicare margin	Percent of freestanding dialysis facilities
All	3.9%	100%
Urban	4.7	79
Rural	-0.08	21
Two largest dialysis organizations	4.2	77
All others	3.5	23
Treatment volume (quintile)		
Lowest	-13.0	20
Second	-3.4	20
Third	2.1	20
Fourth	5.2	20
Highest	9.4	20

Source: Compiled by MedPAC from 2012 cost report and outpatient claims submitted by facilities to CMS, the 2012 Dialysis Compare file, and the 2012 CMS Provider of Service file.

Projecting the Medicare margin for 2014

On the basis of 2012 payment and cost data, provider cost growth between 2011 and 2012, and policy changes that are going into effect between 2012 (the year of our most recent margin estimates) and 2015, we project a 2.9 percent aggregate Medicare margin for dialysis facilities in 2014. The policy changes that are included in this projection include:

- statutory updates of 2.3 percent in 2013 and 2.8 percent in 2014;
- other policy changes that resulted in increased payments in 2013 and 2014 of 0.7 percent and 0.6 percent, respectively;
- 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 payment PPS; and
- an estimated reduction of 0.29 percent of payments due to the ESRD Quality Incentive Program (QIP) in 2013 and 2014.

This projection does not consider the impact of the sequester, which would lower the margin by about 2 percentage points.

How should Medicare payments change in 2015?

Two major provisions under current law affect the 2015 outpatient dialysis payment rate. First, MIPPA and the Patient Protection and Affordable Care Act of 2010 mandated, beginning in 2012, that the Secretary annually update the outpatient dialysis payment rate by an ESRD market basket index reduced by a productivity adjustment. CMS measures price inflation for ESRD goods and services associated with the new prospective payment bundle. CMS's latest forecast of this index for calendar year 2015 is 2.8 percent. Under current law, the ESRD update is subject to a productivity adjustment, which is currently estimated at 0.3 percent.

Second, the American Taxpayer Relief Act of 2012 rebases the outpatient dialysis payment rate, effective 2014, to reflect more current use of dialysis drugs and biologics. The law mandates that the Secretary (1) rebase the outpatient dialysis payment rate effective 2014 based on changes between 2007 and 2012 in the use of ESAs, other drugs, and biologics, and (2) delay the inclusion of oral-only ESRD-related drugs into the payment bundle until 2016. In 2015, the Secretary intends to offset the (negative) drug utilization adjustment with positive offsets, including the payment update increase and other policy changes, which would result in no change to 2015 total payments compared with 2014 total payments.

In addition to these statutory provisions, the ESRD QIP will have an effect on providers' total payments. For 2015, CMS predicts that the effect of the QIP will decrease total payments by 0.17 percent.

Update recommendation

The evidence on payment adequacy suggests that 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 2012.

RECOMMENDATION 6-1

The Congress should not increase the outpatient dialysis payment rate for calendar year 2015.

RATIONALE 6-1

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 nearly 4 percent in 2012 and is projected to be nearly 3 percent in 2014.

The decline in dialysis drug use is not unexpected. Under the prior payment method, providers had little incentive to control use of separately billable dialysis drugs, including ESAs, because Medicare paid providers according to the number of units of the drug administered. In addition, the implementation of PPSs in Medicare has historically been characterized by providers quickly reducing use of services included in the payment bundle, resulting in periods of “overpayment”—in which providers benefit from the change in practice patterns and the Medicare program does not realize savings until the payment rate is adjusted. The inpatient hospital, home health, skilled nursing facility, and long-term care hospital PPSs have demonstrated this pattern.

Current law mandates that rebasing begin in 2014, and the Secretary has said that the payment reduction will be phased in over a three- to four-year period. The Commission’s long-held position in many reports and comment letters is that payment rates are not intended to protect each and every provider but instead protect beneficiary access while conserving beneficiaries’ and taxpayers’ resources. In general, the Medicare program should move expeditiously to correct overpayments. At the same time, the payment adjustments should be made such that providers have time to respond to avoid disrupting beneficiary access. The Commission believes that rebasing should be considered year by year and that costs need to be examined broadly, not just for dialysis drugs. Examining the adequacy of Medicare’s payments year by year accomplishes two goals. First, it moves the payment system toward greater accuracy. Second, it protects beneficiary access and gives the Commission the ability to report back to the Congress on any developing issues.

IMPLICATIONS 6 - 1

Spending

- In 2015, the Secretary intends to offset the negative drug utilization adjustment with positive offsets, including the payment update increase and other policy changes, which would result in no change to 2015 total payments compared with 2014 total payments. The Commission’s update recommendation

is to hold the 2015 payment rate at the 2014 level. Therefore, we estimate that this recommendation would not change federal program spending relative to current Medicare law over one year or five years.

Beneficiary and provider

- We do not anticipate any negative effects on beneficiary access to care. According to our assessment of the payment adequacy indicators, dialysis facilities should be able to accommodate expected cost changes in 2015 with the base payment rate held at 2014 levels. That is, the 2015 base payment rate in the dialysis payment system should be the same as the rate in 2014. This recommendation will increase financial pressure on some providers, but it is not expected to affect providers’ willingness or ability to serve beneficiaries.

Regulatory improvements to the new dialysis PPS

To address three concerns with the new PPS, we recommend that the Congress direct the Secretary to (1) hold providers accountable for poor outcomes related to anemia management; (2) focus the low-volume payment adjustment on protecting facilities critical to beneficiary access; and (3) examine the accuracy of dialysis cost report data under the new PPS. The Secretary has the authority to make these regulatory changes.

The ESRD QIP should hold providers accountable for poor outcomes of anemia management

As discussed earlier, anemia management under the new PPS has changed. Like any PPS, bundled payments create an incentive for providers to furnish fewer services (included in the bundle) than medically necessary. The ESRD QIP in 2013 and beyond does not assess the outcomes associated with the provision of fewer anemia services than medically necessary. The Congress should direct the Secretary to use her authority to develop an ESRD QIP measure that would hold providers accountable for any poor outcomes of anemia management.

Issues and analysis

Under the new PPS, anemia management has changed. As discussed earlier, between 2010 and 2012, ESA use per treatment declined by 40 percent. The measures that

CMS uses to assess the outcomes of anemia management include:

- **Median hemoglobin level**—Between January 2010 and June 2013, this measure has declined from 11.4 g/dL to 10.6 g/dL.
- **Incidence of cardiovascular events**—Between 2007 and 2013, the cumulative share of beneficiaries experiencing stroke, acute myocardial infarction, and heart failure—associated with higher ESA use—generally declined.

The change in anemia management (i.e., the reduction in the use of ESA per treatment) is not unexpected. Under the prior payment method, Medicare paid providers according to the number of units of the drug administered; in other words, the more units provided, the higher the Medicare payment. The new PPS increased the incentive for providers to be more judicious in providing dialysis drugs because they are included in the payment bundle (and thus are a cost center). In addition, the FDA in 2011 called for more conservative ESA dosing. However, the FDA did not provide a specific hemoglobin lower bound considered safe for patients treated with ESAs but said that clinicians could consider starting ESA treatment when the hemoglobin level is less than 10 g/dL and could use the lowest dose of ESA sufficient to reduce the need for red blood cell transfusions.

The 2012 ESRD QIP included a measure that assessed the proportion of beneficiaries receiving ESAs with an average hemoglobin level less than 10 g/dL. Beginning in payment year 2013, CMS retired this measure because (1) it could not identify a specific hemoglobin lower bound that has been proven safe for all patients treated with ESAs and (2) the agency believes that it would not be appropriate for the QIP to continue to incentivize ESRD providers to achieve hemoglobin levels above 10 g/dL. Since payment year 2013, the ESRD QIP includes one outcome measure related to anemia management—the proportion of beneficiaries receiving ESAs who have an average hemoglobin level greater than 12 g/dL.

The Commission wants to ensure that beneficiaries continue to have access to effective and appropriate anemia management. Consequently, the ESRD QIP should include a clinical outcome that holds providers accountable for poor outcomes associated with furnishing fewer anemia services than medically necessary. Rather than impose a new administrative burden on providers, the Secretary should, to the extent possible, use data that

are already collected from dialysis facilities. One option for such a measure is assessing the rate of inpatient hospitalizations rather than a specific hemoglobin level (because the FDA has not identified such a level).

CMS could consider using a facility-level measure developed by the agency's contractor that calculates a risk-adjusted standardized hospitalization ratio for admissions. The measure compares the facility's observed number of events with the number of events that would be expected if patients at the facility were subject to the national average rate (University of Michigan Kidney Epidemiology and Cost Center 2013). This measure will be included in the 2014 reports that CMS, through its contractor, provides to each dialysis facility to assess the facility's quality performance to state and national benchmarks.

The low-volume payment adjustment should focus on protecting only facilities critical to beneficiary access

The low-volume payment adjustment under the new PPS is not targeting facilities that might be critical to beneficiary access. The distance requirement in CMS's definition does not prevent facilities that are close to other facilities (e.g., within five miles of one another) from receiving the 18.9 percent payment adjustment to their base rate. Medicare and dialysis beneficiaries would be better served by an adjuster that targets low-volume facilities that are not close to another facility. Only low-volume facilities that are necessary to maintain access—those located in isolated areas—should receive enhanced payment. The Congress should direct the Secretary to use her authority to redesign the payment adjustment so that it considers distance between dialysis facilities.

Issues and analysis

CMS defines a low-volume facility as one that provides fewer than 4,000 treatments (Medicare and non-Medicare) in each of the three years before the payment year and has not opened, closed, or received a new provider number because of a change in ownership during the three-year period.²³ For existing facilities (i.e., those that were certified for Medicare participation as of December 31, 2010), CMS's definition does not impose a distance requirement between the facility that receives the low-volume adjustment and the next closest facility. However, for new facilities (i.e., those that were certified on or after January 1, 2011), for purposes of determining eligibility for the adjustment, the number of treatments is equal to the sum of the number of treatments provided by a facility

**TABLE
6-5****Distance of low-volume dialysis facilities to nearest facility, by provider type, 2012**

	Percent of low-volume facilities	Median miles to nearest facility	Percent of low-volume facilities within 5 miles of nearest facility
All low-volume facilities	100%	7	48%
Freestanding	81	4	52
Hospital based	19	24	32
Urban	52	2	72
Rural	48	25	22
Two largest dialysis organizations	61	4	52
All others	39	18	41

Source: MedPAC analysis of 2012 claims submitted by dialysis facilities to CMS.

and any other facilities under common ownership that are within 25 road miles from the facility in question.

Our analysis of 2011 and 2012 Medicare claims data shows that 363 facilities received the low-volume payment adjustment in 2012, an increase from 2011 of nearly 10 percent. In 2012, 81 percent of low-volume facilities were freestanding, 19 percent were hospital based, 52 percent were located in urban areas, and 48 percent were located in rural areas (Table 6-5).

Some facilities receiving the low-volume adjustment were close to other dialysis facilities. Of the facilities that received the low-volume payment adjustment in 2012, nearly 50 percent were within five miles of the next facility. The median distance between the facility receiving the adjustment and the next facility was seven miles. Facilities that were freestanding, urban, and affiliated with the two largest dialysis organizations tended to be closer to the next facility than facilities that were hospital-based, rural, and not affiliated with those organizations (Table 6-5). For example, the median distance between urban facilities and the next closest facility was 2 miles; for rural facilities, the median distance to the next closest facility was 25 miles. Our analysis of the proximity of low-volume facilities to other facilities in 2011 generally found similar results (Medicare Payment Advisory Commission 2013).

In 2012, 14 facilities that received the low-volume payment adjustment had the same street address as another dialysis facility that did not receive the low-volume payment adjustment. Most of the 14 facilities had

the same ownership as the facility with the same street address.

In addition to the lack of a distance requirement for facilities certified before 2011, the design of the low-volume payment adjustment also raises concerns because it gives facilities an incentive to limit services to avoid reaching the 4,000 treatment threshold (the so-called “cliff” effect) (Government Accountability Office 2013). A payment approach that decreases the payment adjustment as facility volume increases might reduce this incentive.

This payment adjustment is targeting facilities that have on average higher cost per treatment than other facilities, as specified by MIPPA.²⁴ In 2011 and 2012, the adjusted cost per treatment for freestanding facilities that received the low-volume payment adjustment was about 20 percent greater than for freestanding facilities without the adjustment.

Dialysis facilities’ cost report data under the new PPS should be examined for accuracy

CMS has not yet examined the appropriateness of the costs that facilities include in their cost reports under the new PPS. The Congress should direct the Secretary to use her authority to conduct audits that assess the accuracy of dialysis facilities’ cost report data.

Issues and analysis

It is important to examine the accuracy of facilities’ cost reports for several reasons. First, it is basic fiscal management to ensure that facilities’ cost reports are

accurate. The Medicare margin is calculated from this data source, and policymakers consider the margin (and other factors) when assessing the adequacy of Medicare's payments for dialysis services. If costs are overstated, then the Medicare margin is understated. Medicare cost principles are designed to ensure that Medicare pays reasonable expenses related to patient care. Second, it has been more than 10 years since cost reports were audited, and in 2011, the outpatient dialysis payment system underwent a significant change.

Third, historically, facilities' cost reports have included costs that Medicare does not allow. Analysis of previous audits (in 1988, 1991, 1996, and 2001) of dialysis facilities' cost reports found that facilities' allowable costs ranged from 90 percent to 96 percent of costs submitted. CMS's recent audit of a sample of 100 home health agency cost reports demonstrates the importance of validating these data. The agency found that agencies in the audit sample overstated their costs by an average of about 8 percent (Centers for Medicare & Medicaid Services 2013b).

Medicare's contractors (e.g., fiscal intermediaries) and the Department of Health and Human Services' Office of Inspector General have conducted past audits of dialysis facilities' cost reports (Government Accountability Office 1993). Medicare administrative contractors conducted the recent audit of cost reports submitted by home health agencies. To ensure that audits are thorough and complete, auditors should (1) evaluate whether the reported costs are supported by facilities' accounting records; (2) assess whether the costs are reasonable and related to patient care; and (3) assess the appropriateness of transactions with affiliated entities—called related organizations—that are under common ownership or control.

Recommendation

Regulatory changes are needed to include a measure in the ESRD QIP that holds providers accountable for poor outcomes related to providing fewer anemia services than medically necessary, redesign the low-volume payment adjustment, and assess the accuracy of dialysis facilities' cost report data under the new PPS.

RECOMMENDATION 6-2

The Congress should direct the Secretary to:

- **include a measure that assesses poor outcomes related to anemia in the End-Stage Renal Disease Quality Incentive Program.**
- **redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility.**
- **audit dialysis facilities' cost report data.**

RATIONALE 6-2

This recommendation would hold providers accountable for the poor outcomes of anemia, target the low-volume payment adjustment only to facilities that are isolated, and help ensure that dialysis facilities' cost reports are accurate.

IMPLICATIONS 6-2

Spending

- We expect that the spending implications of this recommendation will be budget neutral. This recommendation would redistribute payments to low-volume facilities. We are unable to calculate the impact of the first and third provisions of this recommendation.

Beneficiary and provider

- This recommendation might improve the quality of anemia management. It should help ensure that, under the new PPS, beneficiaries' access to care is maintained at isolated, low-volume facilities. The recommendation is not expected to affect providers' willingness or ability to serve beneficiaries. Payments would decrease for providers who currently receive the low-volume payment adjustment but are in close proximity to other facilities and would increase for providers who have lower treatment volumes, are not in close proximity to other facilities, but currently do not receive the low-volume payment adjustment. ■

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. Most dialysis patients are covered by Medicare as either the primary or secondary payer.
- 3 The total number of individuals on dialysis in 2012 was estimated by inflating the 2011 United States Renal Data System's number of dialysis patients by the annual growth in the dialysis population between 2006 and 2011.
- 4 This estimate remained relatively steady between 2006 and 2011.
- 5 According to CMS's *Medicare Managed Care Manual*, an individual who receives a kidney transplant and who no longer requires a regular course of dialysis to maintain life is not considered to have ESRD for purposes of MA eligibility. Such individuals may elect to enroll in an MA plan, if they meet other applicable MA eligibility requirements.
- 6 ESRD patients include those who initiate dialysis or receive a kidney transplant.
- 7 The incidence of ESRD increased by 1 percent per year for individuals 19 years or younger. In 2011, this age group accounted for only 1 percent of new ESRD cases (United States Renal Data System 2013).
- 8 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.
- 9 *Higher levels of residual kidney function* refers to patients with an estimated glomerular filtration rate (a measure of residual kidney function calculated using the Chronic Kidney Disease Epidemiology Collaboration formula) above 15 milliliters per minute per 1.73 square meters (United States Renal Data System 2013). Clinicians use the estimated glomerular filtration rate to assess residual kidney function; lower values of this measure suggest reduced residual kidney function.
- 10 In 2012, the American Kidney Fund provided assistance to one out of every five dialysis patients for health insurance premiums and other treatment-related expenses (American Kidney Fund 2014).
- 11 No later than November 1, 2010, dialysis facilities could have elected to be reimbursed 100 percent by the new PPS. Between 2011 and 2013, CMS paid facilities that did not elect to be reimbursed by the new PPS by a blended payment rate composed of the older payment method (basic case-mix-adjusted composite rate payment system) and the new PPS. In 2012, we estimate that 95 percent of all facilities were paid under the new PPS instead of the four-year transition rate. Facilities that received Medicare certification after January 1, 2011, are paid under the new PPS.
- 12 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.
- 13 In 2011, Fresenius acquired Liberty Dialysis and DaVita acquired DSI Renal.
- 14 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).
- 15 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.
- 16 According to OIG, in 2009, most (93 percent) Medicare-certified dialysis facilities had protocols in place for administering ESAs (Office of Inspector General 2009). For dialysis facilities with protocols in place for administering ESAs, physicians may approve the protocols as patients' standing orders.
- 17 In March 2007, the FDA included a "black box warning" on ESA drug labels advising physicians that the risks of death and serious cardiovascular events are greater when ESAs are administered to achieve higher target hemoglobin levels and that dosing should be individualized to maintain hemoglobin levels between 10 g/dL and 12 g/dL.
- 18 Anemia is measured by a blood test to check the level of hemoglobin, the protein that carries oxygen in red blood cells.
- 19 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.

- 20 USRDS data show that the percent of dialysis patients with one or more transfusion events remained relatively steady between 2003 and 2009 (United States Renal Data System 2011, United States Renal Data System 2010).
- 21 MIPPA does not permit dialysis facilities to bill for KDE services.
- 22 Under contract to CMS, Arbor Research Collaborative, in collaboration with the University of Michigan Kidney and

Epidemiology Cost Center, provides each dialysis facility a report that compares the facility's quality performance with state- and national-level rates. Kidney transplantation was one of the measures included in the 2013 report (University of Michigan Kidney Epidemiology and Cost Center 2013).

- 23 Pediatric dialysis treatments are not eligible for the low-volume adjustment.
- 24 MIPPA required the new dialysis PPS to "include a payment adjustment that reflects the extent to which costs incurred by low-volume facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other facilities in furnishing such services."

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CHAPTER

7

**Post-acute care providers:
Steps toward broad
payment reforms**

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

- 7** The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.

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

Post-acute care providers: Steps toward broad payment reforms

Chapter summary

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after 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). As with any service, the Commission's goal is to recommend policies related to payments for PAC providers that ensure beneficiaries receive medically necessary, high-quality care in the least costly setting appropriate for their condition.

The Commission has long noted the shortcomings of Medicare's fee-for-service (FFS) payment systems for PAC and the clear need for reforms. High Medicare margins indicate that program payments are exceptionally high, and the wide variation across providers in Medicare margins highlights core problems with the design of the prospective payment systems (PPSs). The PPSs encourage providers to furnish certain services to boost payments or admit certain kinds of patients based on profitability. Although CMS has adopted setting-specific rules to delineate the types of patients appropriate for IRFs and LTCHs, there is overlap in the types of patients treated in different settings. Because Medicare pays very different rates across settings, treating similar patients in different settings can unnecessarily increase program spending.

In this chapter

- Challenges to improving Medicare's payments for post-acute care
- Broad reforms for post-acute care
- Moving forward with a common patient assessment tool

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

Challenges to improving Medicare's payments for post-acute care

Though Medicare payments for post-acute care (PAC) must be reformed, making improvements is challenging for several reasons. First, the need for PAC is not well defined; some patients can go home from the hospital without it, while others need it but receive varying amounts of service in different settings. Still others remain in the acute care setting a few days longer and avoid PAC altogether. While Medicare rules (conditions of participation and payment and coverage rules) provide some guidance regarding placement in PAC, providers of PAC have considerable latitude in terms of which patients they admit among the patients referred to them by hospitals. The Commission and others have documented the similarity of patients treated in different PAC settings (Gage et al. 2011, Medicare Payment Advisory Commission 2013). Reflecting this ambiguity, Medicare per capita spending (adjusted for prices and health status) on PAC varies more than on most other covered services. Geographic areas (core-based statistical areas) with the highest and lowest per capita spending (comparing the 10th and 90th percentile) vary by more than a twofold difference for PAC services but by only about 20 percent for acute inpatient and ambulatory services (Medicare Payment Advisory Commission 2011). The range in spending indicates opportunities for more effective purchasing of PAC services by the Medicare program.

Second, PAC providers treat similar types of patients, yet Medicare pays different prices depending on the setting (Medicare Payment Advisory Commission 2013). For example, patients recovering from strokes and hip replacements are treated in inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs), but Medicare's payments per stay to IRFs are 40 to 50 percent higher than its payments to SNFs for these conditions.

Further complicating reform efforts are utilization patterns that do not reflect efficient care. There are no financial incentives for hospitals to refer patients to the most efficient or effective setting, so actual PAC use does not indicate where patients would best receive their care or how much care is optimal. Instead, placement decisions often reflect the availability of PAC settings in a local market (and whether there is an available bed), the hospital's and family's proximity to PAC providers, patient and family preferences, or financial relationships between

providers (for example, a hospital may prefer to discharge patients to providers that are part of its system or those with which it contracts).

Finally, there is no common patient assessment instrument used across PAC settings. Medicare requires three of the PAC settings (home health agencies (HHAs), SNFs, and IRFs) to use setting-specific patient assessment tools in determining a patient's resource requirements. Although the tools are similar in the domains covered by the questions, each tool asks different questions, defines the activities being assessed differently, uses different scales to gauge patient functional status, and assesses patients over varying time frames (Table 7-1, p. 172). The questions regarding cognition are especially different across the tools. In addition, the tools vary in how independence and dependence are gauged. For example, tools differ in whether they consider verbal cues or the use of assistive devices in determining level of assistance required. In addition, the tools differ in whether they assess a patient over a period of time and record the patient's most dependent level of functioning or whether they record the patient's functioning at a single point in time. Acute care hospitals are not required to submit patient assessment data at discharge, while long-term care hospitals (LTCHs) began submitting limited information in their quality reporting program in October 2012. LTCHs are required to report information related to pressure ulcers and in the future will be required to submit information on the administration of influenza vaccine (October 2014) and patients experiencing one or more falls with major injury (January 2016). LTCHs are not required to submit comprehensive patient assessment information at admission and discharge.

The lack of comparable information undermines our ability to fully evaluate whether patients treated in different settings are, in fact, the same or whether one PAC setting is more appropriate than another for patients with specific conditions. As a result, we do not know whether there are selection practices that are common across settings in terms of the patients admitted. Furthermore, without comparable information, we cannot systematically evaluate the cost and outcomes of the care that beneficiaries receive across settings. Providers may look more efficient or able to achieve better outcomes, when actually they treat fewer complex cases. Adequate risk adjustment is critical to make fair comparisons across providers and give beneficiaries accurate information about high-quality providers.

**TABLE
7-1**

Frequency, time period covered, and measurement scales differ across post-acute patient assessment tools required by Medicare at admission and discharge

Dimension	Inpatient rehabilitation facilities	Skilled nursing facilities	Home health agencies
Tool	IRF-PAI	MDS	OASIS
Frequency of assessments	At admission and discharge	Initial (day 1-8); day 14; day 30; thereafter every 30 days up to day 100; change in therapy; and significant change in status	At admission; every 60 days thereafter and discharge
Time period covered	Lowest level within first 3 days (at admission) and last 3 days (at discharge)	Generally 7-day look back	Status of patient on day of assessment
Method of assessment	Direct observation preferred but can be combined with reported performance	Information gathered from multiple caregivers' descriptions and documentation. Direct observation not required.	Direct observation preferred but often use interviews with patient in-home caregiver
Minutes to complete	51 minutes	90 minutes	90 minutes

Note: IRF-PAI (Inpatient Rehabilitation Facility-Patient Assessment Instrument), MDS (Minimum Data Set), OASIS (Outcome and Assessment Information Set). Long-term care hospitals are required to submit limited information for quality reporting but are not required to submit comprehensive patient assessment information at admission and discharge.

Source: MedPAC's June 2005 report and CMS's Paperwork Reduction Act disclosure statement, available at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/InpatientRehabFacPPS/Downloads/IRF-PAI-FINAL-for-Use-Oct2014-updated-v4.pdf>.

Broad reforms for post-acute care

Across all services, the Commission believes Medicare needs to move away from fee-for-service (FFS) payment and toward integrated payment and delivery systems to control unnecessary volume and enhance patient outcomes. Our work on accountable care organizations (ACOs) and bundled payments are examples of reforms that center payments on the beneficiary or episode of care rather than on specific services furnished or the site of delivery. Under these approaches, providers are encouraged to furnish the lowest cost mix of services necessary to achieve the best outcomes and to coordinate care across settings.

While broad payment reforms are needed, the Commission acknowledges that FFS methods remain important because they are likely to remain an option for providers and beneficiaries for the near term and may remain the dominant option in certain markets even longer. Therefore, CMS needs to continue to improve the accuracy of program payments for PAC. At the same time, CMS

needs to ensure the comparability of payments across settings when providers treat similar patients. A common set of patient assessment information would also assist beneficiaries and providers in making decisions about whether PAC is needed and, if so, the setting and provider best able to meet a beneficiary's care needs. ACOs and Medicare Advantage plans, with the focus on the entire episode of care, could use the information to lay out the best trajectory of care across settings. Finally, comparable patient-level information will facilitate the refinement of risk adjusters for quality and cost measures.

The Commission has also begun to develop outcome-based quality measures that are risk adjusted so that the efficacy of settings and services can be evaluated. For example, risk-adjusted rates of rehospitalization are a good gauge of the care furnished by the facility and, when the measures extend to a period after discharge, hold providers accountable for safe care transitions. Aligning measures across settings allows quality to be compared.

Broad reforms require common patient assessment information across the PAC settings so we can evaluate

differences in the mix of patients treated in different settings, the care providers furnish, and the outcomes patients achieve. Yet CMS has been slow to implement the gathering of common assessment information. In 1999, the Commission recommended that the Secretary collect a core set of patient assessment information across all PAC settings (Medicare Payment Advisory Commission 1999). In 2005, with no tool yet in place, the Deficit Reduction Act of 2005 required the Secretary to conduct a demonstration to develop and test a tool. CMS successfully developed, validated, and tested a uniform tool (the Continuity Assessment Record and Evaluation, or CARE) in its Post-Acute Care Payment Reform Demonstration (PAC-PRD) (Gage et al. 2011). The tool was tested in each PAC setting (at a patient's admission and discharge) and at acute care hospitals (only at discharge). CMS confirmed the tool's inter-rater reliability within and across settings. Providers in the five settings were generally positive about the CARE items, noting the specificity of the items measuring severity and change in function and the standardization of measuring pressure ulcers and other factors that affect staffing (Centers for Medicare & Medicaid Services 2012).

Criticisms of the CARE tool focused on two aspects: the tool was too long and did not adequately measure clinical complexity. CMS estimated that the assessment took 30 minutes to 60 minutes, depending on the complexity of the patient (Gage et al. 2011). This estimate is consistent with the time required by tools currently in use. Second, some providers thought the tool would not adequately assess complex or vulnerable patients. With input from providers in LTCHs and acute hospitals, the CARE tool included items to specifically measure medically complex patients, such as whether the patient had severe pressure ulcers or required ventilator support/weaning or hemodialysis.

CMS found considerable overlap in the mix of patients across some of the settings (for example, between SNFs and IRFs). In addition, two risk-adjusted outcomes (rehospitalization rates and changes in mobility) did not differ significantly across SNFs, IRFs, and HHAs. LTCHs had lower rehospitalization rates, reflecting their capacity as hospitals to handle medically complex patients. Risk-adjusted changes in self-care were higher for patients treated in IRFs and HHAs than the changes for patients treated in SNFs, though thresholds for defining clinically meaningful differences were not established. These findings suggest that the settings generally provide similar quality of care when they serve similar patients.

The overlap in patients treated across settings and the relatively similar outcomes suggest that, in the near term, payment differences could be narrowed for similar patients receiving similar services in different settings. In the longer term, at least some of the PAC settings could be consolidated into a single payment system. Common information would enable us to develop a single case-mix system to adjust payments based on patient characteristics, not the setting. Using a common set of factors gathered with the CARE tool, CMS was able with reasonable accuracy to predict direct staffing (predominately nursing) and therapy resources across the PAC settings. CMS concluded that a common case-mix system was feasible for at least the institutional settings, with further work perhaps required to consider payments for HHAs, given their lower acuity patients on average.

Moving forward with a common patient assessment tool

The findings of the demonstration provide strong support for a common assessment tool. The demonstration found that a common tool not only was possible but also allowed us to meet three objectives simultaneously: to compare the mix of patients, the outcomes achieved, and costs of care across settings. In contrast, the setting-specific tools were not designed with these three objectives in mind nor tested across all PAC settings and at hospital discharge. While some providers have developed assessment tools to guide PAC placement decisions, the tools often do not gather the information needed to meet all three objectives.

Common assessment items must gather the information needed to define comparable outcomes and to risk adjust costs and outcomes. A core set of domains—in combination with diagnoses and comorbidity information from claims—predicts resource use, changes in functional status, and hospital readmissions (Table 7-2, p. 174). Given the focus on rehabilitation for many patients receiving PAC, starting the collection of common assessment information with functional status and cognitive status (at admission and discharge) would facilitate the comparison of resource use and outcomes across the settings. Other key predictors of resource use and outcomes include the provision of special services (such as ventilator and dialysis), certain medical conditions (such as the presence of severe pressure ulcers), and patient impairments (such as the inability to see). The gathering of information needs to balance the objectives

**TABLE
7-2**

Key predictors of readmissions, changes in functional status, and resource use

Source	Domain	Examples
Claims	Demographics	Age
	Clinical	Diagnoses
		Comorbidities
Patient assessment	Functional status	Mobility and self-care; sitting endurance
	Cognitive function	Able to express ideas, able to understand, comatose, depression
	Special services	Ventilator, dialysis, chemotherapy, central line placement, total parenteral nutrition, IV medications
	Medical condition	Severe pressure ulcers, major wound present
	Impairments	Inability to hear, see, swallow; incontinence
	Prior service use	Hospital or PAC use within past 2 months, ICU days
	Prior functioning	Mobility and self care; history of falls

Note: IV (intravenous), PAC (post-acute care), ICU (intensive care unit).

Source: Carter et al. 2012, Gage 2011, Kramer et al. 2014, and Nuccio et al. 2011.

of its use with the need to minimize the time required to complete the assessment. Because the select items make up only part of the CARE tool, they should take less time to complete than the entire tool. At the same time, questions must avoid observer bias or manipulation.

It is possible that one or two questions within each domain are sufficient to meet these multiple objectives. A shortened version of the CARE tool being used by participants in CMS's bundling initiative (the Bundled Payments for Care Improvement Initiative–Continuity Assessment Record and Evaluation, or B–CARE, tool) includes key predictors from all patient assessment domains but is shorter than the tool used in the PAC–PRD demonstration. For example, the sections on skin integrity, physiological factors, cognitive status, impairments, and functional status include fewer items. While the required items need not be some version of the CARE tool, it is readily available, meets these multiple objectives, and could be implemented relatively quickly.

CMS has outlined several follow-on activities for the CARE tool and the PAC–PRD data. CMS has begun efforts to assess the feasibility of using CARE-based assessment items (instead of the setting-specific patient assessment items) in the current PAC prospective payment systems (PPSs). A refined set of quality measures based

on the CARE items is also under development, beginning with the standardization of pressure ulcer items. CMS plans to use the consistent measures in its quality reporting programs. As these efforts are completed, CMS intends to integrate CARE items into the existing assessment tools for IRF, SNF, and home health care. Time frames for using the CARE tool items in existing PPSs and the adoption of the CARE tool (or items from it) have not been established. We are concerned that without the motivation of a statutory mandate and deadlines, the implementation may continue to lag far behind the imperative for a common set of items, particularly if the efforts are overtaken by other priorities.

RECOMMENDATION 7

The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.

RATIONALE 7

The PAC demonstration found that establishing a set of common patient assessment items is operationally feasible, that there was considerable overlap in the patients treated in different PAC settings, patient outcomes were similar, and a core set of patient characteristics could establish

**TABLE
7-3**

A possible phased approach to implement common assessment items

Year	Activity
2016	<ul style="list-style-type: none"> • Common items are added to existing tools • For long-term care hospitals, the common items are required
2017	<ul style="list-style-type: none"> • Test post-acute care prospective payment systems using the common items instead of items from existing tools • All post-acute care providers continue to gather common items • Existing assessment tools remain in place
2018	<ul style="list-style-type: none"> • Replace overlapping “old” assessment items with common items • Use common assessment items in current post-acute care prospective payment systems • Long-term care hospitals continue to submit common items • Existing assessment tools remain in place, with standardized items substituted for “old” items

a common payment system. Common assessment items would gather the information necessary to develop comparable outcomes measures and facilitate adjusting payments and outcomes to reflect differences across patients. Knowing which sites produce the best outcomes for each condition could be used to inform PAC placement decisions and could possibly serve as evidence for Medicare to refine its coverage policies for these services.

One pathway to implement common elements would be for the Secretary to begin with a required set of elements to be collected at all four sites and to expand this core set over time. The initial core would include a limited number of items from select domains that are the most important for having comparable outcomes data and for adjusting outcomes and payments for patient differences. These domains would include functional status, cognitive status, and the provision of special services. This core set should be added to the existing patient assessments and required in fiscal year 2016 (Table 7-3). For LTCHs, this initial core set would constitute the required tool for assessing their patients at admission and discharge.

In subsequent years, CMS would focus on integrating the use of the new tool in its case-mix systems for the PAC PPSs and on streamlining the reporting requirements for providers. During 2017, CMS would verify that the common new items, instead of the current assessment tool items, can be used in the existing PPSs. Providers would continue to use the tools required of each setting in addition to the new common core elements. In 2018, CMS would replace the “old” overlapping assessment items with the common items. By dropping duplicated items, the reporting burden for HHAs, SNFs, and IRFs

would be reduced. The existing (now modified) patient assessment tools would continue to be used by HHAs, SNFs, and IRFs, with LTCHs using the common core as their assessment tool. The core set could be expanded over time if CMS decides that additional items are needed to more accurately describe clinically complex or vulnerable patients seen across PAC settings. Consistently defined, publicly reported quality measures would make it easier to compare performance across PAC settings and providers. In the future, the common items could be required at discharge from the hospital to facilitate placement decisions and to link PAC use to patients’ abilities when they left the hospital.

Given the importance of the assessment items for comparing patients, assessing quality across settings, and risk-adjusting payments and outcomes, the Commission urges the Congress to require the Secretary to move as quickly as possible in implementing common assessment items. If this effort can be made sooner than the possible time frame discussed above, the Secretary should make every effort to do so.

To meet the implementation time frame, CMS should consider implementing elements from the B-CARE tool. The Commission is concerned that using another tool that needs to be validated and tested would further delay the 15-year wait since it first recommended gathering uniform patient assessment information. Moreover, this tool is in use by providers participating in CMS’s Bundling Initiative and includes the key factors required for risk-adjusting resource use, change in functional status, and readmission rates.

Spending

- There would be no direct impact on program spending. CMS will incur additional costs to modify the PPSs to use elements from the commonly collected items in the case-mix classification systems for IRFs, HHAs, and SNFs. In the long run, administrative costs may decline if CMS has to maintain fewer silo-specific assessment items.

Beneficiary and provider

- Beneficiary care may improve because providers will have common information about relative PAC performance. Providers can use this information to facilitate appropriate placement at hospital discharge, improve transition care, and refine the care processes that improve their outcomes. If commonly

defined outcome measures were publicly reported, beneficiaries and their caregivers would have consistent information to independently compare and select PAC providers.

In the initial years of implementation, providers will incur modest costs associated with integrating the new patient assessment items into their information collection systems and training their clinical staff on these new items. These costs will vary by setting. However, for providers already using an assessment instrument, the added costs would be short term, since the new assessment items will replace existing items. On the benefit side, PAC providers will be better able to compare their performance with that of other providers. ■

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CHAPTER

8

Skilled nursing facility services

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

(The Commission reiterates its previous recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 204.)

Skilled nursing facility services

Chapter summary

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

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 that provided relatively high-quality care at relatively low costs—had high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

Beneficiaries' access to care—Access to SNF services remains stable for most beneficiaries.

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program was stable between 2011 and 2012. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available bed days

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?
- Medicaid trends

increased slightly. The median occupancy rate was 87 percent, indicating some excess capacity for admissions.

- **Volume of services**—Days and admissions per FFS beneficiary declined between 2011 and 2012, consistent with declines in inpatient hospital admissions (a prerequisite for Medicare coverage).

Quality of care—The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, rehospitalizations for potentially avoidable conditions during a beneficiary’s SNF stay, and rehospitalizations within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. We also report on a measure of change in beneficiaries’ functional status during their SNF stay. In 2012, across facilities, the facility mean rate of improvement in one or more activities of daily living (ADLs) during the SNF stay was about 27 percent, and the mean percent of facility stays with no decline in any of the three ADLs was about 89 percent. The average risk-adjusted rates remained essentially unchanged between 2011 and 2012.

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

Medicare payments and providers’ costs—In 2012, the Medicare margin was 13.8 percent, down from 21 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were the result of unwarranted overpayments generated by the industry’s response to Medicare policy changes. For the 13th consecutive year, Medicare margins were above 10 percent. Margins continue to vary greatly across facilities, depending on the share of intensive therapy days, facility size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics (such as share of very old, dual-eligible, and minority beneficiaries). Rather, they reflect shortcomings in the SNF prospective payment system (PPS) that favor SNFs treating patients who receive high levels of rehabilitation therapy. The disparity in margins between for-profit and nonprofit facilities is considerable and reflects differences in patient mix, service provision, and costs. We found 11 percent of freestanding facilities furnished relatively low-cost and high-quality care and had substantial Medicare margins over three consecutive years.

The projected margin for freestanding SNFs in 2014 is 12 percent. This projection does not consider the impact of the sequester, which would lower the margin by about 2 percentage points.

In 2012, the Commission recommended first restructuring the SNF payment system and then rebasing payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF PPS; during the year of revision, payment rates were to be held constant (no update). The Commission discussed three revisions to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics, not services provided. Second, payments for nontherapy ancillary services (such as drugs) should be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy should be added to the PPS. After the PPS is revised, in the following year, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

This multiyear recommendation to revise the PPS in the first year and rebase payments the next year was based on several facts: (1) high and sustained Medicare margins; (2) widely varying costs unrelated to case mix and wages; (3) cost growth well above the market basket in all but one of the past 10 years, reflecting little fiscal pressure from the Medicare program; (4) the ability of many SNFs (almost 900) to have consistently below-average costs and above-average quality of care; (5) the continued ability of the industry to maintain high margins despite changing policies; and (6) in many cases, Medicare Advantage payments to SNFs are considerably lower than the program's FFS payments, suggesting that some facilities are willing to accept rates much lower than FFS payments to treat beneficiaries.

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

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare (private pay and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities decreased slightly between 2012 and 2013. In 2012, the average non-Medicare margin was -2 percent. The average total margin, reflecting all payers and all lines of business, was 1.8 percent. ■

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 2012, almost 1.7 million fee-for-service (FFS) beneficiaries (4.5 percent) used SNF services at least once. Program spending on SNF services was \$28.7 billion in 2012, or about 6 percent of FFS spending. Of all FFS beneficiaries hospitalized in 2012, 20 percent were discharged to SNFs.¹

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least three days.² For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment rate for the first 20 days of care. Beginning with day 21, beneficiaries are responsible for copayments. For 2014, the copayment is \$152 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 as nursing homes (which typically furnish less-

intensive, long-term care services). Thus, a facility that provides skilled care often also furnishes long-term care services that Medicare does not cover. Medicaid accounts for the majority of nursing facility days (see p. 202).

The mix of facilities where beneficiaries seek skilled nursing care has shifted toward freestanding and for-profit facilities (Table 8-1). Between 2006 and 2012, freestanding facilities and for-profit facilities accounted for growing shares of Medicare stays and spending. In 2012, 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 2012, these shares were fairly stable.

Medicare-covered SNF patients typically comprise a small share of a facility’s total patient population but a larger share of the facility’s revenues. In freestanding facilities in 2012, the median Medicare-covered share of total facility days was 11 percent, but 22 percent of facility revenue.

The most frequent hospital conditions of patients referred to SNFs for post-acute care were 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 more likely to be female, disabled, living in an institution, and

**TABLE
8-1**

A growing share of fee-for-service Medicare stays and spending go to freestanding SNFs and for-profit SNFs

Type of SNF	Facilities		Medicare-covered stays		Medicare spending	
	2006	2012	2006	2012	2006	2012
Total number	15,178	14,938	2,454,263	2,396,548	\$19.5 billion	\$26.2 billion
Freestanding	92%	95%	89%	94%	94%	97%
Hospital based	8	5	11	6	6	3
Urban	67	70	79	82	81	84
Rural	33	30	21	18	19	16
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 2012.

dually eligible for both Medicare and Medicaid (Medicare Payment Advisory Commission 2013). SNF users are two times more likely than other beneficiaries to report poor health status and four times more likely to have three to six limitations in their activities of daily living, or ADLs (such as dressing, bathing, and eating), with 49 percent reporting this level of impairment. SNF users are much more likely to be living in an institution (33 percent of SNF users) compared with beneficiaries who have not used a SNF (4 percent). SNF users are more than twice as likely as other beneficiaries to be disabled.

SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay 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 furnish to a patient (such as the amount and type of 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 ADLs. Medicare’s payment system for SNF services is described in Medicare *Payment Basics*, available on the Commission’s website (http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_SNF.pdf). 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 total Medicare spending for SNF care. Although the daily rate is set prospectively, program spending depends on how long the beneficiary stays in the SNF and how much therapy is provided, making these aspects of the PPS similar to a fee schedule.

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. Under this PPS, payments are not proportional to costs. That is, Medicare’s therapy payments rise faster than providers’ therapy cost increases (Garrett and Wissoker 2008, Medicare Payment Advisory Commission 2008). 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 and establish a separate component within the PPS that adjusts payments for the need for NTA services, and implement an outlier payment policy. A revised PPS would raise providers’ payments for medically complex care and lower providers’ payments for high-intensity therapy (Carter et al. 2012, Wissoker and Garrett 2010, Wissoker and Zuckerman 2012). Assuming no other changes in patient mix or care delivery, aggregate payments would increase for hospital-based facilities (27 percent) and nonprofit facilities (8 percent) and decrease slightly for freestanding facilities (1 percent) and for-profit facilities (2 percent), but the effects on individual facilities could vary substantially.

Based on its work examining the billing practices of SNFs, the Department of Health and Human Services (HHS) Office of Inspector General (OIG) recommended that CMS change the way it 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).

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 more accurately pay for NTAs or 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 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 required providers to reassess patients when the provision of therapy changed or stopped (which would, in turn, change assignments to case-mix groups).⁶ Despite these changes, we found

that Medicare continues to overpay for therapy services and disadvantage facilities that treat medically complex patients (Carter et al. 2012).

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 to the SNF PPS (Liu et al. 2007, Maxwell et al. 2003, Urban Institute 2004). Yet, to date, CMS continues to evaluate alternative ways to pay for NTA and therapy services. CMS is expected to issue a report in 2014 reviewing the literature (including the Commission's work) on possible approaches to pay for therapy services. In the next phase, it will select a narrow set of options to further explore. CMS expects this development work to take about two years. Because CMS does not have the authority to establish an outlier policy, rebase payment rates, or update the SNF rates using alternatives to the market basket, congressional action is required to make these changes.

SNFs continue to be adept at modifying their practices in response to changes in policy. By furnishing more intensive rehabilitation therapy (which is more profitable), freestanding facilities increased their payments per day by more than 5 percent despite payment reductions of 1.1 percent in 2010. In 2012, when rates were lowered by 11 percent to correct for an overpayment in 2011, average payments per day declined only 6.3 percent. When CMS lowered its payments for therapy provided to groups of beneficiaries, SNFs shifted their mix of modalities to furnish therapy in one-on-one sessions almost exclusively. In 2012, individual therapy made up over 99 percent of therapy furnished, up from 74 percent in 2006 (Centers for Medicare & Medicaid Services 2012a).

Are Medicare payments adequate in 2014?

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. 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. Most SNFs are freestanding (95 percent), and for-profit facilities make up 70 percent of the industry.

Most beneficiaries live in counties with multiple SNFs. In 2012, over three-quarters of beneficiaries lived in counties with 5 or more SNFs, and the majority of beneficiaries lived in counties with 10 or more. Few beneficiaries (less than 1 percent) lived in a county without a SNF.

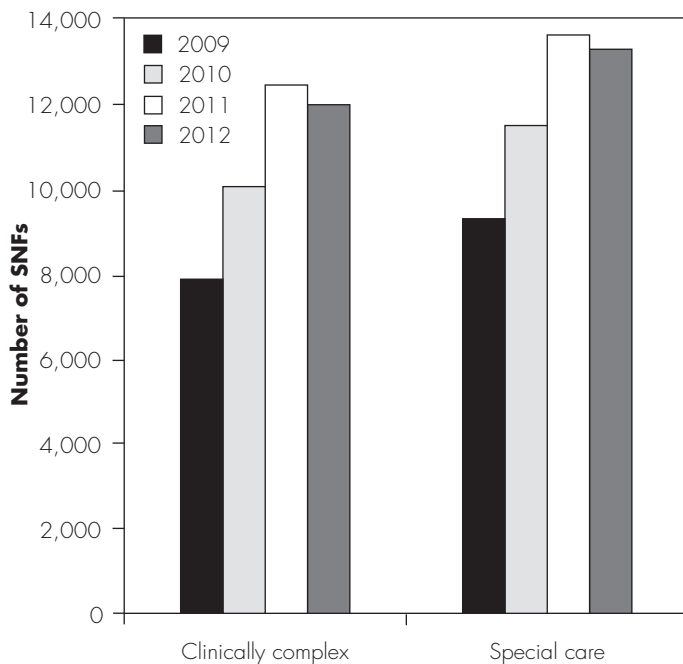
SNF bed days available (defined as days available for occupancy after adjusting for beds temporarily out of service due to, e.g., renovation or patient isolation) in freestanding facilities increased slightly (less than 1 percent) between 2011 and 2012. In 2012, the median occupancy rate was 87 percent in freestanding facilities, indicating some capacity to admit beneficiaries seeking SNF care. Nonprofit and urban facilities had higher occupancy rates than rural and for-profit facilities.

The number of SNFs admitting medically complex patients (those assigned to the clinically complex or special care case-mix groups) decreased slightly between 2011 and 2012 but remained above 2009 levels (Figure 8-1, p. 188). Most SNFs (84 percent) admitted clinically complex cases and almost all (92 percent) admitted special care cases. Hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top quartile) of medically complex patients. Because minority beneficiaries make up a disproportionate share of medically complex admissions to SNFs, they could face impaired access to SNF services.⁷

The larger number of SNFs since 2009 treating medically complex patients reflects the increased rates paid for this care. In the past, many of these patients would have received enough therapy (at least 45 minutes a week) to qualify them for a higher paying therapy group. Although the higher payment rates may increase the willingness of SNFs to admit medically complex patients, the PPS

FIGURE 8-1

Number of SNFs with clinically complex and special care cases decreased slightly from 2011 to 2012 but remain above 2009 levels



Note: SNF (skilled nursing facility). Category based on the case-mix group assignment of the day-5 assessment. The clinically complex category includes patients who have burns, surgical wounds, hemiplegia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a SNF patient. The special care category includes 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.

Source: MedPAC analysis of 2009–2012 Minimum Data Set data from CMS.

continues to disadvantage SNFs that admit high shares of medically complex cases (Wissoker and Zuckerman 2012). In addition, some facilities may avoid admitting medically complex patients if the patients are more likely to require long stays and exhaust their Medicare benefits. If facilities did so, daily payments could decline, depending on the payer.

SNF volume of services was slightly lower in 2012 than in 2011

In 2012, 4.5 percent of FFS beneficiaries used SNF services, a slightly lower share than in 2011. Between 2011 and 2012, 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. Because MA enrollment continues to increase, changes in utilization could reflect slower growth in the number of FFS beneficiaries rather than changes in service use. Admissions per 1,000 FFS beneficiaries declined 4.5 percent, while covered days declined less (–3.8 percent), resulting in a small increase in covered days per admission (Table 8-2). The reductions in per capita SNF admissions are identical to the declines in per FFS admissions to acute care hospitals. An acute care hospital stay of at least three days is a prerequisite for Medicare coverage of SNF services.

Intensity of rehabilitation services unexplained by health status factors

Between 2002 and 2012, the share of days classified into rehabilitation case-mix groups increased from 78 percent to 93 percent.⁸ During the same period, the share of intensive therapy days as a share of total days rose from 29 percent to 77 percent.⁹ Recent changes indicate the continued intensification of therapy provision. Between 2011 and 2012, the share of intensive therapy days increased from 75 percent to 77 percent, and the share of days assigned to the highest rehabilitation case-mix groups (the ultra-high groups) increased from 48 percent to 51 percent. Facilities differed in the amount of intensive therapy they furnished. For-profit facilities and facilities located in urban areas had higher shares of intensive therapy (78 percent for each group) than nonprofit facilities and facilities in rural and frontier areas (71 percent and 68 percent, respectively).

For the period 2005 to 2012, 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 2005, the average SNF user in 2012 had more independence (as measured by a higher modified Barthel score) and was younger (by two years). Over a more recent period (between 2008 and 2012), the shares of SNF users requiring the most help with the nine individual activities of daily living decreased (an average of 3 percentage points).¹⁰ Although more patients may be able to tolerate the highest levels of therapy, the increase in the most intensive therapy days (18 percent) far outpaces the changes in patient characteristics. Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF sector. For example, between 2008 and 2012, hospital lengths of stay decreased 9 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

**TABLE
8-2**

SNF service use declined between 2011 and 2012

Volume measure	2006	2008	2010	2011	2012	Percent change 2011-2012
Covered admissions per 1,000 FFS beneficiaries	72	73	71.5	71.2	68	-4.5%
Covered days (in thousands)	1,892	1,977	1,938	1,935	1,861	-3.8
Covered days per admission	26.3	27.0	27.1	27.2	27.4	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: Data from CMS, Office of Information Products and Data Analytics 2012.

Quality of care: Small improvements between 2011 and 2012

The Commission tracks three indicators of SNF quality: risk-adjusted rates of community discharge, rehospitalizations for potentially avoidable conditions during beneficiaries' SNF stay, and rehospitalizations within 30 days after discharge from the SNF. All three measures showed small improvement between 2011 and 2012. This year, we also report on the change in beneficiaries' functional status during their SNF stays. These risk-adjusted measures of functional change showed considerable variation across facilities and remained relatively stable between 2011 and 2012.

Rehospitalization and community discharge rates show small improvements after a decade of almost no change

Between 2000 and 2010, both the rate of rehospitalization for SNF patients with any of five potentially avoidable conditions and the rate of discharge to the community remained almost the same. Beginning with data for 2011, we revised the rehospitalization measure to better reflect potentially avoidable readmissions. In the past, the

measure included rehospitalized patients with any of five conditions (congestive heart failure, electrolyte imbalance/dehydration, respiratory infection, sepsis, urinary tract infection/kidney infection) listed among the patient's primary or secondary diagnoses. Upon further review, the principal reason for the hospital readmission may have been an unrelated or unavoidable condition, so we shifted to counting potentially avoidable readmissions using only the primary diagnosis for the hospital readmission. We also expanded the list of conditions that could result in a potentially avoidable readmission, though the original five conditions constitute the majority of the readmissions (see text box, p. 190). This expanded measure is consistent with the Commission's preference to track potentially preventable readmissions (not all-cause measures) across all admissions as a quality metric.

Between 2011 and 2012, SNF quality on average improved by a small amount (Table 8-3). Risk-adjusted community discharge rates increased from 28.8 percent to 30.6 percent and potentially avoidable rehospitalization rates (while the beneficiary was still a SNF patient) declined between 2011 and 2012 from 12.5 percent to 11.7 percent.

**TABLE
8-3**

Small improvements were made in risk-adjusted rates of community discharge and potentially avoidable rehospitalization

Measure	2011	2012
Discharged to the community	28.8%	30.6%
Potentially avoidable rehospitalizations during SNF stay	12.5	11.7
Potentially avoidable rehospitalizations during 30 days after discharge from SNF	5.9	5.8
Combined during and after SNF stay rehospitalization rate	15.6	14.9

Note: SNF (skilled nursing facility). High rates of discharge to community indicate better quality. High rehospitalization rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 25 or more stays. Hospital-based units exclude swing beds.

Source: Analysis of fiscal year 2011 and fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

Revised measure of rehospitalizations

The rehospitalization measure was revised in two ways to better demonstrate that the readmission was potentially avoidable. First, only the primary reason for the rehospitalization (as recorded by the hospital) is counted in calculating a facility's readmission rate. Second, the list of conditions was expanded after examining other definitions of readmissions for long-term nursing home residents, ambulatory care-sensitive conditions, and planned readmissions (Carter 2003, Halfon et al. 2006, Horwitz et al. 2011, Jencks et al. 2009, Spector et al. 2013, Walker et al. 2009). Conditions were included in the measure when the primary diagnosis for readmission could reasonably be expected to be managed in the skilled nursing facility (SNF) setting or when the SNF could be held accountable for poor care management—for instance, readmissions for a disease management error such as anticoagulation or diabetic complications. We excluded readmissions from the definition that are likely to be planned (e.g., inpatient chemotherapy or radiation therapy). While readmissions are potentially avoidable for long-stay nursing home residents with chronic conditions (such as anemia or angina), in the case of post-acute SNF admissions, these patients were likely to have been discharged too soon from the hospital for the condition to have been adequately stabilized. Hence, these were not included in the list attributable to the SNF.

The measure now includes the original five conditions (congestive heart failure, electrolyte imbalance/

dehydration, respiratory infection, sepsis, and urinary tract or kidney infection) plus eight new ones: hypoglycemia and diabetic complications, anticoagulant complications, fractures and musculoskeletal injuries, acute delirium, adverse drug reactions, cellulitis/wound infection, pressure ulcers, and blood pressure management (Kramer et al. 2014). The original five conditions account for three quartiles of potentially avoidable rehospitalizations included in the new measure. Using the principal reason for the hospitalization accounted for the majority of the difference between the old and revised measure. The readmission rate across all beneficiaries for any reason (i.e., all causes) in 2011 was 24.4 percent, and the potentially avoidable conditions accounted for almost half of them.

The observed facility rates were risk adjusted for medical comorbidity, cognitive comorbidity, mental health comorbidity, function, and clinical conditions (e.g., surgical wounds, shortness of breath). The rates reported are the average risk-adjusted rehospitalization rates for all facilities with 25 or more admissions. This risk adjustment relies on information contained in the Minimum Data Set. 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).¹¹ ■

Last year, the Commission began tracking the rate of readmission for beneficiaries discharged from a SNF and readmitted to a hospital within 30 days. This performance measure gives information about how well facilities prepare beneficiaries and their caregivers for safe and appropriate transitions to the next health care setting (or home). The risk-adjusted rehospitalization rate for beneficiaries during the 30 days after discharge from the SNF also declined slightly (from 5.9 percent to 5.8 percent). The rate of rehospitalization during the SNF stay or within 30 days of SNF discharge declined between 2011 and 2012 from 15.6 percent to 14.9 percent, largely due to declines in rehospitalization during the SNF stay.¹²

The lower rehospitalization rates may reflect several trends. First, hospitals are subject to readmission penalties and are seeking SNFs that can work with them to lower their own readmission rates. Some SNFs are also interested in securing volume from MA plans and accountable care organizations by positioning themselves as preferred post-acute care providers. To do that, SNFs need to demonstrate improvements in their readmission rates. One study found that hospitals with stronger relationships to SNFs (as measured by the concentration of a SNF's admissions from the hospital) had lower readmission rates, especially for readmissions shortly after discharge from the hospital (Rahman et al. 2013).

In addition, industry associations such as the American Health Care Association (AHCA) are emphasizing reduction of readmissions through quality initiatives, aiming to lower readmission rates 15 percent by 2015. Using a 30-day all-cause measure across all patients (not just Medicare), AHCA members reported lowering their average readmission rate between October 2011 and December 2012 from 18.2 percent to 17.9 percent (American Health Care Association 2013).

When the separate rehospitalization rates are considered together, they indicate that 15 percent of beneficiaries were rehospitalized for the 13 conditions that were considered potentially avoidable. This finding suggests there are opportunities for SNFs to improve the care they provide and the care furnished by others after discharge. Some rehospitalizations during the period after discharge will result from inadequate care provided by physicians and the patients' caregivers, but SNFs should make careful arrangements to minimize potentially avoidable rehospitalizations. Holding SNFs accountable for rehospitalizations during a period after discharge is identical to hospitals being held responsible for readmissions under the Hospital Readmissions Reduction Program. Considerable program spending is made for hospitalizations that could have been avoided.

Tracking facility performance in managing functional status changes

Most beneficiaries receive rehabilitation therapy, and the amount of therapy furnished to them has steadily increased over time. To see how facilities compare in their ability to improve or maintain the functional status of the beneficiaries they treat, we worked with a contractor to develop a risk-adjusted measure of functional change (Kramer et al. 2014). We wanted a measure that reflects whether patients improved or did not decline (i.e., at least maintained) in their functional status during the SNF stay, given their functional status at admission and how much improvement they would be expected to make. Some patients, such as relatively healthy 65-year-olds recovering from an elective knee replacement, are likely to improve across several ADLs during their SNF stay. Other patients, such as those who are 85 years old and suffering from a progressive neurological disease, may have poor prognoses (e.g., they are unlikely to walk without extensive assistance but could attain some independence and enhanced quality of life through improved bed mobility). In fact, for certain patients who are not expected to improve across several ADLs, maintaining their function may constitute a realistic outcome.

To develop risk-adjusted measures of functional change, our contractor designed a classification system to categorize patients into 22 groups defined by patients' functional ability at admission and rehabilitation prognoses during the SNF stay (see text box, pp.192–193). Functional ability at admission was defined using the support a patient required to perform three mobility-related ADLs at admission: bed mobility, transfer, and ambulation. Rehabilitation prognosis was based on self-performance of two other ADLs, the ability to eat and dress. These two ADLs affect the likelihood of improving mobility because they encompass cognitive functioning as well as other dimensions of physical functioning that facilitate rehabilitation. The classification system acts as the risk adjustment, differentiating patients based on their expected ability to independently perform the three mobility-related ADLs.

Two observed-change measures were created to gauge the change in functional status between the first and last assessments for each of the three mobility-related ADLs: the share of a facility's patient stays that improved and the share of patient stays with no decline in functional status.

We also defined a facility-level composite measure of mobility improvement calculated as the facility average of the three ADL improvement rates (weighted by the number of stays with the potential for improvement in each ADL). Across all stays (not the average facility rate), 43 percent of stays improved in one or more ADLs, 26 percent improved in two or more ADLs, and 14 percent improved in all three ADLs. About 48 percent of patients had no measureable change in mobility during the stay. The share of patients who declined was small for each of the three mobility measures (less than 5 percent in each ADL), so we developed a composite measure of no decline in mobility when all three ADLs were maintained or improved. Across all stays (not the facility average), about 91 percent of stays had no decline in mobility. Thus, across the three mobility measures, patients declined or had no measureable change in function during the majority (57 percent) of SNF stays. This finding supports the need for both an improvement measure and a measure of functional maintenance.

Risk-adjusted rates were calculated by comparing a facility's observed rates with its expected rates based on the mix of patients in the 22 functional outcome groups. For each of the 22 groups, an expected rate of achieving each outcome was based on national average rates. The facility's risk-adjusted rate for each outcome was calculated by adjusting the observed rates by the expected rates, using each facility's mix of patients.

Measuring change in functional status for beneficiaries treated in SNFs

The measures of functional change are based on patient assessment information collected on each patient admitted to a skilled nursing facility (SNF) or nursing facility and recorded periodically throughout the Medicare-covered stay. Each stay's initial assessment was used to assign the patient to one of 22 case-mix groups using three measures of mobility (bed mobility, transfer, and ambulation) and two additional measures (eating and dressing) to capture the patient's potential to change on each of the three focal mobility measures. Change in the amount of support needed in the three mobility measures was used to gauge each patient's functional performance across the SNF stay. For example, a patient's functional status improved if the patient went from needing a two-person support at admission to a one-person support at discharge. This scale was used instead of the self-performance information because it allows for more discrimination among patients' function and is less subjective. Although we could not evaluate the accuracy or subjectivity of the activities of daily living (ADLs), or the extent to which payment incentives influenced the recording of ADLs, the use of the more objective support scale helped counter the limitations of the functional measures in the Minimum Data Set (MDS). That said, the eating and dressing ADLs were gauged using the self-performance scale because the range in the amount of support needed to conduct these activities is limited (e.g., almost no one required two-person support for either activity).

To calculate facility-level risk-adjusted outcome measures for functional change, we calculated the observed rates of stays with improvement in each mobility measure (e.g., the share of stays with

improvement in bed mobility) and the observed rates of stays with no decline in each mobility measure between the first and last assessments (e.g., the share of stays with no decline in bed mobility). Patients at the highest functional ability were excluded from the improvement calculation because these patients could not improve—they were already at the top of the scale at admission. Conversely, if a patient was unable to move in bed, transfer, or ambulate at admission, they were excluded from the no-decline calculations.

We calculated two composite mobility measures. To calculate the stay-level composite measure of stays with no decline, each patient's changes in the three mobility-related functions were examined to assess whether the patient maintained or improved in all three mobility measures. The composite measure of stays with no decline is calculated by dividing the number of stays with no decline in any one of three measures by the number of all stays. To calculate a facility-level observed composite measure of mobility improvement, the share of stays with improvement in each of the three mobility ADLs (bed mobility, transfer, and ambulation) was computed and then averaged across the three ADLs, weighted by the number of stays included in each measure. The composite measure of improvement thus includes patients who improved in one or more of the three ADLs. The facility-expected rate for each outcome measure is calculated by averaging the expected outcomes, where the expected outcome for a stay is the national proportion of stays with the outcome for the patients' case-mix groups. The facility's observed rate was essentially divided by the facility's expected rate to calculate the facility's risk-adjusted rate.

(continued next page)

Across all eligible facilities, the mean facility rate of improvement in one or more mobility ADLs during the SNF stay in 2012 was 27.4 percent, and the mean percent of facility stays with no decline in any of the three ADLs was 88.9 percent of stays (Table 8-4). These risk-adjusted rates consider the likelihood that a patient will change given the functional ability at admission. Thus, a facility that admits patients with worse prognoses will have a

lower expected rate of achieving these outcomes, which will be reflected in the risk-adjusted rate. The average risk-adjusted rates remained essentially unchanged between 2011 and 2012, indicating that even if case mix changed, SNF performance did not. We will continue to track these measures to see if there are longer term trends over time.

These analyses uncovered two problems with the current collection of patient assessment information that

Measuring change in functional status for beneficiaries treated in SNFs (cont.)

The magnitude of the change was not calculated for two reasons. First, the MDS data do not collect highly disaggregated data on functional ability. Patients are assigned to one of five categories of functional ability ranging from independent (no set-up or physical help is needed) to the most dependent. Therefore, fine differentiation between patients is not possible. Second, most patients did not change more than one “step” (e.g., they required two-person assistance when they were first assessed and required one-person assistance—the next step in improvement—when they were last assessed). For bed mobility and transfer, less than 1 percent of SNF patients declined two or more

steps during the SNF stay, and only about 7 percent of SNF patients improved two or more steps during the SNF stay. At the facility level, the composite measures do, however, capture whether a facility has stays during which patients improve in more than one ADL. SNF stays with improvement in two ADLs will count in each ADL rate calculation; in contrast, a facility with improvement in a single ADL will have that improvement count in only one of the three rate calculations. Thus, facilities with more patients with improvements in two or more ADLs will have higher composite rates of improvement than facilities with improvement in only one ADL. ■

undermine measurement of changes in functional status. First, to compare providers’ performance in improving or maintaining their patients’ functional status, assessment information needs to be collected at admission and preferably on the same ordinal day of the stay. But current Medicare rules give providers discretion about when they conduct their first assessments (the 5-day assessments). Furthermore, the first assessment is most frequently done on day 8, well into the SNF stay and after some change in functional status may have occurred. Thus, depending on when assessments are done, facilities can look worse or better than other facilities even though they treat identical patients. The second problem is that a sizable share of stays (13.7 percent) did not have two assessments (even though an end or discharge assessment has been required since October 1, 2010). To accurately measure facilities’ performance, we need information about all patients’ functional status at admission (or close to it) and discharge

(including assessments for patients who remain in the facility but end their Medicare-covered stay). Without it, Medicare cannot assess the efficacy of its spending.

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-fourth of facilities had risk-adjusted community discharge rates lower than 23.3 percent, whereas the best performing fourth of facilities had rates of 38.4 percent or higher (Table 8-5, p. 194). Rehospitalization rates varied even more—the worst performing quartile had rates of potentially avoidable readmissions at or above 14.7 percent whereas the best quarter had rates at or below 8.4 percent. Finally, rates of rehospitalization in the 30 days after discharge from the SNF varied most—more than twofold between the 25th and 75th percentiles. The

**TABLE
8-4**

Mean risk-adjusted functional outcomes in SNFs were stable between 2011 and 2012

Composite measure	2011	2012
Rate of improvement in one or more mobility ADLs	27.1%	27.4%
Rate of no decline in mobility	88.7	88.9

Note: SNF (skilled nursing facility), ADL (activity of daily living). The rate of 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. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of no decline in mobility is the share 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. Hospital-based facilities exclude swing bed units.

Source: Analysis of fiscal year 2011 and fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

**TABLE
8-5**

SNF quality measures varied considerably across SNFs, 2012

Risk-adjusted rate

Quality measure	Mean	Minimum	25th percentile	75th percentile	Maximum
Discharged to the community	30.6%	0.0%	23.3%	38.4%	70.8%
Potentially avoidable rehospitalizations during SNF stay	11.7	0.0	8.4	14.7	43.2
Potentially avoidable rehospitalizations within 30 days after discharge from SNF	5.8	0.0	3.7	7.7	28.3
Rate of mobility improvement in one or more mobility ADLs	27.4	0.0	19.9	33.9	100.0
Rate of no decline in mobility	88.9	31.9	84.7	94.3	100.0

Note: SNF (skilled nursing facility), ADL (activity of daily living). High rates of discharge to community indicate better quality. High rehospitalization rates indicate worse quality. The rate of 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. Stays with improvement in one, two, or three ADLs are counted in the improvement measure. The rate of no decline in mobility is the share 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. Hospital-based facilities exclude swing beds.

Source: Analysis of fiscal year 2012 Minimum Data Set data (Kramer et al. 2014).

amount of variation across and within the groups suggests considerable room for improvement, all else being equal. For the average mobility improvement measure, the rate at the 75th percentile was 33.9 percent compared with 19.9 percent at the 25th percentile. There was less variation across facilities in the no-decline measure.

We controlled for facility and geographic characteristics (with multiple regression models) and found that, compared with freestanding facilities, hospital-based facilities had community discharge rates that were higher by 4.8 percentage points and readmission rates that were lower by 2.8 percentage points. Nonprofit facilities had moderately higher community discharge rates (by 1.2 percentage points) and lower readmission rates (by 1.2 percentage points) than for-profit facilities. Compared with urban facilities, rural SNFs had lower community discharge rates (by 2.2 percentage points).

Across the quality measures, there were not consistent differences by facility type or location, but there were similar patterns across the measures by ownership. Compared with the average freestanding facility, the average hospital-based facility had higher rates of community discharge, lower rehospitalizations during SNF stays, and higher rates of stays with no decline in mobility, but they had lower rates of functional improvement. The average hospital-based facility's rate of rehospitalization after discharge from the SNF was comparable with the average freestanding facility's rate. The average rural facility had similarly uneven performance relative to the average urban facility: a better rate of rehospitalization

after discharge from the SNF and improvements in mobility but worse rates of community discharge and no decline in mobility. In contrast to these mixed performances, the average nonprofit facility had better rates for all five measures compared with the average for-profit facility.

Providers' access to capital: Lending in 2013

A vast majority of SNFs operate within nursing homes; therefore, in assessing 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 use their Medicare payments to subsidize low payments from other payers. Lenders increasingly focus on a facility's outcomes, the quality of the management team, and the stability of the company's cash flow and rely less on using Medicare patient mix as a metric of a facility's financial health. They want to see that a facility's management has depth, understands its operations, and can track and communicate its outcome measures with potential partners. For example, as Medicare's patient mix shifts from FFS to MA, lenders look at a facility's strategy to address the anticipated reductions in length of stay. The diversification of the borrower's risk is also considered, such as whether its operations span multiple states (some lenders avoid states with low Medicaid payments) and other businesses (such as hospice and home health care).

The Department of Housing and Urban Development (HUD) is a key source of lending for nursing homes. Since 2008, HUD's lending dramatically increased as a result

of an overhaul of its federally insured mortgage program for nursing homes under Section 232/222(f).¹³ Between 2010 and 2013, the number of projects financed more than doubled (to 766), and the insured amounts increased 76 percent to \$5.8 billion in 2013 (Department of Housing and Urban Development 2013, Department of Housing and Urban Development 2012). The Federal Housing Administration plays an increasing role in securing bank loans, which lowers nursing homes' financing costs (Pruitt 2013a).

Analysts reported the sector's need for capital may increase as providers ready themselves for evolving health care delivery systems and the accompanying IT requirements to track outcomes. Yet they note the bifurcation of the industry into facilities concentrated on treating high rehabilitation-acuity patients and those that are not (Andrews 2013b, Monroe 2013). Operators that can adjust to changes in their financial environment and demonstrate their good outcomes are likely to succeed and have access to capital. Hospitals increasingly want to meet with facility operators to discuss readmission rates and ways to lower them. The providers needing capital to renovate space and adopt information technology may look less attractive to a lender than SNFs that already have taken these steps. Credit may be more expensive for borrowers without a solid performance record (both financial and quality of care), and overall diligence is more thorough than before the financial crisis of 2008 (Andrews 2013a).

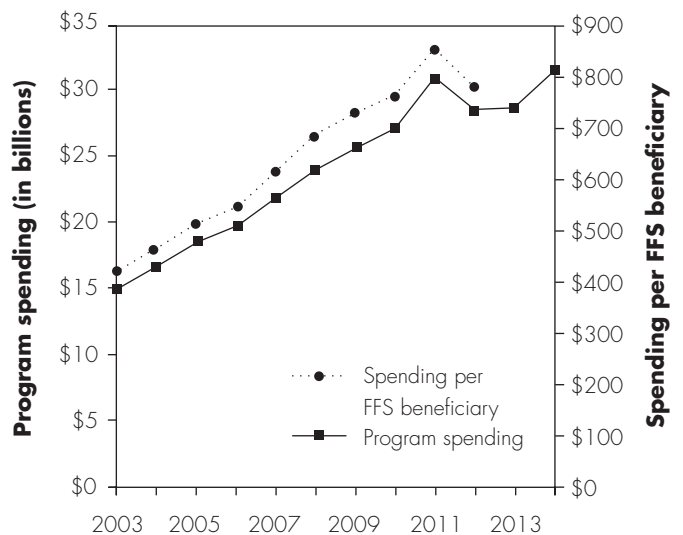
Market analysts and lenders we spoke with reported that capital is generally available and expected to continue, especially for borrowers with good financial, management, and quality performances. Analysts note that only a small number of lenders understand the risks of the "nursing home space." These lenders are highly selective about the facilities they lend to. Other lenders are more reluctant to enter this market, reflecting a general unease about across-the-board cuts in spending (from sequestration) or possible cuts to Medicare's payments to some sectors to pay for changes to the sustainable growth rate formula for paying physicians (Pruitt 2013b). This reluctance is not a statement about the adequacy of Medicare's payments to SNFs.

Medicare payments and providers' costs: Medicare margins remained high in 2012

In 2012, the Medicare margin was 13.8 percent, down from 21 percent in 2011, a year of exceptionally high Medicare margins. The 2011 margins were the result of unwarranted overpayments generated by the industry's response to Medicare policy changes. For the 13th

FIGURE 8-2

Program spending for SNF care slowed after overpayments taken back but estimated to return to previous growth rate



Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year spending is shown. Data for 2013 and 2014 are estimates.

Source: Office of the Actuary 2013a.

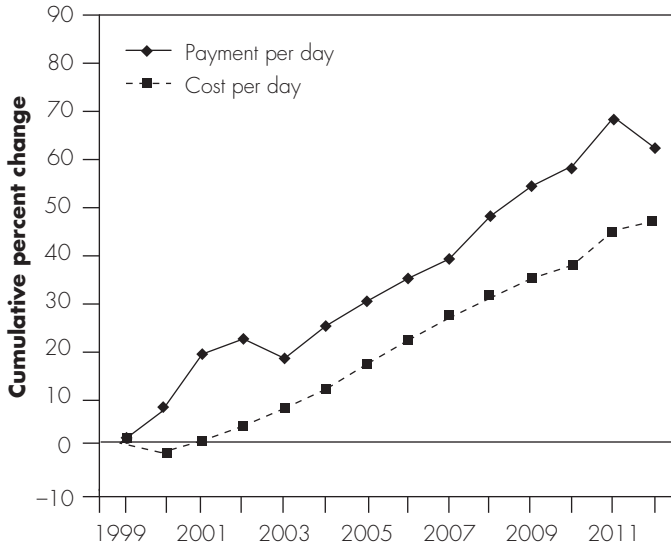
consecutive year, Medicare margins were above 10 percent. Margins continue to be highly variable, depending on the facilities' share of intensive therapy days, size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics (such as share of very old, dual-eligible, and minority beneficiaries). Differences by ownership were considerable, with for-profit facilities having much higher Medicare margins than nonprofit facilities. We found about 11 percent of freestanding facilities furnished relatively low-cost, high-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.

Trends in spending and cost growth

In 2013, the Office of the Actuary projects program FFS spending for SNF services to be almost \$29 billion, reflecting slower growth than in prior years (Figure 8-2). For fiscal year 2014, spending growth is estimated to regain its prior pace, with spending estimated to be \$31.4 billion. In 2011, payments were unusually high because the rates included an adjustment for implementation of the new case-mix classification system. Once 2011

FIGURE 8-3

Cumulative growth in Medicare cost and payments per SNF day, 1999-2012



Note: SNF (skilled nursing facility).

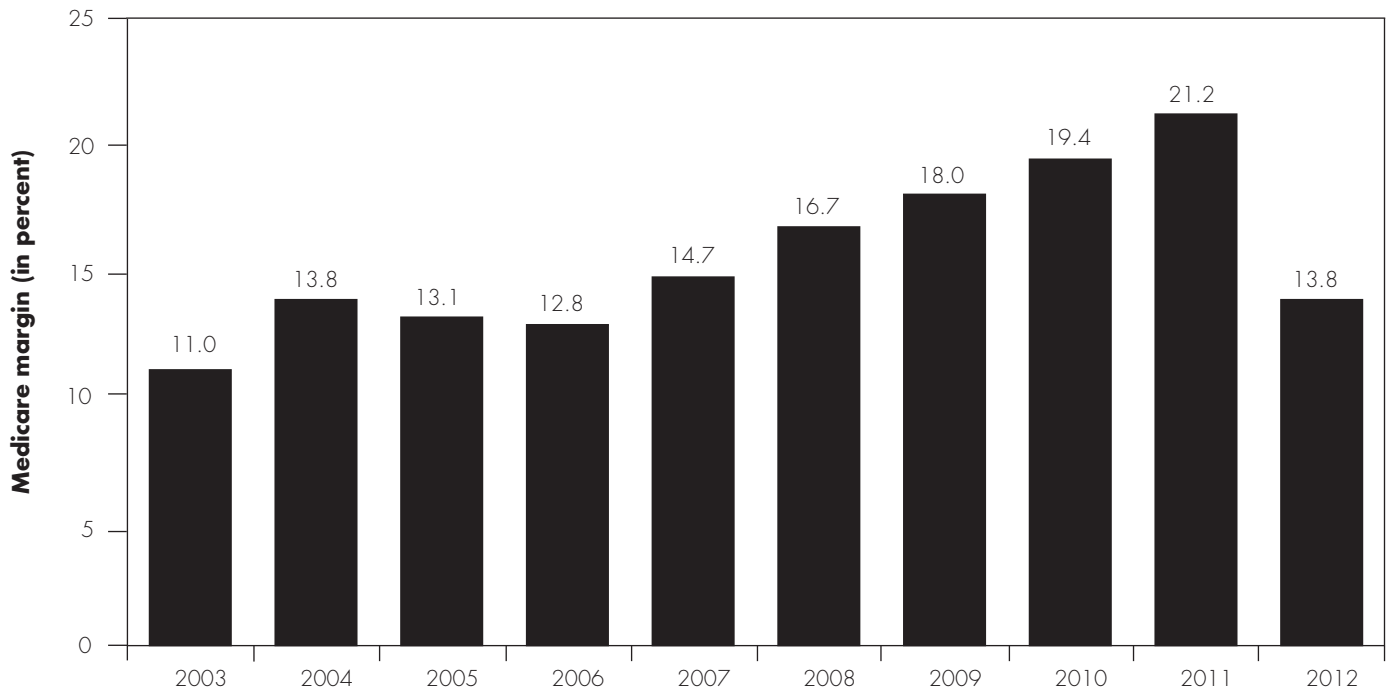
Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 2000 to 2012.

data were available, it was clear the adjustment was too large and the resulting payment rates had been set too high. CMS revised the adjustment downward in 2012, lowering payments and putting spending back in line with previous trends. After the reductions, 2012 rates were 3.7 percent higher than those in 2010, and program spending increased 6 percent over this two-year period. On a per FFS beneficiary basis, spending in 2012 was \$782, a decline from the high spending in 2011 (\$856) but a 3 percent increase over 2010. Spending per Medicare SNF user increased slightly more over this two-year period (3.2 percent), reflecting the small increase in length of stay.

From 1999 to 2012, the cumulative increase in payments per day outpaced the increases in cost per day (Figure 8-3). Costs per day rose 47 percent during this period, while payments grew 62 percent. The large increase in payments reflects the intensification of the provision of therapy during this period. On the cost side, except for 2011 to 2012, cost increases were larger than the market basket updates. Between 2011 and 2012, when Medicare lowered its rates by 11 percent to correct for the previous year's overpayments, providers held their cost growth to 1.7 percent (below the market basket).

FIGURE 8-4

Freestanding SNF Medicare margins remain high despite reductions in payments



Note: SNF (skilled nursing facility).

Source: MedPAC analysis of freestanding SNF cost reports from 2003 to 2012.

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. Total margins are presented as context for the Commission's update recommendation.

Despite recent reductions to SNF payments, Medicare margins remained high in 2012 (13.8 percent) (Figure 8-4). In 2011, the Medicare margin was 21.2 percent, reflecting the large increase in payments with the implementation of the new case-mix groups and an incorrect adjustment factor. Once this adjustment factor was corrected in October 2011, payments were reduced and margins were lower than in the previous year. The 2012 margin is lower than the 2009 margin in part because current law requires market basket increases to be offset by a productivity adjustment beginning in 2011. Though lower than in recent years, the 2012 margin is the 13th year of Medicare margins above 10 percent.

In 2012, hospital-based facilities (3 percent of facilities) continued to have extremely negative Medicare margins (-62 percent), in part due to their higher cost per day. Prior work found that routine costs in hospital-based SNFs were higher, reflecting more staffing, more 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 admissions. As a result, SNFs can contribute to the bottom line financial performance of the hospitals. Prior work found that hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs. Deciding to retain or close a hospital-based SNF reflects a hospital's larger strategy about how to best use its beds. Many hospitals closed their SNFs during the past decade, noting the large losses and figuring the beds and space could be better used in other ways (Medicare Payment Advisory Commission 2007). Other hospitals kept their units open, citing the savings on the acute care business, maintaining continuity of care, and, in areas with few alternatives, ensuring access to post-acute care.

**TABLE
8-6**

Variation in freestanding SNF Medicare margins reflect mix of cases and cost per day, 2012

Subgroup	Medicare margin
All	13.8%
For profit	16.1
Nonprofit	5.4
Rural	12.9
Urban	14
Frontier	7.3
25th percentile	4.8
75th percentile	23
Intensive therapy: High share of days	15.7
Intensive therapy: Low share of days	7.7
Medically complex: High share of days	11.1
Medically complex: Low share of days	14.6
Small (20-50 beds)	4.6
Large (100-199 beds)	15.3
Cost per day: High	3.5
Cost per day: Low	26.5
Cost per discharge: High	11.3
Cost per discharge: Low	15.4
Minority: High share of beneficiaries	18.4
Minority: Low share of beneficiaries	9.4
Dual eligible: High share of beneficiaries	9.0
Dual eligible: Low share of beneficiaries	16.5
Very old: High share of beneficiaries	19.7
Very old: Low share of beneficiaries	7.9

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. "Frontier" refers to SNFs located in counties with six or fewer people per square mile. "Very old" is defined as 85 years or older.

Source: MedPAC analysis of 2012 freestanding SNF Medicare cost reports.

High and widely varying SNF Medicare margins indicate reforms to the PPS are still needed

The persistently high Medicare margins and the wide variation by mix of patients indicate that the PPS needs to be revised so that payments match patient characteristics, not the services furnished to them. One-quarter of SNFs had Medicare margins of 23 percent or higher, while one-quarter of SNFs had margins of 4.8 percent or lower (Table 8-6). Facilities with the highest SNF margins

**TABLE
8-7**

Cost and revenue differences explain variation in Medicare margins for freestanding SNFs in 2012

Characteristic	Top margin quartile	Bottom margin quartile	Ratio of top margin quartile to bottom margin quartile
Cost measures			
Standardized cost per day	\$247	\$355	0.7
Standardized cost per discharge	\$11,389	\$13,268	0.9
Standardized ancillary cost per day	\$112	\$152	0.7
Standardized routine cost per day	\$136	\$199	0.7
Average daily census (patients)	89	70	1.3
Average length of stay (days)	47	36	1.3
Revenue measures			
Medicare revenue per day	\$467	\$421	1.1
Medicare revenue per discharge	\$22,562	\$15,633	1.4
Share of days in intensive therapy	79%	70%	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	1.37	1.28	1.1
Dual-eligible share of beneficiaries	40%	26%	1.5
Percent minority beneficiaries	12%	4%	3
Percent very old beneficiaries	30%	36%	0.8
Medicaid share of days	65%	59%	1.1
Facility mix			
Percent for profit	89%	59%	N/A
Percent urban	77%	68%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). Top margin quartile SNFs (n=3,136) were in the top 25 percent of the distribution of Medicare margins. Bottom margin quartile SNFs (n=3,137) were in the bottom 25 percent of the distribution of Medicare margins. "Standardized cost per day" is 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" is defined as 85 years or older. Values shown are medians for the quartile.

Source: MedPAC analysis of freestanding 2012 SNF cost reports.

had high shares of intensive rehabilitation therapy and low shares of medically complex days, were larger, and had lower cost per day. The SNF Medicare margin for facilities with the lowest cost per day was 26.5 percent, while the margin for facilities with the highest cost per day was 3.5 percent. The disparity between for-profit and nonprofit facilities is considerable and reflects differences in case mix, service provision, and costs. In aggregate, the Medicare margin was higher for facilities with higher shares of minority or very old beneficiaries but lower for facilities with higher shares of dual-eligible beneficiaries compared with facilities with low shares.

Comparing freestanding facilities with the highest and lowest Medicare margins (those in the top and bottom 25th percentiles of Medicare margins), we found cost and revenue differences that underscore the need to revise the PPS and more closely align payments with costs. High-margin SNFs had lower daily costs (by 30 percent, after adjusting for differences in wages and case mix) and higher revenues (by 11 percent) associated with intensive therapy case-mix groups (Table 8-7). Facilities with the highest margins had higher shares of beneficiaries who were dually eligible and minority than facilities with lowest margins.¹⁴ 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.¹⁵

These differences in financial performance underscore the need to revise the PPS. Even after CMS expanded the number of medically complex case-mix groups and shifted spending away from therapy care, the PPS continues to result in higher Medicare margins for facilities furnishing intensive therapy and treating few medically complex patients (Carter et al. 2012). 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 furnished (see discussion, p. 186).

Ownership of low-margin and high-margin facilities did not mirror the industry mix. Although for-profit facilities make up 70 percent of SNFs, they composed a smaller share (58 percent) of the low-margin facilities and a higher share (89 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 \$278 to \$314 per day after differences in wages and case mix were taken into account (Table 8-8). However, there was more variation 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, p. 201). 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. To be included in the relatively efficient

TABLE 8-8

Freestanding SNFs' standardized costs per day vary within and across groups, 2012

Subgroup of SNF	Median	Within-group variation (ratio of 75th to 25th percentile)
All freestanding	\$291	1.24
Location		
Rural	289	1.23
Urban	292	1.24
Ownership		
Nonprofit	314	1.25
For profit	285	1.22
Share of dual-eligible beneficiaries		
Low share	312	1.26
High share	279	1.24
Minority share		
Low share	298	1.26
High share	278	1.24
Very old beneficiaries (over 85 yrs old)		
Low share	284	1.22
High share	305	1.26

Note: SNF (skilled nursing facility). Low share includes facilities in the bottom 25th percentile. High share includes facilities in the highest 25th percentile. Standardized costs account for differences in wages and case mix.

Source: MedPAC analysis of freestanding SNF Medicare cost reports 2012 and Medicare denominator file.

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, 11 percent of SNFs provided relatively low-cost, high-quality care.

Our analyses found that SNFs can have relatively low costs and provide good quality of care while maintaining high margins (Table 8-9, p. 200). Compared with the national average, in 2011, relatively efficient SNFs had community discharge rates that were 18 percent higher and rehospitalization rates that were 12 percent lower. In 2011 and 2012, costs per day were 4 percent lower than the average. We did not find significant differences between relatively efficient and other SNFs in terms of

**TABLE
8-9**

Financial performance of relatively efficient SNFs is a combination of lower cost per day and higher revenues per day

Performance measure	Type of SNF	
	Relatively efficient	Other
Share of SNFs	11%	89%
Performance in 2011		
Relative:*		
Community discharge rate	1.18	0.97
Rehospitalization rate	0.88	1.02
Cost per day	0.96	1.01
Medicare margin	25.0%	22.7%
Performance in 2012		
Community discharge rate*	1.16	0.97
Rehospitalization rate*	0.89	1.02
Cost per day	\$280	\$292
Medicare margin	17.3%	15.0%
Facility case-mix index	1.36	1.35
Medicare revenue per day	\$463	\$453
Medicare average length of stay	33 days	39 days
Share intensive therapy days	76%	77%
Share medically complex days	0.6	0.6
Total margin	3.5%	2.3%
Medicaid share of facility days	58%	62%
Trends in cost and revenue growth 2005-2010		
Share of facilities with low growth in cost per day	17%	83%
Share of facilities with high growth in revenue per day	12%	88%

Note: SNF (skilled nursing facility). The number of freestanding facilities included in the analysis was 7,814. Efficient SNFs were defined by their cost per day (2008-2010) and two quality measures (community discharge and rehospitalization rates) for 2008 through September 2010. 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 include days classified into the ultra-high and very high case-mix groups. Table shows the medians for the measure.
*Measures are relative to the national average.

Source: MedPAC analysis of quality measures for 2008 to 2012 and Medicare cost report data for 2005 to 2012.

occupancy rates, size of facility, or case-mix complexity. Consistent with previous years' findings, efficient SNFs furnished less intensive therapy compared with other SNFs. Relatively efficient facilities were more likely to have experienced low cost growth: Efficient SNFs were 11 percent of all SNFs but made up 17 percent of SNFs with the lowest cost growth (bottom third of the distribution). They were slightly more likely to have had high revenue growth (were in the top third of the distribution of growth in revenue per day) relative to other facilities.

We recognize that a SNF may appear to be efficient in providing its own care 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 raising total Medicare program spending. In the future, we may compare providers' costs for the episode of care. Another refinement may be to consider changes in the functional status of the patients SNFs treat as a quality measure in defining efficient providers.

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.

The cost per day 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 rehospitalization for patients with any of five conditions (congestive heart failure, respiratory infection, urinary tract and kidney infections, sepsis, and electrolyte imbalance) within 100 days of hospital discharge. Quality measures were calculated for all facilities with at least 25 stays. We used quality data from January 2008 through September 2010 to identify facilities with relatively high quality and identified facilities with relatively low cost using cost report data from 2008 through 2010.

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, we avoided having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. We used quality and cost performance over three years to categorize SNFs into relatively efficient and other groups; once the groups were defined, we evaluated their performance in 2011 and 2012. 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.

The mix of efficient providers was comparable with the urban–rural mix of freestanding SNFs but not with a mix of profit status. Nonprofits were more likely to be in the efficient group relative to their share in the industry. ■

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 payments. We compared Medicare FFS and MA payments at four large nursing home companies where such information was publicly available. Medicare’s FFS payments averaged 25 percent higher than MA rates

(Table 8-10).¹⁶ We compared the patient characteristics of beneficiaries enrolled in FFS and managed care plans in 2013 and found small differences that would not explain the payment differences between the two. Compared with beneficiaries enrolled in FFS, MA beneficiaries were the same age, had slightly higher Barthel scores (2 points, indicating slightly more independence), and had risk scores in 2011 that were 4 percent lower (indicating fewer

**TABLE
8-10**

Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2013 for four companies

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	MA	
Ensign Group	\$565	\$393	1.4
Extendicare	476	439	1.1
Kindred	503	417	1.2
Skilled Healthcare	519	389	1.3

Note: FFS (fee-for-service), MA (Medicare Advantage). The MA payments are listed for Kindred. In the other companies’ reports, the rates are reported as “managed care payments,” of which MA would make up the majority.

Source: Second quarter 10-Q 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—presumably the facilities that need revenues the least—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 those 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 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**

Distribution of Medicare and Medicaid shares of facility days in freestanding facilities, 2012

SNF type and payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	12%	17%	25%
	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicaid share	0	44	62	74	82

Note: SNF (skilled nursing facility).

Source: MedPAC analysis of SNF and hospital Medicare cost reports, 2012.

comorbidities). The considerably lower MA payments indicate some facilities accept much lower payments to treat MA enrollees who are not that different in some ways from FFS beneficiaries.

Total margins remained positive in 2012

The average total margin for freestanding SNFs in 2012 was 1.8 percent. A total margin reflects services to all patients (public and private) across all lines of business

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).

Publicly traded companies report several trends in revenues. First, declines in Medicare business (days and payments) have been partially offset by an increase in MA business (Ensign Group 2013, Extencicare 2013,

Skilled Healthcare 2013). Second, expansion of MA at the expense of FFS Medicare will lower facility revenues, given MA's shorter stays and lower payment rates. Third, companies try to grow their high-acuity rehabilitation days and spread their risk by expanding into other businesses, including home health care, hospice, and outpatient therapy (Ensign Group 2013, Extencare 2013, Kindred Healthcare 2013a, Skilled Healthcare 2013).

Publicly traded firms report higher average Medicaid rates for 2013 than for 2012 (Ensign Group 2013, Extencare 2013, Kindred Healthcare 2013b, Skilled Healthcare 2013). Higher Medicaid rates in 2013 reflect many states' improved economies, prompting 34 states to increase their nursing home payments in fiscal year 2013 and 38 states in fiscal year 2014 (Smith et al. 2013). More states also adopted provider taxes to bolster their Medicaid payments (see p. 206).

Because Medicaid payments are lower than those made by Medicare (case-mix differences aside, see discussion, p. 206), 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 2014

In assessing the payment update for 2015, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2014. To estimate costs for 2013 and 2014, we assumed cost growth of the market basket. To estimate 2013 payments, we began with reported 2012 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. We also factored in the Medicare program's first year of a three-year phase-in of reduced payments for bad debt, as required by the Middle Class Tax Relief and Job Creation Act of 2012. For 2014, estimated 2013 payments were increased by the market basket and offset by the productivity adjustment and a forecast error correction. In addition, we considered the program's reduced payments for bad debt. For 2014, the projected Medicare margin is 12 percent. The margin is lower than the reported margin for 2012 because costs are likely to increase faster than

the payment updates that were lowered by the productivity adjustment and the other policy changes. If the sequester is in place, the projected margin would be about 2 percentage points lower.

How should Medicare payments change in 2015?

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, p. 204). The Commission discussed three revisions needed to improve the accuracy of payments. First, payments for therapy services should be based on patient characteristics (not services provided). Second, the payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' need for these services. Third, an outlier policy would be added to the PPS.

The recommendation begins with revising the PPS and not updating payments in the first year (now 2015). 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 care. 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. 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 narrow 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 may be disadvantaged by the design of the current payment system.

The Commission's 2012 update recommendation for skilled nursing facility services

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 for 2013. Rebasing payments should begin in 2014, 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

Spending

- When this recommendation was made in January 2012, the spending implications of this recommendation 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 to \$10 billion over five years. Savings result from current law requiring a market basket increase (offset by a productivity adjustment, as required by the Patient Protection

and Affordable Care Act of 2010). Updated for implementation two 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 over \$10 billion.

Beneficiary and provider

- We do not expect an adverse impact on beneficiary access. 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. ■

The Commission based its 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.
- Variation in Medicare margins is not related to differences in patient characteristics but rather to the amount of therapy furnished to patients.
- Cost differences are unrelated to wage levels, case mix, or 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 in two ways. First, even in years when CMS lowers payments, providers tempered the impacts with longer stays and the assignment of days into higher payment case-mix groups. For example, in 2010, when payments were recalibrated and lowered to reflect the implementation of new case-mix groups in 2006, program spending still increased. Second, Medicare's cost growth has consistently been above the SNF market basket since 2001, except between 2011 and 2012. In 2012, when CMS corrected the 2011 overpayments, providers responded to the lower payments by focusing on the efficiency of their operations, and cost growth was the lowest it had been in a decade.

These factors have not changed for the industry and illustrate that the PPS has exerted too little fiscal pressure on providers. Moreover, Medicare payments, which are financed by taxpayer contributions to the Trust Fund, currently subsidize payments by Medicaid and private payers. If the Congress wishes to help nursing facilities

**TABLE
8-12**

Number of nursing homes treating Medicaid enrollees declined slightly in 2013

	2002	2004	2006	2008	2010	2012	2013	Percent change 2012-2013
Number of facilities	15,993	15,611	15,274	15,161	15,081	15,043	14,971	-0.5%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2002-2013.

with a high Medicaid payer mix, a better targeted and separately financed program could be established to do so.

Therefore, the Commission stands by its 2012 recommendation, believing that the PPS requires fundamental reforms to correct the known shortcomings and more closely align payments with costs. With no action taken this past year, the Congress needs to act as soon as practicable to direct CMS to implement the PPS revisions and subsequent staged rebasing of payment rates.

In 2015, there are no policy changes known at this time aside from the required update and productivity adjustment and the final year of the reductions to program payments for bad debt. The payment update in current law is the forecasted change in input prices as measured by the SNF market basket minus a productivity factor. The market basket for SNFs in 2015 is projected to be 2.4 percent, and the productivity adjustment is estimated to be 0.3 percent, but CMS will update both before establishing the payment rates for 2015.

Medicaid trends

Section 2801 of the Patient Protection and Affordable Care Act of 2010 requires the Commission to examine spending, utilization, 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 utilization 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 and 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 2013).

Medicaid covers nursing home (long-term care) and skilled nursing care furnished 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

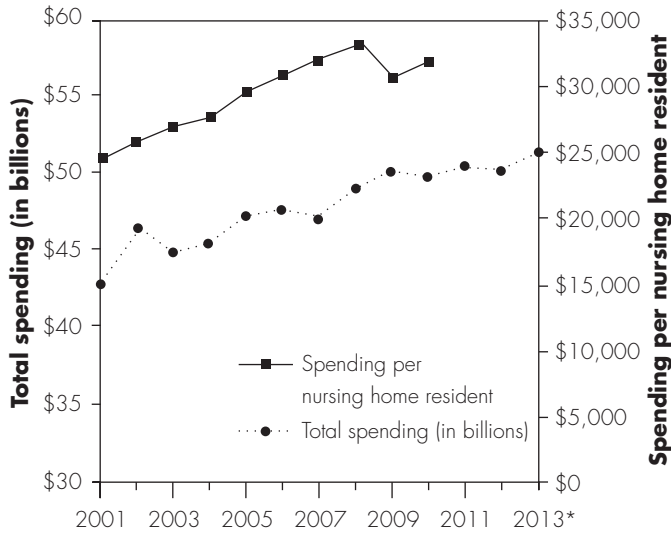
There were over 1.54 million users of Medicaid-financed nursing home services in 2010, the most recent year of data available (Centers for Medicare & Medicaid Services 2012b). This use represents a small decrease from 2009 and a 9 percent decline from 2000. The number of nursing facilities certified as Medicaid providers also declined slightly between 2012 and 2013 (Table 8-12). However, the vast majority of nursing home facilities are certified as Medicare and Medicaid providers. The decline in users and facilities reflects 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 year 2011, spending on HCBS services accounted for 45 percent of total Medicaid long-term care spending, up from 32 percent in 2002 (Smith et al. 2013).

Spending

In 2013, CMS estimates that about \$51 billion was spent on Medicaid-funded nursing home services (combined state and federal funds) (Figure 8-5, p. 206) (Office of the Actuary 2013b). Spending increases averaged 1.8 percent annually between 2001 and 2013, for a total of 24 percent over the period. Year-to-year changes in spending were variable, increasing in some years and decreasing in others. Between 2012 and 2013, CMS estimates that spending will increase by about 5 percent. On a per user basis, spending per nursing home resident averaged \$31,735 in 2010, the most recent year for resident counts. Between 2009 and 2010, spending per resident increased

FIGURE 8-5

Total and per user Medicaid spending



Note: Resident counts (and therefore per resident spending) are not available for 2011 through 2013.
*Spending in 2013 is estimated.

Source: Total spending data come from CMS, Office of the Actuary. Per user spending data come from Health Care Financing Review 2011 Statistical Supplement available at <https://www.cms.gov/Medicare/MedicaidStatSupp>.

by about 7.5 percent and represented a 57 percent increase from 2000 (Centers for Medicare & Medicaid Services 2012b).

In 2013, Medicaid spending growth averaged 3.8 percent. This growth rate is expected to be lower compared with historical rates, but higher than in 2012 when Medicaid spending growth was at a historic low. Most states report slower enrollment growth and improvement in the economy as the primary factors contributing to the lower

rate of Medicaid spending in 2013. In 2013, 17 states restricted payments (14 states enacted freezes and 3 states enacted rate reductions) for nursing homes. For 2014, 12 states adopted rate restrictions, with 2 of the states adopting rate cuts. This decline marks a shift from 2012 when 16 states froze nursing home rates and 12 states reduced them (Smith et al. 2013).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2014, 44 states had provider taxes on nursing homes (Smith et al. 2013). The President’s budget includes a proposal to slowly reduce provider taxes from a maximum 6 percent to 3.5 percent in 2017. In fiscal year 2014, four states increased provider tax rates on nursing facilities and two states decreased them.

Medicare’s payments are much higher than Medicaid’s, in part because the acuity of the average Medicare beneficiary is considerably higher, as reflected in the average nursing case-mix index for Medicaid and Medicare patients. Using data from 2011, we 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.

Non-Medicare and total margins in nursing homes

In 2012, total margins (reflecting services to all patients across all lines of business and including revenue sources) were positive (1.8 percent) but decreased from 2010. This decrease reflects the impact of Patient Protection and Affordable Care Act of 2010 reductions to Medicare payments since 2010 and a growing share of managed care payments that are often lower than Medicare’s payments. Non-Medicare margins (i.e., for Medicaid and private payers) were –2 percent (Table 8-13). ■

TABLE 8-13

Non-Medicare margins were negative but total margins were positive

Type of margin	2002	2004	2006	2008	2010	2012
Non-Medicare margin	-2.7%	-1.3%	-0.8%	-2.4%	-1.5%	-2.0%
Total margin	1.2	1.8	2.2	2.2	3.6	1.8

Note: Non-Medicare margins include the revenues and costs associated with non-Medicare payers (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 2002–2012 skilled nursing facility cost reports.

Endnotes

- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay (Part A) coverage is paid for by Medicare. Some beneficiaries remain in the facility to receive long-term care services, which is 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 conditions of participation (COPs) and agree to accept Medicare’s payment rates. Medicare’s COPs 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 furnished 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 lowered payments for therapy furnished concurrently (multiple patients engaged in different therapy activities at the same time) and required end-of-therapy assessments to prevent paying for therapy services after they have been discontinued. In 2011 (for fiscal year 2012), CMS lowered payments for therapy furnished in groups (multiple patients engaged in the same therapy activities at the same time).
- 7 Minority beneficiaries made up 20 percent of medically complex admissions in 2012 compared with only 16 percent of all SNF admissions.
- 8 Medically complex days make up the other 7 percent of days. See endnote 5 for the definition of *medically complex*.
- 9 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 furnished per week. *Ultra-high rehabilitation* includes patients who received over 720 minutes per week; *very high rehabilitation* includes patients who received 500–719 minutes per week.
- 10 A modified Barthel score is a composite measure of a patient’s ability to perform nine activities of daily living, including control bowel and urinary incontinence, transfer, walk in the facility corridor, feed themselves, toilet, bathe, perform personal hygiene, and dress.
- 11 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.
- 12 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, the separate measures count each relevant stay in its count of readmissions.
- 13 The HUD Section 232 program finances new or substantial reconstruction of nursing homes. The Section 232/222(f) program covers the refinancing or purchase of existing facilities.
- 14 The finding that high-margin SNFs have higher shares of dual-eligible beneficiaries appears to contradict the finding in Table 8-6 showing that the aggregate margin for SNFs with high shares of dual-eligible beneficiaries was lower than the margin for SNFs with low shares (9 percent vs. 16.5 percent). However, the difference is due to the statistic reported. Table 8-6 reports aggregate margins, effectively weighting the margin by facility size (their costs and revenues). Large SNFs

(those with high Medicare revenues) have lower shares of dual-eligible beneficiaries compared with the smallest SNFs. However, across SNFs of varying size, SNFs with more dual-eligible beneficiaries have higher margins than smaller SNFs. Table 8-7 shows the median share of dual-eligible beneficiaries for facilities in the top and bottom quartiles of Medicare margins. The shares of dual-eligible beneficiaries were consistently higher in high-margin (and larger) SNFs compared with low-margin SNFs.

- 15 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).
- 16 The differences for Extencicare 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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CHAPTER

9

Home health care services

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

- 9** The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

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

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(Additionally, the Commission reiterates its previous recommendations on improving the home health payment system. See text box, pp. 234–236.)

Home health care services

Chapter summary

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

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 2012, the number of agencies continued to increase, with a net gain of 257 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers.
- **Volume of services**—In 2012, the volume of services declined slightly, and total payments declined by about 2 percent, or \$400 million. Payments also declined due to a small reduction in the Medicare base rate,

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?
- Designing a home health care readmissions policy

though this decline was partially offset by an increase in the average case-mix index value. The lower spending comes after several years of increases; total spending between 2002 and 2012 increased by 89 percent. Between 2002 and 2012, the average number of 60-day episodes per home health user increased from 1.6 to 2.0, indicating that beneficiaries who used home health care stayed on service for longer periods of time.

Quality of care—Quality was steady or showed a small improvement in measures of beneficiary function.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because it is less capital intensive than most other health care sectors. According to capital market analysts, the major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs, although terms were not as favorable as in prior years. The significant number of new, smaller agencies in 2012 suggests that they had access to the capital necessary for start-up.

Medicare payments and providers' costs—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 14.4 percent in 2012 and averaged 17.5 percent in 2001 through 2011. Two factors have contributed to payments exceeding costs: Fewer visits were delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care. We project that average Medicare margins for home health agencies will be 12.6 percent in 2014.

The Commission reiterates payment recommendations from prior years

This report reiterates the 2011 recommendations the Commission made to rebase home health payments (Medicare Payment Advisory Commission 2011). The Patient Protection and Affordable Care Act of 2010 includes modest reductions in payment for home health care, but these policies will leave home health agencies with margins well above cost. Overpaying for home health services has negative financial consequences for the federal budget and raises the Medicare premiums that beneficiaries pay. Implementing the Commission's prior recommendation for rebasing would reduce payments more swiftly and better align Medicare's payments with the actual costs of providing home health services.

The Commission recommends the establishment of a financial incentive to reduce readmissions to home health care

The Commission recommends that Medicare establish a program to incentivize agencies to reduce avoidable hospital readmissions from home health care. This measure would apply to home health stays preceded by a hospitalization. About 29 percent of post-hospital home health stays result in readmission, and there is tremendous variation in performance among providers within and across geographic regions. The broad variation in performance suggests the potential for poorer performing agencies to lower their readmission rates. Implementing a readmission penalty for home health care could improve care for beneficiaries and lower Medicare spending. Such a policy would also align the incentives of home health agencies with those of hospitals under the Hospital Readmissions Reduction Program and would prepare these agencies for participating in coordinated-care models that seek to reduce avoidable readmissions, like those of accountable care organizations. ■

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 for most services, Medicare does not require copayments or a deductible for home health services. In 2012, about 3.4 million Medicare beneficiaries received home care, and the program spent about \$18 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. In 2012, the number of home health agencies (HHAs) participating in Medicare exceeded 12,300.

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. (An overview of the home health prospective payment system (PPS) is available at http://medpac.gov/documents/MedPAC_Payment_Basics_13_HHA.pdf.) Coverage for additional episodes generally has the same requirements (e.g., the beneficiary must be homebound and need skilled care) as the initial episode.

Use and growth of the 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 stay 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. 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 2012 from 10 percent of visits to 34 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 2012, the number of home health episodes rose from 3.9 million to 6.7 million. The number of agencies in 2012 was over 12,300, almost 1,400 more agencies than 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 do 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 had not declined between the IPS and the PPS (Medicare

**TABLE
9-1**

Changes in supply and utilization of home health care, 1997-2012

	1997	2000	2012	Percent change	
				1997-2000	2000-2012
Agencies	10,917	7,528	12,311	-31%	64%
Total spending (in billions)	\$17.7	\$8.5	\$18.0	-52	112
Users (in millions)	3.6	2.5	3.4	-31	38
Number of visits (in millions)	258.2	90.6	113.7	-65	25
Visit type (percent of total)					
Skilled nursing	41%	49%	52%	20	6
Home health aide	48	31	14	-37	-54
Therapy	10	19	34	101	77
Medical social services	1	1	1	1	-2
Number of visits per user	73	37	33	-49	-10
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.4%	-30	28

Note: FFS (fee-for-service). Medicare did not pay on a per episode basis before October 2000.

Source: Home health standard analytical file; Health Care Financing Review, Medicare and Medicaid Statistical Supplement 2002; and Office of the Actuary, CMS.

Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced 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 will require the program to clarify the language in its benefit manual regarding the coverage of services needed to maintain or prevent the deterioration of a patient's current condition. Coverage will hinge on existing requirements: that the beneficiary needs skilled care and meets the homebound requirement. In 2013, CMS released revised standards 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.

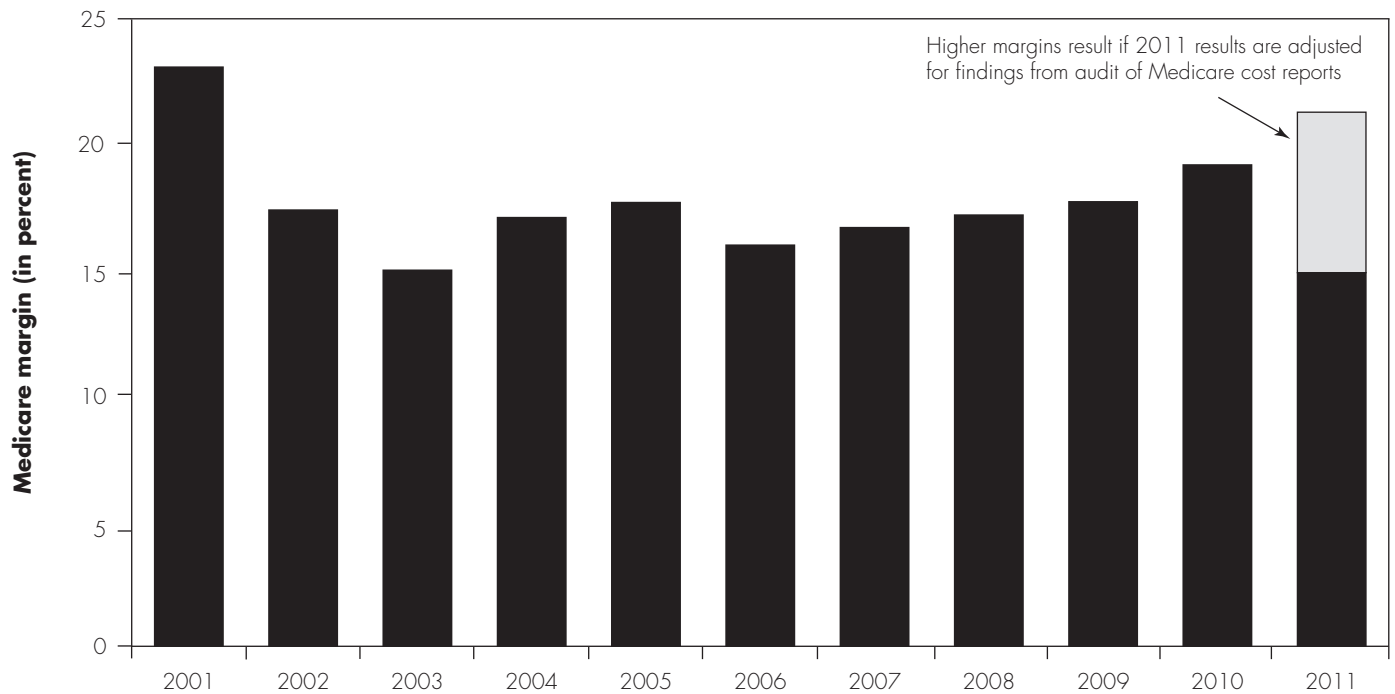
Home health margins for freestanding HHAs have been very high since the PPS was implemented; Medicare margins averaged 17.5 percent between 2001 and 2011 (Figure 9-1). These high margins likely have encouraged the entry of new HHAs; the total number of agencies participating in Medicare has increased by an average of about 530 agencies a year since 2002. 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 2011).

The average margin may be even higher than these amounts for many agencies. The margins the Commission reports rely on the cost and payment information reported by HHAs on Medicare cost reports. 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 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.

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

**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 in this year by 8 percent. The figure shows the reported margin, without adjustment, in the solid line; the gray box indicates that margins would have exceeded 20 percent if the results were adjusted for the audit finding.

Source: Medicare cost reports.

consistent with costs, a policy 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. The Commission has concerns that the rebasing called for in PPACA will ultimately be too modest and leave agencies with substantial profit opportunities while unduly burdening taxpayers and beneficiaries.

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 \$81 per 60-day episode. However, the base rate has increased since 2010, so this reduction will be less than 3.5 percent and will equal 2.7 percent to 3 percent in 2014 through 2017. In addition, over this period, the payment update will raise payments, resulting in a cumulative net payment reduction of 1.6 percent (Table 9-2, p. 220).

This modest reduction will likely leave substantial HHA margins, which have always exceeded 14 percent since the implementation of the 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 5 visits and makes a per visit payment instead 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 for rebasing covers only a portion of this shortfall. LUPAs are a small share of home health volume, 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 \$344, compared with \$3,056 for

**TABLE
9-2**

Impact of PPACA rebasing on payments for 60-day episodes

	2014	2015	2016	2017	Cumulative change, 2014-2017
Rebasing adjustment	-2.7%	-2.8%	-2.9%	-3.0%	-10.9%
Legislated payment update	2.3	2.4	2.7	2.6	10.5
Net annual payment reduction	-0.5	-0.4	-0.2	-0.5	-1.6

Note: PPACA (Patient Protection and Affordable Care Act of 2010). Data are based on 2013 third-quarter forecast of home health market basket. Annual and cumulative impacts of payment changes are multiplicative. Data do not include impact of reduction in 2014 due to changes to the home health grouper.

Source: MedPAC analysis based on data from CMS.

the average full episode in 2010. 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.

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 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, which most home health beneficiaries do (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, and beneficiaries, once they meet program coverage requirements, can receive an unlimited number of home health episodes. 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 need 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 be 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. While Medicare typically covers unskilled care in the institutional post-acute care (PAC) settings, most home health episodes are not posthospital services. The aide service in home health is the only instance in which Medicare will cover these services for community-dwelling beneficiaries, and the eligibility for them does not require that a patient qualify for an acute level of care.

In 2010, the Commission made a recommendation to curb wasteful or fraudulent home health services (Medicare Payment Advisory Commission 2010). This recommendation calls on CMS to use its 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 Miami-Dade and Chicago metropolitan areas. Medicare also has the authority to require HHAs to hold surety bonds, but it has not exercised this authority.¹

Are Medicare payments adequate in 2014?

The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2014. We assess

**TABLE
9-3**

Number of participating home health agencies continues to rise

	2003	2005	2007	2009	2010	2011	2012	Average annual percent change	
								2003-2011	2011-2012
Active agencies	7,235	8,353	9,291	10,568	11,453	12,054	12,311	6.6%	2.1%
Number of agencies per 10,000 beneficiaries	2.0	2.3	2.6	3.0	3.2	3.3	3.3	6.4	0.6

Note: "Active agencies" includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Provider of Service file and 2013 annual report of the Boards of Trustees of the Medicare trust funds.

beneficiary access to care by examining the supply of home health providers and annual changes in the volume 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 2012, 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.² These findings are consistent with our review of access from prior years.

Capacity and supply of providers: Agency supply surpasses previous peak

In 2012, 12,311 HHAs participated in Medicare, a net increase of 257 agencies from the previous year. Most new agencies in 2012 were for-profit agencies. The number of agencies exceeded the 1997 record when supply exceeded 10,900 agencies. The high rate of growth is a particular concern because the new agencies appear to be concentrated in states that have had a number of significant fraud reports, including California, Florida, 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.³

From 2003 to 2012, the number of agencies per 10,000 FFS beneficiaries rose 60 percent, from 2.0 to 3.3 (Table 9-3). Most of the new agencies were for profit. However,

supply varies significantly among states. In 2012, Texas averaged 9.9 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 2,810 episodes compared with 391 episodes per agency in 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 to meet their patients' needs.

Growth in episode volume slows after many years of rapid growth

In 2012, total spending for home health care dropped by about 2 percent (Table 9-4, p. 222), resulting from a slight decline in volume and a 1 percent decrease in average payment per episode. The per episode payment declined because of a reduction to the home health base rate, though this reduction was offset by an increase in the average case-mix value. The slight volume decline is in sharp contrast to utilization trends in prior years. From 2002 to 2011, the number of episodes increased by 64 percent, from 4.1 million to 6.8 million episodes. Between 2002 and 2012, the share of beneficiaries using home health care increased from 7.2 percent to 9.4 percent.

Home health care volume slowed in 2011 relative to prior years, which could be at least partially attributable to a new Medicare requirement: The physician certifying the need for home health care, or the physician's delegated nonphysician practitioner, must have had a face-to-

**TABLE
9-4**

Fee-for-service home health care services increased rapidly from 2002 to 2010

	2002	2006	2010	2011	2012	Average annual percent change		Cumulative change, 2002-2012
						2002-2011	2011-2012	
Medicare enrollees (in millions)	35.0	36.1	36.0	36.5	37.1	0.5%	1.6%	6%
Home health users (in millions)	2.5	3.0	3.4	3.4	3.4	3.5	-0.2	37
Share of beneficiaries using home health care	7.2%	8.4%	9.6%	9.6%	9.4%	3.2	-1.5	31
Episodes (in millions):	4.1	5.5	6.8	6.8	6.7	5.9	-1.5	64
Per home health user	1.6	1.8	2.0	2.0	2.0	2.2	-1.3	20
Per FFS beneficiary	0.12	0.15	0.19	0.19	0.18	5.5	-2.8	58
Payments (in billions)	\$9.6	14.0	19.4	18.4	18.0	7.5	-2.0	89
Per home health user	\$3,803	\$4,606	\$5,679	\$5,347	\$5,247	3.9	-1.9	38
Per FFS beneficiary	\$274	\$387	\$539	\$505	\$487	7.0	-3.5	78

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded.

Source: MedPAC analysis of 2013 home health standard analytical file.

face encounter with the patient when authorizing care. Office visits or telehealth encounters with a physician or nurse practitioner up to 90 days before or 30 days after the beginning of home health care qualify toward the requirement. The change was intended to ensure that beneficiaries receive a complete evaluation when home health care is ordered and that physicians do not rely solely on information provided by HHAs when making decisions about patient care. It is possible that the additional scrutiny required by this examination led to fewer referrals for home health care.

The decline in volume in 2012 relative to the prior year was concentrated in states with the highest utilization rates—Texas, Louisiana, Oklahoma, Mississippi, and Florida. Volume declined by 5 percent in Texas (more than 50,000 episodes) and by 8 percent in Louisiana. However, these areas experienced substantial growth in the previous 10 years. Even after these declines, these states had the highest utilization rates on a per beneficiary basis; as a group, the five states averaged 33 episodes per 100 beneficiaries, more than twice the average of all other states. In addition, growth continued in other areas, and 20 states had an increase in volume in 2012. California led this group with an increase of 25,000 episodes.

Since 2002, home health care stays have grown longer and less focused on post-acute care

Between 2002 and 2012, the average number of episodes per user increased by 20 percent. 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 PAC service. Over the 2001–2011 period, the number of episodes not preceded by a hospitalization or PAC stay increased by 117 percent, compared with a 25 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

**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	2011		2001	2011
Episodes not preceded by a hospitalization or PAC stay:					
First	0.8	1.3	67%	20%	19%
Subsequent	<u>1.3</u>	<u>3.2</u>	148	<u>32</u>	<u>46</u>
Subtotal	2.1	4.5	117	53	66
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.8	17%	40	27
Subsequent	<u>0.3</u>	<u>0.5</u>	66	<u>8</u>	<u>7</u>
Subtotal	1.9	2.3	25	47	34
Total	3.9	6.8	73	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 hospital (including long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility stay. "Episodes not preceded by a hospitalization or PAC stay" (community-admitted episodes) indicates that there was no hospitalization or PAC stay in the 15 days before episode start. Numbers may not add to subtotals and totals due to rounding.

Source: CMS Datalink file, 2012.

hospitalization or PAC stay rose from about 53 percent to 66 percent.

The Commission 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.

The differences between the two populations suggest 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 of the factors that determine 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

**TABLE
9-6**

Most counties with the highest rates of beneficiaries using home health in 2012 are rural

State	County	Rural or urban	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval*	Rural	35.2%	4.4	154.5
TX	Brooks*	Rural	34.6	4.1	141.2
FL	Miami-Dade*	Urban	29.2	2.6	76.2
TX	Jim Hogg*	Rural	28.9	4.1	119.3
TX	Willacy*	Rural	28.5	3.5	100.9
MS	Claiborne*	Rural	27.7	3.0	84.2
TX	Jim Wells*	Rural	27.2	3.9	107.1
TX	Starr*	Rural	26.6	4.0	106.3
OK	Choctaw*	Rural	25.9	4.2	107.9
TX	Zapata*	Rural	25.1	4.3	108.6
LA	Madison*	Rural	23.8	4.4	104.1
LA	East Carroll*	Rural	23.4	4.4	103.0
TX	Webb*	Urban	23.3	4.0	92.3
TX	Collingsworth	Rural	23.3	4.3	99.8
TX	Hidalgo*	Urban	22.7	3.6	82.4
OK	McCurtain*	Rural	22.4	4.4	97.4
TN	Hancock*	Rural	22.4	3.2	70.8
MS	Holmes	Rural	21.9	3.3	72.2
TX	Red River*	Rural	21.6	4.0	85.7
OK	Latimer*	Rural	21.5	4.4	95.5
TX	Cameron*	Urban	21.5	3.2	69.0
TX	Throckmorton	Rural	21.3	4.1	87.7
LA	Avoyelles*	Rural	20.8	4.0	82.4
OK	Pushmataha*	Rural	20.7	4.0	82.6
LA	St. Helena	Urban	20.1	3.6	73.2
National average			9.4	2.0	18.0

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded. The table includes the top 25 counties with the highest share of FFS beneficiaries using home health.

*County has been in the top 25 of counties ranked by utilization since 2011.

Source: MedPAC analysis of the 2012 home health standard analytical file and the 2012 Medicare denominator file.

on patient characteristics—not the number of services provided—for setting payment, but CMS has yet to implement this recommendation (Medicare Payment Advisory Commission 2011).

A review of historical trends in the volume of therapy services indicates that payment incentives generally influenced provider behavior. From 2001 to 2007, CMS had a single payment adjustment for therapy that increased payment for episodes with 10 or more therapy visits. In this period, the growth rate for episodes that just met the threshold was almost double the growth for all other home

health episodes. This trend led to concerns that providers were deliberately targeting the 10-visit threshold.

Responding to these concerns, CMS implemented changes in 2008 that lowered payments for episodes with 10 to 13 therapy visits and increased payment for episodes in the 6 to 9 or 14 or more therapy visit ranges. The subsequent changes in therapy utilization reflected the new incentives: Episodes with 10 to 13 therapy visits decreased, while those with 6 to 9 therapy visits and 14 or more visits increased. This shift was the largest one-year shift in therapy volume since the PPS was implemented.

**TABLE
9-7**

Average agency performance on select quality measures

	2004	2008	2011	2012	2013
Share of an agency's beneficiaries with improvement in:					
Transferring	47%	51%	51%	52%	52%
Bathing	56	62	62	63	63
Walking			53	55	57
Medication management			43	45	46
Pain management			65	65	65
Unplanned urgent care use					11

Note: The measures for walking, medication management, and pain management changed in 2011 and are not comparable with data from prior years. Data are not available prior to 2013 for unplanned urgent care use. Data are risk adjusted for differences in patient condition among home health agencies.

Source: MedPAC analysis of CMS Home Health Compare data.

Since 2008, the growth in episodes has followed this pattern, with episodes involving 14 or more visits growing significantly.

In 2011, CMS tightened supervision requirements for episodes reaching the 14th and 20th therapy visit. Claims data for 2011 suggest that these requirements had some impact because the number of episodes with visits at and beyond these thresholds decreased relative to 2010. In 2012, CMS raised the relative weight payments for episodes with fewer than six therapy visits and lowered them for episodes with six or more therapy visits but retained the number of visits furnished as a payment factor. This adjustment at least partially addresses the Commission's past concerns that therapy services may be overvalued, but agencies can still garner higher payments by providing additional therapy visits. The distribution of episodes for 2012 in each of the therapy payment groups did not change significantly relative to the prior year, suggesting that the payment changes may not have been sufficient to significantly affect provider behavior.

Rural areas with high utilization benefit most from Medicare's rural add-on payment

In 2010, PPACA implemented an add-on payment of 3 percent for each home health care episode provided to beneficiaries in rural areas, presumably to bolster access to home health services. The high level of utilization in many rural areas results in Medicare's per episode add-on being poorly targeted, with many payments made to areas with above 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 drawing a disproportionate share of the

add-on payments. For example, 71 percent of the episodes that received the add-on payments in 2012 were in rural counties with utilization above the national average (equal to or greater than the 60th percentile of episodes per FFS beneficiary among all counties). The rural counties in the bottom 40 percent of utilization, those below the national average, accounted for 11 percent of the episodes eligible for the add-on payment.

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 2012). 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 that suggest fraud and abuse are rural; for example, 20 of the 25 top spending counties in 2012 are rural areas (Table 9-6). 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.

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 care management (Table 9-7). In general, the share of beneficiaries showing improvement in these measures has

**TABLE
9-8****Medicare margins for freestanding home health agencies, 2011 and 2012**

	2011	2012	Percent of agencies, 2012	Percent of episodes, 2012
All	15.0%	14.4%	100%	100%
Geography				
Majority urban	14.8	14.8	83	82
Majority rural	15.5	12.8	17	18
Type of ownership				
For profit	15.8	15.2	88	81
Nonprofit	12.0	12.0	12	19
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	6.8	6.8	20	5
Second	8.3	8.0	20	7
Third	10.1	10.2	20	15
Fourth	13.5	13.2	20	26
Fifth (largest)	17.4	16.7	20	47

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.

increased since 2004, and measures either held steady or improved slightly in 2012 and 2013. However, 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.

Providers' access to capital: Adequate access to capital for expansion

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 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 2012, though the recent declines in reimbursement for home health care have made capital more difficult to obtain. The PPACA changes in home health care policy implemented in the 2011 and 2012 PPS regulations have trimmed revenues for the home health care industry. In addition, several federal investigations have been launched into the therapy billing practices of some of the publicly held home health companies. These factors have weakened investor outlook for these firms and have made lenders more cautious in the terms they offer home health firms seeking capital, but for-profit HHAs still appear to have access to capital for their operating needs. Even with these concerns, some of the majorly traded home health firms completed substantial transactions that suggest they have adequate access to capital. Gentiva purchased Harden Healthcare for about \$409 million, and Almost Family purchased two regional home health chains for approximately \$110 million. For smaller or nonpublic entities, the entry of new providers indicates that access to capital for privately held agencies is adequate. In 2012, over 257 new HHAs entered Medicare; most of these agencies were for profit.

Medicare payments and providers' costs: Payments decreased in 2012 but costs decreased more

In 2012, average Medicare payments per episode declined by about 0.5 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. At the same time, however, the average cost per episode in 2012 declined by about 1.4 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. The ability of HHAs to keep costs low has contributed to their high margins under the Medicare PPS.

Medicare margins remained high in 2012

In 2012, HHA margins in aggregate were 14.4 percent for freestanding agencies (Table 9-8). For-profit agencies had higher margins than nonprofit agencies, and urban agencies had slightly higher margins than rural agencies. Financial performance varied from -0.3 percent for the agency at the 25th percentile of the margin distribution to 23 percent for the agency at the 75th percentile (data not shown).

The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies operate in the financial context of hospital operations. Margins for hospital-based agencies in 2012 were -15 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 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 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 9-9, p. 228). The measure of cost is risk-adjusted cost 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 is in the lowest third on at least one measure (either low cost per episode or a low hospitalization rate) and is not in the highest third of the other measures for three consecutive years (2008 to 2010). About 15 percent of agencies met these criteria in this period.

Relatively efficient agencies had margins that were 6 percentage points higher with a hospitalization rate that was 23 percent lower compared with other HHAs, and the average cost per visit was 15 percent lower compared with other HHAs. Relatively efficient HHAs provided more episodes but about 1.8 fewer visits per episode. There was generally no significant difference between the patient attributes of relatively efficient providers and other agencies because they served similar shares of rural and dual-eligible beneficiaries. Compared with other regions, the Middle Atlantic, South Atlantic, and Mountain regions had greater shares of relatively efficient providers.

Projecting margins for 2014

In modeling 2014 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2012, and the year for which we are making margin predictions, 2014. The major changes are:

- -0.1 percent payment change in 2013, the result of a positive payment update (1.3 percent) and a reduction for improvements in coding (-1.32 percent);
- -1.1 percent payment change in 2014, the result of a positive payment update (2.3 percent), a reduction due to changes to the grouper that lowered average payments (-0.6 percent) and the rebasing adjustment (-2.7 percent);
- 3 percent add-on in effect for episodes provided in rural areas in 2013 and 2014; and
- assumed episode cost growth of 0.5 percent a year for 2013 and 2014, a conservative assumption relative to the trend in recent years.

On the basis of these policies and assumptions, the Commission projects a margin of 12.6 percent in 2014. The margins for 2014 would be about 2 percent lower if the sequester required by the Budget Control Act of 2011 were included.

Medicare has always overpaid for home health services under PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In

**TABLE
9-9****Performance of relatively efficient home health agencies**

Provider characteristics	All	Relatively efficient provider	All other providers
Number of agencies	3,971	600	3,371
Share of for-profit agencies	82%	73%	83%
Medicare margin			
2010	19.1%	25.6%	19.1%
2009	18.6%	25.7%	18.6%
Quality			
Hospitalization rate (2010)	28%	23%	30%
Costs and payments			
Cost per visit, standardized for wages (2010)	\$133	\$116	\$137
Average payment per episode (2010)	\$2,884	\$2,711	\$2,916
Visits per episode			
Total visits per episode (2010)	17.6	16.2	18.0
Share of visits by type			
Skilled nursing visits	51%	52%	50%
Aide visits	16%	11%	17%
MSS visits	1%	1%	1%
Therapy visits	33%	35%	32%
Size, 2010 (number of 60-day payment episodes)			
Mean	991	1,092	973
Median	579	701	560
Share of episodes, 2010			
Low-use episode	8%	10%	9%
Outlier episode	2%	2%	2%
Community-admitted episodes	33%	41%	32%
Therapy episodes	36%	37%	35%
Share of agencies by region			
New England	4%	3%	4%
Middle Atlantic	6%	11%	5%
South Atlantic	15%	24%	14%
East North Central	19%	14%	19%
East South Central	5%	5%	5%
West North Central	6%	11%	5%
West South Central	30%	18%	32%
Mountain	6%	9%	5%
Pacific	10%	5%	11%
Beneficiary demographics, 2010			
Share of episodes provided to dual-eligible Medicare/Medicaid beneficiaries	35%	32%	36%
Average age	78	78	78
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 (2008–2010). A home health agency is classified as relatively efficient if it is in the lowest third in cost per episode or rehospitalization and is not in the highest third of either measure for three consecutive years. Quality is measured using a risk-adjusted measure of hospitalization, and cost is measured using risk-adjusted cost per episode. Sample includes freestanding agencies with complete data for three consecutive years. Agencies in high-utilization areas were excluded. Low-use episodes are those with four 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 post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and home health standard analytic file.

**TABLE
9-10****Medicare visits per full episode before and after implementation of PPS**

Type of visit	Visits per episode			Change in visits per episode	
	1998	2001	2012	1998-2001	2001-2012
Skilled nursing	14.1	10.5	9.3	-25%	-11%
Therapy (physical, occupational, and speech language)	3.8	5.2	6.2	39	18
Home health aide	13.4	5.5	2.6	-59	-52
Medical social services	0.3	0.2	0.1	-36	-32
Total	31.6	21.4	18.6	-32	-15

Note: PPS (prospective payment system). The PPS was implemented in October 2000.

Source: Home health standard analytic file.

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 9-10). By providing fewer visits than anticipated, HHAs were able to garner extremely high average payments relative to the services provided.

This structural 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 has some mandated reductions for home health care that begin to reduce payments, but these reductions would leave HHAs with margins well in excess of cost. 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 2015?

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. Our recommendations from 2011 included multiyear payment changes intended to restructure the incentives of the home health benefit and address the high Medicare margins. These

recommendations call for expanding efforts to fight fraud, improving beneficiary and provider incentives, and rebasing home health payments (see text box, pp. 234-236, for a summary of recommendations from 2011).

Designing a home health care readmissions policy

Home health care is commonly cited as a tool for avoiding hospital readmissions for patients receiving services after an acute hospital stay, and about 40 percent of home health stays are preceded by a hospital stay. However, it is not clear that this tool has been fully effective. On average, about 29 percent of posthospital spells of home health care result in readmission in 2010.⁴ In addition, the rate of readmission varies drastically among regions and providers, suggesting that regions and providers with high rates have significant opportunity for improvement. For example, the agency at the 25th percentile of readmissions had a rate of 25 percent, compared with 39 percent for the agency at the 75th percentile.

There is also significant geographic variation among regions in the amount of Medicare spending for home health care, and this spending is highest in many of the states with the highest readmission rates. For example, agencies in four of the states with the highest utilization—Louisiana, Mississippi, Oklahoma, and Texas—averaged a readmissions rate of 38 percent. By contrast, agencies in the Pacific census region, which typically has lower rates of utilization, averaged a readmissions rate of 28 percent.⁵

**TABLE
9-11****Comparison of agencies with
the highest readmission rates
(top quartile) with other agencies**

	All other	Top quartile of readmission rates
Readmission rate	26%	58%
Average number of admissions	347	97
Agency length of stay	46.0	64.2
Share of agencies:		
In 4 states with highest rates of readmission (LA, MS, OK, TX)	19%	45%
For profit	69%	90%
Facility based	15%	4%
Rural	22%	16%

Source: MedPAC analysis of University of Colorado data on readmissions to hospitals from home health.

The agencies with the highest readmission rates averaged a rate of 58 percent, more than double the rate of all other agencies (Table 9-11). These measures suggest that significant improvements in readmission could occur if agencies with higher rates could achieve the performance of higher performing or even average performing agencies. Currently, Medicare does not tie HHA payments to readmissions or any other quality indicator.⁶ Providing incentives for HHAs to reduce readmissions could improve care for beneficiaries, lower costs for Medicare, and move FFS reimbursement to an approach based on the value of care as opposed to one that rewards volume.

Home health care is the most frequently used setting of formal post-acute care among the four settings covered by Medicare; home health care is in a unique position to influence an episode of acute care as the provider that assists beneficiaries with the transition back to the home. Home health care can be a bridge between the higher level of care provided during institutional stays and the ambulatory care system that will be responsible for the beneficiary's care after discharge from inpatient facilities.

A readmission policy for home health agencies could help to align agency incentives with other providers that are seeking to reduce readmissions and encourage better care coordination. An incentive for HHAs would be consistent with the Hospital Readmissions Reduction Program (HRRP), which holds hospitals accountable for some

readmissions. Data from the first year of the HRRP suggest that the incentive has led to lower readmission rates, and adding a similar incentive for HHAs would encourage them to work more closely with hospitals and accountable care organizations (ACOs). The Commission has also recommended a readmission incentive for skilled nursing facilities, which frequently discharge patients to home health care. Recommending a similar policy for HHAs would ensure consistent expectations for the two most common providers of PAC services covered by Medicare.

Focusing on readmissions in home health care would also be consistent with the concern that holding HHAs accountable for initial hospital admissions might be inappropriate because initial admissions could represent appropriate care for many conditions.

Defining the elements of a home health readmissions reduction program

The key elements of a home health readmissions program include a financial incentive strong enough to compel agencies to reduce unnecessary readmissions without penalizing agencies whose patients warrant hospital care and a quality assessment measure that accounts for the diversity of clinical conditions treated in home health care. The measure would apply to patients who are using home health as a PAC service, and not to those patients admitted to home health from the community with no prior hospitalization.

Financial structure of the policy

A readmission reduction policy would include a penalty for agencies with high rates of readmission. A target rate could be established based on the performance in an index year, for example the 40th percentile of the index year. Agency performance in future years would be compared with the target rate from the index year. Agencies with rates above the target would be subject to a reduction to their base rate, while agencies below it would not. Such an approach could encourage a significant number of agencies to improve. The Commission recently considered a similar approach when it reviewed the HRRP.

Only readmissions above the target rate would be included in this policy. The penalty amount could vary, depending on the magnitude of the incentive deemed necessary to motivate agencies to invest in the infrastructure necessary to reduce readmissions to an acute care hospital. One approach would be to set the penalty to the average Medicare payment for the home health care services

provided before the readmission. If a stronger incentive is necessary, the penalty could be set higher. Even a penalty twice the amount of home health services would be less than the cost to Medicare of the hospital readmission. To give agencies with high readmission rates the time and incentives to put the necessary readmissions mitigation process in place, Medicare should establish a stop-loss provision that limits the aggregate reduction in payments an agency can experience, but the reduction would increase over time. For example, the stop-loss provision could be set at a level comparable with that established for the HRRP: 1 percent of total Medicare payments to the agency in the first year, increasing to 3 percent of Medicare payments by the third year.

Setting a target readmission rate in advance would establish the rate agencies need to be below to avoid a payment reduction, and it would provide them with an opportunity to improve. Medicare savings would be achieved either through reduced hospital readmissions or through reductions to HHA payments. For example, if all providers lowered readmissions below the target, there would be no penalties. Instead, savings would be generated by reducing readmissions. In contrast, if readmissions did not improve, savings would come from holding back a portion of the Medicare payment to HHAs. Since agencies are compared with a fixed target, they would also have an incentive to collaborate and share lessons learned with one another. This model would be appropriate in fee-for-service Medicare, where we observe large disparities in performance between those agencies with the highest rates of readmissions and those in the rest of the industry. Adopting this model might encourage HHAs to participate in other new models of payment, such as the Medicare Shared Savings Program or the Pioneer ACO Initiative, that potentially include bonuses for better performance.

Several interventions are available to agencies that seek to lower their readmission rates, such as the use of protocols to improve communication between providers, providing patient coaches for beneficiaries to assist with transitions, and the use of advanced nurse practitioners who assist with improving the continuity of care (Boutwell and Hwu 2009, Coleman et al. 2006, Naylor et al. 2004). A recent systematic review of the literature on transitional care interventions identified several practices that demonstrated reduced rates of readmission, including improved processes for hospital discharges and care planning and better self-management support (Naylor et al. 2011).

Protecting access to care for dual-eligible Medicare and Medicaid beneficiaries

The risk-adjusted rates of readmission are higher for agencies that serve a higher than average share of beneficiaries who are dually eligible for Medicare and Medicaid. A home health care readmission policy should seek to establish incentives for all agencies to improve, without penalizing agencies that serve significant numbers of dual-eligible Medicare–Medicaid beneficiaries.

Adjusting for dual-eligible status in the risk-adjustment model would diminish any differences in outcomes experienced by this group, effectively masking their higher rates of readmissions. This approach could be viewed as tacitly accepting the higher rate for dual-eligible beneficiaries. The Commission supported an alternative approach for addressing this issue with respect to the HRRP. Providers would be compared with a peer group serving a similar share of dual-eligible patients. HHAs would continue to report their all-condition risk-adjusted readmission rate; it would not be adjusted for socioeconomic status and, thus, disparities would not be masked. Instead, each HHA's target readmission rate would be based on the performance of providers with a similar share of low-income patients.

Our review of the HRRP concluded that race did not have a consistent effect on outcomes. Other measures, such as education or race, are either not currently readily available or sometimes give inconsistent results across measures. For example, in an examination of acute care hospital measures, the effect for African American patients varied depending on the measure used. In a readmission measure, African American status indicated a higher rate of readmission, while such status was found to be tied to lower rates of mortality. Including race would tie Medicare payments to a patient's race, effectively creating financial incentives that may encourage patient selection based on this demographic.

The Commission's review of the HRRP found that a hospital's share of low-income patients was a stronger and more consistent predictor of readmissions than race or the disproportionate share hospital percentage (Medicare Payment Advisory Commission 2013). The University of Colorado, in a contract for the Commission, also examined the role of race and low-income status for readmissions in home health and found that Medicaid–Medicare dual-eligible status had a greater influence on readmissions risk than race (Nuccio et al. 2013). For home health care, we believe a similar approach that compares an HHA with

**TABLE
9-12****Share of agencies with readmission rates greater than the 40th percentile of their peer group**

	Percent
All agencies	60%
Freestanding	61
Facility based	46
For profit	65
Government	48
Nonprofit	44
Urban	60
Micropolitan	57
Rural, adjacent to urban	58
Rural, nonadjacent to urban	59
States with highest readmission rates	
Four highest states (LA, MS, OK, TX)	74
All other	55

Note: A micropolitan county has a population of 10,000 to 50,000.

Source: Based on MedPAC analysis of University of Colorado data.

a peer group that serves similar shares of low-income individuals will balance the need to protect access to care for these individuals by establishing a credible target for tying Medicare payment to readmissions. This approach would require that the performance target for an agency be established after the agencies have been separated into peer groups based on the share of their patients classified as low income (i.e., quartile, decile, etc.). An agency's target would be derived from a cohort of agencies with similar shares of low-income patients, not the overall national average.

In 2010, Medicare directed its quality improvement organizations (QIOs) to increase their assistance of low-performing providers. Agencies with high readmission rates could be appropriate candidates for these efforts. QIOs could engage with agencies to help them understand the cause of their high rates, develop potential interventions, and help monitor improvement efforts. These efforts could be targeted at agencies with higher readmission rates. However, it is not clear that QIO assistance would be necessary for many agencies to improve.

Defining the period of measurement

A readmissions measure should hold agencies accountable for the full period of care that they are serving a beneficiary. Similar to the HRRP measure of readmissions, the home health readmission measure could also include a 30-day period after the home health stay. Relatively few readmissions occur in the 30 days after the end of a home health stay, but the presence of a window would encourage agencies to prepare beneficiaries and their caregivers for remaining in the community without the assistance of home health. Some agencies would likely be concerned that including poststay readmissions would hold providers accountable for adverse events they cannot control. However, the home health benefit is intended to help beneficiaries develop efficacy in their own care, and the benefit covers many services such as beneficiary and caregiver education to facilitate this goal. At a technical panel convened by the Commission, a group of home health practitioners, health services research professionals, and physicians with home health care expertise supported a 30-day poststay window for measuring hospitalizations.

Types of readmission to include under a measure

Defining a readmission incentive also requires identifying the clinical scope of home health stays and the causes of readmissions to be included in a measure. The Commission's considerations regarding the HRRP readmissions measure may be instructive for home health care. One such consideration is for an "all-condition, potentially avoidable" measure. Under this approach, all discharges from a hospital to home health care are monitored, but only readmissions that are classified as potentially preventable are counted in the measure. An all-condition measure might be particularly important in home health care because many agencies are small and would not have a sufficient sample size for a statistically reliable measure under narrower parameters. In addition, avoiding a readmission is a key goal for most home health patients. Several methods have been developed for determining readmissions that would be clinically appropriate to attribute to providers. CMS's new measure of readmissions for home health agencies excludes readmissions defined as "planned admissions" under the Agency for Healthcare Research and Quality Conditions Category System, and this strategy could serve as an initial approach.

An illustrative example assessing the effects of a readmission penalty for home health agencies

The Commission modeled a readmissions policy consistent with the desired incentive and measurement elements

discussed above to assess its potential impact on home health agencies. This approach requires that agencies above a fixed target, such as the average readmission rate from a prior year, be subject to the policy's penalty. The policy excludes from its performance measurement readmissions that are planned or part of a course of treatment such as chemotherapy. This example also sorts agencies into peer groups based on the share of their beneficiaries that are dually eligible for both Medicare and Medicaid. Table 9-12 indicates the share of agencies in various categories that would be above the readmission target if it were set at the 40th percentile of readmission rates in 2010 of their dual-eligible peer group. These results do not assume any behavioral response by agencies to lower their readmission rates, thereby likely overstating the estimated share of agencies subject to a payment reduction. Consistent with the national trends in readmissions rates, for-profit agencies would be subject to the penalty at a higher rate than nonprofit agencies, and freestanding agencies would be subject to the penalty at a higher rate than provider-based agencies. Over 70 percent of agencies in the four states with the highest readmissions rates (Louisiana, Mississippi, Oklahoma, and Texas) would be subject to the payment reduction, and all four of these states have higher than average home health utilization. In our analysis, smaller agencies tended to represent a greater share of agencies subject to the penalty. On a national basis, agencies in rural areas generally were subject to the penalty at about the same rate as agencies in urban areas.

Recommendation

RECOMMENDATION 9

The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

RATIONALE 9

A hospital readmission policy for HHAs would create an incentive for agencies to improve the quality of care they provide and would lower Medicare spending. It would align HHA incentives with those of hospitals under the HRRP, and it would complement the incentives that skilled nursing facilities would have if Medicare were to implement the Commission's recommendation for a readmission policy for these facilities. 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. Other providers 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.

The incentive could take several forms but should rely on a risk-adjusted measure of readmission. The clinical scope of the measure should include all posthospital home health stays but only measure readmissions that are due to causes considered potentially avoidable. The period covered by the measure should include the entire home health stay and 30 days after discharge. Including a follow-on period would recognize that the goal of home health care is to successfully transition a patient back to community-based care and would be conceptually similar to the 30-day postdischarge period included in the HRRP measure. The amount of the incentive should be large enough to motivate agencies to improve, particularly given the substantial costs of readmission to the beneficiary and the Medicare program.

CMS could use a modified version of the readmissions measure developed for hospitals to implement this recommendation. Its claims-based measure of readmission for hospitals focuses on the first 30 days of the stay, and it could use the same definition of potentially avoidable readmissions for the hospital-wide readmissions measure. The measure is risk-adjusted for clinical and functional severity. If the period were modified to include the entire home health stay with a 30-day home health window afterward, the measure would be consistent with the Commission's recommendation. CMS may also need to take measures to ensure that risk-adjustment information submitted by HHAs is accurate.

IMPLICATIONS 9

Spending

- This policy would lower Medicare spending by \$50 million to \$250 million in 2015 and yield less than \$1 billion over five years.

Beneficiary and provider

- The quality of beneficiary care and the process of transitioning between providers could improve as better coordination between home health providers and hospitals occurs. The recommendation should not adversely affect beneficiary access or affect providers' willingness or ability to care for Medicare beneficiaries, particularly if implemented with safeguards to protect agencies that serve disproportionate shares of low-income beneficiaries. Payments would be lowered for providers with consistently high rates of readmissions. ■

Strengthening incentives for effective and efficient use of the home health benefit

In 2011, the Commission noted several problems with the 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.

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 in 2011 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 9-6, p. 224). 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 Miami-Dade County and Chicago. CMS expanded the moratoria to Fort Lauderdale, FL; Dallas, TX; Houston, TX; and Detroit, MI, in 2014. However, many other parts of the country with aberrant patterns of utilization also require further scrutiny. 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 the Office of Inspector General 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. Payments should be rebased as soon practicable, with a short period of time that allows for an appropriate transition to the lower level of payments (e.g., no more than three years). Our recommendation would also eliminate the market basket update during rebasing. 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 a rebasing may cause some agencies 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. It does not require extensive capital expenditures like facility-based providers, and many states do not require certificate-of-need analysis establish a new home health agency.

Implications 8-2

Spending

- This recommendation would reduce Medicare spending by \$250 million to \$750 million in 2015 and \$5 billion to \$10 billion over five years.

(continued next page)

Strengthening incentives for effective and efficient use of the home health benefit

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 the 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 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 copayment 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 use.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

(continued next page)

Strengthening incentives for effective and efficient use of the home health benefit

beneficiary cost consciousness to counterbalance the permissiveness 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 Medicare spending \$250 million to \$750 million in 2014 and \$1 billion to \$5 billion over five years. Expenditures for services would decrease because

some beneficiaries who would otherwise use home health services might decline them. Since many of these services are funded by Part B, decreases in spending growth would reduce Part B premiums.

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 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).
- 2 As of November 2013, 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.
- 3 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.
- 4 This risk-adjusted measure of readmissions includes those that occur during a home health stay or within 30 days of the end of a stay.
- 5 The Pacific census region consists of California, Oregon, Washington, Hawaii, and Alaska.
- 6 Medicare has a pay-for-reporting program that requires agencies to submit quality data to receive a full market basket update.
- 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 2015.

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

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (IRFs) are hospitals that provide intensive rehabilitation services to patients after an injury, illness, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic devices, and speech–language pathology. In 2012, 1,166 IRFs treated over 373,000 cases among Medicare fee-for-service (FFS) beneficiaries. Between 2011 and 2012, Medicare FFS payments for IRFs increased from \$6.46 billion to \$6.72 billion. In 2012, the number of patients who received care at IRFs increased, as did the average payment per case.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs, discussed below, are generally positive.

Beneficiaries' access to care—Our measures of access to care suggest that beneficiaries generally maintained access to IRF services in 2012. The number of cases increased slightly. Although the number of unique patients per 10,000 FFS beneficiaries decreased slightly from 2011 to 2012, the number has remained relatively stable over recent years, suggesting relative stability in IRF use.

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?

- **Capacity and supply of providers**—The supply of IRFs nationwide was almost unchanged in 2012, a shift from declines in previous years. The total number of freestanding facilities continued to increase slightly, while the number of hospital-based facilities decreased by 0.4 percent. Occupancy rates decreased slightly for both facility types (a 0.8 percent drop overall to 62.8 percent). IRFs are not the sole providers of rehabilitation services in communities, with skilled nursing facilities and home health agencies among potential alternatives for beneficiaries with rehabilitation needs. The overall growth in the number of IRFs, low occupancy rates, and availability of rehabilitation alternatives suggest that capacity remains adequate to meet demand.
- **Volume of services**—The number of Medicare FFS cases treated in IRFs—as a measure of resources or services used—grew by about 0.5 percent in 2012, from 371,000 in 2011 to 373,000 in 2012.

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

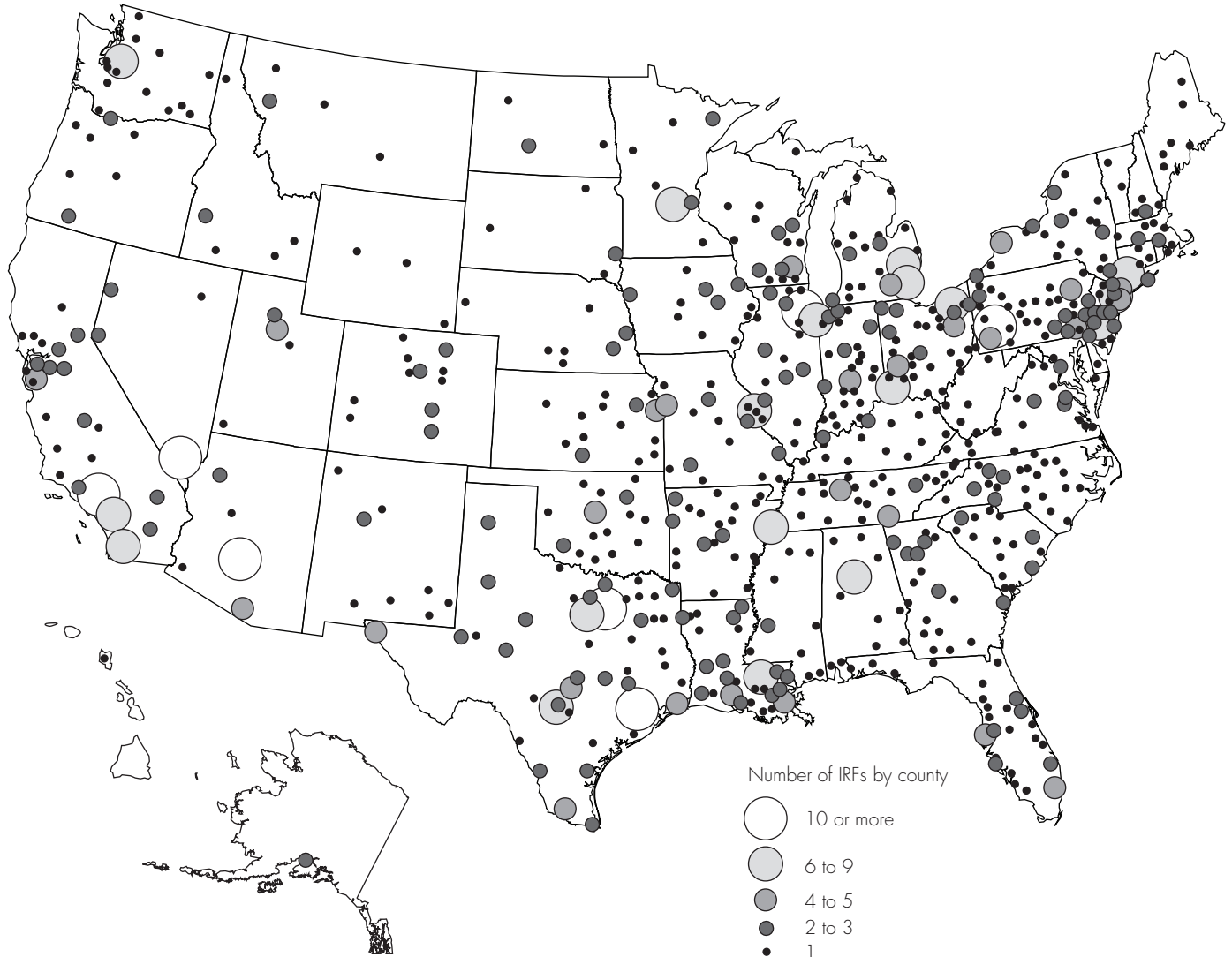
Providers' access to capital—One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF Medicare revenues and 22 percent of revenues for the entire IRF industry has very good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital. The parent institutions of hospital-based IRF units have maintained reasonable access to capital.

Medicare payments and providers' costs—Average Medicare payments per case to IRFs increased more than average costs per case did from 2011 to 2012; average payments grew 3 percent over 2011, compared with 1.5 percent cost growth. The aggregate Medicare margin for IRFs in 2012 was 11.1 percent. We project a 2014 Medicare IRF margin of 11.8 percent. If the sequester is in effect for 2014, the projected margin would be about 2 percentage points lower.

On the basis of these indicators, the Commission believes IRFs can continue to provide Medicare beneficiaries with access to safe and effective rehabilitation care with no update to the payment rates in fiscal year 2015. ■

**FIGURE
10-1**

Geographic distribution of IRFs, 2012



Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of 2012 Provider of Service files from CMS.

Background

After an illness, injury, or surgery, some patients enter intensive rehabilitation programs at an inpatient rehabilitation facility (IRF) and receive services such as physical and occupational therapy and rehabilitation nursing in a physician-led, coordinated, multidisciplinary manner. For these admissions to qualify for Medicare coverage, the care for IRF patients must require supervision by a rehabilitation physician, use an interdisciplinary approach to care, and address

a documented clinical need for therapy in at least two disciplines. IRFs provide hospital-level care and may be specialized units within an acute care hospital or specialized freestanding hospitals, which tend to be larger. Approximately 80 percent of facilities are hospital-based units; the remaining 20 percent are freestanding. However, hospital-based units accounted for only 55 percent of Medicare discharges to IRFs in 2012.

In 2012, there were 1,166 IRFs nationwide, with over 35,000 beds; at least one IRF was in every state and the District of Columbia (Figure 10-1). In general, IRFs are

**TABLE
10-1**

Medicare FFS volume and utilization of and spending for IRFs, 2002–2012

	2002	2004	2008	2010	2011	2012	Average annual change			Annual change
							2002–2004	2004–2008	2008–2011	2011–2012
Total Medicare spending (in billions)	\$4.97	\$6.58	\$5.93	\$6.14	\$6.46	\$6.72	15.1%	-2.6%	2.9%	4.0%
Number of cases	446,000	495,000	356,000	359,000	371,000	373,000	5.3	-7.9	1.4	0.5
Unique patients per 10,000 FFS beneficiaries	117.2	124.4	92.2	91.2	93.1	92.4	3.1	-7.2	0.3	-0.8
Payment per case	\$11,127	\$13,290	\$16,646	\$17,085	\$17,398	\$17,995	9.3	5.8	1.5	3.4
ALOS (in days)	13.2	12.7	13.3	13.1	13.0	12.9	-2.3	1.3	-0.8	-0.5

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), ALOS (average length of stay). With respect to unique FFS patients in a particular year, each IRF FFS patient is counted only once during that year, regardless of whether they had multiple IRF admissions. From 2011 to 2012, Medicare Provider Analysis and Review data show a 3.4 percent increase in payment per case (shown in table). Medicare hospital cost report data from CMS show a 3 percent increase in average payment per case between these years; source differences include accounting for settlements in the cost report data, slight time-period differences, and completeness of data.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

concentrated in highly populated states that have large Medicare populations. Overall, in 2012, 69 percent of beneficiaries lived in a county that had at least one IRF, with 43 percent living in a county with two or more IRFs. IRFs are not the sole provider of rehabilitation services in communities; while not required to provide intensive rehabilitation or hospital-level care, 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.

IRFs treated over 373,000 Medicare fee-for-service (FFS) cases in 2012 (Table 10-1). Relatively few Medicare beneficiaries use IRF services because to qualify for Medicare coverage, IRF patients must be able 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. Nevertheless, at over \$6.7

billion dollars in payments, Medicare is the principal payer for IRF services, accounting for approximately 60 percent of total IRF discharges in 2012. Almost all IRF patients (95 percent) were admitted to an IRF directly from an acute care hospital. A small percentage of patients, 2.5 percent, were admitted from home, and the rest were admitted from other health care facilities, such as SNFs. While patients transferred to an IRF from an acute care hospital pay no additional deductible, patients admitted to an IRF directly from the community must pay the Part A inpatient hospital deductible, which is \$1,216 in 2014. With respect to patient demographics, most Medicare FFS IRF patients in 2012 were White (81 percent) and female (58 percent), 10 percent were African American, and 4 percent were Hispanic.¹ Patients' median age was 77 years.

Medicare facility requirements and coverage criteria

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 furnish—through qualified personnel—rehabilitation nursing, physical therapy and occupational therapy, and, as needed, speech–language pathology, social services, psychological (including neuropsychological) services, and orthotic and prosthetic devices;
- have a medical director of rehabilitation with training or experience in rehabilitating patients who provides services in the facility on a full-time basis for freestanding facilities or at least 20 hours per week for hospital-based rehabilitation 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 treating the patient; and
- meet the compliance threshold, which specifies that no fewer than 60 percent of all patients admitted to the IRF must have at least 1 of 13 conditions, specified by CMS, as a primary diagnosis or comorbidity.^{2, 3}

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. Among others, patient admission criteria include:

- The patient requires therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient generally requires and can reasonably be expected to benefit from intensive rehabilitation therapy that most typically consists of at least three hours of therapy a day at least five days a week.
- 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.

Compliance threshold

The compliance threshold mandates that a certain proportion of all patients in each IRF have diagnoses specified by CMS as typically requiring intensive inpatient rehabilitation. 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 IRF discharge rates. The compliance threshold was originally set at 75 percent of an IRF's cases. CMS suspended enforcement of the rule in 2002 because of inconsistent enforcement patterns among Medicare's fiscal intermediaries, but it began consistently enforcing compliance in 2004 and enacted restrictions to some of the qualifying conditions.⁴ 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. Case-mix severity increased as the IRF patient population shifted to patients with more severe disorders who counted toward the threshold. Growth in cost per case increased as well, owing to greater patient severity and fixed costs being spread across fewer patients.

The compliance threshold, originally set at 75 percent, was permanently capped at 60 percent in 2007 by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA). At that point, the industry was largely operating at 60 percent compliance. Since then, the industry has begun to stabilize. Although IRFs' efforts to meet the compliance threshold since 2004 had a significant impact on IRF volume, the decline was consistent with the underlying reason for the compliance threshold—to direct only the most clinically appropriate cases to this intensive, costly setting.

Determining compliance can be complex. A case is first evaluated for compliance based on the impairment group code (IGC), a category that describes the primary reason for admission, which is also used in the process to assign a case to a case-mix group for payment. 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 (ICD–9) diagnosis codes. Compliance is evaluated either through (1) medical review or (2) the “presumptive” method, 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.

A more detailed summary of the history of the compliance threshold and the 2010 coverage criteria changes can be found in our March 2012 report to the Congress (Medicare Payment Advisory Commission 2012).

In fiscal year 2015, CMS is removing a large number of ICD-9 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 rehabilitation. 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 CMS's goal to improve accuracy in determining the need for the intensive rehabilitation services that IRFs provide. The criteria for hip and knee replacement and for arthritis conditions detail specific clinical factors that indicate whether a patient's condition is severe enough to warrant treatment in an IRF. To ensure that only the most clinically appropriate patients qualify for the 60-percent rule, developing more detailed criteria for all 13 conditions or alternative means of oversight should be evaluated further.

IRF prospective payment system

Before January 2002, IRFs were paid on the basis of their average costs per discharge, up to an annually adjusted facility-specific limit. Pursuant to the Balanced Budget Act of 1997, IRFs began to be paid in 2002 under a prospective payment system (PPS) based on per discharge rates that vary according to rehabilitation needs, area wages, and certain facility characteristics. As of fiscal year 2004, all IRFs were paid under the IRF PPS. Under the PPS, Medicare patients are assigned to one of 92 case-mix groups (CMGs) that are organized by clinical condition and expected resource needs. In 87 of these groups, patients are assigned based on the primary reason for intensive rehabilitation care (for example, a stroke or burns), their age, and levels of functional and cognitive impairments. In each CMG, patients are further categorized into one of four tiers based on the patients' comorbidities, certain of which can increase the cost of care relative to the costs of caring for an average beneficiary in that CMG. Each CMG has its own payment rate, and each tier also has a rate that reflects the costliness of patients in that tier relative to others in the CMG. The other five CMGs are for patients discharged before the fourth day and for those who die in the facility. IRFs may receive lower payments for patients who are transferred

to another facility when the length of stay is less than that typically provided to patients with the same condition. For high-cost outliers, IRFs receive the regular payment rate plus 80 percent of their costs above a fixed-loss threshold. For more information on Medicare's IRF payment system, see the Commission's *IRF Payment Basics* document at http://www.medpac.gov/documents/MedPAC_Payment_Basics_13_IRF.pdf.

Medicare FFS spending trends for IRFs

In 2012, Medicare FFS spending on IRFs increased by 4 percent to \$6.72 billion. While contractions in the market responding to regulations lowered Medicare spending levels in earlier years, 2012 marks the first year that spending exceeded the 2004 level. Aggregate expenditures for IRF services in the Medicare FFS program increased after implementation of the PPS in 2002, growing at an average rate of about 15 percent per year to around \$6.6 billion in 2004 (Table 10-1, p. 244). Between 2005 and 2008, however, aggregate FFS expenditures for IRFs fell, as more beneficiaries enrolled in Medicare Advantage plans and facilities adjusted to meet the compliance threshold that CMS reinstated in 2004.⁵ Aggregate FFS expenditures for IRF services have increased each year since 2009.

Are Medicare payments adequate in 2014?

To assess whether payments for fiscal year 2014 are adequate to cover the costs that efficient providers incur and how much payments should change in fiscal year 2015, we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the supply and capacity of IRF providers and changes over time in the volume of services provided, quality of care, providers' access to capital, and the aggregate relationship between Medicare's payments and IRF providers' costs. Our analysis this year indicates that the Medicare payment adequacy indicators for IRFs are generally positive.

Beneficiaries' access to care: IRF supply and service volume suggest sufficient access

We have no direct indicator of beneficiaries' access to care because no surveys exist that are specific to this small portion of the Medicare population. We also cannot determine the necessity of an IRF versus another post-

**TABLE
10-2**

In 2012 total supply of IRFs increased slightly, but hospital-based and nonprofit IRFs continued to decline

Type of IRF	2004	2005	2006	2008	2010	2011	2012	Average annual change		Annual change
								2004-2008	2008-2011	2011-2012
All IRFs	1,221	1,235	1,225	1,202	1,179	1,165	1,166	-0.4%	-1.0%	0.1%
Urban	1,024	1,027	1,018	1,001	981	972	973	-0.6	-1.0	0.1
Rural	197	208	207	201	198	193	193	0.5	-1.3	0.0
Freestanding	217	217	217	221	233	234	239	0.5	1.9	2.1
Hospital based	1,004	1,018	1,008	981	946	931	927	-0.6	-1.7	-0.4
Nonprofit	768	768	758	738	729	711	698	-1.0	-1.2	-1.8
For profit	292	305	299	291	294	294	307	-0.1	0.3	4.4
Government	161	162	168	173	156	158	157	1.8	-3.0	-0.6

Note: IRF (inpatient rehabilitation facility). For all years, the rural/urban breakdown is by core-based statistical area definition. For 2012, the ownership of four facilities is unknown.

Source: MedPAC analysis of 2012 fourth quarter Provider of Service files from CMS.

acute care setting to provide rehabilitation services. However, our analysis of IRF supply and volume suggests that capacity remains adequate to meet demand.

Capacity and supply of providers: Number of IRFs and occupancy rates suggest adequate capacity

The number of IRFs increased by one between 2011 and 2012, the first year that the number of facilities has not declined since 2005 (Table 10-2).⁶ The number of freestanding facilities has continued to slowly increase. Hospital-based IRFs continued to leave the market, although the decline in 2012 was smaller than in recent years. The majority of freestanding IRFs are for profit, while the majority of hospital-based IRFs are nonprofit. The increase in the growth of for-profit facilities jumped in 2012 (a 4.4 percent increase from 2011), reflecting a net gain of 6 hospital-based for-profit IRFs and 7 freestanding for-profit IRFs.

Occupancy rates provide another view of IRFs' capacity to serve patients, and they indicate that capacity is adequate to handle current demand and can likely accommodate future increases (Table 10-3, p. 248). Between 2011 and 2012, occupancy rates decreased slightly from 63.3 percent to 62.8 percent. In 2012, occupancy rates were higher for freestanding IRFs (67.3 percent) than for hospital-based IRFs (59.7 percent) and higher for IRFs

in urban areas than in rural areas (63.9 percent and 50.2 percent, respectively). Since 2008, occupancy rates have fluctuated slightly but changed overall by less than one percentage point from 2008 to 2012.

Volume of services: In 2012, number of FFS patients in IRFs increased; prevalence of IRF use remained fairly stable 2008-2012

We measure patient volume as the total number of FFS IRF cases and the number of unique FFS IRF patients per 10,000 FFS beneficiaries. The latter measure removes the effect of population growth and changes in Medicare Advantage enrollment, and counts each user only once per year, regardless of whether the patient had multiple IRF admissions. After earlier years of growth, volume declined substantially from 2004 to 2008 as providers adjusted to renewed enforcement of the compliance threshold (Table 10-1, p. 244). Since 2008, the total number of FFS IRF cases grew every year except 2010, reaching 373,000 in 2012.⁷ From 2011 to 2012, volume grew 0.5 percent, less than the average annual growth from 2008 to 2011 of 1.4 percent. While the total number of FFS cases increased between 2011 and 2012, the number of unique FFS IRF patients per 10,000 FFS beneficiaries declined from 93.1 to 92.4. This measure has fluctuated since 2008, but the proportion in 2012 is similar to that in 2008. The trend in

**TABLE
10-3**

In 2012 IRF occupancy rates declined slightly across most groups

Occupancy rates	2004	2008	2009	2010	2011	2012	Average annual change		Annual change
							2004–2008	2008–2011	2011–2012
All IRFs	67.8%	62.1%	62.8%	62.4%	63.3%	62.8%	-2.2%	0.6%	-0.8%
Urban	69.0	63.4	64.0	63.6	64.3	63.9	-2.1	0.5	-0.6
Rural	56.1	49.4	50.8	49.7	50.2	50.2	-3.1	0.5	0.0
Hospital based	65.7	59.8	60.1	59.4	60.1	59.7	-2.3	0.2	-0.7
Freestanding	71.9	66.2	67.3	67.1	67.8	67.3	-2.0	0.8	-0.7
Nonprofit	68.2	63.2	63.6	62.6	63.3	63.1	-1.9	0.1	-0.3
For profit	68.2	61.1	62.2	62.8	63.6	63.1	-2.7	1.3	-0.8
Government	65.0	60.9	60.9	60.0	60.4	60.1	-1.6	-0.3	-0.5
Number of beds									
1 to 10	55.2	51.6	49.3	50.1	51.8	52.4	-1.7	0.1	1.2
11 to 21	63.2	57.2	57.2	56.2	56.8	56.8	-2.5	-0.2	0.0
22 to 59	68.1	61.4	62.6	62.7	63.2	62.9	-2.6	1.0	-0.5
60 or more	71.1	66.8	67.3	66.5	67.2	66.5	-1.5	0.2	-1.0

Note: IRF (inpatient rehabilitation facility). Occupancy rate calculated based on total patient days divided by bed days available during the hospitals' cost-reporting period.

Source: MedPAC analysis of Medicare hospital cost report data from CMS.

patients per 10,000 FFS beneficiaries may suggest relative stability in IRF use compared with other rehabilitation alternatives.

Changes in admission patterns and case mix

We analyzed changes from 2004 through 2012 in posthospital discharge destinations for patients likely to need rehabilitation. We found that among cases of stroke, a condition with relatively high average case-mix severity that counts toward the compliance threshold, the share of hospital patients discharged to IRFs versus other settings remained largely unchanged (Table 10-4). In contrast, for hip and knee replacement cases, conditions for which CMS has limited the types of cases that count toward the compliance threshold, the relative share of hospital patients discharged to IRFs declined by more than half. Over the same period, the share of patients with hip and knee replacements discharged to SNFs and home health agencies grew by the same proportion that the IRF discharges declined, suggesting that these beneficiaries were able to obtain rehabilitation care in other settings.

The mix of patients treated by IRFs has also changed since 2004, as IRFs admitted a higher percentage of patients with diagnoses that met the revised compliance threshold. The percentage of IRF cases with 1 of the 13 specified conditions has increased, according to our analysis of proprietary data for a sample of IRFs (Table 10-5).⁸ In the first three years of renewed enforcement of the revised compliance threshold (2004–2006), the percentage of all Medicare cases meeting the threshold increased rapidly from 45.0 percent to 60.5 percent. However, when MMSEA capped the compliance threshold permanently at 60 percent in 2007, the increase in the compliance rate leveled off, and the rate has remained at about 60 percent through 2013.

As IRFs have adjusted their patient admission patterns to meet the revised compliance threshold, the average case-mix severity of the total Medicare FFS IRF population has increased. The largest increases in case mix occurred during the first years of renewed enforcement, from 2004 to 2007, with case mix increasing a total of 13 percent. From 2008 to 2011, after the compliance threshold was

**TABLE
10-4**

Share of hospital discharges to IRFs declined since 2004 for hip and knee replacements but remained stable for stroke

Condition	Discharge destination	Percent of hospital discharges					Percentage point change in share of hospital discharges
		2004	2008	2010	2011	2012	2004-2012
Major joint replacement/hip and knee replacement	IRF	28%	14%	12%	12%	11%	-17
	SNF/swing bed	33	36	38	38	38	5
	Home health	21	30	32	31	31	10
	All other settings	18	19	19	19	20	2
Stroke	IRF	18	19	19	19	19	1
	SNF/swing bed	27	25	26	25	25	-2
	Home health	11	12	12	12	12	1
	All other settings	45	44	44	44	44	-1

Note: IRF (inpatient rehabilitation facility), SNF (skilled nursing facility). "All other settings" includes outpatient care, other inpatient facilities, and home. Discharge destination totals may not equal 100 percent due to rounding.

Source: MedPAC analysis of hospital inpatient Medicare claims data from CMS.

capped at 60 percent in 2007, the increase in patient severity slowed and case mix increased by an average of 0.9 percent a year. From 2011 to 2012, case mix increased by another 0.9 percent, resulting in a case mix of 1.30 in 2012, and increased by 1 percent between 2012 and the first six months of 2013 for a case mix of 1.32.⁹ The average length of stay for Medicare FFS IRF patients in 2012 was 12.9 days, continuing a slight decline in length of stay since 2008 (Table 10-1, p. 244).

The change in case mix over time is reflected in the shifting pattern of diagnoses admitted to IRFs among IRF FFS cases since 2004 (Table 10-6, p. 250). Between 2004 and the first half of 2013, the share of major joint replacements of the lower extremity fell by 15.2 percentage points, consistent with the more limited definition of eligible joint replacement cases that count

toward the revised compliance threshold implemented in 2004. During the same period, the percentage of IRF patients with conditions included in the compliance threshold—such as stroke, brain injury, and neurological disorders—increased. Also, the shares of debility cases and other orthopedic conditions increased by 4.2 percentage points and 2.5 percentage points, respectively. The growth in debility cases and other orthopedic conditions is noteworthy because neither is among the 13 conditions included in the compliance threshold.

Between 2012 and the first half of 2013, the distribution of case type among FFS patients remained relatively stable. The share of neurological disorders increased by 1 percentage point, and the share of major joint replacement continued to decline, falling by 1.3 percentage points.

**TABLE
10-5**

Compliance rate of Medicare IRF cases continues to meet 60-percent threshold

	2004	2006	2010	2011	2012	2013
Estimated compliance rate of Medicare IRF cases	45.0%	60.5%	61.4%	61.0%	60.2%	60.8%

Note: IRF (inpatient rehabilitation facility). The data for 2013 are limited to discharges that occurred between January 2013 and June 2013. The compliance rate is the aggregate share of IRF cases that falls into 1 of 13 CMS specified conditions. As of July 2007, 60 percent of a facility's cases must fall into one of these diagnoses for Medicare to pay the facility as an IRF.

Source: MedPAC analysis of 2004 to 2013 data from eRehabData®.

**TABLE
10-6**

IRF patient mix has changed, 2004–2013

Type of case	Percent of IRF Medicare FFS cases						Percentage point change		
	2004	2008	2010	2011	2012	2013*	2004–2008	2008–2012	2012–2013
Stroke	16.6%	20.4%	20.1%	19.6%	19.4%	19.4%	3.9	-1.0	0.0
Neurological disorders	5.2	8.0	9.8	10.3	11.6	12.5	2.8	3.5	1.0
Spinal cord injury	4.2	4.3	4.3	4.5	4.6	4.5	0.1	0.3	-0.1
Brain injury	3.9	7.0	7.3	7.6	7.9	8.1	3.0	1.0	0.1
Fracture of the lower extremity	13.1	16.0	14.3	13.8	13.0	12.6	3.0	-3.1	-0.4
Major joint replacement of the lower extremity	24.0	13.1	11.5	10.7	10.1	8.8	-10.9	-3.0	-1.3
Other orthopedic conditions	5.1	6.1	6.7	7.1	7.5	7.6	0.9	1.5	0.1
Debility	6.1	9.1	10.0	10.3	10.0	10.3	3.0	0.9	0.4
Cardiac conditions	5.3	4.7	4.9	5.1	5.3	5.4	-0.6	0.7	0.1
All other	16.4	11.3	11.1	10.9	10.6	10.7	-5.1	-0.6	0.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). "Other" includes conditions such as amputations, major multiple trauma, and pain syndrome. Numbers may not sum to 100 percent due to rounding.

*Data are for the first six months of 2013.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS for 2004–2012, and January 1 through June 30, 2013.

Shares of other case types changed by less than 1 percentage point. Between Medicare Advantage (MA) and FFS patients, we find that MA patients are more concentrated in conditions with higher severity, suggesting that MA plans may be more selective in the patients they authorize to receive care in IRFs (see text box, pp. 252–253).

Freestanding IRFs have historically had substantially greater financial performance compared with hospital-based IRFs. In considering adequacy in Medicare payment rates, we compare patient populations in hospital-based and freestanding IRFs to determine whether differences in financial performance are driven largely by efficiencies or whether differences exist in the patient populations that could substantially influence costs.

Hospital-based and freestanding IRFs appear to have relatively similar patient populations in case types overall and in patient comorbidities. In 2012, the top 10 case types were the same for both types of IRFs, accounting for 91 percent of cases in hospital-based IRFs and 93 percent of cases in freestanding IRFs (Table 10-7). Half of these conditions do not count toward the compliance threshold (miscellaneous, major joint replacement of the lower extremity, other orthopedic conditions, cardiac conditions, and short-stay patients). Although the top 10 case types were the same, the shares of some case types differed. Stroke patients constituted a lower share of freestanding

IRF cases than of hospital-based IRF cases (15 percent vs. 21 percent), while patients with neurological disorders constituted a higher share of freestanding IRF cases (15 percent vs. 7 percent). Other orthopedic conditions, which do not count toward the compliance threshold, also accounted for a higher share of total cases in freestanding IRFs than in hospital-based IRFs (10 percent vs. 5 percent). The impairment groups of neurological disorders and other orthopedic conditions can encompass a broader range of conditions than many of the other group types, which may also allow IRFs to select patients within these groups based on their likely cost. Neurological disorders represent 1 of the 13 conditions that qualify for the 60-percent rule, so IRFs with higher shares of neurological disorder patients may be able to meet the requirements of the rule with a wider variety of case types and potentially lower cost patients. Additional research is needed regarding differences among case types that qualify for the 60-percent rule. Nevertheless, the differences in shares of case types alone are unlikely to account substantially for the historic differences in financial performance between these facility types.

Tier level within each CMG, reflecting patient comorbidities, is another measure of patient severity in comparing hospital-based and freestanding patient populations. Tier 1 reflects the most costly patients (i.e., it has the highest relative weight) and Tier 4 reflects the

TABLE 10-7**Top 10 types of cases in hospital-based and freestanding IRFs, 2012**

Type of case	Type of IRF	
	Hospital based	Freestanding
Stroke	21%	15%
Neurological disorders	7	15
Fracture of the lower extremity	13	11
Miscellaneous	12	12
Major joint replacement of the lower extremity	10	10
Brain injury	8	7
Spinal cord injury	6	4
Other orthopedic conditions	5	10
Cardiac conditions	5	5
Short-stay patients*	4	4
Total	91	93

Note: IRF (inpatient rehabilitation facility).
*The short-stay category includes patients who expired while in the IRF.

Source: MedPAC analysis of 2012 Medicare claims data.

least costly patients, who do not have comorbidities found to increase the cost of care. The distribution of Medicare IRF cases by tier is similar for hospital-based IRFs and freestanding IRFs (Table 10-8). Both IRF types have roughly 60 percent of cases in Tier 4.

Comparability of outcomes among rehabilitation care settings

Comparability of outcomes among different rehabilitation care settings represents an important question, particularly given that some patients do not live near an IRF and others may obtain care at settings other than IRFs due to the compliance threshold. Overall, research studies do not conclusively identify a particular post-acute care setting as having better outcomes for rehabilitation patients than other post-acute settings. 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 the 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 compliance threshold have affected beneficiaries' access to appropriate rehabilitation services.

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—can help CMS compare outcomes for rehabilitation care across settings. The demonstration used the CARE tool to compare outcomes across sites of care, such as readmission to the hospital and improvements on two functional measures, mobility and self-care function. The 2011 report summarizing the findings compared outcomes among home health agencies, IRFs, long-term care hospitals (LTCHs), and SNFs (Gage et al. 2011). Results indicated that unadjusted acute hospital readmission rates did not vary greatly among settings, although IRFs had the lowest rate and LTCHs had the highest rate. Risk-adjusted rates that controlled for differences in patient acuity did not differ significantly among IRFs, SNFs, and home health agencies. On functional outcomes, the risk-adjusted analysis found no significant difference in the average degree of improvement in mobility but a somewhat higher gain in self-care outcomes among patients who received care from an IRF or home health agency.

Differences in outcomes also 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 that typically receive significant amounts of therapy. For nervous system conditions, the average risk-adjusted

TABLE 10-8**Distribution of IRF cases by case-mix group tier, 2012**

Tier	Type of IRF	
	Hospital based	Freestanding
1	5%	5%
2	8	9
3	28	28
4 (no comorbidities)	60	58

Note: IRF (inpatient rehabilitation facility). IRF patients are classified into 92 case-mix groups, and within 87 of these groups, patients are further categorized into one of four tiers based on the presence of certain comorbidities. Columns may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2012 Medicare claims data.

Comparison of MA and Medicare FFS patients' use of IRF services

Patients who reside in areas with inpatient rehabilitation facilities (IRFs) typically have alternatives for rehabilitation care, including skilled nursing facilities and home health. Alternative post-acute care settings are generally less costly but offer less-intensive rehabilitation and medical services. For many patients, multiple settings could be appropriate. Given that Medicare Advantage (MA) plans have incentives to manage care for beneficiaries in a cost-efficient manner, we sought to examine how the population characteristics and use rate of the higher cost IRF services in the MA population compared with use in the fee-for-service (FFS) population.

We found that the use rate of IRFs among the FFS population in 2012 was more than double the rate of MA patients (Table 10-9). These data do 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.

On average, MA IRF patients had longer stays and greater severity of illness than FFS IRF patients, as measured by the IRF case-mix weight. MA patients were more concentrated in conditions with higher severity. A higher percentage of MA IRF users than

**TABLE
10-9**

FFS patients have higher IRF use rate, lower severity than MA patients, 2012

	FFS patients	MA patients
Use rate	1.04%	0.41%
Average length of stay	12.90	13.60
Case-mix weight	1.30	1.37
Discharged home	69.4%	72.1%
Discharged home with home health	51.3%	52.1%
Discharged to SNF	10.2%	7.9%

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility), MA (Medicare Advantage). Use rate is calculated as the number of FFS or MA patients divided by all FFS or MA patients. Patients in the discharged home category also appear in the discharged home with home health category. Discharge destinations do not total 100 percent. Not all discharge destinations are represented in the table.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS. Source for the denominator for the use rates is the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

(continued next page)

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 LTCH, IRF, and SNF patients (the average improvement for home health patients was greater than for SNF patients) (Centers for Medicare & Medicaid Services 2012).

Where results varied, the difference in improvement among settings was relatively small, less than 5 points on a 100-point scale. Home health and IRF patients had better improvement in self-care outcomes, but unobserved factors regarding patient characteristics may have

influenced outcomes. For example, the more intensive therapy requirements in IRFs may result in IRFs attracting patients who are more engaged or more motivated to improve. Likewise, factors such as informal caregiver support that are not included in the model can influence both the likelihood of referral to home health agencies and the outcomes.

Quality of care measures show improvement

We evaluated quality outcomes on three measures: Functional Independence Measure™ (FIM™) gain, discharge to the community, and discharge to an acute

Comparison of MA and Medicare FFS patients' use of IRF services (cont.)

FFS IRF users were stroke, brain injury, and spinal cord patients (Table 10-10). These conditions have higher case-mix weights and longer stays than other conditions. In 2012, the greatest difference in use was among stroke patients, who accounted for 32.7 percent of MA IRF patients, compared with 19.4 percent of FFS IRF patients. MA and FFS patients had overall similar case-mix weights and lengths of stay for most

conditions, with the exception of spinal cord cases. However, the higher proportions of higher severity conditions among MA patients appear to have driven the higher average case-mix weight across all MA patients. These differences suggest that MA plans are more selective in the patients they authorize to receive care in IRFs. ■

**TABLE
10-10**

Patient mix of Medicare FFS and MA IRF patients, 2012

Type of case	FFS IRF patients			MA IRF patients		
	Percent of all FFS patients	ALOS	Case-mix weight	Percent of all MA patients	ALOS	Case-mix weight
Stroke	19.4%	15.4	1.56	32.7%	15.4	1.56
Fracture of the lower extremity	13.0	13.2	1.27	10.7	12.9	1.25
Neurological disorders	11.6	12.9	1.36	8.3	13.5	1.39
Brain injury / nontraumatic	4.9	13.0	1.38	5.8	13.2	1.37
Brain injury / traumatic	3.0	14.0	1.45	4.1	13.8	1.46
Spinal cord / nontraumatic	3.9	14.2	1.45	5.0	15.3	1.51
Spinal cord / traumatic	0.7	19.0	2.08	1.0	20.0	2.20
Major joint replacement of the lower extremity	10.1	9.7	0.88	9.1	9.8	0.90
Debility	10.0	11.6	1.23	5.9	12.1	1.24
Other orthopedic conditions	7.5	11.7	1.12	4.5	11.7	1.11
Cardiac conditions	5.3	10.9	1.15	4.0	11.1	1.15

Note: FFS (fee-for-service), MA (Medicare Advantage), IRF (inpatient rehabilitation facility), ALOS (average length of stay). Not all case types are displayed.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

care hospital. FIM gain is the total difference between admission scores and discharge scores for a range of items addressing functional improvement on the IRF–PAI.¹⁰

Our analysis suggests that in the aggregate, mean quality of care improved on all of these measures between 2010 and 2012 (Table 10-11, p. 254). From 2010 to 2012, FIM gain increased by an average of 3 percent each year. Rates of discharge to the community grew by an average of 0.5 percent each year, while rates of discharge to an acute care hospital declined by an average of 2.7 percent each year. These outcomes do not control for changes in case

mix over these years, although the increase in case-mix severity was relatively small (a 1.5 percent increase in total from 2010 to 2012).

Providers' access to capital: IRFs appear to have adequate access to capital

Eighty percent of IRFs are hospital-based units that would access capital through their parent institution. As detailed in Chapter 3 of this report, hospitals overall maintained reasonable levels of access to capital in 2012. While respondents to *Modern Healthcare's* 2013 Construction

**TABLE
10-11**

From 2010 to 2012, average IRF quality of care improved

	2010	2011	2012	Average annual change 2010-2012
FIM™ gain	25.8	26.5	27.3	3.0%
Discharge to community	69.2%	69.7%	69.9%	0.5
Discharge to acute care hospital	10.8%	10.5%	10.2%	-2.7

Note: IRF (inpatient rehabilitation facility), FIM™ (Functional Independence Measure™). FIM gain rates are comparable with corresponding rates (January–June) in the March 2011 report to the Congress.

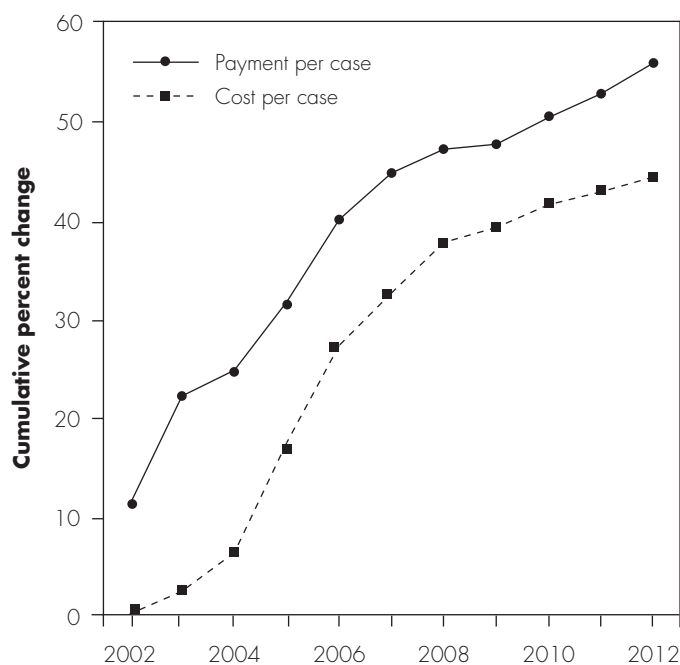
Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS.

& Design Survey indicated that the balance of hospital construction spending has tilted away from inpatient toward outpatient-based projects, a small number of new hospital-based IRFs entered the market in 2012 (Robeznieks 2013).

As for freestanding IRFs, market analysts we spoke with thought that access to capital for one major national chain remains very good. Lower costs of borrowing, continued acquisition and construction of new IRFs, and implementation of shareholder-friendly initiatives reflect good access to capital and positive financial health. Recent financial reports for this chain have demonstrated strong operating performance (Deutsche Bank 2013). Besides this chain, most other freestanding facilities are independent or are local chains with only a few providers. The extent to which these providers can access capital is less clear.

**FIGURE
10-2**

Under the PPS, IRFs' payments per case have increased cumulatively more than costs, 2002-2012



Note: PPS (prospective payment system), IRF (inpatient rehabilitation facility). Costs are not adjusted for changes in case mix.

Source: MedPAC analysis of Medicare cost report data from CMS.

Medicare payments and providers' costs: Payments to IRFs have grown more than costs since 2002 PPS implementation

Medicare's payments per case to IRFs have increased cumulatively more than IRFs' costs per case since implementation of the PPS in 2002. The average Medicare FFS payment per case has grown 56 percent between 2002 and 2012, compared with a 43 percent increase in average cost per FFS case (Figure 10-2). After large growth in average payments from 2002 to 2004, costs per case grew more than payments each year from 2004 to 2009. However, payments per case have grown more than costs each year since 2010. Based on Medicare cost reports, average payments per case grew more than average costs per case did from 2011 to 2012, with 3 percent payment growth compared with 1.5 percent cost growth.

Differences in standardized costs suggest economies of scale

Adjusting IRF costs per discharge for differences in wages, case mix, and outlier payments permits a standardized comparison of costs across different types of IRFs across the country. The mean adjusted cost per

**TABLE
10-12****Mean adjusted costs per discharge
are lower for freestanding
IRFs and larger facilities, 2012**

Type of IRF	Mean adjusted cost per discharge
All IRFs	\$15,738
Hospital based	16,592
Freestanding	12,469
Nonprofit	15,824
For profit	14,858
Government	17,644
Urban	15,349
Rural	17,747
Number of beds	
1 to 10	17,653
11 to 21	16,462
22 to 59	15,524
60 or more	12,953

Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for the wage index, case mix, and outliers. Government-owned facilities operate in a different financial context from other facilities, so costs are not necessarily comparable.

Source: MedPAC analysis of 2012 standard analytical file and Medicare cost report data from CMS.

discharge for all IRFs in 2012 was \$15,738 (Table 10-12). On average, after adjustment, cost per discharge in freestanding IRFs was about \$4,123 lower (25 percent) than in hospital-based IRFs, and cost per discharge in urban IRFs was approximately \$2,398 (14 percent) lower than in rural IRFs. Larger facilities had lower cost per discharge. In 2012, cost per discharge was \$4,700 (27 percent) lower in facilities with more than 60 beds than in facilities in the 1-bed to 10-bed range.

We stratified IRFs into quartiles of standardized costs to compare the characteristics of facilities in the low-cost and high-cost quartiles (Table 10-13) for 2012. IRFs in the lowest cost quartile tended to have more beds and higher occupancy rates. The median number of beds in the lowest cost quartile was 42 compared with the highest cost quartile's median of 17 beds. The median occupancy rate for IRFs in the lowest cost quartile was 69 percent, compared with a 52 percent occupancy rate for IRFs in the highest cost quartile.

The difference in Medicare margins between low-cost and high-cost providers was very large: The median margin for IRFs in the lowest cost quartile was about 26 percent, compared with about -26 percent for IRFs in the highest cost quartile. Low-cost providers were disproportionately freestanding (about 54 percent) since freestanding IRFs constitute only 20 percent of industry facilities. However, margins for hospital-based IRFs that were low-cost and margins for freestanding IRFs that were low-cost were both very high, 21.8 percent and 29.2 percent, respectively.

**TABLE
10-13****High margins among both
hospital-based and freestanding
IRFs in the low-cost quartile of
standardized costs, 2012**

Characteristic	Quartile	
	Low cost	High cost
Number of IRFs	271	271
Percent:		
Hospital based	45.8%	93.7%
Freestanding	54.2	6.3
Nonprofit	38.0	63.1
For profit	59.4	18.5
Government	2.6	18.5
Urban	94.5	69.0
Rural	5.5	31.0
Median Medicare margin		
All	26.4%	-25.5%
Hospital based	21.8	-25.7
Freestanding	29.2	-20.4*
Median		
Number of beds	42	17
Occupancy rate	69%	52%
Case-mix index	1.26	1.20
Median costs per discharge		
All	\$10,929	\$19,671
Hospital based	11,542	19,608
Freestanding	10,488	20,143*

Note: IRF (inpatient rehabilitation facility). Cost per discharge is standardized for the wage index, case mix, and outliers. Government-owned facilities operate in a different financial context from other facilities, so costs are not necessarily comparable.
*Reflects small cell size (17 facilities).

Source: MedPAC analysis of 2012 standard analytical file and Medicare cost report data from CMS.

**TABLE
10-14**

IRFs' Medicare margins rose in 2012

Type of IRF	Share of Medicare discharges, 2012	Margins						
		2004	2006	2008	2009	2010	2011	2012
All IRFs	100%	16.7%	12.4%	9.3%	8.4%	8.7%	9.8%	11.1%
Urban	91.2	17.0	12.6	9.5	8.6	9.0	10.2	11.4
Rural	8.8	13.9	10.6	7.2	5.9	5.6	6.1	7.3
Freestanding	45.3	24.7	17.5	18.1	20.5	21.3	22.9	23.8
Hospital based	54.7	12.2	9.6	3.8	0.2	-0.4	-0.1	0.8
Nonprofit	46.9	12.8	10.7	5.3	2.3	2.1	2.6	2.1
For profit	45.8	24.4	16.3	16.8	19.0	19.6	21.0	22.9
Government	7.3	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of beds								
1 to 10	2.5	3.4	-3.8	-4.8	-11.6	-10.0	-6.8	-7.8
11 to 21	19.0	9.6	7.0	0.5	-2.7	-3.2	-3.3	-1.9
22 to 59	42.3	16.1	12.4	8.3	6.5	6.9	8.0	9.3
60 or more	36.2	22.6	17.5	16.9	18.3	18.4	19.4	20.9

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.

IRF Medicare margins increased in 2012

Between 2011 and 2012, aggregate IRF Medicare margins increased from 9.8 percent to 11.1 percent (Table 10-14). During the first two years of the IRF PPS, margins rose rapidly, reaching 17.8 percent in 2003, with all IRF provider types experiencing solid gains. After this rapid buildup, margins declined each year through 2009, although they remained healthy. Starting in 2010, margins have again risen moderately each year.

As is typical for Medicare providers in other health care sectors, margins varied substantially across providers. Medicare margins in freestanding IRFs far exceeded those of hospital-based facilities. In 2012, margins for freestanding IRFs (45.3 percent of discharges) increased to 23.8 percent, while hospital-based IRFs (54.7 percent of discharges) had margins of 0.8 percent. In 2012, aggregate margins in for-profit facilities were 22.9 percent, while nonprofit IRFs had margins of 2.1 percent. However, margins by ownership status varied by facility type. Between 2011 and 2012, among freestanding facilities, margins in nonprofit facilities declined from 15.3 percent

to 13.8 percent, while margins in for-profit IRFs increased from 25.3 to 26.5 percent. During the same period, among hospital-based IRFs, margins in nonprofits declined slightly from -0.1 percent to -0.2 percent, while margins in for-profits increased sharply from 3.8 percent to 8.3 percent. Total (all-payer) margins for freestanding facilities decreased from 11.7 percent to 9.6 percent.¹¹

The difference in margins is affected by volume and the ability to constrain cost growth. Hospital-based units tend to be smaller facilities yet still generally have lower occupancy rates than freestanding facilities. More than half of hospital-based IRFs (58 percent) have fewer than 22 beds, whereas only 6 percent of freestanding IRF facilities have fewer than 22 beds, and about half have 60 beds or more.

Analysis of changes in component costs shows that freestanding facilities have contained cost growth more than hospital-based facilities have, particularly in routine costs (Figure 10-3). Between 2004 and 2010, routine costs grew 49 percent in hospital-based facilities but only 20 percent in freestanding facilities. In 2010, routine

costs per case were 37 percent higher in hospital-based facilities than in freestanding facilities. Differences in cost growth trends are similar for ancillary costs, which include the costs of therapy, and indirect costs, which include administration, capital, and general overhead. In 2010, indirect costs per case were 11 percent higher in hospital-based facilities than in freestanding facilities, and ancillary costs per case were 19 percent higher in hospital-based facilities than in freestanding facilities. As changes in the compliance threshold resulted in lower patient volumes and higher severity of illness in patients, freestanding facilities may have been more successful at containing costs across all components because of financial necessity among the stand-alone and predominantly for-profit facilities.

In the aggregate, the Medicare payments for hospital-based IRFs appear sufficient for the units to cover their direct costs. In 2010, the direct cost margin (calculated as payments minus direct costs, divided by payments) for hospital-based IRFs was 34.4 percent. Further, hospital margins were higher in hospitals that had IRF units than in hospitals without them. In 2012, the Medicare margin for inpatient hospitals with IRF units was -4.2 percent, compared with -6.1 percent for hospitals without an IRF unit. This difference suggests that IRF units may have been able to make positive financial contributions to their parent hospitals.

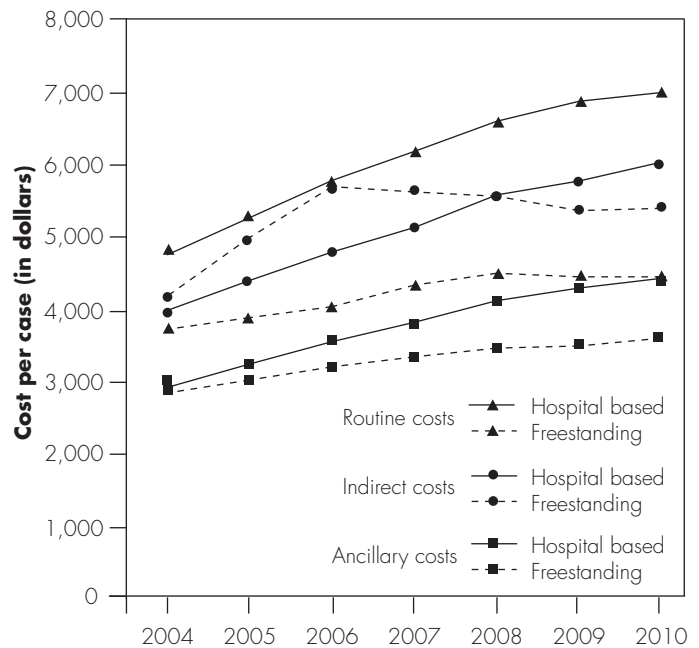
Medicare margins for 2014

To project the aggregate Medicare margin for 2014, we model policy changes that will go into effect in 2013 and 2014. These policies include:

- Increasing payment rates for fiscal year 2013 by 2.1 percent, the net result of a 2.7 percent market basket update, an estimated 0.2 percent payment increase for changes in the outlier threshold, a -0.1 percentage point market basket reduction per the Patient Protection and Affordable Care Act of 2010 (PPACA), and a -0.7 percentage point market basket reduction for productivity per PPACA.
- Increasing payment rates for fiscal year 2014 by 2.3 percent, the net result of a 2.6 percent market basket update, an estimated 0.5 percent payment increase for changes in the outlier threshold, a -0.3 percentage point reduction per PPACA, and a -0.5 percentage point reduction for productivity per PPACA.

FIGURE 10-3

Change in component costs by IRF ownership, 2004-2010



Note: IRF (inpatient rehabilitation facility). Routine costs include room and board and nursing. Indirect costs include administration, capital, and general overhead. Ancillary costs include therapy, drugs, and other supplies.

Source: MedPAC analysis of cost report data from CMS.

To estimate cost growth in 2013 and 2014, we used an average of the previous three years' cost growth. Based on the policy changes listed and our assumptions regarding cost growth, we project that aggregate Medicare margins will increase from 11.1 percent in 2011 to 11.8 percent in 2014. The 2014 margin projection is based on the current law payment rates under Title XVIII of the Social Security Act, which do not include the sequester. If the sequester is in effect for 2014, the projected margin would be about 2 percentage points lower. The margin projection for 2014 does not assume increased cost control efforts by IRFs in response to the market basket reductions or the economy.

How should Medicare payments change in 2015?

RECOMMENDATION 10

The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2015.

RATIONALE 10

Our indicators of Medicare payment adequacy for IRFs are positive. The overall growth in volume, low occupancy rates, and availability of other rehabilitation alternatives suggest that capacity remains adequate to meet demand. Quality of care continues to improve. We calculate an aggregate margin of 11.1 percent in 2012 and project a margin of 11.8 percent for 2014. Based on our assessment of the indicators of payment adequacy, we conclude that IRFs should be able to accommodate cost changes in fiscal year 2015 with the base payment rate held at 2014 levels. That is, the 2015 base payment rate under the IRF PPS should be the same as the base rate in 2014. We will closely monitor our payment update indicators and will be able to reassess our recommendation for the IRF payment update in the next fiscal year.

IMPLICATIONS 10

Spending

- The payment update for IRFs under current law in fiscal year 2015 consists of a forecasted 2.7 percent market basket update for rehabilitation, psychiatric, and long-term care hospitals; a forecasted -0.3 percent productivity adjustment off the market basket update; and a -0.2 percent market basket reduction per PPACA.¹² This recommendation would decrease

federal program spending relative to current law by between \$50 million and \$250 million in 2015 and by \$1 billion to \$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 providers, but overall, a minimal effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries is expected.

Future work will include addressing trends that we have observed in financial performance among sectors of the IRF industry. While margins in hospital-based facilities average 0.8 percent, margins average 24 percent among freestanding facilities, which provide care for 45 percent of all IRF discharges. It is important for Medicare to act as a prudent purchaser, and with these high margins, payments may no longer accurately reflect providers' costs for almost half of Medicare discharges. In future work, we plan to consider options for rebasing IRF payments. Furthermore, we plan to begin evaluating whether there are systematic biases in Medicare's payments that result in the imbalance in financial performance among provider types. ■

Endnotes

- 1 IRF patient demographics are similar to the distribution in the general Medicare population, although the proportion of Hispanic patients treated at IRFs is somewhat lower than in the general Medicare population (4 percent vs. 8 percent) (Medicare Payment Advisory Commission 2013). Data suggest that Hispanic beneficiaries are underrepresented as both IRF and SNF users.
- 2 This rule does not take the place of Medicare’s general medical necessity requirements.
- 3 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation; major multiple trauma; hip fracture; brain injury; neurological disorders (e.g., multiple sclerosis, Parkinson’s disease); burns; three arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; hip or knee replacement when bilateral body mass index ≥ 50 ; and age 85 or older.
- 4 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.
- 5 FFS expenditures also fell when CMS reduced IRF payments by 1.9 percent in 2006 and by 2.6 percent in 2007 to adjust for changes in IRF coding practices that CMS analyses determined did not reflect real changes in IRF patients’ acuity.
- 6 The total number of IRF beds has generally followed trends in number of facilities.
- 7 The decline in 2010 may have been due in part to the clarifications in the coverage criteria that went into effect that year (see p. 245).
- 8 The proprietary data come from eRehabData[®], which has data on a subset of IRFs that subscribe to its inpatient rehabilitation outcomes system. eRehabData[®] has developed a protocol to assess whether a case satisfies the compliance threshold.
- 9 Source: MedPAC analysis of the Inpatient Rehabilitation Facility–Patient Assessment Instrument.
- 10 Scores for each of the 18 FIM items range from 1 (*complete dependence*) to 7 (*independence*). The scores on the 18 measures are summed to calculate a total score.
- 11 All-payer margins for hospital-based facilities reflect a margin for the entire hospital rather than for the IRF unit alone. Therefore, we only present all-payer margins for freestanding facilities.
- 12 The market basket forecast and productivity adjustment were made in the third quarter of 2013. CMS will use the most recent forecast available when setting updates, 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 2015.

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

.....
(The Commission's recommendation for long-term care hospital payment reform is included with its acute care hospital update recommendation in Chapter 3.)

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 (ACHs), and its Medicare patients must have an average length of stay greater than 25 days. In 2012, Medicare spent \$5.5 billion on care furnished in 420 LTCHs nationwide. About 124,000 beneficiaries had more than 140,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs’ discharges.

Assessment of payment adequacy

Beneficiaries’ access to care—We have no direct measures of beneficiaries’ access to 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 the later years of the five-year moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments. In the last year of the moratorium (2012), the number of LTCHs rose from 417 to 420, while the number of LTCH beds increased 0.5 percent.

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?
- Reforming the LTCH payment system

- **Volume of services**—From 2011 to 2012, the number of beneficiaries who had LTCH stays increased by 0.7 percent. Controlling for growth in the number of fee-for-service (FFS) beneficiaries, we found that the number of LTCH cases declined 1 percent between 2011 and 2012. This reduction in per capita admissions is consistent with (though smaller than) that seen in other settings. The small decline is due in part to the congressional moratorium that limited growth in facilities and follows a period of relatively steady growth in the number of LTCH cases per FFS beneficiary.

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 unadjusted rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2012.

Providers' access to capital—For the past few years, the availability of capital to LTCHs has not reflected current reimbursement rates but rather uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. Since 2007, the Congressionally imposed moratorium on new beds and facilities has reduced opportunities for expansion and the need for capital. With the expiration of the moratorium at the end of 2012, LTCH companies appear to be acting with caution, likely because of the continued scrutiny of Medicare spending on LTCH care.

Medicare payments and providers' costs—Since 2007, LTCHs have held cost growth below the rate of increase of the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2011 and 2012, Medicare payments continued to increase faster than provider costs, resulting in an aggregate 2012 Medicare margin of 7.1 percent. Financial performance in 2012 varied across LTCHs and may reflect differences in cost control and response to payment incentives.

We estimate that LTCHs' aggregate Medicare margin will be 6.5 percent in 2014. If the sequester remains in place, the margin would be expected to be about 2 percentage points lower.

On the basis of these indicators, the Commission believes LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care with no update to the payment rates in fiscal year 2015.

If the Congress does not implement the Commission's recommendation for LTCH payment reform (summarized below), our update recommendation applies to Medicare's payment rate for all LTCH services. If the Congress does implement the

Commission's recommended payment reform, our update recommendation applies to Medicare's payment rate for chronically critically ill (CCI) cases in LTCHs.

Reforming the LTCH payment system

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

What Medicare is purchasing with its higher LTCH payments remains unclear. Studies comparing LTCH care with that provided in ACHs have failed to find a clear advantage in outcomes for LTCH users. At the same time, some studies have found that episode payments are higher for beneficiaries who use LTCHs, while others have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill. As a prudent payer, Medicare must ensure that its payments to providers are properly aligned with the resource needs of beneficiaries.

The Commission has held that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

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 Congress should direct CMS to pay higher LTCH rates only for LTCH cases that are CCI. Non-CCI cases should be paid at rates based on the inpatient prospective payment system (IPPS) for ACHs. Savings from reducing payments for non-CCI cases in LTCHs should be allocated to the IPPS outlier pool to better match payments and costs for extraordinarily costly CCI cases in ACHs. This change is part of a package of recommended changes to hospital payments that is designed to align payment rates across settings for similar services, improving financial incentives in the Medicare program while maintaining adequate overall payments.

In the absence of patient-specific data on the metabolic, endocrine, physiologic, and immunologic abnormalities that characterize CCI patients, the Congress should define LTCH CCI cases as those that spent eight or more days in an intensive care unit (ICU) during an ACH stay immediately preceding the LTCH stay. The

Commission has determined that length of stay in the ICU is the best available proxy measure of case complexity and a good predictor of intensive resource use during post-acute care episodes that begin with an ACH stay. 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 during a previous ACH stay were a distinguishing characteristic of LTCH patients. ICU length of stay is collected in the medical record and reported to CMS on the claim; therefore the information can be accessed by both the Medicare program and providers. The Commission also recommends making an exception to the eight-day ICU threshold for LTCH cases that received mechanical ventilation for 96 hours or more during an immediately preceding ACH stay. Such cases are generally considered appropriate for admission to LTCHs and higher LTCH-level payment rates.

The Pathway for SGR Reform Act of 2013 mandated changes to the LTCH payment system, including limiting higher LTCH payments to cases that spent at least three days in an ICU during an immediately preceding ACH stay. The Commission is concerned that this lower threshold may fail to distinguish the truly chronically critically ill and 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 25-percent rule

In fiscal year 2005, CMS established a new policy—the so-called 25-percent rule—to help ensure that long-term care hospitals (LTCHs) do not function as units of acute care hospitals (ACH) and that decisions about admission, treatment, and discharge in both the ACH and the LTCH are 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. An LTCH is paid full LTCH rates for patients admitted from any ACH until the percentage of Medicare admissions from any one ACH exceeds the applicable threshold of the LTCH’s Medicare cases. After the threshold is reached, the LTCH is paid the lesser of the LTCH prospective payment system rate or an amount equivalent to the ACH rate for patients with the same diagnosis.¹ Patients who were

high-cost outliers in the ACH do not count toward the threshold and continue to be paid at the LTCH rate even if the threshold of admissions from that ACH has been reached.

The 25-percent rule initially applied only to colocated LTCHs (called hospitals-within-hospitals (HWHs)) and LTCH satellites. In July 2007, CMS extended the 25-percent rule to apply to freestanding LTCHs as well. But the Congress has repeatedly delayed full implementation of the 25-percent rule for most HWHs and satellites and prevented the Secretary from applying the 25-percent rule to freestanding LTCHs. Most recently, the Pathway for SGR Reform Act of 2013 set the threshold for most HWHs and satellites at 50 percent and delayed any application of the 25-percent rule to freestanding LTCHs until July 1, 2016. ■

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).² These facilities can be freestanding or colocated with other hospitals, as hospitals-within-hospitals 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. (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.³ In 2012, Medicare spent \$5.5 billion on care provided in an estimated 420 LTCHs nationwide. About 124,000 beneficiaries had more than 140,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs’ discharges.

Since October 2002, Medicare has paid LTCHs prospective per discharge rates based primarily on the

patient’s diagnosis and the facility’s wage index.⁴ 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 inpatient PPS 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.⁵ The PPS pays differently for short-stay outlier cases (patients with shorter than average lengths of stay), reflecting CMS’s contention that Medicare should pay adjusted rates for patients with relatively short lengths of stay to reflect the reduced costs of caring for them (see text box, pp. 268–269). In addition, CMS uses the so-called “25-percent rule” to discourage LTCHs from admitting too many patients from any one referring hospital (generally an ACH) (see text box, this page).

Medicare payment policies spur growth in use of LTCHs

Medicare’s special payment policies for LTCHs came about when the inpatient prospective payment system (IPPS) for ACHs was implemented in 1983. About 84

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.⁶ 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 27.4 percent of LTCH discharges received SSO payment adjustments in fiscal year 2012, but this share varied across types of LTCHs. For example, 26.5 percent of for-profit LTCHs' cases were SSOs in fiscal year 2012, compared with 33 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 payment amount as the patient's length of stay increases.

Since December 29, 2012, CMS has applied a different standard to cases with the very shortest lengths of stay—those with stays less than or equal to the IPPS average length of stay for the same type of case plus one standard deviation. These cases are paid the lowest of the four payment amounts listed above, with the fourth amount being an amount comparable with the IPPS payment rate rather than a blended amount. The Commission estimates that in fiscal year 2014, 46.7 percent of SSO cases—or 12.6 percent of all LTCH cases—will be very short stay outliers and subject to the IPPS payment amount.⁷

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

(continued next page)

hospitals with average lengths of stay greater than 25 days were excluded from the IPPS because their patient costs could not be accurately predicted by the IPPS patient classification system and weights. These LTCHs, as they came to be called, had predominantly begun as tuberculosis and chronic disease hospitals. Medicare continued to pay LTCHs on a cost basis in accordance with the payment system established in the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) until CMS implemented an LTCH PPS in 2003. During those years, as the number of LTCHs climbed, the types of patients treated by LTCHs changed dramatically. The Commission and others have 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.

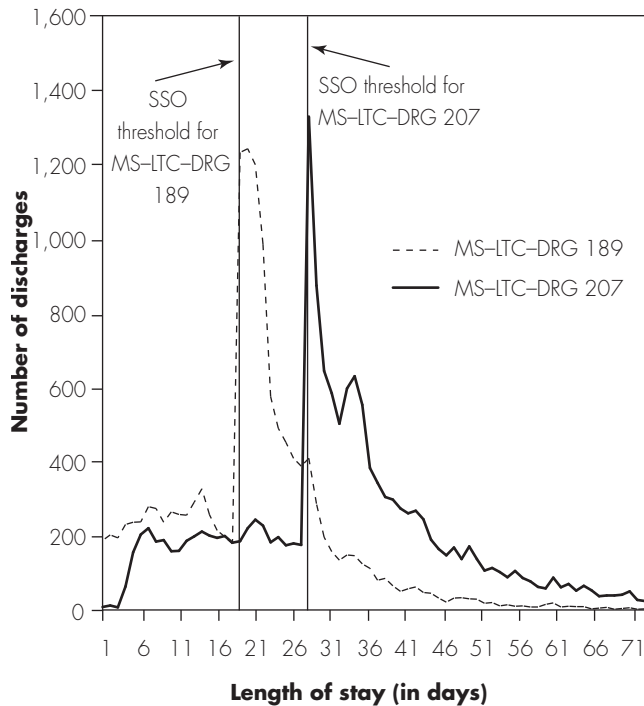
Strong incentives to shift patients from ACHs to LTCHs

Medicare's IPPS and LTCH payment policies create strong incentives for ACHs to shift costly patients to LTCHs (and other post-acute care providers) and for LTCHs to expand capacity. Under the IPPS, per case payments encourage ACHs to reduce their costs by shortening lengths of stay. In the early years of the IPPS, average length of stay declined at a rate of about 1.2 percent per year, falling between 1984 and 1991 from 8.8 days to 8.1 days (Prospective Payment Assessment Commission 1996). The rate of decline accelerated sharply in the early 1990s, with average length of stay dropping by an additional full day, to 7.1 days by 1994. This drop was accompanied by extraordinary growth in the supply and use of post-acute

Payment for short-stay outliers in long-term care hospitals (cont.)

FIGURE 11-1

Many LTCH cases in FY 2012 were discharged in the period immediately following the short-stay outlier threshold



Note: LTCH (long-term care hospital), FY (fiscal year), 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 and 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.

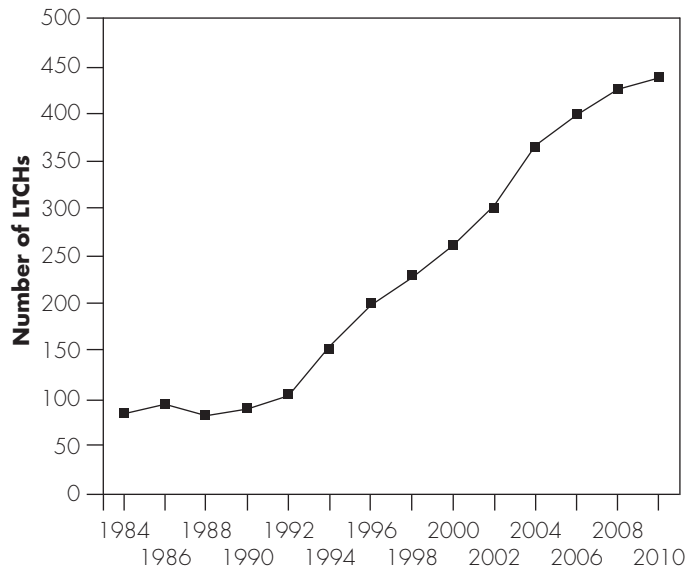
standard IPPS payment in 2014 is \$30,480, while the standard LTCH payment is \$80,098. LTCHs therefore have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type, and they appear to respond to that incentive (Figure 11-1). Analysis of lengths of stay by MS-LTC-DRG for 2012 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 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. ■

care services, including LTCH services. Between 1990 and 1996, the number of LTCHs more than doubled from 89 to 198; growth continued apace until about 2005 (Figure 11-2, p. 270). From 1990 to 2005, the number of Medicare discharges from LTCHs increased ninefold.

Medicare's payment method for LTCHs itself contributed to growth in the use of services. Medicare paid LTCHs under TEFRA rules for about 20 years—much longer than the Congress initially intended. Consequently, several flaws inherent in TEFRA—which would have had little significance in the short run—led to growth in supply, utilization, and expenditures over time. Under TEFRA,

each LTCH was paid on the basis of its average cost per discharge, up to a facility-specific limit. The limit was set at the LTCH's average cost per discharge in a designated base year and updated annually for inflation. LTCHs that kept their average costs per discharge below their limits could receive bonus payments. This payment system proved to be financially attractive to new providers. New LTCHs could maximize their costs in their first years of operation, thereby establishing a high facility-specific limit. The new entrant could then quickly reduce its costs below its limit, resulting in reimbursement of its full costs plus bonus payments.

**FIGURE
11-2****LTCHs have been one of the fastest growing providers in Medicare**

Note: LTCH (long-term care hospital).

Source: Medicare Payment Advisory Commission 2012a; ProPAC 1996.

Although it was hoped that the LTCH PPS would create better incentives for providers to control their costs, evidence suggests that base payments under the PPS were initially set too high. Given the inflationary incentives of TEFRA, using aggregate costs generated under that payment system to establish budget-neutral prospective payment rates resulted in overly generous payments. In the last years of TEFRA, Medicare spending (which reflected underlying costs) for LTCH services was growing at an average annual rate of about 18 percent. That rate accelerated in the first years of the PPS, with LTCH spending climbing 27 percent per year from 2002 to 2005, while the number of discharges rose 11 percent per year. During that same period, LTCH margins shot up from -0.2 percent to 11.9 percent.⁸ Beginning in 2005, CMS implemented a number of regulatory changes that dramatically reduced spending growth, including the introduction of the 25-percent rule, lower payments for many short-stay outlier cases, and smaller annual increases to the base payment rate.

Payment disparities across settings contribute to growth in use of LTCHs

Although LTCHs have positioned themselves as providers of post-acute care for CCI and other medically

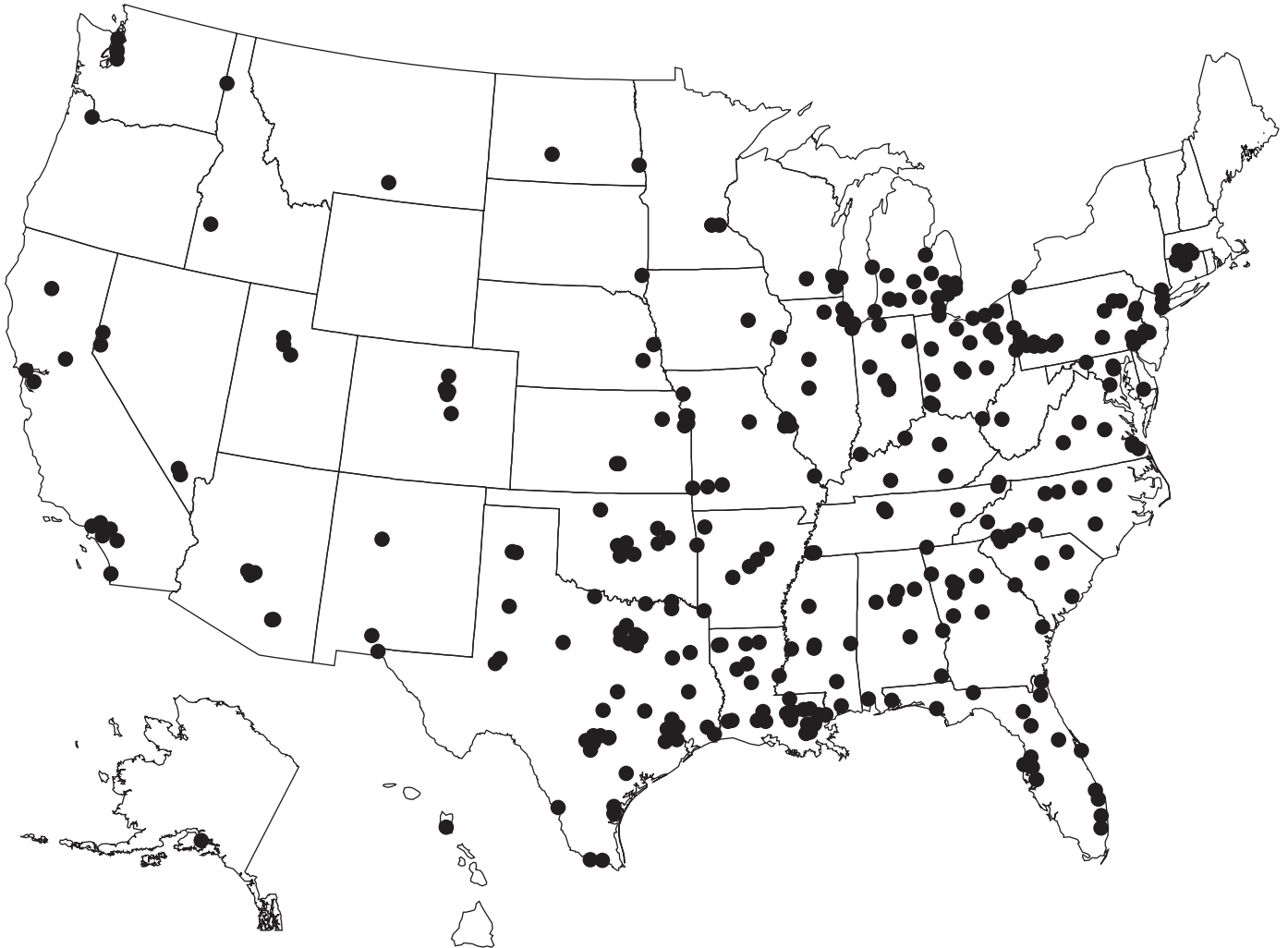
complex patients, most CCI patients nationwide are cared for in ACHs (and later in skilled nursing facilities (SNFs)), and many LTCH patients are not CCI (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012a, Kahn et al. 2010, Medicare Payment Advisory Commission 2013). But Medicare's payments to LTCHs are typically far higher than those made for similar patients in other settings (Gage et al. 2007, Kahn et al. 2013, Kandilov and Dalton 2011).⁹ CMS has long been concerned that incentives under the ACH PPS and the LTCH PPS encourage hospitals to transfer costly patients to LTCHs. Unnecessary transfer of patients to LTCHs increases costs to the Medicare program by triggering two inpatient payments (one for the ACH stay and one for the LTCH stay) for what otherwise might have been one inpatient stay (or one inpatient stay and one less-costly stay in a SNF or other post-acute care setting).

Comparatively attractive payment rates for LTCH care have encouraged an oversupply of facilities in some areas and overuse of LTCH services by patients who are not CCI. Due in part to state certificate-of-need programs that prevent or limit the opening of certain types of health care facilities, many new LTCHs have located in markets where LTCHs already exist instead of in markets with few or no direct competitors.¹⁰ As a result, LTCHs are not distributed evenly across the country (Figure 11-3). Some areas have no LTCHs, underscoring the fact that medically complex patients can be treated appropriately in other settings.¹¹ At the same time, some areas have many LTCHs. This concentration has financial implications for the Medicare program because an oversupply of LTCH beds has resulted in LTCHs admitting less-complex cases that could appropriately be treated in less costly settings. Previous Commission analysis of LTCH claims from 2010 found that, in markets where LTCHs are used most frequently, the average LTCH case mix was lower than in markets where LTCHs are used less often (Medicare Payment Advisory Commission 2013).

As a prudent payer, Medicare must ensure that its payments to providers are properly aligned with the resource needs of beneficiaries. In addition, the Commission has held that payment for the same set of services should be comparable regardless of where the services are provided to help ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

**FIGURE
11-3**

Long-term care hospitals are not distributed evenly across the nation, 2012



Source: MedPAC analysis of cost report data from CMS.

Are Medicare payments adequate in 2014?

To address whether payments for 2014 are adequate to cover the costs providers incur and how much providers' costs are expected to change in the coming year (2015), 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 and volume 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 LTCH care, and the absence of LTCHs in many areas of the country makes it particularly difficult to assess the need for LTCH care and therefore the adequacy of supply (since beneficiaries in areas without LTCHs receive similar services in other settings). Instead, we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish.

**TABLE
11-1**

Growth in the number of LTCHs slowed in the later years of the moratorium

Type of LTCH	Congressionally imposed moratorium									Average annual change		
	2004	2005	2006	2007	2008	2009	2010	2011	2012	2004–2005	2005–2009	2009–2012
All	315	366	373	382	388	411	416	417	420	16.2%	2.9%	0.7%
Urban	299	342	348	358	362	388	389	392	393	14.4	3.2	0.4
Rural	16	24	25	24	26	23	27	25	27	50.0	-1.1	5.5
Nonprofit	67	78	76	76	77	79	82	80	80	16.4	0.3	0.4
For profit	229	265	274	283	291	313	314	319	322	15.7	4.2	0.9
Government	19	23	23	23	20	19	20	18	18	21.1	-4.7	-1.8

Note: LTCH (long-term care hospital). The Medicare, Medicaid, and SCHIP Extension Act of 2008 and subsequent amendments imposed a five-year moratorium on new LTCHs and new LTCH beds in existing facilities. Exemptions from the moratorium were allowed in certain specified circumstances.

Source: MedPAC analysis of Medicare cost report data from CMS.

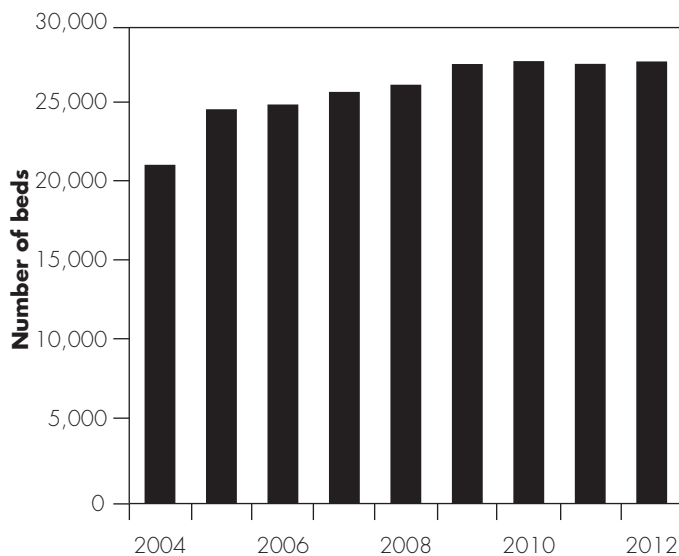
Capacity and supply of providers: Supply stabilized during the congressionally mandated moratorium

The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and subsequent amendments imposed a limited moratorium on new LTCHs and new beds in

existing LTCHs from December 29, 2007, to December 28, 2012.¹² We examined Medicare cost report data to assess the number of LTCH beds and facilities.¹³ Growth in the number of LTCHs filing Medicare cost reports slowed considerably in the later years of the moratorium (Table 11-1). In the last year of the moratorium (2012), the number of LTCHs rose from 417 to 420, while the number of LTCH beds nationwide increased 0.5 percent (Figure 11-4). New LTCHs were able to enter the Medicare program only if they met specific exceptions to the moratorium. Most of the new LTCHs filing cost reports during the moratorium were for-profit facilities. Overall, in 2012, more than 75 percent of LTCHs were for profit, and 94 percent were located in urban areas.

**FIGURE
11-4**

Growth in the number of LTCH beds has slowed



Note: LTCH (long-term care hospital).

Source: MedPAC analysis of cost report data from CMS.

Volume of services: Number of LTCH users holding steady

Beneficiaries' use of services suggests that access is adequate. Growth in the number of LTCH cases was high in the first years of the LTCH PPS but declined from 2005 to 2007 (Table 11-2). Much of this decrease may be explained by a decline in the number of Medicare FFS beneficiaries resulting from growth in 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 2011 to 2012, the number of beneficiaries who had LTCH stays ("LTCH users") increased by 0.7 percent. Because the number of fee-for-service (FFS) beneficiaries grew

**TABLE
11-2**

The number of Medicare LTCH cases and users holding steady

	2004	2005	2007	2011	2012	Average annual change			
						2004–2005	2005–2007	2007–2011	2011–2012
Cases	121,955	134,003	129,202	139,715	140,463	9.9%	-1.8%	2.0%	0.5%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.2	38.3	37.9	9.0	-0.3	1.4	-1.0
Spending (in billions)	\$3.7	\$4.5	\$4.5	\$5.4	\$5.5	21.6	0.0	4.7	2.7
Spending per FFS beneficiary	\$101.3	\$122.2	\$126.0	\$148.0	\$149.6	20.7	1.5	4.1	1.1
Payment per case	\$30,059	\$33,658	\$34,769	\$38,664	\$39,493	12.0	1.6	2.7	2.1
Average length of stay (in days)	28.5	28.2	26.9	26.3	26.2	-1.1	-2.3	-0.5	-0.4
Users	108,814	119,282	114,299	122,838	123,652	9.6	-2.1	1.8	0.7

Note: LTCH (long-term care hospital), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

at a somewhat faster pace during that period, the number of LTCH cases per FFS beneficiary declined 1 percent. This reduction in per capita admissions is consistent with (though smaller than) the reduction seen in other settings. The small decline is due at least in part to the congressional moratorium that limited growth in facilities, and it follows a period of relatively steady growth in the number of LTCH cases per FFS beneficiary from 2007 to 2011. Access to LTCH care appears to be holding fairly steady, even in the presence of the moratorium.

Compared with all Medicare beneficiaries, those admitted to LTCHs are disproportionately disabled (under age 65), over age 85, and 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. 2012b, 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 intensive care unit (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 2012, the top 25 LTCH diagnoses made up 63 percent of all LTCH discharges (Table 11-3, p. 274). The most frequently occurring diagnosis was MS-LTC-DRG 207, respiratory diagnosis with ventilator support for 96 or more hours. Nine of the top 25 diagnoses, representing 34 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 other health care facilities, LTCHs only recently began submitting a limited set of quality data to CMS (see text box, p. 275); those data are not yet available for analysis. Until the data are available, the Commission uses aggregate trends in rates of in-facility mortality, mortality within 30 days of discharge, and readmissions from LTCHs to ACHs. Although we use risk-adjusted measures to assess changes in quality in other health care settings, we do not risk adjust measures of LTCH quality because the available data are not adequate for this purpose. Claims data, which are used to risk adjust ACH measures of quality, do not provide the level of detail needed to adequately adjust for differences in risk

**TABLE
11-3**

The top 25 MS-LTC-DRGs made up two-thirds of LTCH discharges in 2012

MS-LTC-DRG	Description	Discharges	Percentage
207	Respiratory system diagnosis with ventilator support 96+ hours	15,842	11.3%
189	Pulmonary edema and respiratory failure	14,036	10.0
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	8,954	6.4
177	Respiratory infections and inflammations with MCC	4,546	3.2
592	Skin ulcers with MCC	4,004	2.8
208	Respiratory system diagnosis with ventilator support < 96 hours	3,060	2.2
949	Aftercare with CC/MCC	3,060	2.2
539	Osteomyelitis with MCC	2,605	1.9
190	Chronic obstructive pulmonary disease with MCC	2,466	1.8
193	Simple pneumonia and pleurisy with MCC	2,259	1.6
919	Complications of treatment with MCC	2,200	1.6
559	Aftercare, musculoskeletal system and connective tissue with MCC	2,190	1.6
682	Renal failure with MCC	2,142	1.5
314	Other circulatory system diagnoses with MCC	2,061	1.5
862	Postoperative and post-traumatic infections with MCC	2,053	1.5
570	Skin debridement with MCC	1,965	1.4
870	Septicemia or severe sepsis with ventilator support 96+ hours	1,928	1.4
166	Other respiratory system OR procedures with MCC	1,899	1.4
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR procedure	1,840	1.3
291	Heart failure and shock with MCC	1,749	1.2
853	Infectious and parasitic diseases with OR procedure with MCC	1,561	1.1
602	Cellulitis with MCC	1,523	1.1
603	Cellulitis without MCC	1,487	1.1
981	Extensive OR procedure unrelated to principal diagnosis with MCC	1,455	1.0
371	Major gastrointestinal disorders and peritoneal infections with MCC	1,424	1.0
	Top 25 MS-LTC-DRGs	88,309	62.9
	Total	140,496	100.0

Note: MS-LTC-DRG (Medicare severity long-term care diagnosis related group), LTCH (long-term care hospital), MCC (major complication or comorbidity), CC (complication or comorbidity), OR (operating room). MS-LTC-DRGs are the case-mix system for LTCHs. Columns may not sum due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

across LTCH patients because the variation in patient severity and complexity in LTCHs is small compared with that in other health care settings. LTCH cases are highly concentrated in a few MS-LTC-DRGs; in addition, the vast majority of LTCH patients have multiple diagnoses and comorbidities. Clinicians and researchers participating in a Commission panel on LTCH quality measures agreed that risk adjustment was unnecessary for some proposed LTCH quality measures (Medicare Payment Advisory Commission 2011).

In 2012, 10 percent of LTCH cases were readmitted to an ACH. Thirteen percent of LTCH cases 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 an additional 13 percent died within 30 days of discharge. By comparison, among patients with a principal diagnosis of cellulitis without major complications or comorbidities, 1 percent died in the LTCH and an additional 3 percent died within 30 days

Quality measures for long-term care hospitals

The Patient Protection and Affordable Care Act of 2010 requires CMS to collect data on quality in long-term care hospitals (LTCHs) and implement a pay-for-reporting program by 2014.¹⁴ Beginning October 1, 2013, CMS pays LTCHs for reporting three measures—catheter-associated urinary tract infections, central line catheter-associated bloodstream infections, and new or worsened pressure ulcers. Data on urinary tract and central line infections 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 instrument called the LTCH Continuity Assessment Record and Evaluation (CARE) Data Set.

On October 1, 2014, CMS will begin collecting data on the share of LTCH patients assessed for and appropriately given influenza vaccine, as well as influenza vaccination coverage among health care personnel. Data on the share of patients appropriately given influenza vaccine will be collected using the LTCH CARE Data Set, while data on

influenza vaccination coverage among LTCH personnel will be collected through the CDC's NHSN. Payments for reporting for these two measures will begin on October 1, 2015.

CMS has announced that it intends to begin collecting data to support the development of three additional measures: LTCH-acquired cases of methicillin-resistant *staphylococcus aureus* (MRSA), LTCH-acquired cases of *Clostridium difficile* (*C. difficile*) infection, and the share of LTCH patients experiencing falls resulting in major injury. CMS will begin collecting data related to MRSA and *C. difficile* infections via the CDC's NHSN on January 1, 2015, with payments for reporting beginning on October 1, 2016. CMS will begin collecting data on patients experiencing falls resulting in major injury using the CARE Data Set on January 1, 2016, with payments for reporting beginning on October 1, 2017.

CMS also intends to begin 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. ■

of discharge. Among the top MS–LTC–DRGs in 2012, patients with a diagnosis of complications of treatment with major complication or comorbidity (MS–LTC–DRG 919) had the highest readmission rate (17 percent).¹⁵

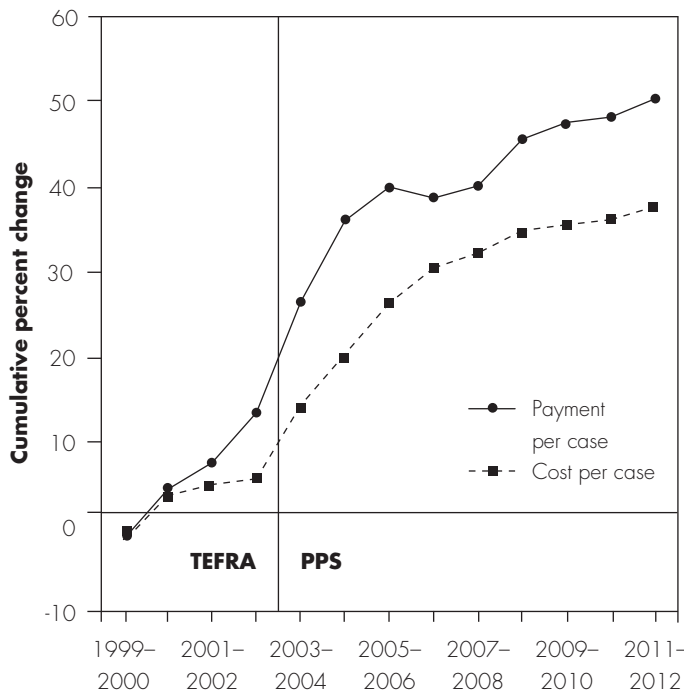
We considered readmission and mortality trends for the top LTCH diagnoses over the period from 2008 to 2012. Although rates of readmission and death can vary from year to year, over time we found stable or declining rates of readmission and both death in LTCHs and death within 30 days of discharge for these diagnoses.

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 says more about uncertainty regarding changes to regulations and

legislation governing LTCHs than it does about current reimbursement rates. Payment reductions implemented by CMS and a congressional moratorium on new LTCH beds and facilities from December 2007 through December 2012, combined with ongoing concern by the policy community about the appropriateness of LTCH admissions appear to have altered industry behavior for the time being. Although the moratorium has lifted, LTCHs appear to be taking a “wait and see” approach. As discussed in the text box (p. 285), the Pathway for SGR Reform Act of 2013 will reimpose a moratorium on new LTCHs and LTCH beds from January 1, 2015, until September 30, 2017, which will limit future opportunities for growth and reduce the need for capital.

Some LTCHs and LTCH companies have been positioning themselves for a changing reimbursement environment and what they believe are inevitable reductions in payments to LTCHs. Kindred Healthcare, which owns more than one-quarter of all LTCHs, has continued to pursue an “integrated market” strategy, whereby the company operates SNFs, home health agencies, outpatient

FIGURE 11-5**LTCHs' per case payments continue to increase more than costs**

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.

rehabilitation providers, and LTCHs within a single market in order to position itself as an integrated provider of post-acute care (Kindred Healthcare 2013a). 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 acquired 11 new facilities and other post-acute care providers while selling 23 LTCHs and SNFs in markets it identified as not conducive to its integrated cluster model (Kindred Healthcare 2013b).

Medicare's payments and providers' costs: Growth in payments continues to outpace growth in 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 2011 and 2012, Medicare payments continued to increase faster than provider costs, resulting in an aggregate 2012 Medicare margin of 7.1 percent. Financial performance in 2012 varied across LTCHs, reflecting differences in cost control and response to payment incentives.

Reductions in the LTCH base rate slowed spending growth in 2011 and 2012

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 overpayments to LTCHs. As a result, spending jumped more than 6 percent per year between 2008 and 2010.¹⁶ Although the MMSEA provisions continued through fiscal year 2012, spending growth slowed between 2010 and 2012, due in part to mandated reductions in Medicare's LTCH payment rate for 2011 and 2012.¹⁷

LTCHs respond to policy changes by restraining cost growth

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 following a surge in payment per case (Figure 11-5). Between 2005 and 2007, growth in cost per case slowed considerably as 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 due to ongoing concerns about possible changes to Medicare's payment policies for LTCH services. Between 2009 and 2011, the average cost per case increased less than 1 percent per year. Between 2011 and 2012, the average cost per case increased 1.6 percent.

Aggregate LTCH margins continue to grow

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. However, in 2009, LTCH margins began to climb again as providers consistently held cost growth below that of payments. In 2012, the aggregate LTCH margin was 7.1 percent.

**TABLE
11-4**

The aggregate average LTCH Medicare margin rose in 2012

Type of LTCH	Share of discharges	2004	2005	2006	2007	2008	2009	2010	2011	2012
All	100%	9.0%	11.9%	9.7%	4.6%	3.6%	5.6%	6.7%	6.7%	7.1%
Urban	95	9.2	12.0	9.9	4.9	3.9	5.9	7.0	6.8	7.2
Rural	4	2.6	10.2	4.7	-0.4	-3.2	-3.0	-0.1	3.0	3.4
Nonprofit	14	6.9	9.1	6.5	1.4	-2.5	-0.9	-0.2	0.9	-1.4
For profit	84	10.0	13.1	10.9	5.6	5.3	7.3	8.2	8.2	8.9
Government	2	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). Share of discharges column groupings may not sum to 100 percent due to rounding or missing data. 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.

Nonprofit LTCHs may be less successful at controlling costs

Financial performance in 2012 varied across LTCHs. At 8.9 percent, margins were highest for for-profit LTCHs, which account for about three-quarters of all LTCHs and 84 percent of all LTCH cases. The aggregate margin for nonprofit LTCHs fell from 0.9 percent in 2011 to -1.4 percent. This decline was due to cost growth that exceeded growth in payments. Between 2011 and 2012, per case costs grew more than twice as fast in nonprofit LTCHs than in for-profit LTCHs. Still, more than half of nonprofit LTCHs posted positive margins in 2012.

The comparatively poor performance of nonprofit LTCHs reflected a number of differences that can affect providers' ability to control their costs. First, though occupancy rates in the two groups were fairly similar (65 percent in nonprofit LTCHs vs. 67 percent in for-profit LTCHs), nonprofit LTCHs were smaller and had fewer total cases than for-profit LTCHs (an average of 467 vs. 533). Seventy-one percent of nonprofit LTCHs had fewer than 50 beds compared with half of for-profit LTCHs. Nonprofit LTCHs therefore may benefit less than for-profit LTCHs 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 may have a distinct advantage over other LTCHs because they may be better able to control their mix of patients and lengths of stay. Nonprofit LTCHs had a larger share of cases with extraordinarily high costs—15.6 percent of nonprofit

LTCHs cases qualified for high-cost outlier payments versus 10 percent of for-profit LTCHs' cases—although it is not clear whether this difference stems from differences in efficiency or case complexity or both. Nonprofit LTCHs also had more short-stay outliers than did for-profit LTCHs (33 percent vs. 26.5 percent) 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. As noted above, a higher share of cases in nonprofit LTCHs qualified for high-cost outlier payments. Further, a higher share of cases in nonprofit LTCHs were high-cost outliers during an immediately preceding ACH stay (15.9 percent compared with 12.9 percent of for-profit LTCHs' cases). Nonprofit LTCHs also had a slightly higher share of cases that had long ICU stays during an immediately preceding ACH stay (37 percent compared with 35 percent of for-profit LTCHs' cases). Another possible indicator of a sicker patient population is length of stay: The average Medicare-covered length of stay was one day longer in nonprofit LTCHs than in for-profit ones (27 days vs. 26 days). However, longer lengths of stay may also be due to 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 and for-profit LTCHs had similar shares of patients admitted without an immediately preceding ACH stay (11.5 percent vs. 12.5 percent); these patients may be less severely ill.

**TABLE
11-5**

LTCHs in the top quartile of Medicare margins in 2012 had lower costs

Characteristics	High-margin quartile	Low-margin quartile
Mean margin	20.5%	-13.0%
Mean total discharges (all payers)	510	409
Medicare patient share	71%	64%
Average length of stay (in days)	26	27
Mean CMI	1.13	1.05
Occupancy rate	76%	56%
Mean per discharge:		
Standardized costs	\$28,356	\$38,743
Standard Medicare payment*	38,094	34,626
High-cost outlier payments	1,311	4,980
Share of:		
Cases that are SSOs	25%	30%
Medicare cases from primary-referring ACH	38	41
LTCHs that are for profit	91	66

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 2011 and 2012. Top margin quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Bottom 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. Case-mix indexes have been adjusted for differences in short-stay outliers across facilities. The primary referring ACH is the acute care hospital from which the LTCH receives a plurality of its patients. Government providers were excluded. *Excludes outlier payments.

Source: MedPAC analysis of LTCH cost reports and Medicare Provider Analysis and Review data from CMS.

High-margin LTCHs had lower unit costs

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).¹⁸ After accounting for differences in case mix and local market input price levels, low-margin LTCHs had standardized costs per discharge that were 37 percent higher than high-margin LTCHs (\$38,743 vs. \$28,356). Low-margin LTCHs may have benefited less from economies of scale. Compared with their high-margin counterparts, low-margin LTCHs had fewer cases overall (an average of 409 compared with 510 for high-margin

LTCHs) and lower occupancy rates (56 percent vs. 76 percent). Notably, high-margin LTCHs had a higher average Medicare share of discharges than did low-margin LTCHs (71 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 were almost four times those of high-margin LTCHs (\$4,980 vs. \$1,311). When these outlier payments were removed from total payments, we found that the standard payment per discharge for low-margin LTCHs was 9 percent lower than that for high-margin LTCHs (\$34,626 vs. \$38,094). This difference was in part because they had a lower average case mix (1.05 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 30 percent of low-margin LTCHs' cases, compared with 25 percent in high-margin LTCHs.

How should Medicare payments change in 2015?

To estimate 2014 payments, costs, and margins with 2012 data, the Commission considered policy changes effective in 2013 and 2014. Those that affect our estimate of the 2014 Medicare margin include:

- a market basket increase of 2.6 percent for 2013, offset by required Patient Protection and Affordable Care Act of 2010 (PPACA) reductions totaling 0.8 percent, for a net update of 1.8 percent;
- a market basket increase of 2.5 percent for 2014, offset by required PPACA reductions totaling 0.8 percent, for a net update of 1.7 percent;
- budget-neutrality adjustments in 2013 and 2014 to account for CMS's underestimate of LTCH spending in the first year of the PPS. These adjustments, intended to bring total 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; and
- changes to the short-stay outlier policy in 2013, which will decrease payments.

We did not consider policy changes mandated by the Pathway for SGR Reform Act of 2013 because they will not begin to be implemented until fiscal year 2016.

We estimate that LTCHs’ aggregate Medicare margin will be 6.5 percent in 2014. 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, though still below market basket level. The 6.5 percent margin also does not factor in the effect of the sequester, which is currently reducing Medicare program payments to LTCHs by about 2 percent. Therefore, if the sequester remains in place, margins would be expected to be about 2 percentage points lower.

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. If the Congress does not implement the Commission’s recommendation for LTCH payment reform (discussed later in this chapter), our update recommendation applies to Medicare’s payment rate for all services furnished in LTCHs in fiscal year 2015. If the Congress does implement the Commission’s recommended LTCH payment reform, our update recommendation applies to Medicare’s payment rate for CCI cases in LTCHs, as described below.

RECOMMENDATION 11

The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2015.

RATIONALE 11

In the last year of the congressional moratorium on new LTCHs and LTCH beds, supply of facilities and beds increased slightly. The number of LTCH cases increased somewhat more slowly than growth in the number of FFS beneficiaries. Notably, on a per FFS beneficiary basis, the decline in the number of LTCH cases was much smaller than that seen in the ACH and SNF settings. These trends suggest that access to LTCH care has been maintained. The limited quality trends we measure appear stable. The availability of capital to LTCHs reflects uncertainty about possible changes to Medicare’s regulations governing LTCHs rather than current reimbursement rates. Medicare margins for 2012 were positive. These trends suggest that LTCHs are able to operate within current payment rates. Therefore, the 2015 LTCH base payment rate should be the same as the 2014 rate.

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.

Reforming the LTCH payment system

In addition to evaluating the level of LTCH payments, the Commission has been considering for some time whether Medicare is paying appropriately for services provided in LTCHs. As discussed earlier, LTCHs have positioned themselves as providers of hospital-level care for long-stay CCI patients—patients who typically have long, resource-intensive hospital stays often followed by post-acute care—but nationwide most CCI patients are cared for in ACHs, and most LTCH patients are not CCI. Medicare’s payments to LTCHs are higher than those made for similar patients in other settings. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of LTCHs in some areas and have generated unwarranted use of LTCH services by patients who are not CCI. This situation may be advantageous for providers, but it is costly to the Medicare program and may encourage unnecessary transitions between care settings, which are detrimental to patients.

Problems with the current payment system

Although growth in spending on LTCH care has slowed in recent years, the Commission remains concerned about the accuracy of Medicare’s payments for these services. Questions have been raised about whether payments are properly aligned with the resource needs of patients and whether Medicare pays more for LTCH patients than for similar patients in other settings. In considering these questions, policy analysts must also consider whether LTCHs achieve better outcomes that might justify higher payments.

Medicare's payments for LTCH services are not aligned with the resource needs of patients

The Commission has long held that payments to providers should be properly aligned with the resource needs of beneficiaries (Medicare Payment Advisory Commission 2009). But Medicare's payments to LTCHs do not always reflect this principle. As discussed, inflated costs were used to set the initial LTCH PPS payment rates. CMS's efforts to slow the growth in LTCH spending through regulation have reduced payments but likely have not altered the underlying inaccuracies in payments across types of cases.¹⁹ Further, the requirement that LTCHs maintain an average length of stay of more than 25 days likely continues to distort both patients' use of resources and the underlying cost of care. The short-stay outlier (SSO) policy also appears to encourage unnecessary resource use. SSO cases are subject to a payment adjustment that can reduce payment substantially below what would be paid for LTCH cases with longer stays. Our analysis of 2012 LTCH claims data provides strong evidence that LTCHs try to avoid the SSO payment adjustment by keeping patients until their lengths of stay reach the SSO threshold for the case type (see text box, pp. 268–269).

Medicare's payments for similar services differ across settings of care

Another important principle espoused by the Commission is that, subject to risk differentials, payment for the same services should be comparable regardless of where the services are provided. Such "site neutrality" helps to ensure that beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions. Here, too, Medicare's payment policies continue to fall short. The types of patients treated in LTCHs are also treated in ACHs and some SNFs (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012a, Dalton et al. 2012b, Gage et al. 2011, Kahn et al. 2013, Kahn et al. 2010, Koenig et al. 2013, Medicare Payment Advisory Commission 2004). But Medicare's payments to LTCHs are higher than those made for similar patients in either of those settings (Gage et al. 2007). The effects of the disparities in Medicare's payments across settings are exacerbated because CCI patients can be unprofitable in ACHs and often are less profitable than other types of cases in SNFs (Centers for Medicare & Medicaid Services 2013, Gage et al. 2007, Medicare Payment Advisory Commission 2013). This disparity has resulted in a documented decline in the number of SNFs admitting medically complex patients.²⁰ For ACHs paid under the IPPS, the high cost of caring for CCI patients relative to other patients in the same MS–

DRG likely influences providers' decisions about service delivery, transfer, and discharge, and thus may result in inappropriate care, unnecessary use of services, and program overpayments. Comparatively attractive payment rates for LTCH care have resulted in an oversupply of facilities in some areas and may generate unwarranted use of LTCH services by patients who are not CCI. Meanwhile, as discussed earlier in this chapter, certificate-of-need laws have limited the growth of LTCHs in several states. While these restrictions have no doubt had some dampening effect on growth in Medicare spending for LTCH care, they have also helped to create inequities across ACHs in the relative profitability of CCI cases. In areas with LTCHs, ACHs may be able to reduce the costs of caring for CCI patients by transferring them earlier in the course of illness.²¹ In areas without LTCHs, ACHs may have to keep CCI patients longer—and therefore accrue additional costs—until they are stable enough to be discharged to a lower level of post-acute care.

LTCH use often increases Medicare spending without improving beneficiary outcomes

After a decade of research, it remains unclear what Medicare is purchasing with its higher LTCH payments (see text box, pp. 282–283). Paying more for LTCH care might be justified if such care produced better outcomes for beneficiaries. But studies comparing LTCH care with that provided in ACHs have failed to find a clear advantage for LTCH users. Alternatively, paying more for LTCH care might be a good investment for the Medicare program if LTCH use reduced Medicare spending for other services. But, as discussed in the text box (pp. 282–283), some studies have found that, on average, episode payments are higher for beneficiaries who use LTCHs. In addition, some studies have found that per episode spending may be the same or lower for the most medically complex patients who use LTCHs but not for those who are less severely ill.

Defining CCI cases

As early as 2004, the Commission recommended that the Congress and the Secretary of Health and Human Services develop facility and patient criteria to ensure that LTCHs serve only the most medically complex patients. But a key issue in reforming the LTCH payment system is determining how to define the CCI. Clinicians have described CCI patients as exhibiting metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure (Nierman and Nelson 2002). Such abnormalities and debilities in hospital patients are not readily identifiable using available

administrative data. However, the research literature is consistent in describing such 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). (For Medicare’s definition of an ICU, see text box, p. 284.)

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, although these patients are often treated in ACH “step-down” units (Centers for Medicare & Medicaid Services 2013, Dalton et al. 2012b). As described by Dalton and colleagues in a study conducted for CMS, such patients account for one-third to one-half of LTCH patients (Dalton et al. 2012a). Among these cases are ventilator-dependent patients with major comorbidities, patients who have had multiple organ failures, and patients with septicemia and other complex infections. Some have severe surgery- or trauma-related wounds. Notably, these patients are heavy users of ICU and cardiac care unit services during their preceding ACH stays. Often, such patients are transferred directly from ICUs to the LTCH. Dalton and colleagues found that these patients generally require ongoing nursing care at nurse-to-patient staffing levels from 1:1 to 1:4, as well as nutritional and rehabilitation services (to address the deconditioning that accompanies long-term critical illness) and access to multiple physician-specialist consulting services (Dalton et al. 2012a).

LTCHs care for other, less acutely ill patients as well. These patients may require lengthy hospitalizations and subsequent post-acute care, but they do not have (or no longer have) intensive nursing care needs (Centers for Medicare & Medicaid Services 2013). Research has consistently shown that caring for these lower acuity patients in LTCHs increases Medicare expenditures without demonstrable improvements in quality of care or outcomes, yet such patients make up a majority of cases in most LTCHs.

Analysis of findings from the Post-Acute Care Payment Reform Demonstration, which tested the use of a standardized patient assessment tool in various post-acute care settings, revealed meaningful differences in the intensity of nursing care and nutritional, rehabilitation, and physician services across LTCH patients, differences that could be used to define CCI cases in LTCHs. One striking finding was that length of time in an ICU during an immediately preceding ACH stay was by far the

most important factor in explaining variation in routine (nontherapy) resource intensity in the LTCH setting (Gage et al. 2011).²² Length of stay in the ICU was significantly associated with post-acute care case complexity, although the impact of the variable diminished as the ICU stay got longer (Gage et al. 2011). Further, the length of the ICU stay was noted as a distinguishing characteristic of patients who used LTCHs as opposed to patients who used only SNFs, inpatient rehabilitation facilities (IRFs), or home health care. Post-acute care episodes that had preceding ACH ICU stays of seven days or more were found only among LTCH users (Gage et al. 2011).

Length of stay in the ICU thus appears to be predictive of intensive resource use during post-acute care episodes that begin with an ACH stay. The Commission maintains that this variable can be used to capture the vast majority of CCI patients who may be appropriate candidates for LTCH care and who have resource needs that are likely to be aligned with the standard LTCH payments. This information is collected in the medical record and reported to CMS on the claim and therefore is available to both the Medicare program and LTCH providers to determine whether patients are appropriate for admission.

To identify CCI patients who will be eligible for standard payments in the LTCH, it is necessary to specify the required number of days in the ICU. As noted above, ICU days are positively associated with case complexity. As the ICU length of stay threshold is reduced, the complexity and resource needs of the patient decrease. If the threshold is set too low, less-complex cases would be designated as CCI and CMS would continue to pay too much for many cases that could be cared for appropriately in other settings at a lower cost to the Medicare program.

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 (see text box, p. 285). Our analysis of IPPS claims data from 2012 found that 22.8 percent of IPPS discharges spent three or more days in an ICU (Figure 11-6, p. 283). The Commission is concerned that this threshold is too low to distinguish the truly CCI patient.

The Commission maintains that CCI cases are a small share of Medicare ACH cases; the ICU length of stay threshold identifying CCI cases should be set accordingly. The Commission therefore recommends that the Congress limit standard LTCH payments to cases that spent eight or more days in an ICU during an immediately preceding

Do long-term care hospital outcomes justify higher payments?

Paying more for long-term care hospital (LTCH) care might be justified if it produced better outcomes for beneficiaries. However, until recently, LTCHs have not been required to submit quality data to CMS; those data are not yet available for analysis. Further, Medicare collects no clinical assessment data for acute care hospital (ACH) patients and very limited assessment data for LTCH patients, so comparisons of outcomes have generally been limited to mortality and readmissions.

A decade of research comparing readmission and mortality rates for LTCHs with those of ACHs has failed to find a clear advantage for LTCH users. Regarding readmissions, several studies have found lower rates of readmission among some LTCH users. For example, previous Commission analysis of 2001 claims found lower readmission rates for the most medically complex beneficiaries who used LTCHs compared with similar patients who did not have an LTCH stay (Medicare Payment Advisory Commission 2004). CMS's Post-Acute Care Payment Reform Demonstration compared beneficiaries using LTCHs with those using skilled nursing facilities and inpatient rehabilitation facilities and found that, after controlling for differences in case mix, LTCH patients had a lower risk of ACH readmission within 30 days of discharge from the ACH (Gage et al. 2011). Another recent study, sponsored by the National Association of Long Term Hospitals (NALTH), found that Medicare beneficiaries who used LTCHs had lower rates of readmission to the ACH in 17 of 24 major conditions compared with beneficiaries who did not use LTCHs (Koenig et al. 2013). That LTCH patients would have lower readmission rates is not unexpected since most LTCHs provide a higher level of care than do most other post-acute care providers. However, in a related study using data from the CMS demonstration, researchers found that LTCH cases were more likely than other post-acute care cases to be readmitted to an ACH on day 30 and beyond (Morley et al. 2011).

Regarding mortality, the Commission's analysis of 2001 claims found no clear benefit for beneficiaries

who use LTCHs (Medicare Payment Advisory Commission 2004). But another study, conducted by RTI International under a CMS contract, found that for the most complex ventilator patients in Texas, Louisiana, and Oklahoma (three states with a history of high LTCH use), mortality was lower for those who used an LTCH (Kennell and Associates Inc. 2010). This study (which used 2004 claims data from the three states to construct episodes of care for beneficiaries assigned to ventilator-related diagnosis related groups during initial ACH admissions and compared outcomes for beneficiaries who went on to use LTCHs with those who did not) also found that the most complex ventilator patients who used LTCHs were more likely to be discharged home than similar patients who did not use LTCHs. But for the least complex ventilator cases, the researchers found that outcomes were worse for beneficiaries who used LTCHs. In yet another study, Kahn and colleagues examined claims data from 2002 through 2006 for beneficiaries who required mechanical ventilation and spent at least 14 days in an ACH intensive care unit (ICU) and found no differences in mortality one year after discharge for beneficiaries who were subsequently transferred to an LTCH compared with those who were not (Kahn et al. 2013). NALTH's 2013 study also found no difference in one-year survival rates for ventilator patients who used LTCHs (Koenig et al. 2013). However, the NALTH study did find lower rates of mortality one year after discharge for LTCH patients in 9 of the 24 major conditions studied (Koenig et al. 2013).

Paying more for LTCH care also might be a good investment for the Medicare program if LTCH use reduced Medicare spending for other services. In its analysis of data from 2001, the Commission found that Medicare pays more for episodes that include LTCH care but that the payment differences were not statistically significant when LTCH care was targeted at the most severely ill patients (Medicare Payment Advisory Commission 2004). The CMS-sponsored RTI International analysis of 2004 claims data from three states with high LTCH use found that for the most complex ventilator patients, Medicare payments

(continued next page)

Do long-term care hospital outcomes justify higher payments? (cont.)

for the episode of care were the same or lower for those who used an LTCH than for those who did not. However, for the least complex ventilator patients, Medicare payments were considerably higher for the beneficiaries who used LTCHs than for those who did not (Kennell and Associates Inc. 2010). By contrast, Kahn and colleagues found that, for beneficiaries requiring mechanical ventilation who spent at least 14 days in an ACH ICU between 2002 and 2006, transfer to an LTCH was associated with lower total provider costs but higher total Medicare payments (Kahn et al. 2013). The recent study sponsored by NALTH found lower total episode payments for LTCH users for only 4 of the 24 conditions studied (circulatory, digestive, nervous system, and injuries/poisoning/toxic effect of

drugs), representing about 20 percent of LTCH patients (Koenig et al. 2013).

Yet another recent study by RTI for CMS looked at 2007 claims nationwide and identified 74 ACH diagnosis groups for which LTCH referral is most common (Kandilov and Dalton 2011). The researchers created episodes of care for beneficiaries admitted to the ACH with those diagnoses and compared Medicare payments for episodes that included LTCH care with those that did not. This analysis found that both Medicare payments and provider costs were higher for episodes that included LTCH stays, even for ventilator patients, although the difference in payment was smallest for this group.²⁴ ■

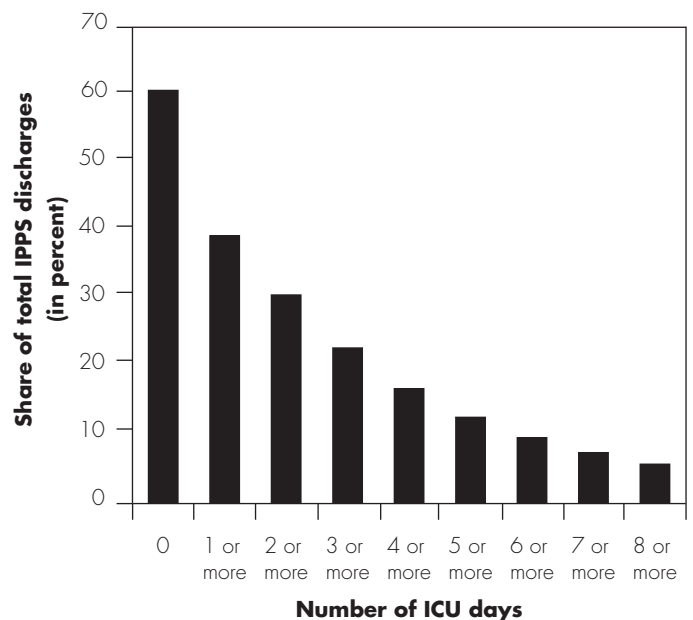
ACH stay. Our analysis of IPPS claims data found that cases with eight or more days in an ICU accounted for 5.7 percent of all Medicare discharges in 2012 (Figure 11-6). IPPS cases that had eight or more days in an ICU were concentrated in a small number of MS-DRGs: 23 MS-DRGs accounted for half of the cases. Of these, seven were respiratory MS-DRGs involving mechanical ventilation, major complications and comorbidities, or both; three were severe infections with mechanical ventilation or major complications and comorbidities; and five were major surgical procedures (such as thoracic aortic aneurysm repair or major bowel procedures) with major complications and comorbidities. These conditions correspond with the “ideal” LTCH patients described by the LTCH representatives and critical care clinicians interviewed during the CMS-sponsored site visits by Kennell/RTI (Dalton et al. 2012b).²³ These MS-DRGs also accounted for about half of the IPPS cases that went on to use LTCH services in 2010. Such severely ill patients should be among those who have been found in previous studies to be more likely to benefit from LTCH care (see text box, this page).

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

FIGURE 11-6

Almost 6 percent of IPPS discharges had ICU stays of 8 or more days in 2012



Note: IPPS (inpatient prospective payment system), ICU (intensive care unit). The IPPS is Medicare’s payment system for acute care hospitals. ICU days include coronary care unit days.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

What is an intensive care unit?

Intensive care units (ICUs) are staffed and supplied to provide care to critically ill patients. Medicare's conditions of participation do not require hospitals to have ICUs, nor do they specify required attributes of ICUs in hospitals that have them. However, Medicare requires both acute care hospitals and long-term care hospitals to submit cost reports that apportion each hospital's total allowable costs between Medicare beneficiaries and other patients, with separate average per diem costs calculated for general routine patient care and intensive or coronary unit care. To properly identify ICU costs, Medicare regulations stipulate that ICUs must:

- provide care to critically ill patients, and may include trauma units, coronary care units, pulmonary care units, and burn units;²⁵
- be physically and identifiably separate from general routine patient care areas, including subintensive or intermediate care units and ancillary service areas;
- have a nursing staff separate from other units or areas providing different levels or types of care;²⁶
- have specific written policies that include criteria for admission to and discharge from the unit;
- have registered nurses available on a continuous 24-hour basis with at least one registered nurse present in the unit at all times;
- maintain a minimum nurse–patient ratio of one nurse to two patients per patient day;²⁷ and
- be equipped with or have available for immediate use life-saving equipment necessary to treat critically ill patients, such as respiratory and cardiac monitoring equipment, respirators, cardiac defibrillators, and wall or canister oxygen and compressed air. ■

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.) To ensure that patients requiring prolonged mechanical ventilation have appropriate access to specialty weaning services offered by many LTCHs, Medicare should allow an exception to the eight-day ICU threshold for LTCH cases that receive mechanical ventilation for 96 hours or more during an immediately preceding ACH stay. The Commission's analysis of IPPS claims for patients who were discharged alive from ACHs in 2012 found that about 103,000 cases (1.1 percent of all live IPPS discharges) received prolonged mechanical ventilation services during their ACH stay. Of these cases, 81,600 (79 percent) would have met the CCI criterion because they spent eight or more days in an ACH ICU. The exception to the eight-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 2012 by 21,000 nationwide.

Designing a revised LTCH PPS

The Commission's approach is based on the premise that the most medically complex patients have always been a

small share of the total population of hospital inpatients. Although hospital case mix has increased over time, the explosive growth in the number of LTCHs that followed implementation of the IPPS was not driven by a need for these services but rather by payment policies that created opportunities for financial gain.

The Commission's recommendation for long-term care hospital (LTCH) payment reform includes the stipulation that savings be used to improve payment for chronically critically ill (CCI) cases paid under the inpatient prospective payment system (IPPS) for acute care hospitals. Therefore, the recommendation for LTCH payment reform is included with the Commission's acute care hospital update recommendation for 2015. The recommendation text related to LTCHs is:

The Congress should direct the Secretary of Health and Human Services to set LTCH base payment rates for non-CCI cases equal to those of acute care hospitals, and redistribute the savings to create additional inpatient outlier payments for CCI cases in IPPS hospitals. The change should be phased in over a three-year period from 2015 to 2017.

The Pathway for SGR Reform Act of 2013 mandates changes to the long-term care hospital prospective payment system

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 new moratorium on LTCHs.

“Site-neutral” payments

The Pathway for SGR Reform Act of 2013 establishes “site-neutral” payments for specified cases in LTCHs, beginning in fiscal year 2016. Under the law, LTCH payment rates will be allowed only for LTCH discharges that had an immediately preceding acute care hospital stay (ACH) and:

- the ACH stay included at least three days in an intensive care unit, or
- the discharge receives an LTCH principal diagnosis indicating the receipt of mechanical ventilation services for at least 96 hours.

All other LTCH discharges—including any discharges assigned to psychiatric or rehabilitation Medicare severity long-term care diagnosis related groups, 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, with payments in fiscal years 2016 and 2017 a blend of one-half the standard LTCH payment rate and one-half the site-neutral rate.

New criteria for LTCHs

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 site-neutral rates. Medicare Advantage patients will be excluded from the average length of stay calculation. In addition, beginning in fiscal year 2020, to continue to receive LTCH payments 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 rolls back the 25-percent rule for most hospitals-within-hospitals (HWHs) and satellites to 50 percent until October 1, 2016. Most HWHs and satellites will thus 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. In addition, the Secretary is prohibited from applying the 25-percent rule to freestanding LTCHs before cost-reporting periods beginning on 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

Beginning January 1, 2015, the Pathway for SGR Reform Act of 2013 imposes a moratorium on new facilities and new beds in existing facilities. The moratorium expires on September 30, 2017. No exceptions are allowed. ■

Based on the evidence outlined earlier, the Commission has concluded that Medicare pays too much for some patients in LTCHs. The Commission therefore seeks to improve the accuracy of Medicare’s payments for LTCH services. The Commission focuses on how to use available data to identify the CCI patients who require costly extended hospital-level care and how to direct

LTCH payment rates to those patients while paying more appropriately for patients who are less severely ill.

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 recommends that standard LTCH payment rates be paid

only for LTCH patients who meet the CCI profile at the point of transfer from an ACH. Such cases should be those that (a) spent eight or more days in an ICU during the IPPS stay or (b) received mechanical ventilation for 96 hours or more during the IPPS stay. Medicare would pay for all other cases admitted to LTCHs using IPPS-based rates. As discussed in this report's Chapter 3, this recommendation is part of a package of recommended changes to hospital payments that is designed to improve financial incentives in these payment systems while maintaining adequate overall payments.

Setting payment rates for LTCH services

Under this revised LTCH PPS, CMS would calculate a CCI base payment and new relative weights for each MS–LTC–DRG based solely on the most recent available standardized costs associated with the CCI cases in each DRG. This change would be budget neutral—aggregate LTCH payments for CCI cases would be held to the same aggregate payments these cases receive currently. Other LTCH cases that are not CCI would receive IPPS-based payment rates.

The LTCH PPS would continue to make additional payments for CCI and non-CCI cases that qualify as high-cost outliers. Total outlier payments in the LTCH PPS would continue to account for 8 percent of total LTCH PPS payments for CCI and non-CCI cases, with a uniform national fixed loss amount applied to both CCI and non-CCI cases. As discussed in this report's hospital chapter (Chapter 3), the Commission recommends that the savings from this reform be added to the outlier pool in the IPPS and used to make higher outlier payments for the costliest CCI cases in ACHs. Together, these actions would help improve parity between the LTCH and ACH settings in Medicare's payments for CCI cases and non-CCI cases.

CMS should continue to apply a payment adjustment for CCI cases with unusually short stays. However, as discussed in the text box (pp. 268–269), CMS should change the methodology used to calculate the payment for short-stay outlier CCI cases to discourage provider gaming. The current payment method for SSOs generates a payment “cliff” that creates incentives for providers to lengthen patient stays, thereby avoiding the SSO penalty.

Removing non-CCI cases from the calculation of LTCHs' average length of stay

To qualify as an LTCH under current law, 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. Maintaining a minimum average length of stay for CCI cases is necessary to help ensure that Medicare is paying standard LTCH rates only for the most severely ill cases and to help guard against providers unbundling care by transferring CCI cases to a lower level of post-acute care. However, in concert with the payment changes outlined above, the Congress should change the law to require an average length of stay of greater than 25 days only for Medicare CCI cases. Freed from the length of stay requirement for non-CCI cases, LTCHs could continue to admit non-CCI cases that could benefit from LTCH services but would be free to alter their practice patterns as appropriate to better meet patients' clinical needs.

Improving payment accuracy using a patient assessment tool

As noted above, LTCHs currently submit very limited patient assessment data for quality reporting purposes. The relative lack of information about LTCH patients' resource requirements continues to undermine our ability to evaluate patients' service needs and use of resources and to compare those characteristics with patients in other post-acute care settings. As a result, we do not know whether there is selection across settings in the patients admitted. Furthermore, without comparable information, we cannot systematically evaluate the cost and outcomes of the care beneficiaries receive across settings. As discussed in Chapter 7, the Commission recommends that the Secretary implement a common assessment tool for LTCHs, home health agencies, SNFs, and IRFs by 2016.

Implementing a revised LTCH PPS

The Commission recommends that the new LTCH payment policies described above be implemented over a three-year period. In the first year of the transition, the new base payment rates and weights for CCI cases should be implemented in full. For non-CCI cases, the base payment rate should be a blend of two-thirds of the base payments that otherwise would have been made under current policy plus one-third of the IPPS-based rate described above. A revised short-stay outlier policy also should be fully implemented for both CCI and non-CCI cases in the first year. In the second year of the transition, payments for non-CCI cases should be a blend of one-third of the base payments that otherwise would have been made under current policy and two-thirds of the IPPS-based rate. In the third year, non-CCI cases would be paid the full IPPS-based rate. During (and after) the transition, the pool of funds available for making high-cost outlier payments would continue to account for 8 percent of total projected

LTCH payments. The size of the pool would change as the (blended) rates for non-CCI cases declined. The national fixed loss amount should change accordingly.

Improving payments for CCI cases in IPPS hospitals

As discussed in this report's Chapter 3, the Commission recommends that the Congress use the savings achieved from improving the accuracy of LTCH payments to improve the accuracy of payments for CCI cases in ACHs paid under the IPPS. The savings would be allocated to the IPPS outlier pool to finance higher outlier payments for the highest cost IPPS CCI cases. For example, outlier payments for IPPS CCI cases could be calculated using a lower fixed loss amount, and Medicare could pay a higher percentage (e.g., 90 percent) of hospitals' costs above the CCI outlier threshold. The outlier policy for non-CCI cases in IPPS hospitals would remain unchanged.

Evaluating the impact of a revised LTCH PPS and preventing undesirable responses

Revising the current LTCH PPS will improve the accuracy of Medicare's payments to LTCHs by removing certain policies that likely lead to distortions in the cost of care. Payments to LTCHs for non-CCI cases will be reduced, but because LTCHs will no longer be required to maintain an average length of stay of more than 25 days for non-CCI cases, providers will be able to restructure their patterns of care to reflect patient needs rather than payment policy.

The Commission's recommendations will also help improve payment parity across care settings. Medicare would pay higher rates only for the most severely ill cases in LTCHs and would reduce its rates in line with IPPS payments for less severely ill patients. LTCHs' average standard payment per discharge for CCI patients would remain at roughly \$50,000, while the average standard payment per discharge for non-CCI patients would fall from about \$40,000 to \$12,000 (the average IPPS standard payment for the same case types; additional LTCH outlier payments would be made as applicable). This change would reduce incentives for LTCHs to admit cases that are not CCI, thereby reducing opportunities for unbundling of IPPS payments in areas that have LTCHs. In areas without LTCHs, ACHs that have to keep CCI patients longer—and therefore accrue additional costs—may be able to recoup some of those costs through higher IPPS outlier payments. Better alignment of payments and costs should weaken previous incentives to increase the number of LTCH beds

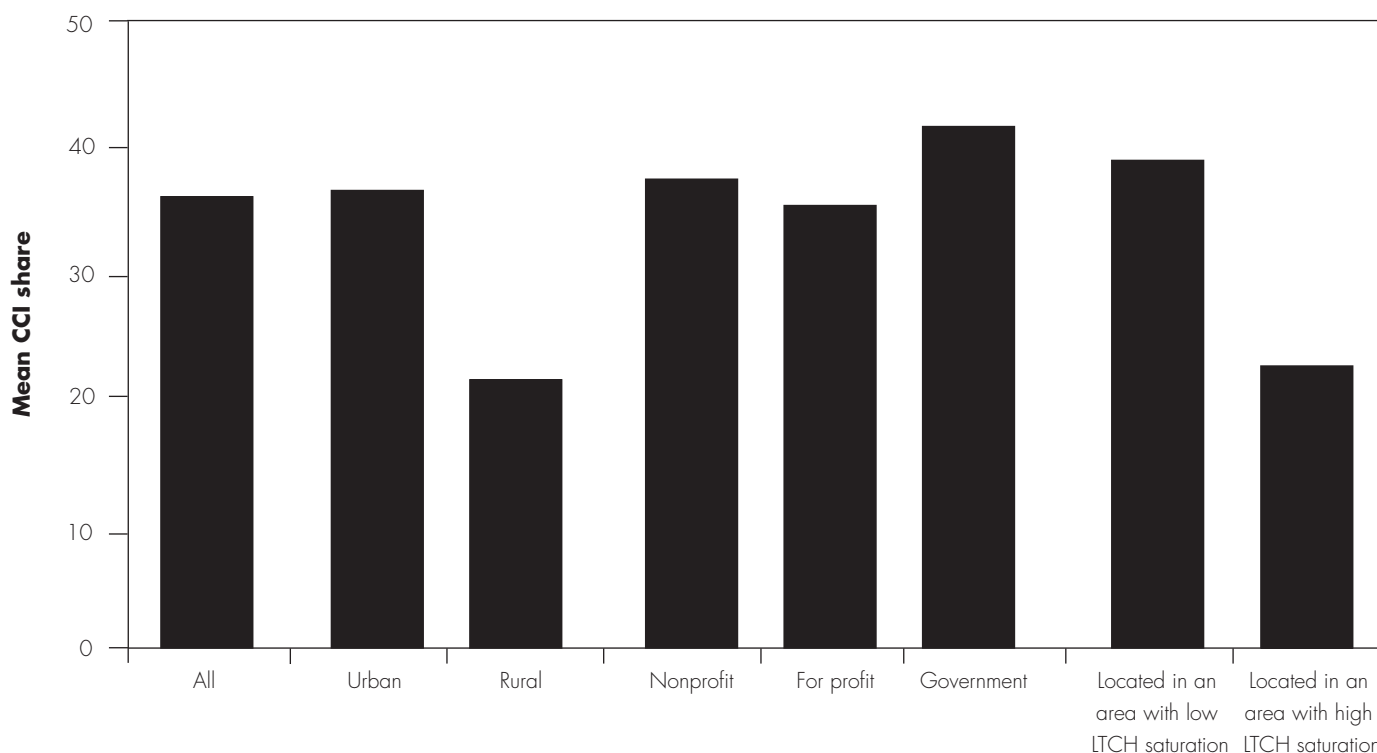
and facilities and reduce unnecessary use of expensive LTCH care.

The Commission's analysis of LTCH claims data from 2012 found that 36 percent of LTCH cases had immediately preceding ACH stays that included eight or more days in an ICU and therefore met MedPAC's recommended definition of CCI. CCI shares varied across types of LTCHs (Figure 11-7, p. 288). Notably, LTCHs located in areas of high LTCH saturation had a mean CCI share more than 40 percent lower than that of LTCHs located in other areas (22.5 percent vs. 38.9 percent).

An additional 5 percent of LTCH cases in 2012 would have been eligible for the higher CCI payment rate because they had used prolonged mechanical ventilation services during an immediately preceding ACH stay even though they did not have eight or more days in an ICU. Thus, if the Commission's recommended payment reforms were implemented, aggregate payments for about 41 percent of LTCH cases would remain unchanged. The remaining 59 percent of LTCH cases would be paid for using IPPS-based rates.

Without behavioral changes, total payments for virtually all LTCHs would decline substantially. The Commission estimates that, when the recommended payment changes are fully implemented, aggregate payments to LTCHs would decline by about \$2 billion (Table 11-6, p. 289). On average, assuming no behavioral change, an LTCH's total Medicare payments would decline by 36.5 percent by year three of the transition. LTCHs with higher shares of non-CCI cases would be disproportionately affected. The Commission estimates that payments would fall more than average for for-profit LTCHs and LTCHs in LTCH-saturated markets. Savings from MedPAC's recommendation would be used to increase outlier payments for CCI cases in ACHs, increasing aggregate outlier payments under the IPPS by \$2 billion. About 6 percent of IPPS discharges would meet the definition of CCI and be eligible for higher outlier payments. Medicare payments for these cases would increase, on average, 10.8 percent. On average, an IPPS hospital's total Medicare payments would increase by 1.8 percent. Large urban hospitals, major teaching hospitals, low-margin hospitals, and hospitals in areas with no LTCHs would benefit more from the Commission's recommendation.

The Commission anticipates substantial changes in behavior that should significantly lower LTCHs' costs for non-CCI cases and therefore will reduce the impact

**FIGURE
11-7****Mean CCI share differed by type of LTCH, 2012**

Note: CCI (chronically critically ill), LTCH (long-term care hospital). CCI cases are those that had eight or more days in an intensive care or coronary care unit during an immediately preceding acute care hospital stay. The CCI share is the percent of total Medicare cases that met the definition of CCI. Areas with high LTCH saturation had more than 2 LTCH beds per 1,000 Medicare beneficiaries, while areas with low LTCH saturation had 2 or fewer LTCH beds per 1,000 Medicare beneficiaries.

Source: MedPAC analysis of Medicare Provider Analysis and Review and cost report data from CMS.

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. Such change is expected and desired. Under the Commission's recommended policy changes, LTCHs will face incentives to admit fewer non-CCI cases and to be more selective in choosing which non-CCI cases they do admit. LTCHs also will likely alter their delivery of care—such as by reducing lengths of stay—to reduce the costs of care. As shown in the hypothetical example in Table 11-7, 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.

The Commission's analysis of LTCH margins suggests that LTCHs do not systematically make their margins on their less complex, non-CCI cases. There is no relationship between an LTCH's margin and its CCI share of cases (Figure 11-8, p. 290). Thus, LTCHs can focus on caring for CCI cases and still maintain positive margins. However, in areas with many LTCHs, some providers may find it more difficult to increase the share of CCI cases they admit. In these areas, provider consolidation may occur.

Other changes in provider behavior, however, may not be in the best interests of the Medicare program, its beneficiaries, or the taxpayers. As discussed later, it will be necessary to carefully monitor provider response to these payment reforms to safeguard against undesirable responses and outcomes. In addition, Medicare's 25-percent rule will need to continue. Finally, as LTCHs become more selective about the non-CCI cases they admit, to maintain access to care for beneficiaries it will

**TABLE
11-6**

Estimated impact of MedPAC’s recommendation to reduce differences in payment rates for LTCHs and ACHs (fully implemented)

	LTCH PPS	IPPS
Total Medicare payments		
Aggregate change (in billions)	-\$2.0	\$2.1
Mean percent change	-36.5%	1.8%
Change in payments greatest for facilities that are:	<ul style="list-style-type: none"> • For profit • In areas with high LTCH saturation • Low CCI 	<ul style="list-style-type: none"> • Large urban • Major teaching • Low margin • In areas with fewer LTCHs

Note: LTCH (long-term care hospital), ACH (acute care hospital), PPS (prospective payment system), IPPS (inpatient prospective payment system), CCI (chronically critically ill). The IPPS is Medicare’s payment system for acute care hospitals. CCI cases are those that had eight or more days in an intensive care or coronary care unit during an immediately preceding ACH stay. Areas with high LTCH saturation had more than 2 LTCH beds per 1,000 Medicare beneficiaries. Impacts assume no change in provider behavior.

Source: MedPAC analysis of Medicare Provider Analysis and Review and cost report data from CMS.

become even more important for CMS to fix payment policies that presently create disincentives for SNFs to admit medically complex cases.

Monitoring changes in utilization, spending, and outcomes

Because payment for non-CCI cases would be sharply reduced, LTCHs might find that admitting these patients is not financially advantageous. To maintain an acceptable profit margin, LTCHs may seek to increase the number of CCI cases they admit. Policymakers should monitor

changes in LTCH utilization, patient mix, spending, and outcomes to ensure that beneficiaries are receiving efficient, high-quality care. Policymakers should also monitor use of ICU services and prolonged mechanical ventilation services in the ACH. Under a revised IPPS outlier policy, ACHs might be tempted to extend patients’ stays in the ICU or delay weaning from the ventilator to qualify for more generous outlier payments and thereby reduce their losses.

Continuing the 25-percent rule

The 25-percent rule was designed to discourage inappropriate shifting of patients from ACHs to LTCHs (see text box, p. 267). In the absence of criteria for admission to an LTCH, the Commission has always viewed the 25-percent rule as a blunt but necessary instrument to help ensure that LTCHs do not function as units of ACHs. Under a revised LTCH payment system, incentives remain for ACHs to unbundle care—both for CCI and non-CCI cases—that is paid for under the IPPS. Therefore, the Commission recommends that CMS continue to apply the 25-percent rule.

Improving payments for medically complex cases in skilled nursing facilities

The payment reforms recommended by the Commission will reduce incentives for LTCHs to admit cases that are not CCI. Some cases currently cared for in LTCHs may be shifted to SNFs and other post-acute care settings.

**TABLE
11-7**

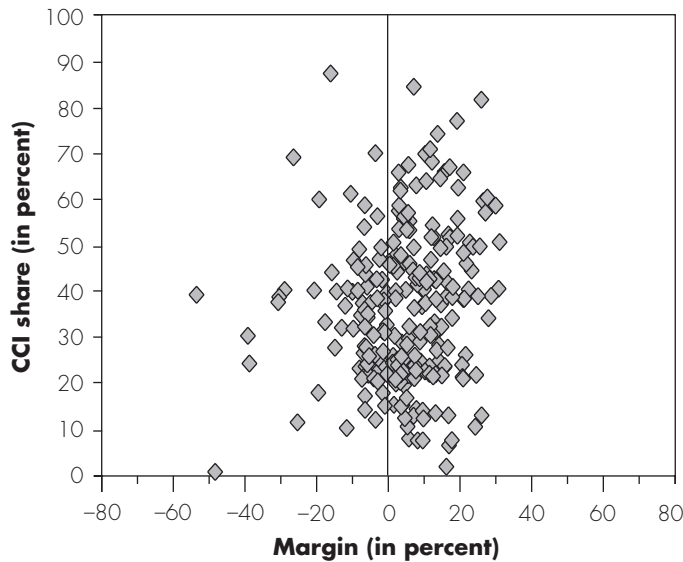
The Commission’s recommendation will create incentives for LTCHs to reduce lengths of stay for non-CCI cases

	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.

**FIGURE
11-8**

Many LTCHs with high CCI shares have high margins



Note: LTCH (long-term care hospital), CCI (chronically critically ill). CCI cases are those that had an immediately preceding acute care hospital stay that included eight or more days in an intensive care or coronary care unit.

Source: MedPAC analysis of Medicare Provider Analysis and Review and cost report data from CMS.

Medicare’s payment policies must be aligned so as to ensure that beneficiaries receive care in the lowest cost setting consistent with their clinical condition. Patients who are appropriate candidates for SNF care should be treated there and not in higher cost LTCHs. As revisions are made to the LTCH PPS to improve the accuracy of payments and reduce inappropriate incentives to admit non-CCI cases, similar reforms must be made to remove disincentives for SNFs to admit such cases. SNFs have proven adept at modifying their practices in response to changes in policy. The Commission reiterates its recommendation that these policy changes be made. ■

To facilitate this shift, it is important that the accuracy of Medicare’s payments to SNFs for medically complex cases be improved.

The Commission has repeatedly recommended to the Congress and the Secretary that changes be made to the PPS for SNFs that would improve the accuracy of payments for medically complex cases (Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2008). As described in Chapter 8, the SNF PPS disadvantages SNFs that admit high shares of medically complex cases such as those with septicemia or pneumonia or those that need intensive respiratory services—the types of cases that have often been admitted to LTCHs. In fact, as noted above, growth in the use of LTCH services in some areas may have been spurred by a SNF PPS that encourages SNFs to admit patients needing rehabilitation services over those needing medically complex care.

Endnotes

- 1 During the year, the LTCH is paid the LTCH rate for these cases. If the facility is found to have been overpaid during retrospective settlement at the end of the cost report year, CMS collects the overpayments from future payments.
- 2 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 found that, although the overall number of Medicare admissions to ACH ICUs 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 (Kahn et al. 2010).
- 3 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.
- 4 More information on the prospective payment system for LTCHs is available at http://medpac.gov/documents/MedPAC_Payment_Basics_13_LTCH.pdf.
- 5 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 (\$13,314 in 2014). Medicare pays 80 percent of the LTCH’s costs above the threshold. In fiscal year 2012, about 11 percent of LTCH cases received high-cost outlier payments. The prevalence of high-cost outlier cases differed by LTCH ownership. About 10 percent of cases in for-profit LTCHs were high-cost outliers, compared with 16 percent of cases in nonprofit LTCHs and 19 percent of cases in government-owned 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.
- 6 A geometric average is derived by multiplying all numbers in a set and raising the product to the exponent of one divided by the number of cases in the set. This statistic is useful for analyzing data that are highly skewed.
- 7 In a previous analysis, the Commission compared cases that would have been very short-stay outliers (VSSOs) in 2011 with cases that were not SSOs to get a better understanding of how very short stays differ from longer ones. Compared with cases that were not SSOs, VSSO cases were more likely to be of an extreme severity level and to require prolonged mechanical ventilation. Many LTCH VSSO cases were short because the beneficiary was readmitted to an ACH or died. Twenty-seven percent of VSSO cases were discharged to an ACH, while only 5 percent of longer stay cases were readmitted. Similarly, 41 percent of VSSO cases died in the LTCH compared with 6 percent of longer stays. Even when VSSO cases were discharged alive, only 27 percent were still living one year after discharge, compared with more than half of non-SSO cases (Medicare Payment Advisory Commission 2013).
- 8 RTI, under contract to CMS, reported a similar finding (Gage et al. 2007). RTI reviewed LTCH Medicare costs and payments for the two years before and two years after implementation of the LTCH PPS. Immediately after the PPS was implemented, LTCH margins were found to be much higher than margins in the 2001–2002 period under the prior payment system. RTI attributed higher overall LTCH margins to the fact that the initial base LTCH PPS rate was substantially overstated.
- 9 In its 2007 report to CMS, RTI found that LTCH margins were much higher than IPPS margins for the same DRGs. RTI found that ventilator and other respiratory-related LTCH DRGs were paid far in excess of expected costs and generated very high margins, whereas LTCH DRGs related to rehabilitation and wound care were paid at rates at or slightly above costs, generating margins that were closer to, although still slightly higher than, average IPPS margins.
- 10 Even in states without certificate-of-need requirements, new LTCHs have been more likely to open in markets where LTCHs already exist than in areas without LTCHs. Interviews conducted by Kennell and Associates and RTI during CMS-sponsored site visits to several LTCHs suggest a possible reason for this practice: one LTCH corporate executive reported that the company had found it easier to enter a mature LTCH market and attract patients away from other LTCHs than to enter a market without LTCHs and have to educate area physicians and hospitals about the LTCH care model (Dalton et al. 2012b).
- 11 Among all Medicare ICU patients receiving mechanical ventilation in 2006, only 16 percent of patients discharged alive were discharged to LTCHs, while 46 percent were discharged to SNFs or inpatient rehabilitation facilities (Kahn et al. 2010).
- 12 MMSEA and subsequent amendments 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.
- 13 It is difficult to determine a precise number of LTCHs because of discrepancies in Medicare's data sources on these facilities. Cost report data indicate that 420 LTCHs filed valid cost reports in 2012, 3 more than in 2011. However, as we have found in previous years, Medicare's Provider of Service (POS) file includes a larger number of facilities (442 in 2012) than are found in the cost report file. The two data sources differ for a number of reasons. Some Medicare-certified LTCHs may not yet have filed a cost report for 2012 when we undertook our analysis. In addition, LTCHs with very low Medicare patient volume may be exempt from filing cost reports. At the same time, POS data may overstate the total number of LTCHs because facilities that close may not be immediately removed from the file. The cost report data therefore provide a more conservative estimate of total capacity and supply but may not accurately reflect the most recent changes in supply. A previous Commission analysis revealed inaccuracies in ownership status in the POS data, so we have opted to rely on cost report data to determine the distribution of facilities across ownership and location categories.
 - 14 Such a policy has been in place for hospitals since 2003. Under Medicare's Hospital Inpatient Quality Reporting Program, CMS requires hospitals to report a specified list of quality measures each year in order to receive a full update to Medicare payment rates in the ensuing year. This program creates incentives for providers not only to report the quality of their care but also to take steps to improve it and raise their quality scores. CMS makes some of the quality data available to consumers on Medicare's Hospital Compare website. More than 95 percent of hospitals opt to participate in the program.
 - 15 We observed a higher readmission rate (21.7 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 since 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 four days will be assigned to MS-LTC-DRG 208, while a similar patient who stays in the LTCH for a longer period likely will be 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 13.6 percent of these cases were readmitted in 2012.
 - 16 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.
 - 17 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 a 1.1 percent reduction in the LTCH standard payment rate in 2012.
 - 18 Many new LTCHs operate at a loss for a period of time after opening. For this analysis of high- and low-margin LTCHs, we examined only LTCHs that submitted valid cost reports in both 2011 and 2012. We excluded government-owned LTCHs.
 - 19 In a CMS-sponsored study using data from 2005 and 2006, RTI found that overall LTCH margins had declined since the first years of the LTCH PPS, but LTCH DRG weights continued to be systematically distorted in favor of case types that use extensive respiratory therapy and other ancillary services and against case types that rely on more intense nursing (Gage et al. 2007).

- 20 The Commission found that the number of SNFs admitting medically complex patients declined between 2005 and 2009 and reported that the decline likely reflected the relative attractiveness of the payments for other case-mix groups, such as rehabilitation (Medicare Payment Advisory Commission 2012b). Following changes in the payment rates for medically complex patients, the number of SNFs admitting such cases increased between 2009 and 2011, but the SNF PPS continues to disadvantage SNFs that admit high shares of medically complex patients (Medicare Payment Advisory Commission 2013, Wissoker and Zuckerman 2012).
- 21 The Commission and other researchers have found that patients who use LTCHs tend to have shorter acute care hospital stays than similar patients who do not use these facilities, suggesting that LTCHs substitute for at least part of the acute hospital stay (Kahn et al. 2013, Medicare Payment Advisory Commission 2004). Early transfers may distort the acute inpatient PPS relative weights by reducing the costs of acute care hospitals that routinely transfer patients to LTCHs. To the extent that such distortion occurs, even after recalibration, acute care hospital payments may be too low for some patients in areas without LTCHs.
- 22 Routine resource intensity was measured using the weighted sum of total nontherapy direct care staff time per individual patient. The time of nontherapy support staff directly involved in the care of specific patients was also included. The weights were national average wages for each person’s occupation and licensure level. This is, in effect, a measure of the summed labor-related portion of direct care costs, ignoring fringe benefits.
- 23 In a report on CMS-sponsored site visits to LTCHs and IPPS critical care units, Dalton and colleagues reported that every LTCH they visited claimed to focus on identifying medically complex but currently stable patients with a history of organ failure or complicating chronic conditions and continuing acute care needs. These included tracheostomy patients with a history of failure to wean (but a prognosis as weanable), recently weaned but still severely compromised respiratory patients, patients with serious infections and complicating comorbidities requiring multiple intravenous medications, and complex wound patients (Dalton et al. 2012b).
- 24 One important limitation in this study is that it excluded payments for SNF and other post-acute care services used during the episode of care. As the authors point out, if LTCH stays were substituting, even in part, for high-level SNF care, the model would overstate the episode payment differential attributable to LTCH use. To explore the effects of this limitation, the researchers looked at episodes that included SNF days and found that, on the basis of days of care, there was little evidence of a substitution effect between SNFs and LTCHs. Overall, 41.2 percent of episodes that used LTCHs and 42.7 percent of matched non-LTCH episodes had a SNF stay during the episode.
- 25 Postoperative recovery rooms, postanesthesia recovery rooms, maternity labor rooms, and subintensive or intermediate care units are specifically excluded by statute. See 42 CFR §413.53(b).
- 26 Two or more intensive care type units that concurrently share nursing staff can be reimbursed as one combined intensive care type unit if all other criteria are met. Nurses who “float” or work in different units on an as-needed basis can be utilized in the ICU, with costs allocated to the appropriate units depending upon the time spent in those units. See 42 CFR §413.53(d)(2).
- 27 Included in the calculation of this nurse–patient ratio are registered nurses, licensed vocational nurses, licensed practical nurses, and nursing assistants who provide patient care. General support personnel such as ward clerks, custodians, and housekeeping personnel cannot be included. See 42 CFR §413.53(d)(5).

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CHAPTER 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 2015.

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

Hospice services

Chapter summary

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries must elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal condition. In 2012, more than 1.27 million Medicare beneficiaries received hospice services from over 3,700 providers, and Medicare expenditures totaled about \$15.1 billion.

Assessment of payment adequacy

The indicators of payment adequacy for hospices, discussed below, are generally 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 2012, hospice use increased across all demographic and beneficiary groups examined. However, hospice use rates remained lower for racial and ethnic minorities than for Whites.

- **Capacity and supply of providers**—The supply of hospices increased nearly 4 percent in 2012, 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.
- **Volume of services**—The proportion of beneficiaries using hospice services at the end of life continues to grow, and average length of stay

In this chapter

- Are Medicare payments adequate in 2014?
- How should Medicare payments change in 2015?

increased in 2012. About 46.7 percent of Medicare beneficiaries who died in 2012 used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000. Average length of stay among decedents, which increased between 2000 and 2011 from 54 days to 86 days, grew to 88 days in 2012. The median length of stay for hospice decedents was 18 days in 2012 and has remained stable at approximately 17 or 18 days since 2000.

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 must report data for specified quality measures or face a 2 percentage point reduction in their annual update for the subsequent fiscal year. Initially, two limited quality measures were adopted. CMS is replacing those measures in future years. Beginning in July 2014, seven new quality measures will be collected through a standardized data collection instrument. In 2015, a hospice experience-of-care survey for bereaved family members will be implemented. CMS has indicated that public reporting of quality information is unlikely before 2017.

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 6.9 percent increase in 2012) suggests that access to capital is adequate for these providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited. Hospital-based and home health-based hospices have access to capital through their parent providers.

Medicare payments and providers' costs—The aggregate Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 8.7 percent in 2011, up from 7.4 percent in 2010. The projected margin for 2014 is 7.8 percent. The 2014 margin projection is based on the current law payment rates under Title XVIII of the Social Security Act, which does not include the sequester. If the sequester is in effect for 2014, the projected 2014 margin would be about 2 percentage points lower. The margin estimates also exclude nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce margins by at most 1.4 percentage points and 0.3 percentage point, respectively). Margins also do not include any adjustment for the higher indirect costs observed among hospital-based and home health-based hospices (which, if such an adjustment were made, would increase the overall aggregate Medicare margin by up to 1.5 percentage points).

Given that 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 2015. ■

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 worker 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 may also be provided in nursing facilities, assisted living facilities, hospice facilities, and hospitals. In 2012, more than 1.27 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about \$15.1 billion.

Beneficiaries must 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 initially elect hospice, 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 six 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.

In recent years, Medicare spending for hospice care increased dramatically. Spending exceeded \$15 billion in 2012, a more than 400 percent increase since 2000. This 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 during this time period has been substantial entry of for-profit providers.

Medicare's payment to hospice providers does not cover services unrelated to the terminal condition. Instead, Medicare FFS or Part D plans pay the providers or suppliers who furnish these unrelated services. In 2012, Medicare spent about \$1 billion on nonhospice services while beneficiaries were enrolled in hospice (for more details see online Appendix 12-A, available at <http://www.medpac.gov>).³

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 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. 302). A hospice is paid the routine home care rate (about \$156 per day in 2014) 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 about 97 percent of hospice care days. The payment rates for hospice are updated annually by the inpatient hospital market basket index. Beginning fiscal year 2013, the market

**TABLE
12-1**

Medicare hospice payment categories and rates

Category	Description	Base payment rate, 2014	Percent of hospice days, 2012
Routine home care	Home care provided on a typical day	\$156.06 per day	97.4%
Continuous home care	Home care provided during periods of patient crisis	\$37.95 per hour	0.4
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	\$161.42 per day	0.3
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	\$694.19 per day	1.9

Note: These rates reflect the statutory base rates under Title XVIII of the Social Security Act; they do not reflect the sequester. If the sequester is in effect in 2014, the payments received by hospices would be about 2 percent lower. 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 \$303.60 per day (8 hours at \$37.95 per hour); maximum daily payment at the CHC level is \$910.78 per day (24 hours at \$37.95 per hour).

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 2766, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, Quality Reporting Program and the Hospice Pricer for FY 2014," August 2013.

basket index is 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 fiscal years 2013 and 2014, and possibly will be in fiscal years 2015 through 2019 if certain targets for health insurance coverage among the working-age population are met. Beginning in fiscal year 2014, hospices that do not report quality data will receive a 2 percentage point reduction in their annual payment update. 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

furnished 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/MedPAC_Payment_Basics_13_hospice.pdf.)

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 report 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.

March 2009 Commission recommendations on hospice

The Commission recommended in March 2009 that the hospice payment system be reformed to better align payments with the cost of care throughout an episode. 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 reprinting the Commission's recommendation on payment reform below. That recommendation, which was made in March 2009, urged payment reform by 2013. While that time frame has already passed, the indicators that led us to make this recommendation have not changed, and thus the need for payment reform still exists and the recommendation stands.

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.

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 reprinting the recommendation that included focused medical review below.

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. ■

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 (see text box). The Commission recommended that the hospice payment system be changed from a flat per diem payment to one where 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 reprinting the Commission's March 2009 recommendation for payment reform in this report (see text box). 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).

For a number of reasons, it is important that an initial step to improve the hospice payment system be taken as soon as possible. Improving payment accuracy is important given the substantial amount of Medicare hospice spending devoted to long-stay patients, who are more profitable than other patients under the current payment system. In 2011, Medicare spent nearly \$8 billion, more than half of all hospice spending that year, on patients with stays exceeding 180 days (Medicare Payment Advisory Commission 2013).⁴ Reforming the payment system as the Commission has recommended would also address concerns about payment for very short stays, which may currently be reimbursed at levels below their cost (due to the high visit intensity of these stays and the fewer days over which to spread fixed costs). 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. Improving the hospice payment system is also important from a program integrity perspective. Financial incentives under the current payment system may have spurred some providers to pursue business models that enroll patients likely to have long stays who may not meet the hospice eligibility criteria, an issue that has also been noted by others (Rau 2011, Whoriskey and Keating 2013).

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 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, so we are reprinting the Commission's recommendation (see text box, p. 303).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 that beneficiaries who elect hospice incur less Medicare spending in the last two months of life than comparable beneficiaries who do not, but also show 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 (\$26,157.50 in 2013), it must repay the excess to the program.^{6, 7} 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 average annual 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 exceeding the cap (with the number peaking in 2009). 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 2014?

To address whether payments in 2014 are adequate to cover the costs efficient providers incur and how much providers' payments should change in 2015, 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 since information on hospice quality is generally not available.

Beneficiaries' access to care: Use of hospice continues to increase

Hospice use among Medicare beneficiaries increased in 2012, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life. In 2012, 46.7 percent of Medicare beneficiaries who died that year used hospice, up from 45.2 percent in 2011 and 22.9 percent in 2000 (Table 12-2, p. 306). Hospice use varies by beneficiary characteristics (i.e., enrollment in traditional fee-for-service (FFS) Medicare or Medicare Advantage (MA); Medicare-only beneficiaries and beneficiaries dually eligible for Medicare and Medicaid; urban and rural residence; and age, gender, and race), but it increased across all beneficiary groups examined in 2012.

Use of hospice is slightly more prevalent among beneficiaries enrolled in MA than in FFS, although differences in hospice use rates have narrowed over time. In 2012, in rounded figures, 46 percent of Medicare FFS decedents and 50 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 (see Chapter 13 for more details).

Hospice use varies by other beneficiary characteristics. In 2012, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (about 42 percent and 48 percent, respectively). Hospice use has increased in all age groups but is more prevalent

and has grown more rapidly among older beneficiaries. In 2012, more than half (about 54 percent) of Medicare decedents ages 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 among women than men and greater hospice use among older beneficiaries.

Hospice use also varies by racial and ethnic groups (Table 12-2, p. 306). As of 2012, hospice use was highest among White Medicare decedents, followed by Hispanic, African American, Native North American, and Asian American decedents. Hospice use grew among all these groups between 2011 and 2012 and has grown substantially for all groups since 2000. Nevertheless, differences in hospice use across racial and ethnic groups persist. 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 beneficiaries than rural, although use has grown in all types of areas (Table 12-2, p. 306). In 2012, the share of decedents residing in urban counties who used hospice was about 48 percent; in micropolitan counties, 43 percent; in rural counties adjacent to urban counties, 42 percent; in rural nonadjacent counties, 38 percent; and in frontier counties, 32 percent. Use rates for beneficiaries residing in all five of these areas increased between 1 percentage point and 1.9 percentage points 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 2012, 68 percent of Medicare decedents who used hospice had a noncancer diagnosis, up from 48 percent in 2000.⁸ Heart and circulatory conditions, neurological conditions, and debility and nonspecific signs and symptoms are the three largest noncancer diagnosis groups, each accounting for 16 percent to 17 percent of hospice decedents in 2012.

Capacity and supply of providers: Supply of hospices continues to grow, driven by growth in for-profit providers

In 2012, 3,720 hospices provided care to Medicare beneficiaries, a 3.8 percent increase from the prior year (Table 12-3, p. 307). This increase marks a continuation of

**TABLE
12-2**

Use of hospice continues to increase

Percent of Medicare decedents who used hospice

	2000	2009	2010	2011	2012	Average annual percentage point change 2000-2011	Percentage point change 2011-2012
All beneficiaries	22.9%	42.0%	44.0%	45.2%	46.7%	2.0	1.5
FFS beneficiaries	21.5	41.0	43.0	44.2	45.6	2.1	1.4
MA beneficiaries	30.9	46.1	47.8	48.9	50.2	1.6	1.3
Dual eligibles	17.5	37.5	39.2	40.3	41.6	2.1	1.3
Nondual eligibles	24.5	43.4	45.5	46.8	48.3	2.0	1.5
Age							
<65	17.0	26.1	27.2	27.8	29.1	1.0	1.3
65-74	25.4	37.3	38.6	39.3	40.5	1.3	1.2
75-84	24.2	43.1	45.1	46.3	47.7	2.0	1.4
85+	21.4	48.0	50.4	52.0	53.9	2.8	1.9
Race/ethnicity							
White	23.8	43.7	45.8	47.0	48.5	2.1	1.5
African American	17.0	32.6	34.1	35.4	36.7	1.7	1.3
Hispanic	21.1	34.8	37.0	38.3	39.3	1.6	1.0
Asian American	15.2	26.0	28.1	30.0	31.7	1.3	1.7
Native North American	13.0	29.7	30.6	32.4	33.9	1.8	1.5
Sex							
Male	22.4	38.6	40.4	41.3	42.7	1.7	1.4
Female	23.3	45.1	47.2	48.6	50.1	2.3	1.5
Beneficiary location							
Urban	24.3	43.5	45.5	46.6	47.9	2.0	1.3
Micropolitan	18.5	37.5	39.8	41.4	43.2	2.1	1.8
Rural, adjacent to urban	17.6	36.9	38.7	40.2	42.1	2.1	1.9
Rural, nonadjacent to urban	15.8	32.8	34.5	35.9	37.6	1.8	1.7
Frontier	13.2	27.1	30.1	30.7	31.7	1.6	1.0

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 six people per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

more than 10 years of growth in the number of hospices providing care to Medicare beneficiaries. For-profit hospices account almost entirely for the growth in the number of hospices. Between 2011 and 2012, the number of for-profit hospices increased 6.9 percent while the number of nonprofit hospices was relatively flat, and the number of government hospices declined by about 3 percent. As of 2012, about 59 percent of hospices were for profit, 35 percent were nonprofit, and 6 percent were government.

Freestanding hospices account for most of the growth in the number of providers (Table 12-3). From 2011 to 2012, the number of freestanding providers increased 5.7 percent while the number of hospital-based hospices declined 2.7 percent, and the number of home health-based hospices increased by 1.4 percent.⁹ The number of skilled nursing facility (SNF)-based hospices is small, and increased from 21 to 23. As of 2012, about 71 percent of hospices were freestanding, 15 percent were hospital based, 13 percent

**TABLE
12-3**

Increase in total number of hospices driven by growth in for-profit providers

Category	2000	2007	2010	2011	2012	Average annual percent change		
						2000-2007	2007-2011	2011-2012
All hospices	2,255	3,250	3,498	3,585	3,720	5.4%	2.5%	3.8%
For profit	672	1,676	1,952	2,054	2,196	13.9	5.2	6.9
Nonprofit	1,324	1,337	1,324	1,314	1,313	0.1	-0.4	-0.1
Government	257	237	222	217	210	-1.2	-2.2	-3.2
Freestanding	1,069	2,103	2,397	2,491	2,633	10.1	4.3	5.7
Hospital based	785	683	612	587	571	-2.0	-3.7	-2.7
Home health based	378	443	466	486	493	2.3	2.3	1.4
SNF based	22	21	23	21	23	-0.7	0.0	9.5
Urban	1,424	2,190	2,430	2,536	2,638	6.3	3.7	4.0
Rural	788	1,012	1,002	986	982	3.6	-0.6	-0.4

Note: SNF (skilled nursing facility). Numbers may not sum to total because of missing data 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.

were home health based, and less than 1 percent were SNF based.

Overall, the supply of hospices has increased substantially since 2000 in both urban and rural areas, although the number of hospices located in rural areas has declined modestly since 2007 (Table 12-3). Roughly proportionate with the share of Medicare beneficiaries residing in each area, 73 percent of hospices were located in urban areas and 27 percent were located in rural areas as of 2012. Hospice location does not provide a full picture of access to services because a hospice’s service area may extend beyond the boundaries of the county where it is located. 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 and average length of stay grew in 2012

The number of Medicare beneficiaries receiving hospice services continues to increase. In 2012, more than 1.27 million beneficiaries used hospice services, up from about 1.22 million in 2011 and just over 0.53 million in 2000 (Table 12-4, p. 308). Between 2011 and 2012, the number of hospice users grew 4.5 percent, outpacing

growth in the Medicare decedent population (1.6 percent) during this period.

Average length of stay among decedents reached 88 days in 2012, up from 86 days in 2011 (Table 12-4, p. 308). Average length of stay, which has increased substantially since 2000, has grown more slowly in the last few years than earlier in this period. 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, p. 308). Between 2000 and 2012, 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, although it increased some in 2012. Between 2008 and 2011, the 90th percentile of length of stay grew six days; between 2011 and 2012, it grew five additional days. In 2012, median length of stay, which held steady at 17 or 18 days since 2000, was 18 days. In 2011, 25 percent of stays were five days or less, unchanged from the prior year.

The Commission has previously expressed concern about very short stays. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay which is commonly thought to be of less benefit to patients than enrolling earlier. As we have discussed previously, a complex set of dynamics—largely unrelated to the hospice payment system—contributes

**TABLE
12-4**

Hospice use and expenditures increased in 2012

Category	2000	2011	2012	Average annual change, 2000–2011	Change, 2011–2012
Number of hospice users	534,000	1,219,000	1,274,000	7.8%	4.5%
Total spending (in billions)	\$2.9	\$13.8	\$15.1	15.2%	9.3%
Average length of stay among decedents (in days)	54	86	88	4.5%	2.0%
Median length of stay among decedents (in days)	17	17	18	No change	+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 figures displayed in the table are rounded; the percent change is calculated using unrounded numbers.

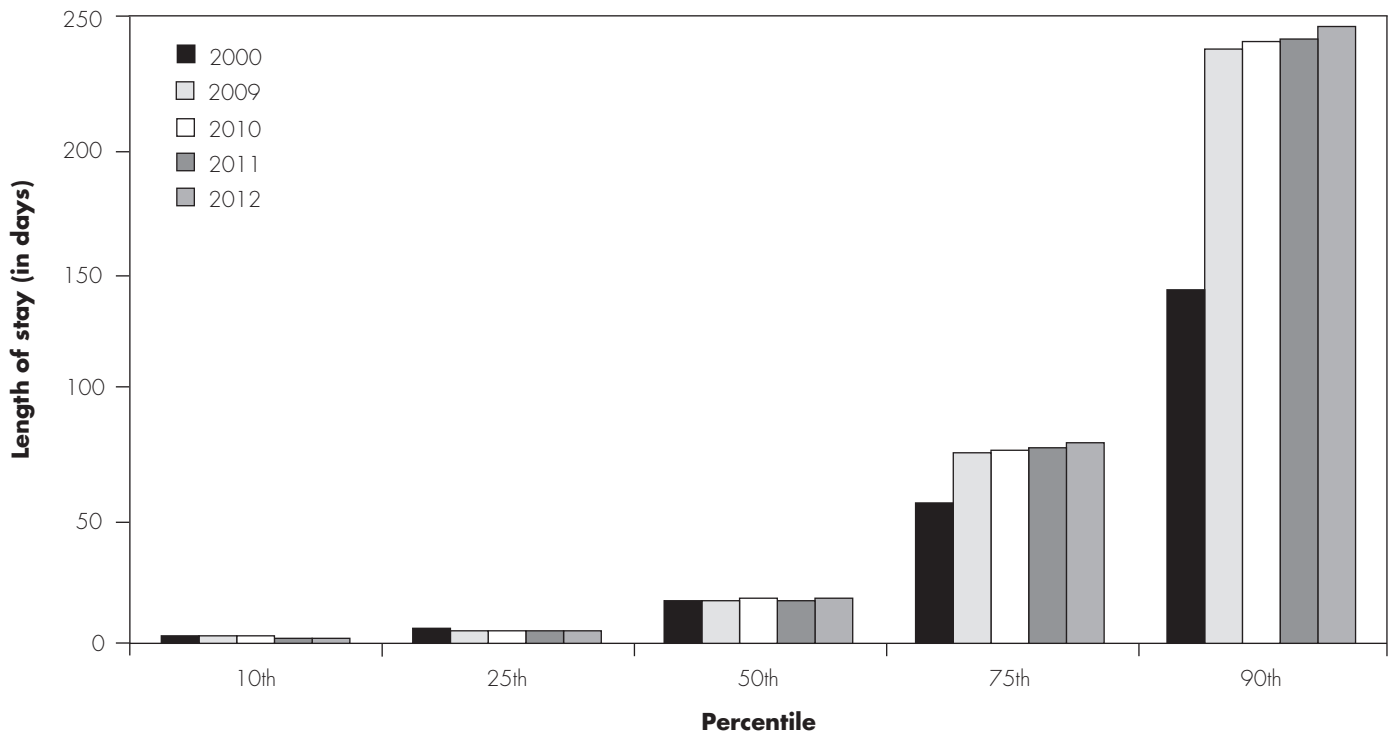
Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

to very short hospice stays (see text box, pp. 310–311). Concern about very short hospice stays is part of a broader concern about the care that patients with advanced illnesses or multiple chronic conditions receive throughout the health care system. Some have advocated for a variety of policy approaches aimed at improving care for patients with

advanced illnesses (e.g., approaches to facilitate voluntary advanced care planning or shared decision making, improvements in medical training of health professionals, advancements in quality measurement, and demonstrations of concurrent hospice and conventional care), which we discuss in more detail in the text box (pp. 310–311).

**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 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.

Source: MedPAC analysis of the Medicare Beneficiary Database from CMS.

**TABLE
12-5**

Hospice length of stay among decedents by beneficiary and hospice characteristics, 2012

Characteristic	Average length of stay	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	51	3	6	17	51	126
Neurological conditions	139	3	7	26	144	426
Heart/circulatory	76	2	4	11	56	215
Debility	100	3	7	25	105	293
COPD	112	2	5	21	112	333
Other	89	2	4	13	84	266
Main location of care						
Home	90	4	9	27	88	237
Nursing facility	112	3	6	22	107	335
Assisted living facility	154	5	13	53	188	435
Hospice						
Hospice ownership						
For profit	105	3	6	22	97	306
Nonprofit	69	2	5	14	58	185
Type of hospice						
Freestanding	91	3	5	18	80	258
Home health based	70	2	5	16	63	191
Hospital based	59	2	5	13	53	160

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2012 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 or her days while enrolled in hospice.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file data, Medicare Beneficiary Database, Provider of Services file data from CMS.

Hospice length of stay varies by observable patient characteristics, such as patient diagnosis and location, which makes it possible for providers to focus on more profitable patients (Table 12-5). For example, Medicare decedents in 2012 with neurological conditions and chronic obstructive pulmonary disease had substantially higher average lengths of stay (139 days and 112 days, respectively) than those with cancer (51 days) and heart or circulatory conditions (76 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 1 week longer at the 50th percentile, about 3 months longer at the 75th percentile, and 300 days longer at the 90th percentile.

Length of stay also varies by location where care is provided. In 2012, average length of stay was higher among Medicare decedents whose main location of care was an assisted living facility (154 days) or a nursing facility (112 days) rather than home (90 days) (Table 12-5). Length of stay differences across settings are most pronounced among patients with longer stays. For example, the 75th percentile of length of stay varied by about 100 days across the three settings (88 days at home, 107 days at a nursing facility, and 188 days at an assisted living facility), and the 90th percentile varied by just under

Potential policy approaches to improve care for patients with advanced illnesses

The share of Medicare beneficiaries receiving hospice at the end of life has increased dramatically since 2000. The Commission views this trend as a positive signal that beneficiaries are increasingly aware of hospice as an option for end-of-life care and are making choices based on their preferences. Despite this important development, a number of concerns about care for patients with advanced illnesses remains. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, resulting in a length of stay which is commonly thought to be of suboptimal benefit to patients. Beyond hospice, concerns also exist about the care patients with advanced illnesses or multiple chronic conditions receive more broadly throughout the health care system. Care for patients with advanced illnesses and multiple chronic conditions oftentimes can be fragmented and may not be consistent with patients' preferences. Below we discuss these concerns in more detail and describe policies that some have suggested might improve quality of care for these patients.

Very short hospice stays

Very short hospice stays have persisted for many years. Since 2000, over a quarter of Medicare hospice decedents enter hospice in the last week of life. It is commonly thought that patients who enter hospice in the last few days of life do not benefit as fully from the palliative and supportive services that hospice offers as patients who enroll 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 fee-for-service (FFS) system for increased volume of services (Medicare Payment Advisory Commission 2009). The issue of the FFS system rewarding volume over quality is a broader issue that affects not only Medicare's hospice services but also Medicare's other services paid under FFS. Payment system reforms such as accountable care organizations—which restructure incentives and focus on the patient's overall needs rather than fragmented services—may help reduce financial incentives that can deter hospice referral.

Some point to the requirement that beneficiaries forgo intensive conventional care to enroll in hospice as a factor that contributes to deferring hospice care, resulting in short hospice stays. The Patient Protection and Affordable Care Act of 2010 mandates a three-year demonstration at 15 sites to test the effect on quality and cost of allowing concurrent hospice and conventional care. However, no funding was appropriated for this demonstration. Recently, CMS indicated publicly that the agency is committed to pursuing a demonstration to test concurrent palliative

(continued next page)

200 days (237 days, 335 days, and 435 days across the three settings, respectively). Length of stay not only is higher but also is growing more rapidly in assisted living facilities than other settings. Between 2009 and 2012, average length of stay among decedents increased 11 days for patients residing in assisted living facilities compared with 5 days for those in nursing facilities and 3 days for those at home. Differences in the diagnosis profile of patients residing in assisted living facilities and nursing

facilities compared with patients residing in home settings account for some of the length of stay differences, but the markedly longer stays among assisted living facility residents are not understood and warrant monitoring by CMS and the Office of Inspector General (OIG).

The differences in length of stay by patient characteristics are reflected in differences in length of stay by provider type (Table 12-5, p. 309). In 2012, average length of stay

Potential policy approaches to improve care for patients with advanced illnesses (cont.)

care and conventional care. The time line and details for a demonstration have not been released.

A few private insurers are experimenting with concurrent hospice and conventional care among the commercially insured, working-age, managed care population. One insurer reported that its concurrent-care program resulted in greater hospice enrollment, less use of intensive services, and lower costs (Krakauer et al. 2009). It is uncertain whether this type of approach would yield savings in a Medicare FFS environment, given an elderly population with a greater prevalence of noncancer diagnoses (which tend to result in longer hospice stays) and the absence of health plan utilization management. Currently, under Medicare Advantage (MA), plans have little incentive to offer concurrent care because hospice is carved out of the MA benefits package and beneficiaries who elect hospice receive those services paid by Medicare FFS. If hospice were included in the MA benefits package as the Commission has recommended (see Chapter 13), it would increase incentives for plans to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making).

Broader issues with care for patients with advanced illness

It is commonly thought that Medicare FFS beneficiaries with advanced illnesses or multiple chronic conditions often receive care that is fragmented and uncoordinated

and that does not take into account their overall care needs. There is also concern that 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. Shared decision-making tools may offer an opportunity to improve the timeliness and clarity of information patients receive about their condition and treatment options, as well as empower patients to make choices based on their preferences. In addition, steps to make it easier for interested beneficiaries to create advance directives and physician or medical orders for life-sustaining treatment (as well as to make those documents more portable and accessible across care settings and states) may help facilitate care that is consistent with individual patients' preferences. Some have suggested creating a Medicare payment to compensate physicians or interdisciplinary teams for voluntary advanced care planning or shared decision-making consultations on a limited basis (e.g., with limits on the frequency with which it could be billed) as a way to support these efforts. Some have also pointed to a need for better training of health professionals on issues such as patient-centered care, palliative care, and hospice as a longer term approach to improving care for patients with advanced illnesses. There may also be a role for patient experience-of-care surveys or bereaved family member surveys, ideally fielded across multiple settings of care and oversampling relevant populations, to help gauge the extent to which patients (or families) feel they received clear and timely information about their condition and treatment options and had opportunities to participate in their care plans and make choices based on their preferences. ■

was substantially higher at for-profit hospices than at nonprofit hospices (105 days compared with 69 days). Between 2009 and 2012, average length of stay increased five days among for-profit providers and was unchanged among nonprofits. The higher length of stay among for-profit hospices has two components: (1) they have more patients with diagnoses that tend to have longer stays, and (2) they have longer stays for all diagnoses than nonprofits. 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.

One example of unusual hospice utilization patterns is the nearly 10 percent of hospices that exceed the aggregate payment cap. As shown in prior reports, above-cap hospices have substantially higher lengths of stay and rates of discharging patients alive than other hospices.¹⁰ As noted in our March 2012 report, this finding may suggest

**TABLE
12-6****Hospices that exceeded Medicare's annual payment cap, selected years**

	2002	2008	2009	2010	2011
Percent of hospices exceeding the cap	2.6%	10.2%	12.5%	10.1%	9.8%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$571	\$485	\$426	\$424
Payments over the cap as percent of overall Medicare hospice spending	0.6%	1.7%	1.7%	1.2%	1.1%
Total Medicare hospice spending (in billions)	\$4.4	\$11.4	\$12.0	\$12.9	\$13.8

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 claims standard analytical file data and Medicare hospice cost reports from CMS; data on total spending for each fiscal year from the CMS Office of the Actuary.

that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the OIG and CMS.

In 2011, 9.8 percent of hospices exceeded the cap, down slightly from an estimated 10.1 percent in 2010 (Table 12-6).¹¹ The share of hospices exceeding the cap thus declined for the second consecutive year, which appears to be a reversal of the trend we observed in the last decade, when a growing share of hospices exceeded the cap.¹² Among hospices that exceeded the cap, the average amount over the cap was slightly smaller in 2011 than in 2010, continuing the trend since 2006 of above-cap hospices exceeding the cap by smaller amounts over time. Taken together, these data may suggest that some hospices are adjusting their admissions and/or discharge patterns to avoid exceeding the cap or to exceed it by less. While above-cap hospices are required to return payments that exceed Medicare's cap, the government's ability to obtain repayment is less certain from hospices that close. 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).

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 quality data will receive a 2 percentage point reduction in their annual payment update.

For the first year of data reporting, CMS established two quality measures. Hospices were required to report these measures in 2013 (based on data from the last three months of 2012) or face a 2 percentage point reduction in their payment update for fiscal year 2014. The first measure, endorsed by the National Quality Forum (NQF), was a pain management measure (i.e., the share of patients who reported being uncomfortable because of pain at admission whose pain was brought to a comfortable level within 48 hours). The second was a process measure designed to help develop future quality measures (i.e., hospices reported whether they were tracking at least three measures focused on patient care and what those measures were). These two measures (with small changes) were continued for the second year of the reporting program; however, CMS has discontinued collection of these measures in subsequent years. Instead, CMS will collect alternative quality measures through a standardized data collection instrument and an experience-of-care survey.¹³

Beginning July 2014, the CMS quality reporting program will require providers to submit quality data for seven measures through a standardized instrument. The purpose of the instrument is to ensure that hospice quality data are collected consistently across providers. The instrument will include seven quality measures recently endorsed by NQF. 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, addressing beliefs and values (if desired by patient), and provision of a bowel regimen for patients treated with an opioid).

Beginning in 2015, the hospice quality reporting program will require all hospice providers (except very small providers) to participate in a hospice experience-of-care survey. CMS has developed the survey using a similar approach to the other Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) surveys. 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 after the patient’s death, such as how well the provider communicated with the patient and family. According to CMS, public reporting of quality data from these initiatives is not expected to be available before 2017.

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 adequate.

Trends among for-profit providers suggest adequate access to capital. The number of for-profit providers grew nearly 7 percent in 2012, indicating that capital is accessible to these providers. In addition, several publicly traded hospice companies made investments to expand operations in 2012 and 2013 through acquisition of other hospice providers. Some publicly traded nursing home companies have acquired hospice providers in the last two years and continue to express interest in further expanding into the hospice sector. Private equity groups have also made investments in several hospice companies in 2013, and press reports suggest they generally view the hospice sector favorably.

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.

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 efficient providers are expected to spend on delivering high-quality care. Medicare margins illuminate the relationship between Medicare payments and

**TABLE
12-7**

Hospice costs per day vary by type of provider, 2011

	Percentile			
	Average	25th	50th	75th
All hospices	\$144	\$111	\$136	\$169
Freestanding	139	110	131	160
Home health based	149	116	146	184
Hospital based	179	121	159	211
For profit	130	106	126	155
Nonprofit	161	126	153	187
Above cap	120	99	119	142
Below cap	146	113	139	173
Urban	146	114	139	172
Rural	129	104	129	163

Note: Data reflect aggregate cost per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care). Data are for all patients (regardless of payer) and 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’ costs. We examined margins through the 2011 cost reporting year, the latest period for which cost report data 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 12-7), which is one reason for differences in hospice margins across provider types. In 2011, hospice costs per day were \$144 on average across all hospice providers, a very slight increase from \$143 per day in 2010.¹⁴ 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 the Medicare cost report data indicates that, across all hospice types, those with longer average stays have lower costs per day. Freestanding

**TABLE
12-8****Hospice Medicare margins by selected characteristics, 2005–2011**

Category	Percent of hospices 2011	2005	2006	2007	2008	2009	2010	2011
All	100%	4.6%	6.4%	5.8%	5.5%	7.4%	7.4%	8.7%
Freestanding	69	7.2	9.7	8.7	8.3	10.2	10.7	11.8
Home health based	14	3.1	3.8	2.3	3.4	5.9	3.2	5.0
Hospital based	16	-9.1	-12.7	-10.9	-11.3	-12.2	-16.6	-15.9
For profit (all)	57	9.9	12.0	10.4	10.3	11.7	12.3	14.5
Freestanding	52	10.3	12.7	11.3	11.5	12.9	13.4	15.9
Nonprofit (all)	37	1.0	1.5	1.6	0.7	3.8	3.0	2.5
Freestanding	16	3.8	5.8	5.6	3.7	6.6	7.6	6.4
Urban	72	5.1	7.1	6.3	5.9	7.9	7.7	9.0
Rural	28	0.2	0.8	1.4	2.1	3.7	5.2	6.2
Patient volume (quintile)								
Lowest	20	-6.6	-5.1	-7.9	-8.4	-6.5	-5.1	-4.0
Second	20	-1.6	0.3	1.0	-0.1	2.0	3.5	2.8
Third	20	1.9	2.4	3.0	4.4	4.5	7.1	7.7
Fourth	20	4.4	5.8	5.8	7.2	6.8	7.3	9.9
Highest	20	5.9	8.1	7.0	6.1	9.0	8.3	9.5
Below cap	90.2	5.1	7.0	6.1	5.9	7.9	7.7	9.0
Above cap (excluding cap overpayments)	9.8	-0.8	0.3	2.5	1.2	1.4	3.2	4.1
Above cap (including cap overpayments)	9.8	20.7	20.7	20.5	19.0	18.3	17.4	18.4

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.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytical file data, and Medicare Provider of Services data from CMS.

hospices have longer stays than provider-based hospices, which accounts for some but not all of the difference in costs per day.¹⁵ Another substantial factor is the higher level of indirect costs among provider-based hospices. Indirect costs include, among other things, management and administrative costs, accounting and billing, and capital costs. In 2011, indirect costs made up 34 percent of total costs for freestanding hospices, compared with 39 percent of total costs for home health–based hospices and 42 percent of total costs for hospital-based hospices.¹⁶ 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 to the hospices that are not actually related to the hospices' operations or management. However, it is also possible that provider-based hospices have higher indirect costs for certain

overhead activities. For example, we might observe higher indirect costs among provider-based hospices if administrative staff wage rates were higher for parent providers (e.g., hospitals or home health agencies) than for freestanding providers. Regardless of the source of the higher indirect costs among provider-based hospices, the Commission believes the focus should be on the efficient provider. 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 2005 to 2011, the aggregate hospice Medicare margin ranged from 4.6 percent to 8.7 percent (Table 12-8).¹⁷ As of 2011, the aggregate hospice Medicare margin

was 8.7 percent, up from 7.4 percent in 2010. Margins varied widely across individual hospice providers. In 2011, the Medicare margin was -11.7 percent at the 25th percentile, 7.8 percent at the 50th percentile, and 21.5 percent at the 75th percentile. Our estimates of Medicare margins from 2005 to 2011 exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.^{18,19}

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 2011 aggregate Medicare margin by at most 1.4 percentage points. This figure is likely an overestimate of the bereavement costs associated with Medicare hospice patients because we 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.

We also excluded nonreimbursable volunteer costs from our margin calculations. As discussed in more detail 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 (11.8 percent) than home health-based and hospital-based hospices (5.0 percent and -15.9 percent, respectively). Provider-based hospices have lower margins than freestanding providers, due in part to their higher indirect costs (e.g., general and administrative expenses and 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 7 percentage points higher for home health-based hospices and 10 percentage points higher for hospital-based hospices, and the industry-wide aggregate Medicare margin would be about 1.5 percentage points higher.²⁰

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 (14.5 percent) than for nonprofit hospices (2.5 percent). However, freestanding nonprofit hospices, which are not affected by overhead allocation issues, had a higher margin (6.4 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 (9 percent) than those in rural areas (6.2 percent). The difference between rural and urban margins may partly reflect differences in volume.

Hospice financial performance also varies by length of stay (Table 12-9, p. 316). In 2011, hospices with longer stays had higher margins (with margins dropping some for hospices in the longest stay category because some hospices in that category exceeded the cap and our model assumes the return of cap overpayments by these hospices).²¹ 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.

Hospices with a high share of patients in nursing facilities and assisted living facilities also have higher margins than other hospices. For example, in 2011, hospices in the top quartile of the percent of patients residing in nursing facilities had a 15.9 percent margin compared with a margin of roughly 7 percent to 8 percent in the middle quartiles and a 0.9 percent margin in the bottom quartile (Table 12-9, p. 316). Margins also vary by the share of a provider's patients in assisted living facilities, with a margin ranging from roughly 0.8 percent in the lowest quartile to 13.6 percent in 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

**TABLE
12-9**

**Hospice Medicare margins
by length of stay and
patient residence, 2011**

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	-6.9%
Second quintile	2.2
Third quintile	10.3
Fourth quintile	16.6
Highest quintile	12.4
Percent of stays > 180 days	
Lowest quintile	-7.1
Second quintile	3.5
Third quintile	10.4
Fourth quintile	15.4
Highest quintile	14.0
Percent of patients in nursing facilities	
Lowest quartile	0.9
Second quartile	7.4
Third quartile	8.1
Highest quartile	15.9
Percent of patients in assisted living facilities	
Lowest quartile	0.8
Second quartile	3.6
Third quartile	9.1
Highest quartile	13.6

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, and 100 percent hospice claims standard analytical file data from CMS.

more profitable than caring for patients at home for reasons in addition to length of stay. As discussed in more detail 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 due to

the overlap in responsibilities between the hospice and the nursing facility (Medicare Payment Advisory Commission 2013). Some hospice industry representatives offer a different view of the nursing facility setting, asserting that hospices face higher costs for certain activities in nursing facilities (e.g., educating and coordinating with nursing facility staff and communicating and coordinating with patients' families who may live far away) that offset any efficiencies in the nursing facility setting. However, other industry stakeholders have stated that the nursing facility setting can be more efficient when a hospice has a number of patients clustered in the same facility. The Commission continues to hold that a site-of-service payment adjustment for hospice care in nursing facilities may be appropriate and intends to conduct further research on this issue.

Projecting margins for 2014

To project the aggregate Medicare margin for 2014, we model the policy changes that went into effect between 2011 (the year of our most recent margin estimates) and 2014. The policies include:

- a market basket update of 3 percent for fiscal year 2012, 2.6 for fiscal year 2013, and 2.5 percent for fiscal year 2014;
- a reduction to the market basket update of 1 percentage point in 2013 and 0.8 percentage point in 2014 (reflecting a productivity adjustment and an additional adjustment of -0.3 percentage point each year);
- years three through five 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 2012 through 2014; and
- additional wage index changes, which increased payments in fiscal year 2012 and reduced payments in fiscal years 2013 and 2014.²²

We also assume a rate of cost growth in 2013 and 2014 that is higher than the historical rate in light of potentially higher administrative costs related to preparing for and/or implementing several new administrative requirements (i.e., new claims data reporting requirements, new quality reporting initiatives, and a potentially revised cost report). Taking these factors into account, we project an aggregate Medicare margin for hospices of 7.8 percent in fiscal year 2014. If the sequester is in effect in 2014, the margin

projection for 2014 would be roughly 2 percentage points lower. 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 for the higher indirect costs observed among hospital-based and home health-based hospices (which, if such an adjustment were made, would increase the overall aggregate Medicare margin by up to 1.5 percentage points).

In considering the 2014 margin projection as an indicator of the adequacy of current payment rates for 2015, one policy of note is the continued phase-out of the wage index budget-neutrality adjustment. Our 2014 margin projection reflects the first five years (through 2014) of the seven-year phase-out of the wage index budget-neutrality adjustment. In 2015, the sixth year of this phase-out will result in an additional 0.6 percentage point reduction in payments.

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How should Medicare payments change in 2015?

Update recommendation

RECOMMENDATION 12

The Congress should eliminate the update to the hospice payment rates for fiscal year 2015.

RATIONALE 12

Our payment indicators for hospice are generally positive. The number of hospices has increased in recent years because of the entry of for-profit providers. The number of beneficiaries enrolled in hospice and average length of stay also increased. Access to capital appears adequate. The projected 2014 aggregate Medicare margin is 7.8 percent. Based on our assessment of the payment adequacy indicators, hospices should be able to accommodate cost changes in 2015 without an update to the 2014 base payment rate.

Spending

- Under current law, hospices would receive an update in fiscal year 2015 equal to the hospital market basket index (currently estimated at 2.7 percent), less an adjustment for productivity (currently estimated at 0.3 percent). Hospices may also face an additional 0.3 percentage point reduction in the fiscal year 2015 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 2015 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 Of the \$1 billion that Medicare spent on nonhospice services in 2012 for beneficiaries enrolled in hospice, spending was highest on Part D drugs (\$340 million), inpatient services (\$224 million), physician and supplier services (\$202 million), and hospital outpatient services (\$122 million). Among beneficiaries using hospice in 2012, 53 percent received at least one Part A or Part B service or Part D drug during their hospice stay in 2012 that was paid for outside the hospice benefit by Medicare FFS, a prescription drug plan, or an MA prescription drug plan. For drugs and services paid for outside the hospice benefit, data suggest that some portion appears related to the beneficiaries' terminal conditions, although the share is difficult to estimate. For more details, see online Appendix 12-A, available at <http://www.medpac.gov>.
- 4 In 2011, Medicare hospice spending on patients with stays exceeding 180 days totaled \$7.9 billion, more than half of the \$13.8 billion in total Medicare hospice spending that year. Of that \$7.9 billion, about \$5.2 billion was on day 181 and beyond in the beneficiaries' hospice episode, and about \$2.7 billion was on day 1 to day 180.
- 5 PPACA's statutory language on focused medical review has technical issues (Section 1814(a)(7)(D)(ii) of the Social Security Act). Typically, when CMS conducts a medical review and finds that a service is not reasonable or necessary as defined in Section 1862(a)(1) of the Social Security Act or denies a hospice service because the beneficiary is not terminally ill under Section 1879(g)(ii) of the Social Security Act, Section 1879 of the Social Security Act limits beneficiary liability. Under Section 1879, if the beneficiary could not reasonably have been expected to know that the service was not covered, the beneficiary is not financially liable for the service. However, the statutory language associated with the PPACA medical review provision does not reference Section 1879. Consequently, if the PPACA focused medical review provision were implemented, the beneficiary would be fully liable for any services found not covered, even if the beneficiary could not have known the service was not covered. This outcome would be counter to the intent of the provision, which is to focus on providers with unusual utilization patterns and to hold those providers accountable if they are providing noncovered services. The statutory language for the hospice focused medical review provision should be altered so that the standard limitations on beneficiary liability under Section 1879 apply to this provision in the same way they apply to Section 1862(a)(1) or Section 1879(g)(ii). In addition, the statutory language specifying how to calculate a hospice's percentage of stays exceeding 180 days would benefit from clarification to ensure that it identifies those hospices for which stays greater than 180 days make up a high share of that specific hospice's total stays (not a high share of all stays nationally).
- 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 2013 cap threshold is equivalent to an average length of stay of 170 days of routine home care for a hospice with a wage index of 1.0.
- 8 In 2009, cancer was the cause of death for about 22 percent of decedents ages 65 or older (Centers for Disease Control and Prevention 2012). Between 2000 and 2012, as hospice use among beneficiaries with noncancer diagnoses grew, the share of hospice decedents with cancer declined from 52 percent to 32 percent. Thus, the share of hospice decedents with cancer has become increasingly similar over time to the share of deaths attributed to cancer.
- 9 The 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). This information does not necessarily reflect the location where patients receive care. For example, all types of hospices may serve some nursing facility patients.
- 10 Above-cap hospices are more likely to be for-profit, freestanding providers and to have smaller patient loads than below-cap hospices.
- 11 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 fiscal year 2012 hospice final rule (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 will have their cap payments calculated from the challenged year going forward using a new alternative methodology. For estimation purposes, we have assumed that the original cap methodology was used for the 2011 cap calculation for all hospices.
- 12 Because of refinements to our methodology for calculating cap overpayments in 2008 through 2011 (due to changes in data availability and efforts to match as closely as possible the Medicare claims processing contractors' cap calculation approach), the cap estimates displayed in Table 12-6 are not entirely comparable across time. Nevertheless, on the basis of additional analyses we performed using a comparable methodology across time, we found that the share of hospices exceeding the cap increased through 2009 and declined in 2010 and 2011, while the share of total hospice payments over the cap and the average amount of the overpayment per above-cap hospice has declined since 2006.
 - 13 CMS decided not to continue data collection for the NQF-endorsed pain outcome measure for years beyond 2014 because a high rate of patient exclusion makes the measure unstable and because the measure is inconsistently administered across providers. CMS has indicated its interest in developing another pain management outcome measure in the longer run.
 - 14 The cost-per-day calculation reflects aggregate costs for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care). *Days* reflect 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.
 - 15 Some differences exist in the diagnosis mix of patients treated by freestanding and provider-based hospices that contribute to the length-of-stay differences observed for these providers. Freestanding providers have a slightly higher share of patients with a neurological primary diagnosis (who tend to have longer stays) and a slightly lower share of patients with a cancer diagnosis (who tend to have shorter stays) compared with provider-based hospices. However, most of the difference in length of stay between freestanding and provider-based hospices reflects differences in length of stay for patients with similar diagnoses. For example, average length of stay for decedents with neurological conditions was 148 days for freestanding providers compared with 111 days for home health-based providers and 89 days for hospital-based providers.
 - 16 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.
 - 17 The aggregate Medicare margin is calculated as follows: ((sum of total payments to all providers) – (sum of total costs to all providers) / (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 2011 because cost reporting year 2011 is the most recent period for which we have a complete set of claims data. For some hospices, cost-reporting year 2011 includes part of calendar year 2012.
 - 18 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments to be hospice revenues in our margin calculation.
 - 19 Our margin estimates also do not take into account revenues or costs from fundraising and donations.
 - 20 These estimates are adjusted to account for differences in patient volume across freestanding and provider-based hospices.
 - 21 Our assumption of full return of overpayments likely understates margins slightly because not all hospices fully return overpayments. For example, a hospice provider last year closed reportedly to avoid repayment of overpayments (Waldman 2012).
 - 22 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 increase Medicare payments by 0.1 percentage point in 2012 and reduce payments by 0.1 percentage point in both 2013 and 2014, 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

13-1 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.

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

.....
13-2 The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

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

.....

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2013, the MA program included almost 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about \$146 billion. 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 to receive 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. Private plans, because they are paid a capitated rate rather than on an FFS basis, have greater incentives to innovate and use care management techniques.

The Commission has stressed the concept of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program spending. For MA, the Commission recommended that payments be brought

In this chapter

- Trends in enrollment, plan availability, and payment
- Quality in the Medicare Advantage program
- Medicare Advantage and hospice
- Conclusion

down from previous high levels and that they be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Recent legislation has reduced the inequity between MA and FFS. As a result, over the past few years, plan bids have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding has led to either improved efficiency or lower margins that enable MA plans to continue to increase MA enrollment by offering benefit packages that beneficiaries find attractive. However, employer group plans do not demonstrate the same bidding behavior, bidding consistently higher than nonemployer plans. We believe that this difference results from employer group plans' lack of incentive to submit competitive bids. We have made a new recommendation to address this issue.

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. Recent data on quality indicate that plans may be responding to the legislation by paying closer attention to quality measures. More plans have achieved quality ratings that would permit bonuses under the statutory provisions.

The Commission supports the concept of the quality bonus program as called for in the statute. Such a pay-for-performance system, combined with continuing fiscal pressure, will help ensure that a strong MA program will do its part to ensure the continued financial viability of the Medicare program.

Enrollment—In 2013, MA enrollment increased by 9 percent to 14.5 million beneficiaries (28 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent, to nearly 10 million enrollees. Local preferred provider organizations (PPOs) showed continued growth in enrollment between 2012 and 2013, with enrollment growing about 11 percent, to 3.3 million enrollees. Regional PPO enrollment increased about 16 percent, to 1.1 million enrollees. Enrollment in private FFS plans declined from about 500,000 to about 400,000 enrollees, continuing the expected decline resulting from legislative changes. The MA plan bids submitted to CMS project an increase in overall enrollment for 2014 of 3 percent to 5 percent, primarily in HMOs and local PPOs.

Plan availability—In 2014, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a network-based coordinated care plan (CCP), which includes HMOs and PPOs. Eighty-four percent of beneficiaries have access to an MA plan that includes Part D drug coverage and

charges no premium (beyond the Medicare Part B premium). In an average county, beneficiaries are able to choose from 10 MA plan options, including 8 CCPs in 2014.

Plan payments—For 2014, the base county benchmarks used to set plans' payment rates are, on average, about 1 percent higher than the benchmarks for 2013. We estimate that 2014 MA benchmarks, bids, and payments (including the quality bonuses) will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively. Based on an analysis of revised 2013 FFS spending numbers, we find that plans in 2014 have bid, and will be paid, about the same relative to FFS as in 2013.

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

MA and hospice—Under current law, hospice is not included in the MA benefits package. When an MA enrollee elects hospice, the beneficiary typically remains in the MA plan, but hospice services are paid for by FFS Medicare. This carve-out of hospice from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. We have made a new recommendation to include hospice in the MA benefits package. This step would give plans responsibility for the full continuum of care and promote integrated, coordinated care, consistent with the goals of the MA program. A hospice benefit in MA would also make it more feasible for plans to offer concurrent hospice and conventional care as a supplemental benefit if they wished to do so. It is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making). ■

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 2013, the MA program included almost 3,600 plan options, enrolled more than 14.5 million beneficiaries (28 percent of all beneficiaries), and paid MA plans about \$146 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. Alternatively, 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, as well as 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, and payment

In contrast to traditional FFS Medicare, MA enrolls beneficiaries in several types of private health plans. Medicare pays plans a fixed capitated 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 reporting

**TABLE
13-1**

Medicare Advantage enrollment grew in 2013

	MA enrollment (in millions)		Percent change in enrollment	2013 MA enrollment as a share of total Medicare
	November 2012	November 2013		
Total	13.3	14.5	9%	28%
Plan type				
CCP	12.8	14.2	11	27
HMO	8.8	9.7	10	19
Local PPO	3.0	3.3	11	6
Regional PPO	1.0	1.1	16	2
PFFS	0.5	0.4	-26	1
Restricted availability plans included in totals above				
SNPs*	1.6	1.9	18	4
Employer group*	2.4	2.6	9	5
Urban/rural				MA enrollment as share of population
Urban	11.6	12.7	9	30
Rural	1.7	1.9	12	18

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. Totals may not add 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.

requirements. Given that 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. First are special needs plans (SNPs), which offer benefit packages tailored to specific populations (i.e., beneficiaries

who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. Second are 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 cannot be PFFS plans. Both SNPs and employer group plans are included in our plan data, with the exception of plan availability figures since these plans are not available to all beneficiaries. (See the 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://www.medpac.gov/documents/MedPAC_Payment_Basics_13_MA.pdf.

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 2013, Part A and Part B payments to MA plans totaled approximately \$146 billion.

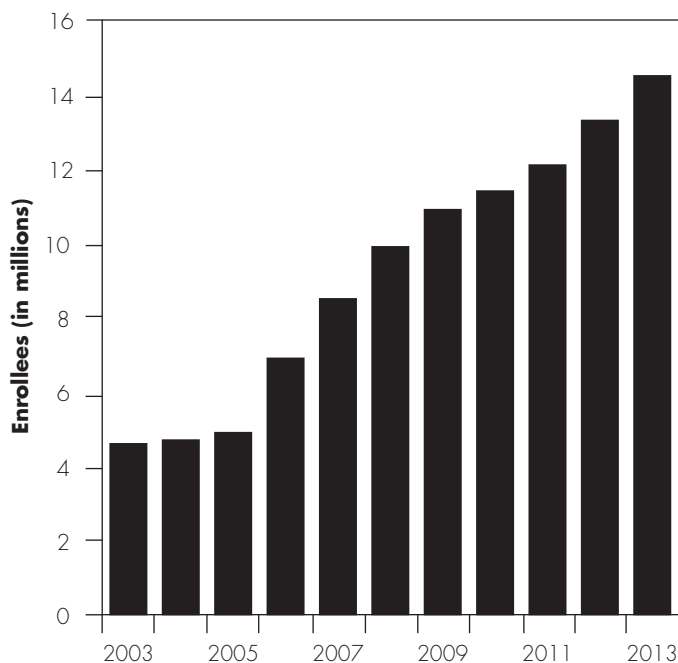
Plan growth continued to outpace total Medicare beneficiary growth in 2013

Between November 2012 and November 2013, enrollment in MA plans grew by about 9 percent—or 1.2 million enrollees—to 14.5 million enrollees (compared with growth of about 4 percent in the same period for the total Medicare population). About 28 percent of all Medicare beneficiaries were enrolled in MA plans in 2013, up from 27 percent in 2012 (Table 13-1).

Among plan types, HMOs continued to enroll the most beneficiaries (9.7 million), with 19 percent of all Medicare beneficiaries in HMOs in 2013. Between 2012 and 2013, local PPOs exhibited continued growth in enrollment, which increased by about 11 percent. Regional PPO enrollment increased by about 16 percent, reversing a decline in the previous year. PFFS enrollment shrank from about 500,000 to about 400,000 enrollees, which was expected, given changes in the law. In 2013, SNP enrollment grew by 18 percent and employer group enrollment grew by 9 percent.

FIGURE 13-1

Medicare Advantage enrollment, 2003–2013



Source: MedPAC analysis of CMS enrollment files.

Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA (about 30 percent) compared with beneficiaries residing in rural counties (about 18 percent). About one-third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 72 percent of urban enrollees. At the same time, 10 percent of rural enrollees were in PFFS plans compared with 2 percent of urban enrollees.

The percentage of Medicare beneficiaries enrolled in MA plans in 2013 varied widely geographically. In some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans, whereas in other areas enrollment was 60 percent or more (Pittsburgh, PA; Rochester, NY; and several areas in Puerto Rico).

Growth in MA enrollment in 2013 continued a trend begun in 2003 (Figure 13-1). Since 2003, enrollment has tripled. We did not have final 2014 enrollment information as of this report's publication, but plans projected overall enrollment growth of 3 percent to 5 percent for 2014. Most of the growth was projected to be in HMOs and local PPO plans, while regional PPO and PFFS plans were projected to contract.

**TABLE
13-2****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
Any MA plan	84%	100%	100%	100%	100%	100%
Local CCP	67	91	92	93	95	95
Regional PPO	N/A	86	86	76	71	71
PFFS	45	100	63	60	59	53
Zero-premium plans with drugs	N/A	85	90	88	86	84
Average number of choices	5	21	12	12	12	10

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). CCP includes 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. Part D began in 2006.

Source: MedPAC analysis of CMS bid data and population reports.

Plan availability for 2014

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 2014, 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 13-2). Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, the same as in 2013 and up from 67 percent in 2005. Regional PPOs are available to 71 percent of beneficiaries. Access to PFFS plans decreased between 2013 and 2014, from 59 percent to 53 percent of beneficiaries. Overall, virtually all Medicare beneficiaries have access to an MA plan (0.4 percent do not), and 99 percent have access to a CCP (not shown in Table 13-2).

In 2014, 84 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 86 percent in 2013.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-2). In 2014, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (the same as in 2013), 47 percent live where SNPs serve institutionalized beneficiaries (up from 46 percent in 2013), and 51

percent live where SNPs serve beneficiaries with chronic conditions (down from 55 percent in 2013). 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 available to beneficiaries are offered by a more limited number of plan sponsors since most sponsors offer multiple plans. For example, beneficiaries in Miami, New York City, and some areas of Pennsylvania and Florida can choose from more than 40 plans in 2014. At the other end of the spectrum, some counties, representing 0.4 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, 10 plans, including 8 CCPs, are offered in each county in 2014, down from 12 plans and 9 CCPs in 2013.² The decrease in plan choices from 2010 to 2014 was due to the reduction in PFFS and regional PPO plan choices.

2014 benchmarks, bids, and payments relative to FFS spending

We use the plan bid projections to 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 year. Plans submit

**TABLE
13-3**

Projected payments exceed FFS spending for all plan types in 2014

Percent of FFS spending in 2014

Plan type	Benchmarks*	Bids	Payments
All MA plans	112%	98%	106%
HMO	112	95	105
Local PPO	113	108	110
Regional PPO	109	102	106
PFFS	114	110	111
Restricted availability plans included in totals above			
SNP**	113	101	107
Employer groups**	112	107	109

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 2014 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

* Benchmarks include both statutory and demonstration 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.

their bids in June and incorporate the recently released benchmarks. Benchmarks reflect current law FFS spending estimates for 2014 made by CMS at the time the benchmarks were published in April 2013.

We estimate that 2014 MA benchmarks, bids, and payments will average 112 percent, 98 percent, and 106 percent of FFS spending, respectively (Table 13-3). (Benchmarks, bids, and payments are weighted by plans' projected 2014 enrollment by county to estimate overall averages and averages by plan type.)

Last year, we estimated that, for 2013, these figures would be 110 percent, 96 percent, and 104 percent, respectively. However, the estimates of 2013 FFS spending were too high last year. Therefore, our ratios were projected too low. Our finding based on the analysis of the new FFS spending numbers is that plans in 2014 have bid, and will be paid, about the same relative to FFS as in 2013.

MA benchmarks

Under PPACA, county benchmarks in 2014 are transitioning to a system in which each county's benchmark in 2017 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

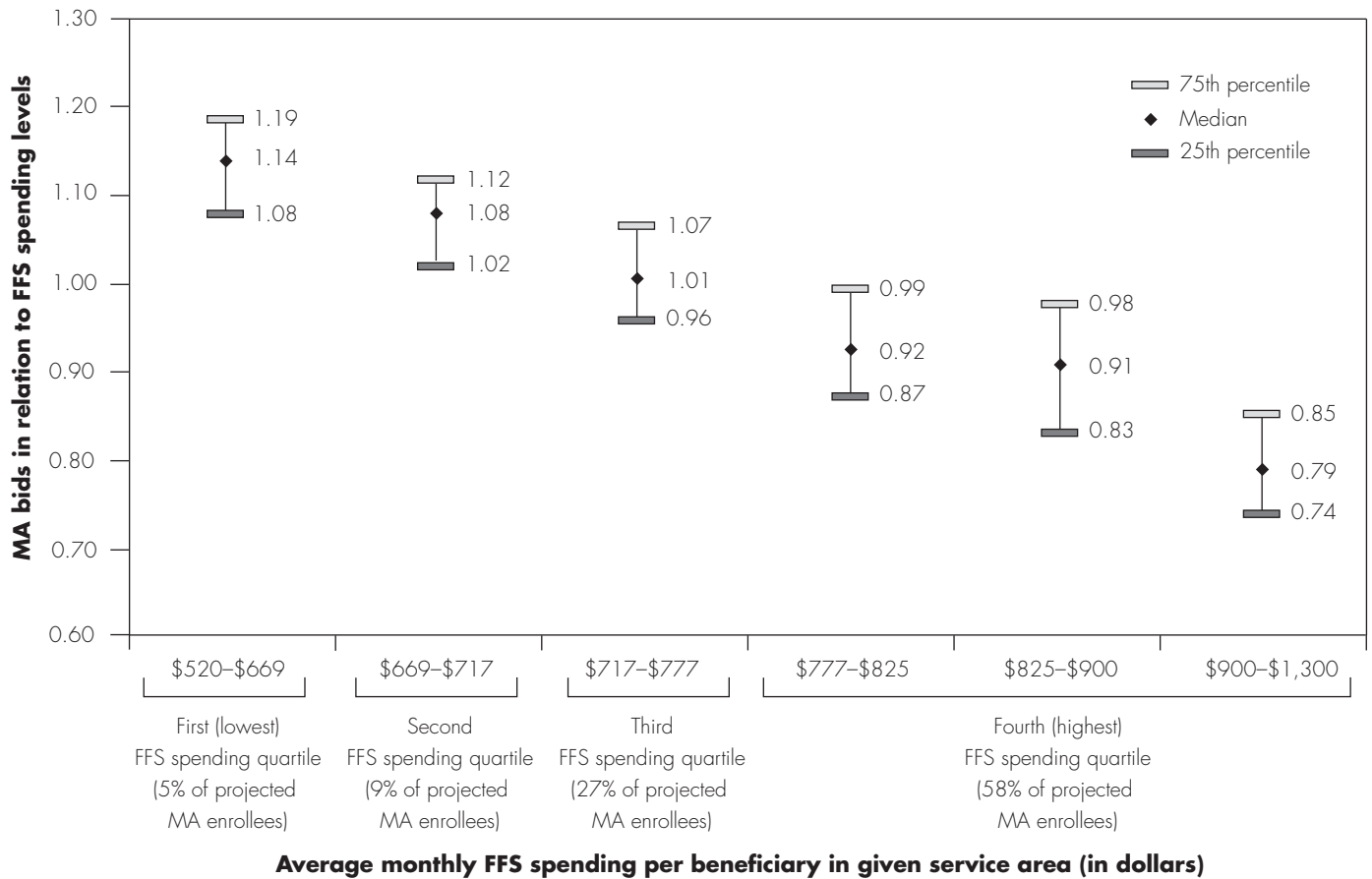
set at 95 percent of local FFS spending, and the lowest spending quartile would have benchmarks set at 115 percent of local FFS spending. The transition from old benchmarks will be complete by 2017. (See the Commission's March 2011 report to the Congress for more details on PPACA benchmark changes.) In 2014, more than half of all counties have base benchmarks that have fully transitioned to the final PPACA levels. However, only 29 percent of all Medicare beneficiaries and only 22 percent of MA enrollees live in these fully transitioned counties. Overall, more than half of the base benchmark transition has occurred:

- In 2011, the last year before the PPACA transition and the inclusion of quality bonuses in MA benchmarks, plan benchmarks averaged 113 percent of FFS spending.
- In 2014, plan base benchmarks (excluding quality bonuses) averaged 106.5 percent of FFS.
- In 2017, fully transitioned base benchmarks (excluding quality bonuses) would average about 101.5 percent of FFS.

For 2014, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 1 percent higher than the benchmarks for 2013. However, for 2014, 95 percent of MA enrollees are

FIGURE 13-2

Medicare Advantage bids in relation to FFS spending levels, 2014



Note: FFS (fee-for-service), MA (Medicare Advantage). Percent of projected MA enrollees may not add to 100 due to rounding.

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

projected to be in plans that will receive add-ons to their benchmarks through the PPACA quality provisions or the 2012 to 2014 CMS quality demonstration program. These quality bonus add-ons range from 3 percent to 10 percent in 2014.

MA bids and payments for different plan types

The modest growth in the benchmarks over the past few years may have exerted fiscal pressure on MA plans and encouraged them to better control costs and restrain the growth in their bids. For 2014, bids increased by an average of 2 percent, and most plans will have to pay a new PPACA premium tax of about 2 percent in 2014. The average bid for 2014 is 98 percent of the projected FFS spending for similar beneficiaries. About 48 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 benefits. These plans

are projected to enroll 52 percent of nonemployer MA enrollees in 2013. About 700,000 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 120 percent of FFS spending.

Figure 13-2, illustrating over 2,000 plan bids (employer group 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 2014. We broke the fourth quartile into the last three FFS ranges because about 40 percent of Medicare beneficiaries live in counties in the highest spending quartile. Each FFS range covers the bids of at

least 120 plans and 800,000 projected enrollees, with about 76 percent of the plans and projected enrollment falling in the three groups between \$717 and \$900 of FFS spending per month.

Plans bid low (relative to FFS) in areas with relatively high FFS spending. When plans bid for service areas that average less than \$777 in monthly FFS spending, they are likely to bid more than FFS (Figure 13-2). However, when plan service areas average more than \$777 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-two percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. While the bidding and payment patterns are reported here in averages, clearly there is much variation within these averages (Table 13-3, p. 331; 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 are high relative to FFS spending. For example, HMOs as a group bid an average of 95 percent of FFS spending, yet 2014 payments for HMO enrollees are estimated to average 105 percent of FFS spending because the benchmarks (including the quality bonuses) average 112 percent of FFS spending. Other plan types have average bids above FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 110 percent and 111 percent, respectively, of FFS spending (Table 13-3, p. 331).

We analyzed bids and payments to SNPs and employer group plans separately because these plans are available only to subpopulations of Medicare beneficiaries, and their bidding behavior differs from that of other plan types. Payments to SNPs and their bids tend to be slightly higher relative to FFS spending than general MA plans. SNP bids average 101 percent of FFS and payments are about 107 percent of FFS. The process for developing bids by employer group plans is different and is discussed in more detail later in this chapter.

The ratio of MA plan payments to FFS spending varies by plan type, but the ratios for all plan types are higher than 100 percent. In 2014, overall payments to plans will average an estimated 106 percent of FFS spending, meaning that the Medicare program will pay approximately \$8 billion more for MA enrollees than it would have paid to cover the same enrollees in FFS Medicare. (This figure includes about \$4.5 billion attributable to quality bonus payments, about two-

thirds of which are due to a demonstration program that will end in 2014.)

Beginning in 2014, MA plans will be required to meet medical loss ratio (MLR) requirements. The primary requirement is that the plans must spend at least 85 percent of the premiums they collect (from both the Medicare program and beneficiaries) on medical expenses (as opposed to administrative costs and margins, or profits). If the plans do not meet this requirement, they will be required to refund a portion of the premiums they collected to the Medicare program. At this point, we could not determine whether the categorization of costs in the bids is the same as required in the law, but if the categorizations match, the average MA plan is close to meeting the MLR requirements. The average plan spends 84 percent of its total revenue on medical care, 11 percent on administrative functions, and maintains a 5 percent margin. HMO and local PPO bids projected average medical expenses of 85 percent of revenue.

Medicare Advantage employer group plans

While most MA plans are available to any Medicare beneficiary residing in a given area, some MA plans are available only to retirees whose Medicare coverage is supplemented by their former employer or union. These plans are called employer group plans. Such plans are usually offered through insurers and are marketed to groups formed by employers or unions rather than to individual beneficiaries. As of September 2013, about 2.6 million enrollees were in employer group plans, or about 18 percent of all MA enrollees (Table 13-4, p. 334).

For 2014, there are 1,042 employer group plan bids, of which 343 are essentially national bids that cover more than 3,000 counties. Those national bids contain about 58 percent of the projected enrollment in employer group MA plans. If the national plans are excluded, the employer group plan bids cover an average of 78 counties. By comparison, the 2,596 nonemployer plan bids cover an average of 16 counties. The average employer group plan is expected to enroll about 2,800 beneficiaries, while the average nonemployer plan is expected to enroll about 4,600 beneficiaries. To summarize the nature and reliability of the bids, employer group plans expect to enroll an average of fewer than 3 beneficiaries per county covered, while nonemployer plans expect to enroll almost 300 beneficiaries per county covered.

All else being equal, employer group plans consistently bid higher than plans that are open to all Medicare

**TABLE
13-4****Comparison of employer group plans and nonemployer plans, 2013–2014**

	Employer group plans	Nonemployer plans
MA enrollment, November 2013	2.6 million	11.9 million
Median ratio of bid to benchmark, 2014*	0.99	0.87
Average ratio of bid to benchmark, 2014*	0.95	0.86
Average ratio of MA bid to FFS spending for comparable beneficiaries, 2014	1.07	0.97
Average ratio of MA payment to FFS spending for comparable beneficiaries, 2014	1.09	1.06
Number of bids submitted to CMS for 2014	1,042	2,596
Average projected enrollment per county in covered area	3	288

Note: MA (Medicare Advantage), FFS (fee-for-service).
* Projected enrollee weighted.

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

beneficiaries. The bidding process for employer group plans differs from other MA plans in that employer group plans can negotiate benefit and premium particulars with employers after the Medicare bidding process is complete. Conceptually, the closer the bid is to the benchmark—that is, the maximum Medicare payment—the better it is for the plan and the employers because a higher bid brings in more revenue from Medicare, potentially offsetting expenses that would have required a larger contribution from employers (or employees). In contrast, nonemployer plans have an incentive to bid below the benchmark to obtain rebates they can use to finance extra benefits that, in turn, are used to attract increased enrollment. In other words, the nonemployer plans are competing for enrollment through the value of the benefit packages their bids allow them to submit, while the employer plans are not competing this way. The employer plans have already ensured themselves of enrollment through negotiations with the employer groups; their bids appear to be set to maximize revenue. In fact, for 2014, the median employer plan (weighted by projected enrollment) has bid 99 percent of its benchmark.

Under the MA bidding process, the employer group MA plans tend to cost the Medicare program more than nonemployer plans would cost for the same enrollees because the employer group plans have less incentive to bid as far below the benchmark. The Part D drug plan bidding process differs in that, for the base (noncatastrophic) part

of the Part D benefit, employer plans are paid based on the bids of nonemployer plans. In our view, using only the nonemployer plan bids would be a better way to set MA payments for employer group plans.

Because employer group plans usually cover very broad service areas, an option for setting plan payments would be to use the national average bid-to-benchmark ratio for nonemployer plans and apply that to employer group plans. In 2014, the average bid of nonemployer plans (weighted by projected enrollment) is 86 percent of their benchmarks. At the same time, employer group plans submitted bids that averaged 95 percent. (While the incentives are for the plans to bid 100 percent of the benchmarks, plans may not always have the actuarial evidence to support bids that high and still pass the CMS bid review, even though the employer group plans may get more latitude under the review process.) Under this option, employer group plans would have their “bids” set at 86 percent of their benchmarks. The employer group plans would be paid 86 percent of their benchmarks plus rebates based on their quality scores. There are alternative strategies for assigning a bid-to-benchmark ratio for employer group plans (e.g., weighting the ratio with employer group plan enrollment).

For the majority of employer group plan enrollees, who are in plans with national service areas, there would be no geographic concerns regarding setting the bids relative to the benchmarks. However, employer group plans might still feel some pressure to drop plans in geographic areas

where nonemployer plans tend to bid higher than average relative to the benchmarks. If this policy option had been in effect for 2014, MA employer plan payments would have been about one-half billion dollars lower.

RECOMMENDATION 13-1

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.

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 attributed to the beneficiary 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, the plans have an incentive to ensure that the providers serving the beneficiary record all diagnoses completely.

Experience supports the contention that MA plan enrollees have higher risk scores than otherwise similar

FFS beneficiaries because of more complete coding. CMS has found that risk scores for MA plan members have been growing more rapidly than risk scores for FFS beneficiaries. 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. Under PPACA, CMS can continue to adjust for the differences it finds, but for 2014 and all future years, PPACA specifies minimum reductions, although CMS has discretion to make larger reductions. The Government Accountability Office (GAO) found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012b). 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 utilization rather than on FFS utilization in the current model; however, CMS will be able to devise an adjustment to account for any difference between FFS and MA risk levels. In the Commission's March 2012 report to the Congress, we noted that a number of issues must be considered in deciding whether to use MA utilization as the basis for risk adjustment and how to go about designing such an alternative (Medicare Payment Advisory Commission 2012). For 2014, CMS has chosen to reduce risk scores by 4.91 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 106 percent of the FFS payment figure projected for 2014 assumes that the risk-adjustment system and the CMS coding adjustment properly correct all health-risk differences between the FFS and MA populations. However, several studies (McWilliams et al. 2012, Medicare Payment Advisory Commission 2012, Newhouse et al. 2012) suggest that MA plans may enjoy some favorable selection (though less than in previous years) that the current risk-adjustment model does not capture. For this reason, 106 percent might understate the additional payments made for plan enrollees relative to Medicare FFS beneficiaries. At the same time, the payments include quality bonuses worth about 3 percent of payments. If there were no quality bonuses or favorable selection, plan enrollees in 2014 would receive about 103 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries.

Quality in the Medicare Advantage program

Comparing last year's quality indicators with the most current results, the majority of measures remained stable, including intermediate outcome measures. Also remaining stable or unchanged were patient experience measures. There was improvement in a number of indicators, including process measures such as cancer screenings, as well as in hospital readmission rates and Part D drug adherence measures. As a result, plan star ratings, which are used to determine quality bonuses, improved for many plans.

Quality indicators in Medicare Advantage

For the most part, plan quality indicators have remained stable over the past year. Intermediate outcome measures (such as control of high blood pressure among plan enrollees with hypertension), patient experience measures (enrollees' perceived access to care and their rating of their plans and providers), and plan disenrollment rates were essentially unchanged over the past year. MA plan process measures and some clinical quality measures have improved. Hospital readmission results show improvement among all plan types, mirroring reduced readmissions in FFS Medicare during the same period. Part D clinical measures in MA prescription drug (MA-PD) plans also improved.

The quality indicators that we track come from four sources, the first three of which are described more fully in an online appendix to the March 2010 report to the Congress (http://medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf):

- The Healthcare Effectiveness Data and Information Set[®] (HEDIS[®]) measures, which health plans report to CMS, are the primary source of clinical process measures and intermediate outcome measures, including hospital readmission rates.
- The Consumer Assessment of Healthcare Providers and Systems for MA[®] (CAHPS[®]-MA), which is a health plan member survey, is the source of patient experience measures that include members' rating of access to care and satisfaction with a health plan and its providers.
- The Health Outcomes Survey (HOS), which is a survey of MA enrollees, is the source of some HEDIS measures and is used to determine whether a plan's

enrollees have experienced improvement or decline in their physical and mental health.

- Measures that CMS reports through the star rating system include plan disenrollment rates and Part D clinical measures for MA-PD plans.

HEDIS results

The quality measures derived from HEDIS encompass clinical process measures, intermediate outcome measures, and hospital readmission rates. The most current HEDIS data (reported in June 2013) reflect care rendered in 2012. Table 13-5 provides a summary of year-over-year HEDIS results for the most recent two-year period, 2012 and 2013. The comparison is on a "same-store" basis, meaning that for each measure a plan has to have reported a result for a measure in each of the two years to be included in the analysis.

Over one-third of the HEDIS clinical process measures improved, but HEDIS outcome measures (other than hospital readmission rates) generally remained stable over the two-year period. However, one such measure declined among local PPOs (cholesterol control among patients with cardiovascular conditions).³ For the hospital readmission measure, all plan types (HMOs, local and regional PPOs, and PFFS plans) showed improvement in the observed-to-expected ratio for rates of hospital readmissions, with those ratios declining between 2.4 percent (for PFFS plans) and 4.9 percent (for HMOs). In the same time period (2012), FFS Medicare also reduced readmission rates (Gerhardt et al. 2013).⁴

Though the differences are narrowing, differences in the HEDIS scores of HMOs and local PPOs persist—in both directions. HMOs perform better on measures that involve the extraction of medical record data (which include all the intermediate outcome measures of HEDIS), partly for reasons related to the change in rules for PPO reporting (Medicare Payment Advisory Commission 2013). However, PPOs perform better on 4 of the 42 HEDIS measures (specifically, initiation of alcohol and other drug dependence treatment, management of urinary incontinence, use of disease-modifying antirheumatic drug therapy in rheumatoid arthritis, and discussion of physical activity with older adult patients).

Between 2012 and 2013, measures that showed no change include six of seven HEDIS intermediate outcome measures: three blood pressure control measures, a second cholesterol control measure (in addition to the measure

**TABLE
13-5**

HEDIS® results for HMOs and local PPOs, 2012 and 2013 reporting

Measure categories	Specific measure(s)	Star status ^a	Plan performance
Measures that improved			
Patient health management	Hospital readmission rates	✓	HMOs and PPOs improved
	Managing fall risks	✓	
	Discussing physical activity with patients ^b	✓	
	Advising physical activity ^b		
Screenings/tests	Colorectal cancer	✓	HMOs and PPOs improved
	Glaucoma screenings	✓	
	Adult BMI recorded	✓	
	Breast cancer screening	✓	
Appropriate drug therapies	DMARD therapy for rheumatoid arthritis	✓	HMOs and PPOs improved
Medication management and monitoring	1 (of 4) specific drug–disease interaction monitoring measures		HMOs and PPOs improved
	Monitoring use of digoxin		HMOs improved; PPOs stable
	Total rate of monitoring drug-disease interactions in the elderly		
Appropriate drug therapies	COPD treatment: Use of corticosteroids, use of bronchodilators		HMOs improved; PPOs stable
Medication adherence	Persistence of beta blocker use after heart attack		HMOs improved; PPOs stable
Measures generally remaining stable			
Intermediate outcome measures	Control of blood pressure	✓	HMOs and PPOs stable ^c
	Blood sugar and cholesterol among diabetics	✓	
	Cardiovascular conditions: cholesterol control	✓	
	Hypertension: control of blood pressure	✓	
Patient health management	Osteoporosis management	✓	HMOs and PPOs stable
	Care for urinary incontinence	✓	
	Discussing fall risks		
Screenings/tests	Comprehensive diabetes care: eye exams	✓	HMOs and PPOs stable
	Comprehensive diabetes care: kidney disease monitoring	✓	
	Comprehensive diabetes care: lipid profile	✓	
	Cardiovascular conditions: lipid profile	✓	
	Spirometry testing in COPD care		
Medication management and monitoring	Measures of monitoring patients on persistent medications		HMOs and PPOs stable ^d
Mental health	2 measures of follow-up after hospitalization		HMOs and PPOs stable
Alcohol or drug dependence treatment	Rate of initiation of treatment		HMOs and PPOs stable
Measures that declined			
Intermediate outcome measure	Cardiovascular conditions: cholesterol control	✓	PPOs declined; HMOs stable
Alcohol or drug dependence treatment	Rate of engagement in alcohol and other drug dependence treatment		HMOs declined; PPOs stable

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), PPO (preferred provider organization), BMI (body mass index), DMARD (disease-modifying antirheumatic drugs), COPD (chronic obstructive pulmonary disease). Data exclude cost-reimbursed HMO plans. Regional PPOs and private fee-for-service plans are not included because too few plans report HEDIS® data.

- a. Indicates measure is used for star rating (which is the basis for bonus payments to plans).
- b. Collected through the Health Outcomes Survey but reported as HEDIS measures.
- c. One such measure declined among local PPOs.
- d. One such measure declined among HMOs.

Source: MedPAC analysis of CMS star ratings and enrollment data.

that declined among local PPOs), and two measures of control of hemoglobin A1c among diabetics.

There are also five HEDIS measures reported only by SNPs. Of those measures, four improved (advance care planning, medication review, functional status assessment, and pain management) and one remained stable (medication reconciliation postdischarge).

CAHPS results

Over the past year, the average rates for all the CAHPS patient experience measures were essentially unchanged from the preceding year.

The flu vaccine measure is also taken from CAHPS. In 2012, flu vaccination rates had statistically significant increases across all plan types other than regional PPOs. The lowest rate was among PFFS plans and regional PPOs (at 69 percent for each vs. 71 percent for HMOs and 72 percent for local PPOs).

The Health Outcomes Survey results

The 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 of 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 (2010 to 2012), fewer than 5 percent of plans had changes in their enrollees' mental or physical health status that differed significantly from the average across all plans.

Part D measures and contract performance measures

CMS gathers data from both MA and Part D for the purposes of program monitoring and for the star rating system. Part D measures in the overall star rating for MA-PD plans include three medication adherence measures (medications for diabetes, hypertension, and cholesterol). Plans improved on each of these measures.

Other measures in the star rating 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. In the most recent period, beneficiary access and performance problems were reduced and appeals processing improved. Disenrollment rates were stable between 2011 and 2012, with a weighted average at slightly under 11 percent in each year. However, disenrollment rates were highest among PFFS and regional PPO plans, averaging 14 percent.⁵

Comparison with FFS Medicare

We have little information on which to base a comparison of the MA quality indicators with the quality of care in FFS Medicare. However, studies show differences in use of services among MA enrollees compared with FFS beneficiaries, which in some cases may be indicative of better access to appropriate care and better integration of care in MA. One study, using data from one chronic care SNP, showed that the plan's diabetic enrollees had lower rates of emergency department use, more primary care visits, and lower hospital admission and readmission rates than the comparison group in FFS, though the differences narrowed after risk adjustment (Cohen et al. 2012). Another study also showed lower rates of hospital admissions and emergency use across MA HMO plans from 2003 to 2009 and differences in the frequency of certain procedures (e.g., MA HMOs had a greater frequency of coronary artery bypass graft surgery but fewer hip and knee replacements than FFS beneficiaries) (Landon et al. 2012). The authors used HEDIS utilization data reported by plans and included beneficiaries age 65 or over who had been members of a plan for the full 12 months of the year. After applying certain exclusions (such as excluding enrollees of SNPs), the study included data from 120 risk-based HMO plans in 2003 and 280 such plans in 2009. The authors matched the population with data from a 20 percent sample of beneficiaries in Medicare FFS. Using essentially the same design and scope as Landon and colleagues, over the same period, 2003 to 2009, Ayanian and colleagues found that MA HMO enrollees were more likely than beneficiaries in FFS Medicare to have received "appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease," though there were differences across plans, with more integrated, larger, older plans performing better (Ayanian et al. 2013). The research of Matlock and colleagues examined geographic variation in the frequency of certain interventional cardiac procedures, finding that "the degree of geographic variation in procedure rates was substantial among MA beneficiaries and was similar in magnitude to that observed among

Medicare FFS beneficiaries” (Matlock et al. 2013). The authors examined data for the years 2003 to 2007 for beneficiaries ages 65 to 99 in 32 hospital-referral regions that included 12 states. The data source for the MA beneficiaries was the research data submitted by 12 of 15 integrated delivery systems whose research divisions participated in the Cardiovascular Research Network of the National Heart, Lung, and Blood Institute. The data included nearly 900,000 MA enrollees and over 5 million Medicare FFS beneficiaries.

The star rating 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, and 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, up to 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. New measures have a weight of 1 in their first year of use.

The highest rated plans (the 11 MA–PD plans and 3 MA-only plans that received 5-star ratings for 2014) can enroll beneficiaries outside of the annual election period.⁶ Their status as high-rated plans is displayed at <http://www.medicare.gov>, while the lowest rated plans are also flagged, and beneficiaries are cautioned about choosing to enroll in a low-rated plan. The bonus payments to higher rated plans also make such plans more attractive to beneficiaries because of the plans’ ability to offer more extra benefits than lower rated plans they may be competing with.

Under the statutory provision originally authorizing the bonus system, plans at or above a 4-star rating receive a bonus of 5 percent (or 10 percent in some counties); 4.5-star and 5-star plans have rebates that are 70 percent of the bid-to-benchmark difference (versus 65 percent or 50 percent for lower rated plans). From 2012 through 2014, CMS used a program-wide demonstration project to give bonuses to plans at the 3- and 3.5-star level. The Commission and the GAO have criticized the basis and design of the demonstration and its very high cost

(Government Accountability Office 2012a, Government Accountability Office 2012b, Medicare Payment Advisory Commission 2013).

For the Part C (Medicare Part A and Part B benefits) component of the star ratings, 17 of the 36 star rating system measures are from HEDIS, and they represent 45 percent of the weighted value of all Part C measures. For MA–PD sponsors that operate SNPs (all of which are required to provide Part D drug coverage), HEDIS measures make up to 30 percent of the total weighted value of star rating measures in the quality bonus program (Table 13-6, p. 340). Outcome measures constitute the majority of the weight of the overall star rating and include HEDIS outcome measures (15.1 percent), HOS-based outcome measures (7.5 percent), and Part D outcome measures (22.6 percent)—for a total of 45.2 percent of the weighted value coming from outcome measures (this share includes the improvement measures for Part C and Part D that CMS computes). We would note that the Part D weighting, at one-third of the overall plan score, is almost three times greater than the proportion of expenditures for Part D within the MA–PD program, which is about 12 percent of MA–PD program expenditures. Although if beneficiary cost sharing is included, the Part D proportion would be higher than 12 percent. The greater weight given to Part D measures may be due to the greater availability of outcome measures from Part D data. The effect that particular measures have on the health of enrollees—to the extent that it is possible to quantify such a concept in relation to measures used to evaluate plans—may be a better basis for weighting the components of the star measurement system.

Star ratings and changes in the ratings

The elements and methodology of the star ratings have changed since the introduction of the star rating system. Greater weight is given to outcome measures, and a number of measures have been discontinued. Comparing the 2013 and 2014 star ratings components and methodology, the two years are very similar in the elements included and the “cut points” determining the assignment of stars for individual measures. There were no changes to the 4-star thresholds for each measure (which is an important threshold because it determines whether a plan is eligible for a quality bonus under the statutory provisions). Some measures had lower thresholds for a 5-star rating, and others had a higher cut point necessary to achieve a 5-star rating. In the main, the star ratings for each of the two years can be used to gauge whether a given plan has improved in its quality and contract performance over the past year.

**TABLE
13-6**

Measures included in the 2014 star ratings and their relative weight (continued next page)

	Weight	Share of total weight for non-SNP MA-PDs	Share of total weight for SNPs (all are MA-PDs)
All Part C		66.7%	67.9%
Outcome measures from HEDIS®			
Diabetes care – blood sugar controlled	3	15.1%	14.5%
Diabetes care – cholesterol controlled	3		
Controlling blood pressure (all members with hypertension)	3		
Plan all-cause readmissions	3		
Process measures from HEDIS			
Breast cancer screening	1	12.6	15.8
Colorectal cancer screening	1		
Cardiovascular care – cholesterol screening	1		
Diabetes care – cholesterol screening	1		
Glaucoma testing	1		
Adult BMI assessment	1		
Osteoporosis management in women who had a fracture	1		
Diabetes care – eye exam	1		
Diabetes care – kidney disease monitoring	1		
Rheumatoid arthritis management	1		
Care for older adults – medication review	1	SNP only	
Care for older adults – functional status assessment	1	SNP only	
Care for older adults – pain screening	1	SNP only	
Outcome measures from HOS (determined by CMS)			
Improving or maintaining physical health	3	7.5	7.3
Improving or maintaining mental health	3		
Process measures from HOS (reported through HEDIS)			
Monitoring physical activity	1	3.8	3.6
Improving bladder control	1		
Reducing the risk of falling	1		
Patient experience measures from CAHPS®			
Getting needed care	1.5	11.3	10.9
Getting appointments and care quickly	1.5		
Customer service	1.5		
Rating of health care quality	1.5		
Rating of health plan	1.5		
Care coordination	1.5		
Process measures from CAHPS			
Annual flu vaccine	1	1.3	1.2
Other measures for Part C			
Health plan quality improvement (outcome computed by CMS)	3	3.8	3.6
Complaints about the health plan	1.5	11.3	10.9
Beneficiary access and performance problems	1.5		
Members choosing to leave the plan (disenrollment rates)	1.5		
Plan makes timely decisions about appeals	1.5		
Reviewing appeals decisions	1.5		
Call center – foreign language interpreter and TTY availability	1.5		

Note: SNP (special needs plan), MA-PD (Medicare Advantage–Prescription Drug plan), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), PPO (preferred provider organization), TTY (teletypewriter), RAS (renin angiotensin system). SNP measures are weighted in proportion to SNP membership in a given contract; a contract that is 100 percent SNP enrollment would have the full weighting shown in the table.

Source: MedPAC analysis of CMS star rating measures.

**TABLE
13-6**

Measures included in the 2014 star ratings and their relative weight (cont.)

	Weight	Share of total weight for non-SNP MA-PDs	Share of total weight for SNPs (all are MA-PDs)
All Part D		33.3%	32.1%
Outcome measures			
Drug plan quality improvement (computed by CMS)	3	22.6	21.8
High-risk medication	3		
Diabetes treatment (appropriate drug prescribing)	3		
Medication adherence for diabetes medications	3		
Medication adherence for hypertension (RAS antagonists)	3		
Medication adherence for cholesterol (statins)	3		
Patient experience measures from CAHPS			
Rating of drug plan	1.5	3.8	3.6
Getting needed prescription drugs	1.5		
Other measures for Part D			
Call center—foreign language interpreter and TTY availability	1.5	6.9	6.7
Appeals auto-forward (appropriate handling of appeals)	1.5		
Appeals upheld	1.5		
Medicare Plan Finder price accuracy	1		

Note: SNP (special needs plan), MA-PD (Medicare Advantage–Prescription Drug plan), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), PPO (preferred provider organization), TTY (teletypewriter), RAS (renin angiotensin system). SNP measures are weighted in proportion to SNP membership in a given contract; a contract that is 100 percent SNP enrollment would have the full weighting shown in the table.

Source: MedPAC analysis of CMS star rating measures.

Comparing 2013 star results with 2014 results, a majority of beneficiaries are in plans with 2014 ratings that are at 4 stars or higher. Based on September 2013 enrollment, plans’ improvement in their star ratings over the past year led to a majority of enrollees being in higher rated plans (Table 13-7, p. 342). These results reflect improvement primarily in Part D star-rated outcome measures, readmission rates, clinical process measures, contract performance measures, and CMS-computed Part C and Part D improvement measures (whereby CMS examines a collection of measures to evaluate whether the plan has shown improved results).

Variation in star ratings by plan type

As noted in CMS’s 2014 star ratings fact sheet, plans with the highest star ratings have certain characteristics (Centers for Medicare & Medicaid Services 2013). Higher rated plans have been in the MA program longer and are more likely to be nonprofit.

There is also variation by plan type in the 2014 star ratings. For HMOs, the enrollment-weighted average is 3.93; for local PPOs, 3.85; for PFFS plans, 3.69; and for

regional PPOs, 3.22. All of the 11 MA–PD plans rated at the maximum 5 stars in the 2014 ratings are HMOs (including one cost-reimbursed HMO). Among MA-only plans with a 5-star Part C rating, all 3 are cost-reimbursed HMOs; only 2 of 11 PFFS plans are rated 4 stars, with the remainder below that level; and 1 of 11 rated regional PPOs has a star rating of 4.5, and the rest are below 4 stars. SNPs tend to have lower star ratings, with an average of 3.19 stars. Among SNPs, the institutional SNPs have the highest enrollment-weighted average number or stars, at 3.51.⁷ Plans with a larger proportion of employer group enrollees tend to have higher star ratings (4.39 for plans with employer group enrollment of 30 percent or more), in part because much of the enrollment is in more established plans that are not-for-profit organizations.

Medicare Advantage and hospice

The Medicare hospice benefit is carved out of—that is, not included in—the MA benefits package. MA enrollees who elect hospice remain in their MA plan, but FFS Medicare

**TABLE
13-7****Distribution of enrollment by
plan star ratings, 2013–2014**

Star rating	Percentage distribution of enrollment	
	2013	2014
4.0, 4.5, 5.0 ^a	36%	51%
3.0, 3.5 ^b	59	48
Below 3.0 stars ^c	5	1

Note: Enrollment is for September 2013. Data exclude cost-reimbursed HMO plans, which are not eligible for bonuses. With cost plans included, 52 percent of enrollees would be in plans at 4 stars or higher.
 a. Eligible for bonus under statutory provisions.
 b. Eligible for bonus only under demonstration; not eligible in 2015.
 c. Not eligible for bonus payments.

Source: MedPAC analysis of CMS star ratings and enrollment data.

pays for their hospice services. Given that the Commission believes a goal of the MA program is to move away from fragmented payment arrangements and to provide an integrated, coordinated benefits package, the Commission is concerned that the hospice carve-out is inconsistent with this goal.

Background

The Medicare hospice benefit covers palliative and support services for beneficiaries with a life expectancy of six months or less. Beneficiaries who elect the Medicare hospice benefit agree to forgo Medicare coverage of conventional care for their terminal condition and related conditions. However, Medicare continues to cover items and services unrelated to the terminal illness. The hospice benefit is available to all beneficiaries who meet the eligibility criteria, whether in FFS Medicare or MA. Typically, MA enrollees who elect hospice remain in their MA plan but receive hospice services paid for by FFS Medicare. (For more detailed information on the hospice benefit, see this report's hospice chapter, Chapter 12).

The rationale for the hospice carve-out from Medicare managed care is not fully known, but the timing of the establishment of the hospice benefit and Medicare managed care plans may have been a contributing factor. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) first established the hospice benefit on a temporary basis (with a scheduled 1986 sunset date); the Omnibus Budget Reconciliation Act of 1985 made it

permanent. TEFRA established full risk-bearing managed care plans as a permanent option within the Medicare program, with the first contracts beginning in 1985. According to a *Health Care Financing Review* article authored by CMS staff, hospice was initially excluded from the capitated payments to Medicare managed care plans because hospice use was small at that time and cost data were very limited (Riley and Herboldsheimer 2001). Many years later, the Balanced Budget Act of 1997 established in statute that hospice is carved out of the Medicare managed care benefits package. Although hospice is excluded from the MA benefits package, hospice services are now commonly covered by private insurance plans for the working-age population (based on our conversations with health plans, hospices, and their associations and our review of state essential health benefits benchmark plans).^{8,9}

Beneficiaries enrolled in MA and FFS Medicare who receive hospice care are relatively similar in terms of hospice primary diagnosis (Table 13-8). In 2012, a slightly higher share of MA hospice users than FFS users (30 percent vs. 27 percent) had a primary diagnosis of cancer, while a slightly smaller share of MA hospice users (16 percent) had dementia or other neurological conditions, compared with FFS users (19 percent). Two other top hospice primary diagnoses—heart failure and debility/nonspecific signs and symptoms (e.g., adult failure to thrive)—had similar prevalence rates in the MA and FFS hospice populations.

**TABLE
13-8****Comparison of FFS Medicare and
MA hospice enrollees by primary
hospice diagnosis, 2012**

Primary hospice diagnosis	Percent of hospice patients	
	FFS	MA
Cancer	27%	30%
Neurological conditions	19	16
Heart or other circulatory conditions	17	17
Debility or nonspecific signs/symptoms	17	17
COPD	5	6
Other	14	14

Note: FFS (fee-for-service), MA (Medicare Advantage), COPD (chronic obstructive pulmonary disease).

Source: MedPAC analysis of data from the denominator file and the 100 percent hospice claims standard analytic file from CMS.

**TABLE
13-9****Comparison of hospice utilization between beneficiaries in FFS Medicare and MA**

	FFS	MA
Number of hospice enrollees, 2011*	859,000	279,000
Medicare hospice payments (in billions), 2011*	\$10.2	\$3.5
Percent of decedents who used hospice, 2012**	45.6%	50.2%
Length of stay among decedents (in days), 2012**		
Average	90	83
10th percentile	2	3
25th percentile	5	6
50th percentile	18	18
75th percentile	82	77
90th percentile	251	234
Percent of hospice enrollees with a live discharge, 2010*	17%	17%

Note: FFS (fee-for-service), MA (Medicare Advantage). 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 hospice user was enrolled in the Medicare hospice benefit during his or her lifetime. Percent of hospice enrollees with a live discharge is based on the cohort of beneficiaries who first enrolled in hospice in 2010 followed through 2012. Cost-reimbursed plans are included in the MA data. *MA status was measured in February of the reference year. Numbers exclude beneficiaries who were not alive in February or who had not yet enrolled in Medicare as of February of that year. **MA status was measured as of the last month of life.

Source: MedPAC analysis of data from the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

Compared with FFS beneficiaries, MA beneficiaries are somewhat more likely to use hospice at the end of life but slightly less likely to have very long stays. In 2012, 50.2 percent of MA decedents received hospice services compared with 45.6 percent of FFS decedents (Table 13-9). MA beneficiaries also had a somewhat shorter average length of stay (83 days) than FFS beneficiaries (90 days). The differences in hospice average length of stay between MA and FFS is largely the result of two phenomena: (1) MA has slightly more cancer patients (who tend to have short stays) and slightly fewer neurological patients (who tend to have long stays) compared with FFS, and (2) very long hospice stays tend to be slightly shorter in MA than in FFS for patients with neurological conditions or debility/nonspecific signs and symptoms. Live discharge rates are similar for MA and FFS hospice enrollees.

The hospice carve-out from MA

When a beneficiary in MA elects hospice, FFS Medicare becomes responsible for most services while the MA plan retains responsibility for certain services. The government payment to the MA plan is reduced to reflect the plan's limited financial responsibility for care. For

hospice enrollees, the government pays the MA plan only the Part D payment and the rebate dollars that fund supplemental benefits; the plan no longer receives the Part A and B portion of the Medicare capitated payment. The beneficiary's premium payments do not change. The beneficiary continues to pay the Part B premium to the government and the Part C and Part D premiums, if any, to the plan.

The hospice carve-out from MA results in a complicated set of coverage rules for MA beneficiaries who elect hospice (Table 13-10, p. 344). The Medicare hospice benefit covers all services associated with the terminal condition or related conditions, and FFS Medicare pays the hospice provider a per diem rate for these services.¹⁰ FFS Medicare also pays separately for any Part A or Part B services unrelated to the terminal condition, which the MA enrollee may obtain from any Medicare provider, not just those in the plan's network. MA-PD plans pay for any Part D drugs unrelated to the terminal condition. The MA plan is also responsible for any supplemental benefits offered by the plan (e.g., dental, hearing, or reduced cost sharing). For example, if the MA plan offers reduced cost sharing for some Part A or Part B services

**TABLE
13-10**

Coverage for MA-PD enrollees who elect hospice

	FFS Medicare covers	MA-PD covers
Before hospice enrollment		<ul style="list-style-type: none"> • All Part A, Part B, and Part D services, and any supplemental benefits
MA-PD enrollee elects hospice	<ul style="list-style-type: none"> • Hospice • Part A and Part B services unrelated to the terminal condition 	<ul style="list-style-type: none"> • Part D drugs unrelated to terminal condition • Any supplemental benefits (e.g., reduced cost sharing)
MA-PD enrollee disenrolls from hospice	<ul style="list-style-type: none"> • Until the end of the month, all Part A and Part B services 	<ul style="list-style-type: none"> • All Part D drugs • Any supplemental benefits (e.g., reduced cost sharing) • Beginning the next month after disenrollment, Part A and Part B services

Note: MA-PD (Medicare Advantage-Prescription Drug plan), FFS (fee-for-service).

Source: MedPAC analysis of Medicare coverage rules.

as a supplemental benefit, the plan must offer the reduced cost sharing to a hospice enrollee in certain circumstances (e.g., when the service is for a diagnosis unrelated to the terminal condition, is furnished by a network provider, and follows plan rules). In terms of coordination between the hospice provider and other providers furnishing services unrelated to the terminal condition, the hospice conditions of participation require the hospice to communicate and coordinate with unrelated providers.¹¹

For beneficiaries who are discharged alive from hospice, financial responsibility for care continues to be split between FFS Medicare and the MA plan for an initial period of up to 30 days. From the day the beneficiary disenrolls from hospice until the end of the calendar month, FFS Medicare is responsible for all Part A and Part B services, and the MA-PD plan is responsible for Part D drugs and supplemental benefits. Beginning the first day of the next calendar month, the MA-PD plan receives its full capitation and becomes responsible for all Part A, Part B, and Part D services.

Overall, these coverage rules fragment financial responsibility and accountability for care. It is not uncommon for a hospice enrollee to receive Medicare services or drugs that are considered unrelated to the terminal condition paid outside of the Medicare hospice benefit. Analysis by a Commission contractor, Acumen LLC, found that about half of hospice patients in MA plans in 2012 received at least one Part A or Part B service

or Part D drug during their hospice episode that was paid for outside the hospice benefit by FFS Medicare or an MA-PD plan.^{12,13} When this occurs, the hospice provider has responsibility for coordinating its care with the care furnished by other providers. However, under such circumstances, no one entity has overall financial responsibility or accountability for the patient’s care, as would otherwise be the case for beneficiaries enrolled in MA plans. In the event that an MA enrollee is discharged alive from hospice, financial responsibility for care continues to be fragmented until the end of the calendar month. Of all MA beneficiaries who first elected hospice in 2010, 17 percent had a live discharge (either initiated by the beneficiary or the hospice).¹⁴ How often beneficiaries go out of network and the extent to which plans are able to engage in care coordination or care management immediately after a live discharge is unknown.

Potential benefits of including hospice in MA

Including hospice in the MA benefits package has the potential to broaden the benefits package to reflect the full continuum of care. The current hospice carve-out from MA makes a plan’s financial responsibility for end-of-life care uneven across beneficiaries. For beneficiaries who elect hospice care, the plan has limited financial responsibility for their care after hospice enrollment. In contrast, for beneficiaries with terminal conditions who do not enroll in hospice, the plan has full financial responsibility for care through the end of life.

If the purpose of MA is to give a health plan financial responsibility and accountability for managing its enrollees' care and for the plan to do so in an integrated, coordinated manner, it would make sense for the plan to have responsibility for the full continuum of care, including hospice. Broadening the bundle of services for which MA plans are accountable would give plans the incentive to consider the needs of their members more broadly and to provide coordinated, efficient care to meet those needs.

The hospice carve-out from MA is one example of a policy for which current Medicare program rules differ across platforms. Accountable care organizations (ACOs) have financial accountability for hospice because hospice expenditures are included within their shared savings benchmarks. This means that overall Medicare program expenditures for all services, including hospice care, for an ACO's beneficiaries are taken into account when determining whether an ACO does or does not receive a bonus (or a penalty in a two-sided risk model). In contrast, MA plans currently do not have any financial responsibility or accountability for hospice expenditures. Putting hospice within the MA benefits package would be a step toward synchronizing accountability across systems.

Further, including hospice in the MA benefits package and consolidating financial responsibility for the full continuum of care under the MA plan would give plans more incentives to develop innovative programs for patients with advanced illnesses both at the end of life and earlier in the disease progression. For example, the inclusion of hospice in the MA benefits package would make it more feasible for MA plans to offer concurrent hospice and conventional care as a supplemental benefit if they wished to do so.¹⁵ Some stakeholders have asserted that the requirement that beneficiaries forgo conventional care as a condition of enrolling in hospice results in some beneficiaries' hesitation to enroll in hospice or only enrolling within the last few days of life. In the commercial managed care market for the working-age population, a few private insurers are experimenting with concurrent care (California HealthCare Foundation 2013, Spettell et al. 2009). Aetna has reported that its program for advanced illness in the working-age population, which permits concurrent hospice and conventional care, has led to increased hospice enrollment, reduced use of hospital and intensive care services, lower costs, and positive family feedback (Spettell et al. 2009). Whether concurrent care would have a similar effect in the Medicare population is not clear because the diagnosis and age profiles of the Medicare and

working-age populations differ.¹⁶ However, MA might be a logical place to test concurrent care within the Medicare program.¹⁷ Aetna has noted that its utilization management approaches and its population's ease with these approaches may be a component of its success (Krakauer et al. 2009). MA plans bear financial risk for the benefits they provide, so the Medicare program would be protected financially if concurrent care were found to be associated with increased costs. Since it is up to MA plans to decide what, if any, supplemental benefits they wish to offer, plans could offer concurrent care as a supplemental benefit if they wished, but they would not be required to do so. Nonetheless, it is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly (e.g., concurrent care or other approaches to provide flexibility in the hospice eligibility criteria, palliative care, and shared decision making).

Including hospice in MA could also simplify some of the complex coverage issues concerning services related and unrelated to the terminal condition for MA enrollees. Currently, which party is financially responsible for the services a hospice enrollee receives depends on whether the services are related to the terminal condition. This is a medical determination that may not always be clear cut and can lead to confusing coverage rules for beneficiaries, hospice providers, and plans. Giving MA plans financial responsibility for all Medicare services for their members who enroll in hospice would lessen the need to precisely distinguish between services related and unrelated to the terminal condition for MA beneficiaries.¹⁸

Operationalizing the inclusion of hospice in MA

If hospice were included in the MA benefits package, it would be important to specify that MA plans must cover the full scope of the hospice benefit as defined in the Social Security Act. Doing so would ensure that an MA plan could not select among the services to cover within the scope of the hospice benefit. Instead, the MA plan would be required to cover the full scope of the benefit for eligible members who elect hospice. This would also ensure that important structural aspects of hospice care are required in MA. For example, as defined in the Social Security Act, hospice care under MA would need to be provided under a written plan of care established and periodically

reviewed by the patient's attending physician, the hospice medical director, and by the hospice interdisciplinary group (with the interdisciplinary group required to include a physician, registered nurse, social worker, and pastoral or other counselor). In addition, the more detailed requirements about what constitutes hospice care outlined in the Medicare hospice conditions of participation would be applicable to hospice care provided through MA since plans must contract with Medicare-certified providers who are required to abide by the Medicare conditions of participation for all patients.

Including hospice in the MA benefits package would necessitate recalculating MA plan payment rates. Plans' capitated payments would need to increase to account for the plans' increased financial responsibility for a broader set of Medicare services. If hospice services (as well as any Part A or Part B services unrelated to the terminal condition provided to hospice enrollees) were included in the MA capitation just like other Medicare services, this would increase the MA base payment rate since payment for these services would be spread across the payment rates for the entire MA population. MA risk scores would also need to be recalculated. Currently, the risk scores reflect the relative risk a beneficiary with certain characteristics has for Medicare expenditures excluding hospice.¹⁹ The risk model would need to be revised to predict the relative risk of total Medicare expenditures including hospice. The combined effect of the increase to the base capitation rate and revisions to the risk model would be increased capitation payments to MA plans, with the increase being largest for patients with diagnoses and demographic characteristics associated with the highest average hospice spending per capita.

To facilitate monitoring of hospice services provided to MA enrollees, hospice should be included in the MA encounter data that plans submit, similar to what is done for other Medicare services. In general, the encounter data reported by plans are expected to include a level of detail similar to FFS claims. The FFS Medicare hospice claims data include rich detail on the number, type, and length of hospice visits received by beneficiaries. With MA encounter data, policymakers would be able to closely monitor the type and amount of hospice services received by beneficiaries in each MA plan and assess whether it differs from the extent of services provided to FFS beneficiaries. As we note in Chapter 12 on hospice, there may also be opportunities to use experience of care surveys or bereaved family member surveys to gauge

satisfaction with care for Medicare patients with advanced illnesses across settings for both FFS and MA.

A majority of MA enrollees are in HMOs, which contract with a network of providers for their members' care. When beneficiaries enroll in such a plan, they agree to accept a more limited network of providers. In exchange, they receive certain additional benefits not covered by traditional Medicare, through an organization that also has the specific role of coordinating and managing their care. As with other Medicare services, these MA plans would be required to meet network adequacy standards to ensure that they have enough hospice providers in their network to meet the needs of their members. Marketing materials for these MA plans are also required to make clear that enrollees must obtain routine services (e.g., nonemergency services) from network providers, a point that may warrant special emphasis for hospice services given that beneficiaries may not be thinking about end-of-life care at the time they enroll in MA.

Some hospice industry representatives have expressed concern that including hospice in MA could limit access to hospice providers for beneficiaries with specific religious preferences. The hospice conditions of participation require that spiritual counseling be a core service offered by each hospice and that it be provided in accordance with the patient's and family's acceptance of this service and in a manner consistent with patient and family beliefs and desires.²⁰ However, if there were circumstances in which an MA plan's network hospice providers were unable to meet an individual's needs for spiritual counseling, general MA policy would give the plan the flexibility to authorize use of out-of-network hospices. When this need for flexibility occurs, plans typically pay non-network providers the FFS rate (out-of-network providers who accept an MA patient must agree to accept FFS rates as payment in full, though the plan and provider can negotiate an alternative payment arrangement).

RECOMMENDATION 13-2

The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

RATIONALE 13-2

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 aimed at improving end-of-life care and improving 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, ACOs, and FFS). 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 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 aimed at improving 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).

Conclusion

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

Employer group plans bid higher than nonemployer plans, we believe, because of a lack of incentive for employer group plans to submit competitive bids. We have made a new recommendation to address this issue.

The hospice carve-out from MA fragments financial responsibility and accountability for care for MA enrollees who elect hospice. We have made a new recommendation to include hospice in the MA benefits package. This

step would give plans financial responsibility for the full continuum of care and promote integrated, coordinated care, consistent with the goals of the MA program. It is the Commission's expectation that with the inclusion of hospice in the MA benefits package, plans would have an incentive to use the flexibility inherent in the MA program to develop and test innovative programs aimed at improving end-of-life care and care for patients with advanced illnesses more broadly. ■

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 The number of plan choices is not enrollment weighted. Because there are more plans in more populous counties, the weighted average by enrollment would be higher.
- 3 The difference in HEDIS results from one year to the next can reflect random variation, or “noise,” in the data. Measures such as the level of cholesterol control—and similar “hybrid” measures in HEDIS that are reported based on a sampling of medical records—show more variation across plans than other types of measures that are based on administrative data (claims data or encounter data). For example, the measure that we report as showing a decline among local PPOs between 2012 and 2013 (cholesterol control among patients with cardiovascular conditions) varied from a minimum of 13.6 for local PPOs in 2013 to a maximum of 73.8, with a ratio between the 90th and 10th percentile of 1.6. In the preceding year, for the same local PPOs reporting in both years, the range was 26.8 to 85.2, with the same 90th-to-10th percentile ratio of 1.6 among the 95 plans. For 257 HMOs reporting in both years, the range for the measure was 1.5 to 86.3 in 2012 (with a 90th-to-10th percentile ratio of 1.7), and for 2013, the range was 6.8 to 86.3 (with a 90th-to-10th percentile ratio of 1.5). A companion measure that is based on administrative data—the measure of whether patients with cardiovascular disease have their cholesterol levels tested—does not show the same extent of variation. The 90th-to-10th percentile ratio in 2012 and 2013 ranged from 1.13 to 1.15 for both HMOs and local PPOs.
- 4 The HEDIS data for 2012 show an all-plan average readmission rate for all age groups of 13.7 percent. For FFS in 2012, Gerhardt and colleagues report a readmission rate of 18.4 percent for all age groups, which is a 3 percent decline from the “stable” trend from 2007 to 2011 (Gerhardt et al. 2013). Similar to the HEDIS approach, Gerhardt and colleagues use an all-cause 30-day readmission rate. However, MA readmission rates are computed only for enrollees who were plan members during the entire 12 months of the calendar year—thus leaving out beneficiaries who died during the course of the year, those who newly enrolled during the year, and those disenrolling during the year. The MA readmission rate of 13.7 percent for all age groups in all plans is therefore not directly comparable with the FFS rate that Gerhardt and colleagues report.
- 5 The disenrollment measure that CMS reports is “members choosing to leave the plan,” which excludes “members who left their plan due to circumstances beyond their control (such as members who moved out of the service area, members affected by a contract service area reduction . . . [and] employer group members . . . also members in PBPs [plan benefit package plans] that were granted special enrollment exceptions. . . . The data for contracts with fewer than 1,000 enrollees are not reported in this measure” (Centers for Medicare & Medicaid Services 2013).
- 6 Star ratings are released to coincide with the October–December annual election period. The star ratings released in October 2013 are referred to as the 2014 star ratings (for enrollments effective in 2014). However, the level of any bonus payments and rebate percentages for each year are determined as part of the bidding process. For the 2014 contract year, bids submitted in June of 2013 used 2013 star ratings, released in October 2012, to determine bonus levels for the 2014 benefit packages. Thus, beneficiaries will be using more current (2014) quality ratings to see differences in quality across plans, but the variation in benefit packages that is due to star ratings is based on an earlier period’s star ratings (2013 star ratings).
- 7 Because star ratings are determined at the contract level and SNPs are often benefit packages within larger contracts, to judge to what extent SNP status affects an organization’s star ratings, we evaluate organizations in which 50 percent or more of their enrollment is in one of the three SNP categories. About half of dual-eligible enrollment in special needs plans (D–SNPs) (52 percent) and institutional special needs plans (I–SNPs) (48 percent) is in a contract in which the majority of enrollees are D–SNP or I–SNP enrollees. It is less common for chronic condition special needs plan enrollment to be the majority of a contract’s enrollment.
- 8 Because the mortality rate is much higher in the elderly population than the working-age population, privately insured working patients make up a small share of all patients currently served by hospice providers. The Commission’s analysis of data from the National Home and Hospice Care survey of 2007 found that about 9 percent of hospice discharges were of patients with private insurance.
- 9 The hospice benefits currently offered by private insurers to the working-age population vary in terms of what they cover. Some insurers offer a hospice benefit that mirrors the Medicare hospice benefit, while other insurers provide more limited benefits (e.g., limits on the number of days, total dollar amount, or type of hospice services covered).
- 10 An exception is payment for physician visits provided by the patient’s hospice attending physician, which are paid separately by Medicare FFS.

- 11 The Medicare conditions of participation require hospice providers to conduct a comprehensive assessment of the patient's needs, including needs unrelated to the terminal condition, and to make referrals to appropriate health care professionals. Hospices are also required to provide for an ongoing sharing of information with other nonhospice health care providers furnishing services unrelated to the terminal illness. For example, in the 2008 CMS final rule implementing the conditions of participation, CMS stated that this requirement for information sharing "will ensure that hospices actively coordinate the care that they are providing with the care being furnished by other providers. The coordination will help hospices avoid a duplication of services as well as potentially dangerous drug prescribing and dosage problems. . . . When coordinating care with other providers, it is essential that hospices are aware of their role within the larger comprehensive plan of care, as well as any gaps in the comprehensive plan of care and the parties responsible for filling those gaps" (Centers for Medicare & Medicaid Services 2008).
- 12 This figure does not include physician visits provided by the hospice patient's attending physician (either those employed by the hospice or independent) that are billed as related to the terminal condition.
- 13 Part D drugs were the most common service unrelated to the terminal condition used. About 44 percent of MA beneficiaries who used hospice in 2012 had a Part D prescription dispensed during their hospice episode. The next most common services unrelated to the terminal condition were physician and supplier services, hospital outpatient services, and inpatient hospital services (about 24 percent, 9 percent, and 3 percent of MA hospice enrollees, respectively, received these services during their hospice episode).
- 14 There are a number of reasons a live discharge may occur. A beneficiary may revoke the hospice benefit (because of beneficiary or family choice, pursuing services not in the plan of care, quality of care, etc.) or the hospice may initiate a discharge because the beneficiary's condition is no longer considered terminal or for other reasons (e.g., beneficiary moves out of the service area or for cause).
- 15 Because the hospice carve-out results in the MA base capitation rate excluding payment for hospice and the MA capitated payment being reduced substantially when a beneficiary elects hospice, MA plans have little incentive to offer concurrent care as a supplemental benefit. Including hospice within the MA benefits package—which would consolidate financial responsibility for the full continuum of care under the MA plan, increase the MA base capitation rate to reflect plans' responsibility for hospice, and ensure that MA plans have contractual relationships with hospice providers serving their Medicare members—would make it more feasible for MA plans to offer concurrent care if they wished to do so.
- 16 Generally, working-age individuals with terminal illnesses are more likely to have cancer and to have shorter hospice stays than the Medicare population with terminal illnesses. Concurrent care may encourage younger people to use hospice more or for a longer time period, potentially avoiding costly acute care services at the end of life. By contrast, Medicare beneficiaries with terminal illnesses have a more diverse set of diagnoses (including neurological conditions, such as dementia, which tend to have longer hospice stays) and consequently, the cost of concurrent care may be more varied among Medicare beneficiaries.
- 17 A demonstration to test concurrent care in the FFS program was enacted by the Congress. The Patient Protection and Affordable Care Act of 2010 mandated a demonstration program of concurrent hospice and conventional care in 15 sites, but no funds were appropriated for the demonstration. However, CMS has indicated its intent to develop a demonstration to test the provision of palliative care and conventional care in the future, but no details have been released to date.
- 18 As noted in the appendix of Chapter 12 on hospice, data analyses by the Office of Inspector General and the Commission suggest that some of the services provided to hospice enrollees outside of hospice are likely related to the terminal condition and should be the financial responsibility of the hospice. Because financial responsibility for care provided to hospice enrollees is fragmented between the hospice, FFS, and Part D, no one entity has full responsibility to ensure that the correct entity has paid for the service. If hospice were included in MA, plans would have financial responsibility for all Medicare services for their members enrolled in hospice.
- 19 The average risk score for MA patients who use hospice in a year is substantially higher than for the MA population overall. For example, the 2011 risk score for MA beneficiaries who used hospice in 2011 averaged 2.5.
- 20 With respect to spiritual counseling, the hospice conditions of participation require that the hospice provide an assessment of the patient's and family's spiritual needs; provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires; make all reasonable efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability; and advise the patient and family of this service.

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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 Part D to:

- provide information on beneficiaries' access to prescription drugs—including enrollment figures and benefit and design changes—program costs, and the quality of Part D services; and
- analyze changes in plan bids, premiums, benefit designs, and formularies.

In 2012, Medicare spent \$62.5 billion for the Part D program, accounting for over 10 percent of total Medicare spending. In 2013, over 35 million Medicare beneficiaries were enrolled in Part D, with about 64 percent of Part D enrollees in stand-alone prescription drug plans (PDPs) and the rest in Medicare Advantage–Prescription Drug plans (MA–PDs). Monthly premiums averaged about \$30 across all plans. The actual premium paid by individual beneficiaries depends on their selected plan and income level, as well as whether they are subject to Part D's late enrollment penalty. In 2014, a total of 1,169 PDPs are offered nationwide along with 1,615 MA–PDs. MA–PD enrollees are much more likely than those in PDPs to receive basic and supplemental benefits combined in their drug plan. Most enrollees report high satisfaction with the Part D program.

An increasing number of plans are adding a nonpreferred generic tier, in some cases with a substantially higher cost-sharing amount relative to the preferred

In this chapter

- Part D enrollees' access to prescription drug benefits
- Benefit offerings for 2014
- Costs of Part D
- Quality in Part D

generic tier. In addition, we are seeing a trend toward the use of tiered network pharmacies that further stratifies cost sharing so that the amounts are lower if a beneficiary fills medications at a pharmacy that is designated as preferred. Both of these strategies provide financial incentives for enrollees to use a lower cost drug (or setting), potentially reducing program costs. However, the use of such financial incentives, while potentially lowering the cost of providing the basic benefit, could increase Medicare's spending for the low-income subsidy (LIS).

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

Access to prescription drug coverage—In 2013, about 68 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 6 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. In 2011, the most recent year for which data are available, 12 percent had no drug coverage or coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier on average. More than half reported not joining Part D because they did not take enough medications to need such coverage. Among Part D plan enrollees, 11.2 million individuals (about 32 percent) received the LIS. Although surveys suggest high satisfaction with Part D among the enrollees, about 6 percent reported having trouble obtaining needed medications. Access to medications depends on multiple factors. We examined available data on Part D's exceptions and appeals process but found insufficient data to evaluate the effectiveness of the process. We also found that the process is complex and burdensome for many individuals. Our review suggests a need for additional data on the outcomes of the exceptions and appeals process and a need for a more transparent and streamlined process.

Benefit offerings for 2014—The number of plan offerings remained stable between 2013 and 2014, with a modest increase in PDP offerings and slightly fewer MA-PDs (1,615 compared with 1,627 in 2013). Beneficiaries will continue to have between 28 and 39 PDPs to choose from in their region, depending on where they live, along with many MA-PDs. MA-PDs continue to be more likely than PDPs to offer enhanced benefits that include some coverage of the gap—the period between when Part D's initial coverage ends and when the enrollee meets the out-of-pocket threshold to enter the catastrophic phase of the benefit. For 2014, more premium-

free PDPs will be available to enrollees who receive the LIS; 352 plans qualified compared with 331 in 2013. A growing number of plan sponsors are choosing to offer preferred pharmacies in their network, with potentially significant price differentials for beneficiaries. In 2014, over 70 percent of all PDPs have tiered pharmacy networks with lower cost sharing at preferred pharmacies.

Part D spending—Between 2007 and 2012, Part D spending increased from \$46.7 billion to \$62.5 billion (an average annual growth of about 6 percent). In 2012, LIS payments continued to be the single largest component of Part D spending, while Medicare’s reinsurance payments continue to be the fastest growing component, growing at an average annual rate of 14 percent between 2007 and 2012. Aggregate Part D payments to plans continue to grow at a faster rate than the growth in Part D enrollment. The “excess” growth in payments appears to be driven in large part by the growth in the average price of drugs filled, particularly among enrollees receiving the LIS. As in the past, we find that drug utilization by Part D enrollees with high spending was driving faster growth in payments for LIS and reinsurance compared with payments for the basic benefits. In 2011, the changes made by the Patient Protection and Affordable Care Act of 2010 (PPACA) to phase out the coverage gap may have increased the number of enrollees with high spending. According to our analysis of the Part D claims data, only 6 percent of the non-LIS enrollees who reached the catastrophic phase of the benefit spent \$4,550 out of pocket (OOP), the amount of the OOP limit for 2011. Others met the OOP limit with the combination of their OOP spending and the manufacturer discounts mandated in PPACA.

Change in Part D bids—The average costs for basic Part D benefits are expected to grow by 4 percent between 2013 and 2014, but plan sponsors are expecting significant changes in costs for individual components of the basic benefit: a decrease of over 10 percent for the direct subsidy and an increase of about 20 percent for the reinsurance component. ■

Each year since 2006, the Commission has provided a status report on Medicare’s Part D program and made recommendations as necessary. To monitor the ability of the program—under its competitive approach—to meet Medicare goals of maintaining beneficiary access while holding down program spending, we examine several performance indicators: beneficiaries’ access to prescription drugs (including data on enrollment and changes in Part D plan benefit designs and formularies for 2014), program costs, and quality of services.

Background

Medicare’s payment system for Part D is different from its prospective payment and fee-for-service payment systems for Part A and Part B services. For Part D, Medicare uses competing private plans to deliver prescription drug benefits; instead of setting prices administratively, Medicare’s payments to Part D plans are based on bids submitted by plan sponsors.

Benefit structure

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 2014, the defined standard benefit includes a \$310 deductible and 25 percent coinsurance until the enrollee reaches \$2,850 in total covered drug spending (not shown in table). The reduction in 2014 in the deductible and other benefit parameters reflects a decrease in average drug expenses CMS estimated for the August 2012 through

July 2013 period. Enrollees exceeding that spending total face a coverage gap up to an annual threshold of \$4,550 in out-of-pocket (OOP) spending that excludes the cost sharing paid by most sources of supplemental coverage, such as employer-sponsored policies. Enrollees with drug spending exceeding that amount pay the greater of either \$2.55 to \$6.35 per prescription or 5 percent coinsurance.

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, beneficiaries face reduced cost sharing for both brand-name and generic drugs filled during the coverage gap.¹ In 2014, cost sharing for drugs filled during the gap phase is 47.5 percent for brand-name drugs and 72 percent for generic drugs.² An individual with no other source of drug coverage reaches the \$4,550 limit at \$6,690.77 in total drug expenses.³

Formularies

In Part D, each plan sponsor uses one or more formularies—lists of drugs the plan covers and the terms under which it covers them—to manage the cost and use of prescription drugs. When designing formularies, sponsors attempt to strike a balance between providing enrollees with access to medications and controlling growth in drug spending, which they accomplish by negotiating drug prices and dispensing fees with pharmacies and negotiating rebates with pharmaceutical manufacturers, as well as by managing enrollees’ utilization. Part D sponsors rely on clinicians (typically,

**TABLE
14-1**

Parameters of the defined standard benefit

	2006	2013	2014
Deductible	\$250.00	\$325.00	\$310.00
Initial coverage limit	2,250.00	2,970.00	2,850.00
Annual out-of-pocket spending threshold	3,600.00	4,750.00	4,550.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,954.52*	6,690.77*
Minimum cost sharing above annual out-of-pocket threshold:			
Copay for generic/preferred multisource drug prescription	2.00	2.65	2.55
Copay for other prescription drugs	5.00	6.60	6.35

Note: *Total covered drug spending at annual out-of-pocket threshold depends on the mix of brand and generic drugs filled during the coverage gap. The amounts for 2013 and 2014 are for an individual not receiving Part D’s low-income subsidy who has no other supplemental coverage.

Source: CMS, Office of the Actuary.

physicians and pharmacists who serve on a pharmacy and therapeutics committee) when deciding which drugs to list, subject to CMS regulations and requirements. 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. Making all medications readily accessible at relatively low levels of cost sharing can lead to a monthly plan premium that is high relative to a sponsor's competitors, whereas an overly restrictive formulary may keep a plan's premium competitive but make the plan less attractive to enrollees because it covers a more limited number of drugs.

Premiums

In 2013, monthly beneficiary premiums averaged about \$30 across all plans. The actual premium paid by individual beneficiaries depends on their selected plan. Two other factors affect the amount of premium paid by a given enrollee: the enrollee's income level and whether the enrollee is subject to Part D's late enrollment penalty (LEP).

As a result of PPACA changes, the premium subsidy for higher income beneficiaries is lower than the statutorily defined subsidy of 74.5 percent. Similar to the income-related premium for Part B, the reduced subsidy applies 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. The adjustment amount ranges from \$12.10 to \$69.30 per month in 2014, depending on income. Nearly 1.5 million beneficiaries were subject to the reduced premium subsidy in 2013.⁴

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 LEP. The process for verifying a beneficiary's prior drug coverage status often requires individuals to submit a document to the plan showing that they had creditable coverage before joining the plan. This process contrasts with how the penalty works under Part B, in which the onus is on CMS to determine whether the late-enrolling beneficiary is subject to the penalty.

The number of LEP-related appeals submitted to an external review entity (MAXIMUS) between 2008 and

2012 ranged from nearly 34,000 cases to about 72,000 cases. According to data from MAXIMUS, the majority of the cases that are not dismissed or withdrawn are overturned, and thus the penalty is not applied.

The high reversal rate observed for the appeals related to the LEP suggests that plans' processes used to verify enrollees' prior creditable coverage status may not be effective. Further, the resolution of cases in which the penalty is incorrectly applied may be delayed by limited awareness among enrollees of the penalty. Anecdotal evidence suggests that many enrollees are confused by the higher premiums they are charged and do not realize that the higher charge is due to the penalty until their cases go through the appeals process, which may also not be well understood.⁵

Competitive design

Part D uses a competitive design to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while controlling growth in drug spending. In contrast to the administrative prices Medicare uses to pay providers for Part A and Part B covered services, Medicare's payments to plans are based on bids submitted by plan sponsors. When designing Part D, policymakers envisioned that plans would compete for enrollees based on their premiums, formularies, quality of services, and network 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. To encourage entry of plans into a market that had not existed before—the provision of stand-alone drug coverage—policymakers included risk-sharing features that would temper incentives for sponsors to engage in selection behavior and features that would pay plans more for higher cost enrollees (see text box, pp. 362–363).

Part D enrollees' access to prescription drug benefits

Implementation of the Part D program in 2006 increased the share of beneficiaries who have some drug coverage from 75 percent before Part D to about 90 percent.⁶ In general, Part D has improved Medicare beneficiaries' access to prescription drugs. All individuals have access to Part D plan options. Some beneficiaries continue to receive drug coverage through former employers.

TABLE 14-2 Nearly three-quarters of beneficiaries had drug coverage through Part D plans or employer plans receiving RDS, 2013

	Beneficiaries	
	In millions	Percent of Medicare enrollment
Medicare enrollment	52.3	100%
Part D enrollment		
Part D plans	35.7	68.3*
Plans receiving RDS**	3.2	6.1
Total Part D	38.9	74.4

Note: RDS (retiree drug subsidy). Figures are based on annual enrollment numbers reported in the Medicare Board of Trustees' report. Totals do not match those reported in Table 14-3, which are based on enrollment as of March 1, 2013. The remaining 25.6 percent of beneficiaries (not enrolled in Part D) received drug coverage through other sources or had no drug coverage. Totals may not sum due to rounding.
 *About 43 percent in stand-alone prescription drug plans and 25 percent in Medicare Advantage–Prescription Drug plans.
 **Excludes federal government and military retirees covered by either the Federal Employees Health Benefit Program or the TRICARE for Life program.

Source: MedPAC based on Table IV.B8 and Table V.B4 of the 2013 annual report of the Boards of Trustees of the Medicare trust funds.

In 2013, nearly three-quarters of Medicare beneficiaries were in Part D plans or employer plans receiving Medicare's retiree drug subsidy

In 2013, about 68 percent of an estimated 52.3 million Medicare beneficiaries were enrolled in Part D plans. This share has grown since the program began in 2006, with Medicare Advantage (MA) plans accounting for more than half of the growth in Part D enrollment between 2006 and 2013. An additional 6 percent of Medicare beneficiaries received their drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy (RDS), a drop from about 15 percent observed during the first few years of the program (Table 14-2).⁸ Employers no longer offering drug coverage to their retirees typically move their Medicare-eligible members to Part D, typically to employer group waiver plans.⁹ Some beneficiaries receive their drug coverage through other sources of creditable coverage, including the Department of Veterans Affairs, TRICARE (the Department of Defense's health benefit for retired military members), and other payers.

About 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D's standard

benefit in 2011 (the most recent year for which data are available), which is somewhat higher than the 10 percent reported by CMS in previous years. Research indicates that beneficiaries who do not enroll in Part D tend to be healthier and have lower drug spending (Medicare Payment Advisory Commission 2013).

In 2013, about 11 million individuals, or 32 percent of Part D enrollees, received the low-income subsidy (LIS). Of those, nearly 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 the Social Security Administration determined that they were eligible after they applied directly to that agency. Among LIS enrollees, about three-quarters (8.3 million) were enrolled in stand-alone prescription drug plans (PDPs) and the rest (2.8 million) were in Medicare Advantage–Prescription Drug plans (MA–PDs) (Table 14-3). CMS randomly assigns most LIS enrollees to PDPs that qualify as premium-free plans, but enrollees may choose a different plan. As a result, a much smaller share of MA–PD enrollees receive the LIS (about 22 percent compared with nearly 37 percent for PDPs).

Part D enrollment varies across regions

Part D enrollment varies geographically. In 2012, enrollment ranged between 39 percent and 71 percent of Medicare beneficiaries across the 34 PDP regions, with the

TABLE 14-3 Part D enrollment by plan type and LIS status, 2013

	Plan type		
	All Part D	PDP	MA-PD
Beneficiaries (in millions)	35.3	22.5	12.8
By LIS status			
LIS	11.2	8.3	2.8
Non-LIS	24.2	14.2	10.0

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Figures based on enrollment as of March 1, 2013. Totals do not match those in Table 14-2, which is based on annual enrollment reported in the Medicare Boards of Trustees' report. Totals may not sum due to rounding.

Source: MedPAC based on monthly Part D enrollment data as of March 1, 2013 (<http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAAdvPartDEnrolData/LIS-Enrollment-by-Plan.html>).

Changing priorities for sharing risk

Two of Part D's risk-sharing arrangements between Medicare and private drug-plan sponsors were devised with the primary goal of ensuring plan entry and formation of competitive markets across the country:

- risk corridors to encourage entry of private providers into a market that had not existed before—that is, the provision of stand-alone drug coverage; and
- individual reinsurance to limit the insurance risk faced by sponsors (which also tempers incentives for sponsors to engage in selection behavior) (see “Aggregate program costs” (p. 375) for more detail on risk corridors and individual reinsurance).

Today, we continue to see a sizable number of plans available in every region of the country, with between 12 percent and 15 percent of enrollees willing to switch plans to lower their premiums, cost sharing, or both (Hoadley et al. 2013b, Suzuki 2013). A larger share are likely comparing their plan options. We heard from some participants in Commission-sponsored focus groups that they regularly compare plan options, although researching plan options did not always lead them to switch plans (Hargrave et al. 2012). It is not clear, however, whether having a large number of plans has led to robust competition and strong incentives for cost control.

Evidence on program spending gives a mixed picture about the success of Part D plans at containing costs. Spending for the competitively derived direct-subsidy payments on which sponsors bear the most insurance risk has grown relatively slowly, while benefit spending on which sponsors bear no insurance risk (low-income cost sharing) or limited risk (the catastrophic portion of the benefit, in which Medicare provides 80 percent reinsurance) has grown much faster. This evidence suggests that sponsors have been less aggressive or successful at cost containment when they were at less risk for benefit spending. The phase-out of the coverage gap that began in 2011 will likely continue to increase the number of people reaching the catastrophic phase of the benefit, further driving the growth in spending for reinsurance.

In most years, Medicare has, on net, collected risk-corridor payments from plans. That is, on average, plans have been making profits above and beyond what is built into their bids. There are many factors that affect plan profits. For example, effective management of enrollees' drug use or higher than expected rebates from manufacturers could result in unexpected profits.

In recent years, more plans have incorporated preferred and nonpreferred tiers for both brand and generic drugs, with higher cost-sharing amounts for nonpreferred tiers compared with the preferred tiers (see “Notable Changes for 2014 in Benefit Offerings,” p. 372). In addition, we are seeing a trend toward the use of tiered network pharmacies that further stratifies cost sharing so that the amounts are lower if a beneficiary fills medications at a pharmacy that is designated as preferred (see text box on trend toward use of tiered pharmacy networks, pp. 370–371). Both of these strategies provide financial incentives to enrollees to use a lower cost drug (or setting), potentially reducing program costs. However, the use of such financial incentives, while potentially lowering the cost of providing the benefit for some beneficiaries, could increase Medicare spending for low-income subsidy (LIS) enrollees. LIS enrollees' out of pocket (OOP) spending is limited to amounts set in statute.⁷ Higher cost sharing for these beneficiaries—for drugs on nonpreferred tiers or charged at nonpreferred pharmacies—is paid for by Medicare through a low-income cost-sharing subsidy.

Another indicator of how well sponsors contain costs is whether they have been able to curb growth in prices for Part D drugs. Again, the evidence is mixed. Generally, sponsors have been successful at encouraging enrollees to use generic alternatives when available. However, they have been less successful with their LIS enrollees. Sponsors typically have large cost-sharing differentials between brand and generic drugs to encourage their enrollees to use generic medications (Hoadley et al. 2012). Those differentials do not apply to LIS enrollees because their OOP spending is limited to the statutorily set amounts. Finally, the prices for unique drugs and biologics have grown rapidly. Because those products lack clear substitutes, sponsors

(continued next page)

Changing priorities for sharing risk (cont.)

have little leverage for price negotiations. As more drugs are introduced with very high launch prices, the use of these expensive drugs and biologics is likely to accelerate the growth in spending for reinsurance.

Given this evidence, policymakers may want to reevaluate the relative priority of policy goals for Part D since there is a trade-off between risk sharing and cost control. In December 2010, we convened a half-day session with a panel of eight outside experts to evaluate Part D's mechanisms for sharing risk with plan sponsors (Schmidt 2011). Panelists generally agreed that Part D's 80 percent reinsurance takes away the urgency for sponsors to manage prescription use among enrollees who use the most drugs (high-cost enrollees). One panelist pointed out that the rebates sponsors receive from manufacturers for brand-name drugs dispensed to high-cost enrollees can more than offset the 15 percent of benefit spending that sponsors must pay. Panelists discussed several ways to restructure Part D's risk-sharing arrangement. For example, Part D could require plan sponsors to pay more than 15 percent of benefit spending above the catastrophic threshold. If policymakers change Part D's reinsurance mechanism, they may also need to give sponsors greater flexibility in using formularies to contain costs, particularly to manage the costs of expensive drugs with few or no substitutes.

As policymakers try to address the growing costs of Part D's reinsurance, they should also explore how plans can do a better job of managing costs for LIS enrollees. Over 80 percent of the enrollees who reach Part D's catastrophic phase of the benefit receive the LIS, with a significant portion of reinsurance payments made on behalf of LIS enrollees. In addition, the subsidy for LIS enrollees has grown to be the single largest component of Part D spending. These

factors and the trends toward the use of tiered cost sharing suggest the need to make changes that would increase incentives to manage drug spending for LIS enrollees. In our March 2012 report, the Commission 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). Another option may be to factor in both the premium and the expected low-income cost-sharing amounts to determine which plans would be available to LIS enrollees at no premium.

There was also considerable consensus among panelists that Part D entails less risk than commercial insurance that covers both medical and prescription drug services, primarily because of the general predictability of an individual's drug use from one year to the next. Most panelists thought that removing the risk corridors would not substantially affect sponsors' decisions about whether to stay in the market. There was a weaker consensus about the effects of removing the risk corridors on sponsors' incentives to contain costs. When the law that enacted Part D was passed, the Congressional Budget Office expected that plan sponsors would not manage drug spending as aggressively in the presence of risk corridors as they might otherwise because they would be insulated from losses resulting from less-aggressive management. As mentioned, in most years, on net, Medicare has collected a portion of unanticipated profits, over and above the returns built into plan bids. If policymakers decide to remove risk corridors, other policy changes would be needed as well to ensure that sponsors bear more insurance risk and Medicare's payments do not result in plans making profits over and above those built into their bids year after year. ■

lowest in region 34 (Alaska) and the highest in region 32 (California) (see online Appendix 14-A, available at <http://www.medpac.gov>). Part D enrollment tends to be lower in states with large employers that receive Medicare's RDS—Michigan and Alaska, for example. Between 2011 and 2012, most regions experienced a reduction in the share of beneficiaries receiving drug coverage through former employers, with a corresponding increase in

the share of beneficiaries enrolled in Part D plans. The reductions were generally small, ranging from 1 percent to 3 percent, with the exception of region 4 (New Jersey), region 13 (Michigan), and region 21 (Louisiana), where the reductions were between 5 percent and 9 percent. In region 5 (Delaware–District of Columbia–Maryland), region 7 (Virginia), and region 34 (Alaska), the share of beneficiaries in Part D plans or in employer plans

**TABLE
14-4**

MA-PD enrollees more likely to be in enhanced plans with no deductible, 2013

	PDP		MA-PD	
	Number (in millions)	Percent	Number (in millions)	Percent
Total	18.0	100%	8.5	100%
Type of benefit				
Defined standard	0.5	3	0.1	1
Actuarially equivalent*	10.5	58	0.7	7
Enhanced	7.1	39	8.6	92
Type of deductible				
Zero	8.1	45	8.2	89
Reduced	0.6	3	0.8	9
Defined standard**	9.4	52	0.2	2

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.

**\$325 in 2013.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

receiving the RDS were lower than in other regions. This finding may be because a higher proportion of beneficiaries receive drug coverage from other sources such as the Federal Employee Health Benefits Program or the Indian Health Service.

Most beneficiaries have access to both stand-alone PDPs and MA-PDs. In general, MA-PD enrollment is high in regions with higher MA penetration. For example, in 2012, more than 45 percent of Part D enrollees were in MA-PDs in parts of the West (Arizona, California, Colorado, Idaho, Nevada, and Utah) and in Florida, Hawaii, and New York. By comparison, in other parts of the Northeast, Midwest, and central states, fewer than 20 percent of Part D enrollees were in MA-PDs.

The number of beneficiaries receiving Part D's LIS also varies considerably by region. In 2012, the share of these beneficiaries ranged from 26 percent in the upper Midwest and several central western states to 60 percent in Alaska. The number of beneficiaries who receive Part D's LIS is related to many factors, such as underlying rates of poverty in each region, the degree to which a state's Medicaid program reaches out to enroll eligible individuals, and the criteria states use to determine eligibility for their Medicaid programs.

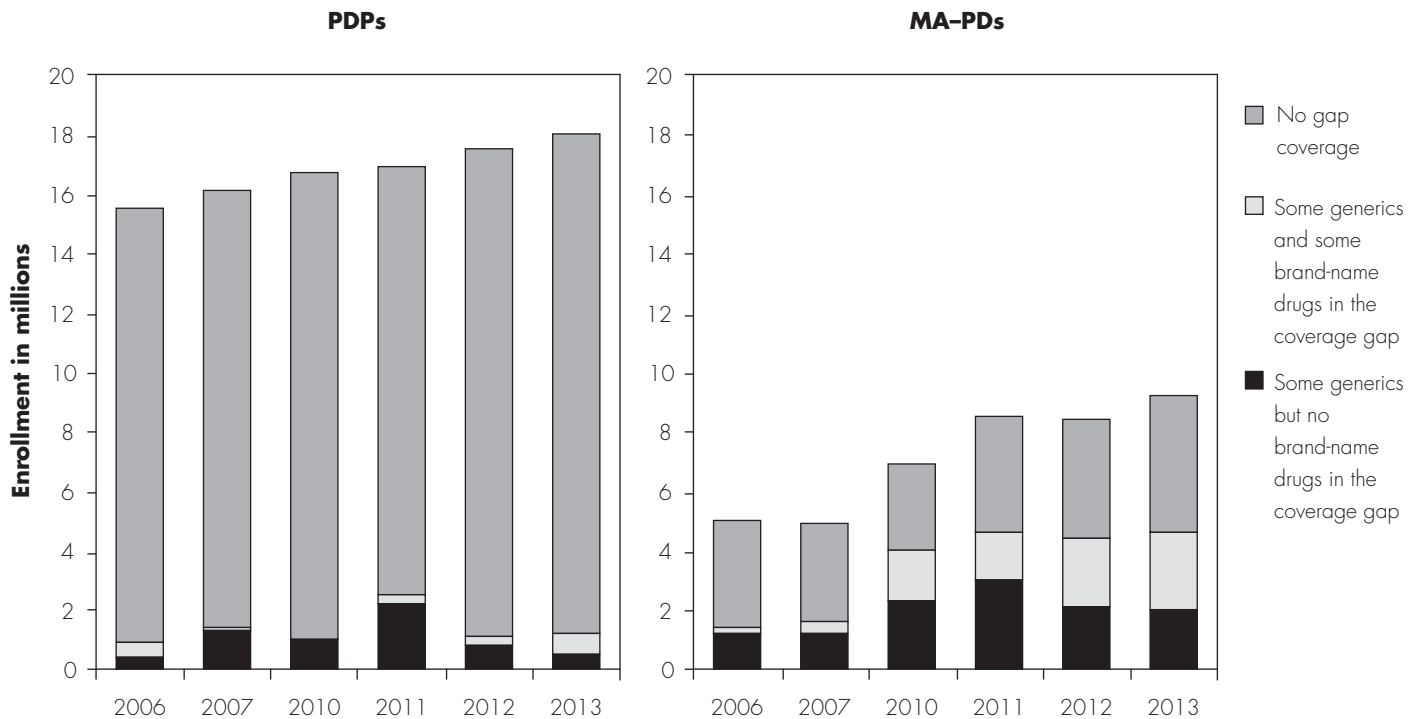
Most enrollees are in plans that differ from the defined standard benefit

Access to prescription drugs can be affected by the type of plan one chooses. 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.¹⁰ 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 sponsor offers at least one plan with basic benefits in a region or a service area, it may also offer a plan with enhanced benefits—basic and supplemental benefits combined, with a higher average benefit value—by including, for example, lower cost sharing, coverage for drugs filled during the gap, and an expanded drug formulary that includes non-Part D-covered drugs.¹¹

In 2013, 58 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard benefit, most with tiered copayments. Another 39

FIGURE 14-1

PDP enrollees are less likely to have 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. Coverage in the gap is typically restricted to a subset of formulary drugs.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data, 2006–2013.

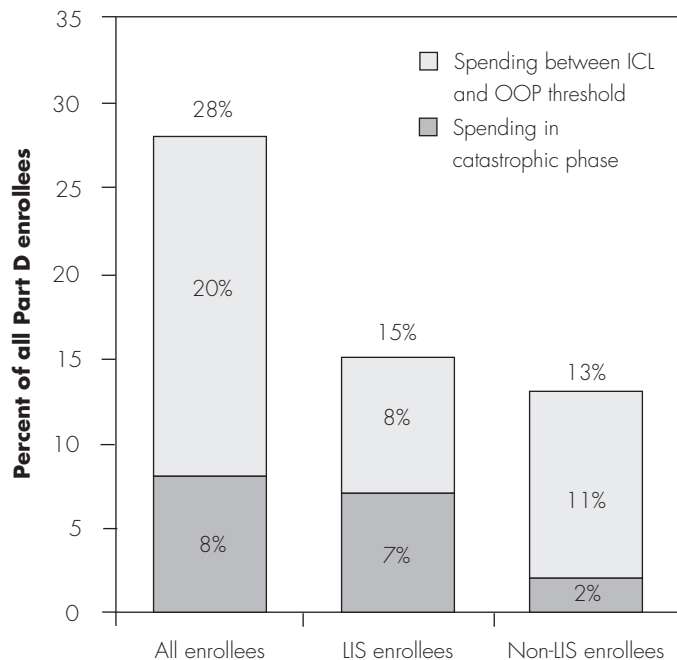
percent of PDP enrollees had enhanced benefits—the typical enhancement being a lower deductible rather than benefits in the coverage gap. Three percent were in defined standard benefit plans. MA–PD enrollees were predominantly in enhanced plans with no deductible (Table 14-4). Enrollees in PDPs are more likely to have a deductible in their plans’ benefit design than enrollees in MA–PDs, which reflects the ability of MA–PDs to use MA (Part C) rebate dollars to supplement benefits or lower premiums.¹²

The ability of MA–PDs to use Part C rebate dollars to enhance their Part D benefits affects the difference between PDPs and MA–PDs in the availability of benefits in the coverage gap (Figure 14-1). In 2013, only 7 percent of PDP enrollees (about 1.2 million beneficiaries) were in plans that offered benefits in the coverage gap beyond what is required by PPACA. However, about 37 percent of PDP enrollees received Part D’s LIS, which effectively eliminated their coverage gap. By comparison, 50 percent of MA–PD enrollees (about 4.6 million beneficiaries) were in plans offering gap coverage.

Use of Part D benefits and enrollees reaching the coverage gap

Prescription drugs are used widely by Medicare beneficiaries. According to the Commission’s analysis of 2011 Part D claims data, about 92 percent of Part D enrollees filled at least one prescription during the year. Enrollees filled an average of 4.3 prescriptions per month, with considerably higher average utilization among those who received the LIS (5.1 per month) than among beneficiaries who did not (3.8 per month).

In 2011, about 28 percent of Part D enrollees had spending high enough to reach the coverage gap (Figure 14-2, p. 366). LIS enrollees accounted for more than half of the enrollees reaching the coverage gap (4.8 million, or about 15 percent of Part D enrollees). Slightly over 2.6 million, or 8.4 percent of Part D enrollees, had spending high enough to reach the catastrophic phase of the benefit. About 2 million of them (about 7 percent of Part D enrollees) received the LIS.

**FIGURE
14-2****Part D enrollees with spending in the coverage gap and catastrophic phase, 2011**

Note: ICL (initial coverage limit), OOP (out-of-pocket), LIS (low-income subsidy). For LIS enrollees, the cost-sharing subsidy effectively eliminates the coverage gap. In 2011, Part D enrollees reached the ICL at \$2,840 in gross drug spending. If they had no supplemental coverage, an enrollee reached the annual OOP threshold at \$4,550 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.

Source: MedPAC analysis of Part D prescription drug event data and Part D denominator file from CMS.

Although over 80 percent of enrollees who reach the catastrophic phase of the benefit continue to be those receiving the LIS, there was a noticeable increase in the number of non-LIS enrollees who reached the catastrophic phase of the benefit in 2011—from about 400,000 in 2010 to slightly over 500,000 in 2011, or an increase of over 27 percent.

Before 2011, Part D enrollees who entered the coverage gap faced 100 percent of the plan's negotiated price for the prescriptions filled unless they were in a plan that provided some benefits in the coverage gap or were an LIS enrollee, for whom the gap is eliminated. Beginning in 2011, non-LIS enrollees see reduced cost sharing as the coverage gap

is gradually phased out between 2011 and 2020 because of changes made by PPACA. Much of the increase in the number of non-LIS enrollees who reach the catastrophic phase in 2011 likely reflects the improved access to drugs as the coverage gap is phased out (see text box on effects of PPACA on drug spending and use, pp. 377–379).

Most Part D enrollees have good access to prescription drugs

Surveys indicate that beneficiaries enrolled in Part D are generally satisfied with the program and their plans (Department of Health and Human Services 2010, Keenan 2007, *Medical News Today* 2009, PRNewswire 2010, Weems 2008). Our analysis of the 2012 Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey shows that over three-quarters of the respondents are satisfied with the drug benefit, and over 90 percent said they would recommend their plans to other people.

Most Part D enrollees appear to have good access to prescription drugs. In 2011, more than 80 percent were satisfied with the drugs listed on plan formularies and over 90 percent reported having good access to pharmacies (Table 14-5). Only 6 percent reported having had prescriptions for medications they did not obtain during the year. Cost was the main reason for not obtaining medications for all enrollees, accounting for roughly half of those who did not obtain medications. Of the 6 percent, between 25 percent and 35 percent of enrollees 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.

Although most enrollees reported being able to obtain medications they needed, about one in five enrollees reported having experienced issues with medication costs at least some of the time. Enrollees reported taking smaller doses, skipping doses to make medication last longer, delaying or not filling a prescription, or spending less in other areas to save up for prescription drugs (Table 14-5). A higher share of LIS enrollees (27 percent) reported having experienced at least some issues with medication costs compared with non-LIS enrollees (17 percent).

Other measures of access to prescription drugs

The number of drugs that sponsors list on a formulary is one way to measure beneficiaries' access to prescription drugs. A plan's use of utilization management tools—

**TABLE
14-5**

Part D enrollees' access to prescription drugs, 2011

	All Part D	Plan type		Subsidy status	
		PDP	MA-PD	LIS	Non-LIS
Percent:					
Satisfied with plan list of drugs covered*	82%	80%	84%	82%	81%
Satisfied with the ease of finding pharmacy that accepts drug plan*	91	91	92	90	92
Reporting medication(s) not obtained	6	6	5	6	5
Reporting some issues with medication costs**	20	22	18	27	17

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy).
 *A small share of respondents 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 about 6 percent. For the question about the ease of finding a pharmacy that accepts the drug plan, the share was about 4 percent. Survey responses to these questions were classified as inapplicable to a small share of respondents, ranging from 3 percent to 5 percent.
 **Includes beneficiaries who experienced any of the following: took smaller doses or skipped doses to make medication last longer, delayed filling a prescription because of cost, did not fill a prescription because of cost, or spent less in other areas to save up for prescription drugs.

Source: MedPAC analysis of 2011 Medicare Current Beneficiary Survey Access to Care file.

such as prior authorization, quantity limits, and step therapy requirements—is another way to measure access.¹³ On the one hand, utilization management tools, if used appropriately, can reduce the use of inappropriate medications. On the other hand, they have the potential to limit or delay access to needed medications. These measures of access are inherently imperfect. For example, formularies that list fewer drugs could still provide adequate access to appropriate medications if plans provide coverage for unlisted drugs through the nonformulary exceptions process.

Plans are required to establish exceptions and appeals processes to ensure that their formularies do not impede access to needed medications. The relative ease or burden associated with the exceptions process varies from plan to plan. We looked into Part D's exceptions and appeals process and found insufficient data to evaluate how well the process is working for beneficiaries to gain access to needed medications. We also found that the process is complex and burdensome for many individuals (see text box, pp. 368–369).

Other factors, such as the amount of cost sharing, can significantly affect beneficiaries' access to medications, regardless of the size of the formulary. For plan sponsors, cost sharing plays an important role in attracting or retaining enrollees while managing drug use to remain competitive.

For example, cost-sharing requirements for specialty-tier drugs can be high, typically about 33 percent of the

negotiated price of a drug. Under CMS's regulations, enrollees are not permitted to appeal specialty-tier cost sharing like they can for other drugs, such as those on tiers for nonpreferred brands. Because drugs on specialty tiers are often used to treat serious chronic illnesses, such as rheumatoid arthritis and multiple sclerosis, patients who need these drugs can face relatively high cost sharing for medications (until they reach the catastrophic phase of the benefit) in addition to significant OOP costs for their medical care. From a sponsor's perspective, higher priced drugs may be used more widely than the evidence of their effectiveness supports, and higher coinsurance may temper their use. Some sponsors may use a specialty tier if most of their competitors also use one to limit the risk of attracting enrollees who take very expensive drugs.

A growing number of PDPs use tiered pharmacy networks that have differential cost sharing to distinguish between preferred and nonpreferred pharmacies (see text box, pp. 370–371). The cost-sharing differential can be significant. In 2014, over 70 percent of PDPs have tiered pharmacy networks with lower cost sharing at preferred pharmacies (Hoadley et al. 2013a). The impact of the higher cost sharing at nonpreferred pharmacies, particularly for beneficiaries who are unaware of or do not understand the distinction between preferred and nonpreferred pharmacies, may be significant. We will continue to monitor the effects of tiered pharmacy networks on beneficiary access and costs.

Part D exceptions and appeals

Under Part D, an enrollee may file a request for an exception for nonformulary drugs or an exception to a tiered cost-sharing structure as long as the request is supported by medical necessity. In 2012, CMS audits found that plans had difficulties in the areas of Part D coverage determination, appeals, and grievances (Centers for Medicare & Medicaid Services 2013f). Examples of problems identified in the CMS audit included meeting mandated time frames, inappropriate denial of requests, and failure to notify the beneficiaries or their prescribers of coverage decisions (Centers for Medicare & Medicaid Services 2013b).

The Part D appeals process is complex, involving multiple levels. It begins with a denied request for an exception—either for a nonformulary drug or a tiered copayment (Figure 14-3). To initiate an appeals request, an enrollee, the enrollee’s prescribing physician, or his or her authorized representative must request a redetermination from the plan. If dissatisfied with the outcome of the redetermination, the enrollee can ask for reconsideration—a review from an independent review entity (IRE). If the enrollee remains dissatisfied, he or she may appeal to an administrative law judge (ALJ), then to the Medicare Appeals Council (MAC), and finally to federal district court, as long as the amount in controversy exceeds specified dollar thresholds.¹⁴

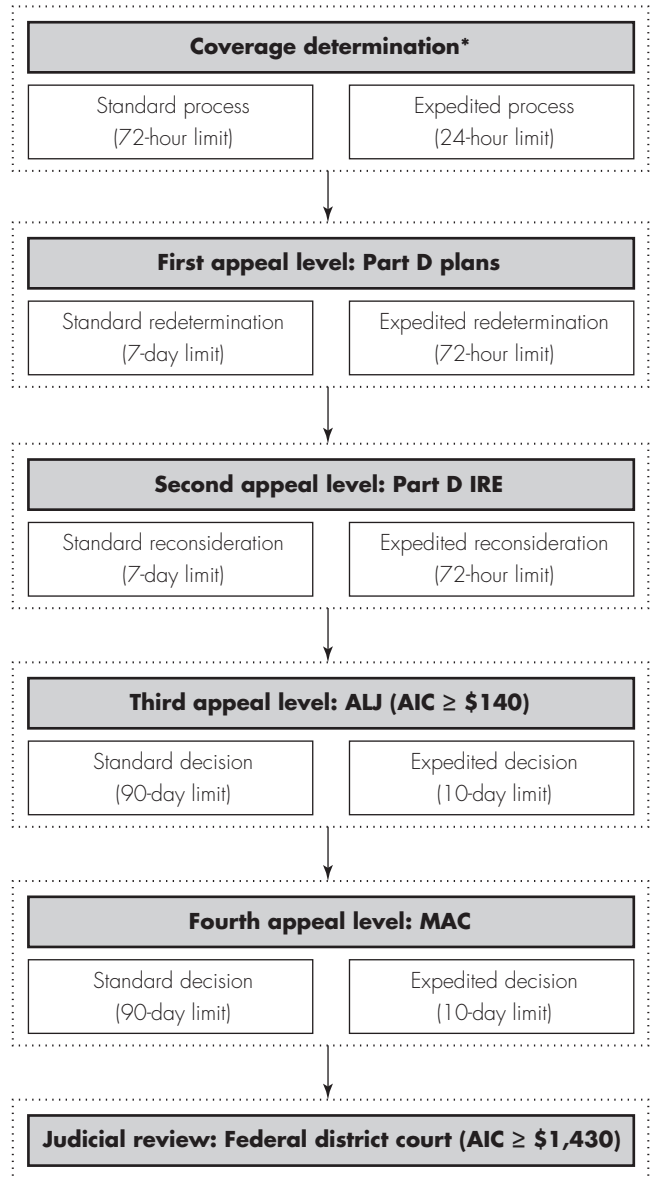
To conduct our own evaluation of the exceptions and appeals process, we examined available data and conducted focus groups and interviews with beneficiaries, physicians, and beneficiary counselors. The data that were available to us were insufficient to make a comprehensive assessment of the plans’ administration of the process, and our discussions with the principal parties involved suggest the need for greater transparency and streamlining.

Need for additional data on the outcomes of the exceptions and appeals process

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 are reviewed by the IRE.

FIGURE 14-3

Appeals process under Medicare Part D



Note: IRE (independent review entity), ALJ (administrative law judge), AIC (amount in controversy), MAC (Medicare Appeals Council).
 *A request for a coverage determination includes a request for a formulary exception or a tiering exception. A request for a coverage determination or an appeal can be submitted by an enrollee, the enrollee’s prescribing physician, or the enrollee’s authorized representative. AICs shown are for 2014.

(continued next page)

Part D exceptions and appeals (cont.)

Between 2006 and 2012, the number of cases that reached the IRE was less than 1 case per 1,000 enrollees in any given year. A comparable figure for the Medicare Advantage program ranged from about 3 cases per 1,000 in 2006 to about 8 cases per 1,000 enrollees in 2012. It is not clear whether the lower appeals rate observed under Part D is a cause for concern. On the one hand, the low appeals rate may reflect the differences in the nature of the services provided under the two programs. For example, beneficiaries may find alternative medications or ways to obtain needed medications outside of the exceptions and appeals process. On the other hand, the low appeals rate may reflect the lack of transparency in the appeals process or excessive administrative burdens imposed on enrollees and prescribers that discourage them from submitting an appeal.

Some trends suggest improvements in the plans' exceptions and appeals process. For example, an increase in the share of appeals upheld by the IRE (i.e., the IRE agrees with plans' coverage decisions) likely reflects improvement in the appropriateness of plans' coverage decisions. Other trends raised concerns. For example, the share of appeals that were upheld by the IRE was consistently below that observed for Medicare Advantage plans. We also found that the outcomes of the IRE review varied widely across plans in both 2012 and 2013, and some plans performed poorly in both years.

The IRE data, however, do not provide information needed to determine how well the process works for

beneficiaries. We believe that providing public access to data on outcomes of the exceptions and appeals process at the plan level—coverage determinations and redeterminations—would improve the ability to assess the effectiveness of the exceptions and appeals process in ensuring access to clinically appropriate medications, as well as provide a useful metric to evaluate plan performance.

Need for increased transparency and a less burdensome process

Our focus groups with beneficiaries and physicians and interviews with beneficiary counselors revealed general confusion and frustration with the process. For example, the majority of beneficiaries were not aware that they could ask for an exception or appeal a plan decision, nor could they understand how the appeals process works. Physicians often found plan exceptions and appeals processes frustrating, noting that some plans' processes are particularly burdensome. Beneficiary counselors reported that they treated the exceptions and appeals process as a last option and often helped beneficiaries find alternative ways to access their medications—for example, by directing them to manufacturers' assistance programs. While the exceptions and appeals process must ensure that exceptions are granted only for clinically appropriate cases to protect the tools that plans use to manage the benefit, these findings suggest a need for increased transparency and streamlining of the processes involved so that beneficiaries and physicians are not discouraged from seeking exceptions for needed medications. ■

Benefit offerings for 2014

Beneficiaries will continue to have many choices of Part D plans in each region. However, each year, a subset of beneficiaries is affected by the entry and exit of plans resulting from decisions by plan sponsors or CMS not to renew contracts. Changes in business strategies also affect plan benefits that are available in a given region.

Number of plans remains stable in 2014, with an increase in PDP offerings

Between 2013 and 2014, the number of stand-alone PDPs increased by about 13 percent—from 1,031 to 1,169—while the number of MA-PDs decreased by 1 percent—from 1,627 to 1,615 (Figure 14-4, p. 372). The number of plans offered has fluctuated over the years. The largest reduction occurred between 2010 and 2011. It was primarily the result of CMS policies that were intended to differentiate more clearly between basic and enhanced

Trend toward use of tiered pharmacy networks

Part D plans contract with pharmacies to fill prescriptions for their enrollees. Plans are required to contract with any pharmacy that agrees to the terms of the contract. However, pharmacies may choose not to do business with the plan. Any pharmacy that contracts with a drug plan is considered to be in the plan's network, whereas any others are considered out of network.

In general, plans do not cover drugs bought from out-of-network pharmacies. Exceptions may include the following: (1) the beneficiary cannot reasonably be expected to obtain such drugs at a network pharmacy, and (2) the beneficiary does not access Part D-covered drugs at an out-of-network pharmacy on a routine basis. In such situations, the plan must cover the prescription but can require higher cost sharing—for example, by requiring the beneficiary to pay the difference in the price the plan would pay to an out-of-network pharmacy compared with an in-network pharmacy. To ensure that beneficiaries have adequate access to

in-network pharmacies, plans are required to meet the statutorily defined network adequacy requirement.¹⁵ Because of these restrictions, plans' networks are usually wide. In 2013, about 80 percent of prescription drug plans (PDPs) contracted with over 95 percent of pharmacies in their respective regions. In most regions, even the plan with the smallest network included at least 90 percent of pharmacies in its network. Only two plans, both issued by the same company, listed less than 70 percent of the pharmacies in their area as in network (NORC at the University of Chicago 2013).

In-network pharmacies can be further classified as preferred or nonpreferred pharmacies. (Network adequacy for plans with preferred and nonpreferred pharmacies is based on access to both types of pharmacies since they are all considered in network.) While the medicines covered by all in-network pharmacies must be the same, the corresponding cost-sharing amounts may depend on the classification of the pharmacy within the plan's network.

(continued next page)

**TABLE
14-6**

Enrollment in PDPs with preferred and nonpreferred pharmacies, 2013

	Number of regions offered	Share of all PDP enrollment	Average share of pharmacies that the plan lists as preferred
AARP MedicareRx Enhanced	32	0.7%	27.5%
AARP MedicareRx Preferred	34	21.4	27.4
AARP MedicareRx Saver Plus	30	2.9	27.4
Aetna CVS/Pharmacy Prescription Drug Plan	29	2.5	13.4
First Health Part D Value Plus	32	3.5	32.8
Humana Enhanced	34	7.3	23.7
Humana Walmart-Preferred Rx Plan	34	9.7	9.4
SilverScript Choice	33	1.9	43.8
SilverScript Plus	33	1.0	43.8
United American-Select	33	0.8	25.7
Other*	varies	1.7	14.1-95.7
Total		53.4	29.7

Note: PDP (prescription drug plan). Average share of pharmacies is weighted by the number of pharmacies in each region and includes only regions in which the plan is offered.

*Includes both national plans—such as SmartD Rx—offered in all 34 regions, and non-national plans—such as Health Alliance Medicare Prescription Plan-Basic—offered in one region. Each of the plans in the "other" category accounts for less than 0.5 percent of total PDP enrollment.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

Trend toward use of tiered pharmacy networks (cont.)

In recent years, a growing number of plan sponsors have chosen to offer preferred pharmacies in their network, with potentially significant price differentials for beneficiaries. In 2012, 14 percent of PDPs, representing 13 percent of total PDP enrollment, used preferred pharmacy networks. One year later, 46 percent of PDPs (over 50 percent of PDP enrollment) had developed preferred pharmacy networks.¹⁶

With an increasing number of plans using tiered pharmacy networks (nearly 70 percent of PDP offerings in 2014), CMS has raised concerns about the potential effect on program costs. CMS requires that plan sponsors offering reduced cost sharing at a preferred pharmacy relative to a nonpreferred pharmacy must do so without increasing CMS payments to the plans (Centers for Medicare & Medicaid Services 2011a). When CMS examined the negotiated prices for the 50 most frequently prescribed drugs, it found that, during the month of March in 2012, prices were higher at preferred pharmacies for about one-third of the PDP contracts (accounting for about 11 percent of PDP enrollees) they examined, potentially increasing program costs (Centers for Medicare & Medicaid Services 2013e).¹⁷

In 2013, plan offerings with preferred networks include some of the largest plans in Part D, such as AARP MedicareRx Preferred and Humana Walmart-Preferred Rx plan. Plans with preferred networks accounted for slightly over 53 percent of PDP enrollment (Table 14-6). For the majority of such plans, no more than one-

third of in-network pharmacies are preferred (i.e., have the lowest cost-sharing amounts).

The share of pharmacies on plans' preferred lists can vary dramatically from one plan offering to another (Table 14-6). The two plan offerings that have the smallest preferred networks are cobranded with a pharmacy chain (Aetna CVS and Humana Walmart). Most of the plans are not cobranded with a pharmacy chain and often have preferred pharmacies from more than one pharmacy chain. For example, First Health Part D Value Plus listed pharmacies in the Target, Walgreens, Kmart, and Walmart chains as preferred. These chain pharmacies combined, on average, accounted for about one-third (32.8 percent) of the pharmacies in regions served by the plan.

CMS rules establish that the viability of a pharmacy network with preferred and nonpreferred pharmacies is conditional on cost sharing that is not "so significant as to discourage enrollees in certain areas (rural areas or inner cities, for example) from enrolling in that Part D plan" (Centers for Medicare & Medicaid Services 2011b). Different plans have interpreted this rule in different ways, with some plans using much stronger incentives than others for their enrollees to use preferred pharmacies. For example, the cost-sharing differential between preferred and nonpreferred pharmacies in the Humana Enhanced plan is only a few dollars for generics and no difference for brand tiers. By contrast, cost sharing is at least \$10 more for every tier of the two SmartD Rx plans if an enrollee uses a nonpreferred pharmacy.¹⁸ ■

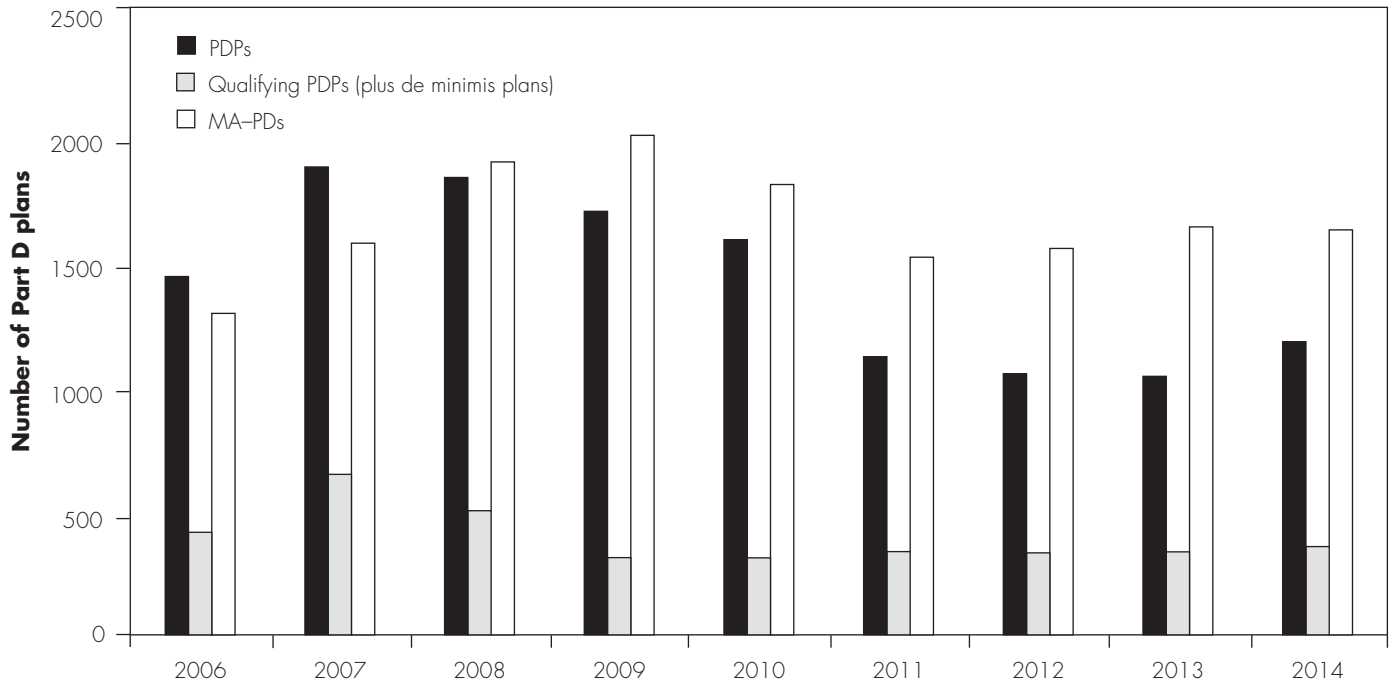
benefit plans and to discourage plans with low enrollment.¹⁹ In 2014, beneficiaries continue to have many plans to choose from, ranging from 28 PDP options in Alaska to 39 PDP options in the Pennsylvania–West Virginia region, along with MA–PD options in most areas of the country. The number of MA–PDs 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 2014, 352 PDPs are available to LIS enrollees with no premium, up from 331 in 2013 (Figure 14-4, p. 372).²⁰

All regions continue to have many premium-free plans available, ranging from four plans in Nevada and Hawaii to 15 plans in the Indiana–Kentucky region. About 1.9 million LIS enrollees were in plans that did not qualify as premium free in 2013 (Hoadley et al. 2013a). As of December 2013, CMS estimated that it will have reassigned about 500,000 LIS enrollees to different plans because their previous plan's premium did not fall below the 2014 threshold.²¹ LIS enrollees who selected a plan that differed from their randomly assigned plan are not reassigned. CMS sends letters to those LIS enrollees

**FIGURE
14-4**

Number of Part D plans remains stable between 2013 and 2014



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Qualifying PDPs are 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, 2006–2014.

about premium-free plan options that are available in their regions.

Notable changes for 2014 in benefit offerings

Beneficiaries are encouraged to reexamine their plan options from time to time. In addition to the annual change in plan availability and premiums charged, most plans make some changes annually to their benefit offerings—such as deductible amounts and plan formularies—that can directly affect access to and affordability of medications. For the 2014 benefit year, the structure of drug benefits for MA-PDs is holding fairly steady, while there were some notable changes for stand-alone PDPs.

Fewer PDPs are offering coverage in the gap

In 2014, fewer PDPs than in 2013 are offering coverage in the gap beyond that required by PPACA—21 percent compared with 34 percent. In 2014, about three-quarters of PDPs that offer gap coverage include some brand-

name drugs. By contrast, the share of MA-PDs with gap coverage is holding steady at about 50 percent in 2014. Among MA-PDs that offer gap coverage in 2014, a slightly smaller share than in 2013 include some brand-name drugs in the coverage gap (51 percent compared with 55 percent).

The extent of coverage in the gap varies from plan to plan. In 2014, about 80 percent of the PDPs that offer brand coverage in the gap provide coverage for between 10 percent and 65 percent of brand-name drugs listed on the formulary. In comparison, most of the brand coverage among MA-PDs includes only a few brand-name drugs, typically less than 10 percent of brand-name drugs listed on the formulary.

The reduction in the number of PDPs offering gap coverage may be due in part to the changes made by PPACA to gradually phase out the coverage gap. In 2014, the basic Part D benefit will cover 28 percent of the cost of generic drugs and 2.5 percent of the cost of brand-

**TABLE
14-7**

2014 formularies for stand-alone PDPs with highest 2013 enrollment

Stand-alone PDPs with the highest 2013 enrollment	Enrollment, 2013 (in millions)	Percent of drugs on formulary		Percent of formulary drugs with any utilization management*	
		2013	2014	2013	2014
AARP MedicareRx Preferred	3.8	92%	92%	21%	23%
SilverScript Basic**	2.8	77	N/A	40	N/A
Humana Preferred Rx Plan	1.8	83	80	48	48
Humana Enhanced	1.3	89	89	49	50
AARP MedicareRx Saver Plus	0.8	83	83	19	25
First Health Part D Value Plus	0.7	80	78	40	41
First Health Part D Essentials	0.7	79	78	31	40
Cigna Medicare Rx Secure	0.7	86	85	33	38
WellCare Classic	0.6	74	73	34	38

Note: PDP (prescription drug plan), N/A (not available). Enrollment figures are for October 2013 and exclude employer group plans and territories. The number of drugs on the formulary for 2013 is 1,174; for 2014, the number is 1,233.

*Utilization management includes the use of prior authorization, quantity limits, and step therapy requirements.

**Not all formulary information for SilverScript plans were available at the time of this analysis was conducted. SilverScript plans were placed under CMS sanction in 2013 and were prohibited from accepting new enrollment during the 2014 annual open enrollment period.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

name drugs in the gap phase. The 50 percent discount paid for by pharmaceutical manufacturers for brand-name drugs further reduces beneficiaries' cost sharing for brand-name drugs to about 47.5 percent.²² The increased generosity of the basic benefit may be replacing some of the supplemental benefits provided during the gap phase of the benefit.

More than half of PDPs continue to charge a deductible in 2014. Among PDPs with a deductible, in 2014 the trend is away from charging a deductible below the standard amount (\$310)—only 4 percent of the plans charge a lower deductible, compared with over 10 percent during the last few years. As in previous years, a much higher share of MA-PDs have no deductible (82 percent) compared with PDPs (47 percent).

Continued widespread use of utilization management tools

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 tools are also often used to encourage the use of lower cost therapies.

Under contract with the Commission, researchers from NORC at the University of Chicago and from Social & Scientific Systems analyzed Part D formulary data for 2014. 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).

For the nine largest nationwide PDPs, which accounted for nearly 60 percent of the PDP enrollment in 2013, the shares of drugs (technically, all distinct chemical entities) listed on their formularies remained stable or saw a modest decrease of 3 percentage points or less between 2013 and 2014 (Table 14-7).²³

The use of utilization management increased for seven out of the nine largest PDPs, with many plans requiring some type of utilization management on more than one-third of drugs listed on their formularies. The most common strategy that plans use to manage enrollees' drug use is to apply a prior authorization requirement. In 2014, about 20 percent of formulary drugs are subject to prior authorization. Among the top nine PDPs, those operated by Humana Inc. (Humana Preferred Rx Plan and Humana

**TABLE
14-8**

2014 cost-sharing amounts for stand-alone PDPs with highest 2013 enrollment

Stand-alone PDPs with the highest 2013 enrollment	Enrollment, 2013 (in millions)	Generic		Preferred brand		Nonpreferred brand		Specialty	
		2013	2014	2013	2014	2013	2014	2013	2014
AARP MedicareRx Preferred	3.8	\$3/\$5	\$3/\$6	\$40	\$40	\$85	\$85	33%	33%
SilverScript Basic	2.8	\$2	\$2	23.5%	20%	45%	42%	25%	25%
Humana Preferred Rx Plan	1.8	\$1/\$4.5	\$1/\$2	20%	20%	35%	35%	25%	25%
Humana Enhanced	1.3	\$2/\$5	\$2/\$5	\$41	\$42	\$90	\$92	33%	33%
AARP MedicareRx Saver Plus	0.8	\$1/\$2	\$1/\$2	\$25	\$20	\$45	\$35	25%	25%
First Health Part D Value Plus	0.7	\$1	\$3/\$11	25%	\$37	45%	\$88	N/A	33%
First Health Part D Essentials	0.7	\$1	\$1	25%	15%	45%	45%	N/A	N/A
Cigna Medicare Rx Secure	0.7	\$0/\$8	\$0/\$3	\$30	\$30	\$80	\$65	25%	25%
WellCare Classic	0.6	\$6	\$0/\$15	\$42	\$40	\$94	\$94	33%	33%

Note: PDP (prescription drug plan). Enrollment figures are for October 2013 and exclude employer plans and territories. In cases where plans vary cost-sharing amounts across regions, we report unweighted median cost-sharing amounts.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

Enhanced) have the highest share of drugs with utilization management.

Modest increase in cost-sharing requirements

Cost-sharing requirements have generally been rising over the years. In 2014, changes in cost-sharing requirements for the top nine nationwide PDPs are modest for the most part, with a few notable exceptions. For example, some enrollees in First Health Part D Value Plus may experience significant change in their OOP spending, depending on the medications they take because cost sharing for brand-name drugs changes from coinsurance to copayments and some drugs are on the new specialty tier with a 33 percent coinsurance (Table 14-8). Of the top nine PDPs, only one plan—First Health Part D Essentials—does not have a specialty tier.

The relative stability of the copayments and coinsurance amounts from year to year observed for many plans is primarily due to the requirement that benefit offerings remain actuarially equivalent to the defined standard benefit and to CMS’s systematic review of plan benefit packages. During the review process, CMS identifies, for example, outlier plans and requires them to bring the cost-sharing amounts in line with those of other plans.

More plans are using a five-tier formulary structure

In 2014, seven of the top nine PDPs are using a five-tier formulary structure that includes two tiers for generic

drugs (preferred and nonpreferred), two tiers for brand drugs, and a tier for specialty drugs. Many plans are keeping their generic cost sharing low, with the exception of two plans—First Health Part D Value Plus and WellCare Classic. Both plans have moved from having a single generic tier to two generic tiers and have set a relatively high copayment for the nonpreferred generic tier (\$11 and \$15, respectively); by comparison, nonpreferred generic cost sharing for the other five plans using a five-tier formulary structure ranges from \$2 to \$6 (Table 14-8).

The widespread use of a nonpreferred generic tier in 2014 is a dramatic shift from earlier years when we began to see some plans use a nonpreferred generic tier in their formulary for a limited number of drugs. In 2014, the majority of the PDPs that have two generic tiers are placing the majority of the covered generic drugs on the nonpreferred tier (on average, about three-quarters of generic drugs on plan formularies).²⁴

A broader use of lower generic cost-sharing amounts and higher cost-sharing amounts on nonpreferred generic tiers both have the potential to lower the overall program costs by encouraging enrollees to use lower priced products. That may not be the case for LIS enrollees, for whom the difference between those amounts and the statutorily set amounts (between \$0 and \$2.55 in 2014, depending on the subsidy level) are picked up by Part D’s low-income cost-sharing subsidy (about 4 percent of enrollees in First Health Part D Value Plus and nearly 70 percent of

enrollees in WellCare Classic in 2013). Thus, higher cost sharing on a nonpreferred generic tier may result in higher program spending for the subsidy.

Costs of Part D

To monitor Part D's costs, we examine aggregate program spending, per capita spending, trends in the prices at the pharmacy counter, and trends in plans' bid amounts. Total program spending continues to grow at a faster rate than the growth in Part D enrollment. The "excess" growth appears to be driven in large part by growth in the average price of drugs filled, particularly among enrollees receiving the LIS. As in the past, we find that drug utilization for Part D enrollees with high spending was driving faster growth for some components of Part D spending than others. Moreover, we find that changes made by PPACA to phase out the coverage gap may have increased the number of enrollees with high spending.

In this section, we present data on Part D spending that we use to understand the sources of the "excess" growth. We also provide an updated analysis of the patterns of drug use for Part D enrollees with high spending to understand the sources of spending growth and the effects of PPACA on Part D program costs (see text box on effects of PPACA on drug spending and use, pp. 377–379).

Aggregate program costs

Medicare pays plan sponsors three major subsidies on behalf of each plan enrollee:

- **Direct subsidy**—Medicare makes a monthly payment to plans, which is set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- **Reinsurance**—Medicare subsidizes 80 percent of drug spending above an enrollee's annual OOP threshold. Reinsurance reduces risk for Part D sponsors by providing greater federal subsidies for the highest cost enrollees.
- **LIS**—Medicare pays the plan to cover expected cost sharing and premiums for enrollees eligible for the subsidy.

Direct and reinsurance subsidies combined cover 74.5 percent of the cost of basic Part D benefits, on average.²⁵ In addition to these subsidies, Medicare establishes

symmetric "risk corridors" separately for each plan to limit its overall losses or profits. Under risk corridors, Medicare finances a portion of costs that are higher than expected or recoups a portion of profits that are higher than expected.

Payments to plans grew faster than enrollment, with the low-income subsidy as the single largest component

Between 2007 and 2012, Part D program spending (including spending for the RDS) grew from \$46.7 billion to \$62.5 billion (Table 14-9, p. 376). In 2012, the total was made up of \$20.9 billion in direct subsidy payments to plans, \$15.6 billion in payments for individual reinsurance, \$22.6 billion for the LIS, and \$3.3 billion in RDS payments (Boards of Trustees 2013). Payments to plans for the three subsidies (not including the RDS) grew by 38 percent during this period, exceeding the Part D enrollment growth (29 percent) by 9 percentage points.

In 2012, LIS payments continued to be the largest component of Part D spending. Moreover, because these individuals tend to use more medications than other Part D enrollees, a disproportionate share of spending for the direct subsidy and individual reinsurance also reflects benefits for LIS enrollees.

Phase-out of the coverage gap likely contributing to the growth in spending for individual reinsurance

Medicare payments for individual reinsurance have grown considerably faster than other components of Part D spending, increasing at an average annual rate of 14 percent between 2007 and 2012, compared with 6 percent for overall Part D spending. Payments for individual reinsurance grew by 13 percent between 2011 and 2012, a rate much higher than the growth rates for direct subsidy payments (4.2 percent) and for LIS payments (about 1.3 percent) (Table 14-9, p. 376).

Multiple factors likely contribute to the growth in reinsurance spending. Our previous analysis of drug spending for and use by enrollees with spending high enough to reach the benefit's catastrophic phase showed that spending was driven primarily by the volume of prescriptions filled by these enrollees and by their tendency to use more brand-name medications than enrollees who do not incur high drug spending. We also found that many of the therapies used by the high-cost beneficiaries were in therapeutic classes that had generic alternatives that would have cost significantly less than

**TABLE
14-9**

Medicare's reimbursement amounts for Part D

	2007	2008	2009	2010	2011	2012
In billions of dollars						
Direct subsidy	\$18.1	\$17.7	\$18.9	\$19.7	\$20.1	\$20.9
Reinsurance	8.0	9.4	10.1	11.2	13.8	15.6
Low-income subsidy	16.7	18.0	19.6	21.0	22.3	22.6
Retiree drug subsidy	<u>3.9</u>	<u>3.8</u>	<u>3.9</u>	<u>3.9</u>	<u>3.6</u>	<u>3.3</u>
Total	\$46.7	\$48.9	\$52.4	\$55.8	\$59.8	\$62.5
Annual percentage change						
Direct subsidy	2.7%	-2.0%	6.5%	4.5%	1.8%	4.2%
Reinsurance	33.0	17.8	7.1	10.7	23.3	13.3
Low-income subsidy	11.0	7.5	8.6	7.5	6.2	1.3
Retiree drug subsidy	2.5	-3.5	3.2	0.4	-6.9	-8.4
Total	9.9	4.7	7.1	6.5	7.1	4.4

Note: The numbers above reflect reconciliation amounts. Most enrollees paid premiums directly to Part D plans, and those amounts are not included above. On a cash basis, the Boards of Trustees estimates that premiums paid by enrollees totaled \$4.1 billion in 2007, \$5 billion in 2008, \$6.1 billion in 2009, \$6.7 billion in 2010, \$7.3 billion in 2011, and \$7.8 billion in 2012. Totals may not sum due to rounding.

Source: MedPAC based on Table IV.B10 of the 2013 annual report of the Boards of Trustees of the Medicare trust funds.

their brand-name counterparts, rather than higher priced products that had few or no therapeutic substitutes (Medicare Payment Advisory Commission 2012).

Our analysis of 2010 and 2011 Part D claims data shows that these findings still hold true. Less than 10 percent of enrollees with high drug spending used biologics, and spending on biologics accounted for 6 percent to 7 percent of drug spending for these beneficiaries, a rate similar to those observed in 2009.²⁶ They also tended to use more brand-name products—about 40 percent compared with about 20 percent for other enrollees. This pattern of drug use generally held true for many therapeutic classes with generic alternatives. For example, among diabetic therapies, brand-name drugs accounted for 62 percent of the prescriptions filled by high-cost enrollees, compared with slightly over 30 percent for other enrollees. Finally, two changes made by PPACA likely contributed to the even higher growth for reinsurance payments between 2010 and 2011 by increasing the number of enrollees who reach the benefit's catastrophic phase (see text box, opposite page).

Another factor that may contribute to the faster growth in spending for individual reinsurance is the manner in which

manufacturer rebates are allocated across the different phases of the benefit—i.e., deductible phase, initial benefit phase, coverage gap phase, and the catastrophic phase—in the plan bids and during reconciliation. However, we do not have access to the rebate data to understand how rebate allocation may be affecting the differential growth in program components.

Decrease in retiree drug subsidy payments likely to continue

The number of Medicare beneficiaries who received primary prescription drug coverage through former employers has been decreasing, from over 7 million in 2006 to about 3 million in 2013 (Boards of Trustees 2013). Employers no longer offering drug coverage to their retirees typically move their Medicare-eligible members to Part D. Enrollment in employer group plans (800 series plans) went up by about 2.3 million (mostly in PDPs) during the first three months of 2013.

The change in the tax treatment of the RDS payments is likely to have accelerated the decline in the number of beneficiaries receiving prescription drug coverage through former employers. Before 2013, the subsidy provided employers with two tax advantages. First, the RDS

Effects of PPACA on drug spending and use

The Patient Protection and Affordable Care Act of 2010 (PPACA) gradually phases out the coverage gap by reducing beneficiary cost-sharing amounts until it reaches 25 percent in 2020. For brand-name drugs, the reduction in cost sharing is achieved with a combination of a manufacturer discount that covers 50 percent of the cost of drugs for enrollees in the coverage gap and an increase in Part D's coverage of costs between 2013 and 2020.

PPACA changes involving manufacturer discounts and their application to the out-of-pocket (OOP) spending threshold are expected to increase the number of enrollees who reach the catastrophic phase of the benefit (high-cost enrollees). Beginning with the 2011 benefit year, manufacturer discounts for brand-name drugs filled during the coverage gap reduces by half the beneficiary cost sharing for brand-name drugs paid by non-low-income subsidy (LIS) enrollees. These manufacturer discounts count toward the OOP threshold, so that individuals taking brand-name medications will reach the catastrophic phase of the benefit without having spent the full amount specified by the OOP threshold. Data on program spending shows that payments for individual reinsurance grew by 23 percent between 2010 and 2011, a much higher rate than observed in most other years (Table 14-9). Much

of that accelerated growth is likely due to the start of the manufacturer discount program.

More non-LIS enrollees reaching the catastrophic phase of the benefit in 2011

Our analysis of Part D claims data between 2010 and 2011 shows that the number of high-cost enrollees grew by 12 percent (Table 14-10). The increase was 9 percent (about 176,000) for LIS enrollees and 28 percent (slightly over 100,000) for non-LIS enrollees. This increase is in contrast to the period before 2011, when the numbers stayed about the same. Although multiple factors can affect the number of people reaching the catastrophic phase of the benefit, the PPACA changes likely account for much of the increase among non-LIS enrollees during this period.

Growth in spending for high-cost enrollees in 2011 driven by more enrollees reaching the catastrophic phase

A comparison of drug utilization patterns before and after PPACA's implementation shows that the accelerated growth after the change was driven primarily by the increase in the number of people reaching the benefit's catastrophic phase. Total drug spending by high-cost enrollees grew by 19 percent after the change compared with slightly less than 7 percent growth before the change. The number of

(continued next page)

**TABLE
14-10**

Part D enrollees reaching the catastrophic phase of the benefit, 2007-2011

	2007	2008	2009	2010	2011	Average annual percent change	
						2007-2010	2010-2011
Enrollees (in millions)	2.3	2.4	2.4	2.4	2.6	1%	12%
By subsidy status							
LIS	1.9	2.0	2.0	2.0	2.1	1	9
Non-LIS	0.4	0.4	0.4	0.4	0.5	-2	28

Note: LIS (low-income subsidy). Growth rates are calculated using figures before rounding is applied.

Source: Data for 2007 and 2008 are based on published figures from CMS. Data for 2009 to 2011 are based on the Commission's analysis of Part D prescription drug event data.

Effects of PPACA on drug spending and use (cont.)

prescriptions also grew much faster after the change—slightly over 11 percent compared with no growth before the change (Table 14-11). Once the changes in the average costliness of each prescription (6.8 percent for the 2009 to 2010 period and 7.1 percent for the 2010 to 2011 period) are taken into account, the growth in both spending and prescriptions filled are nearly identical to the growth in the number of people reaching the catastrophic phase of the benefit during the 2009 to 2011 period.

Following the PPACA changes, growth in drug spending and use for high-cost enrollees far outpaced that for both LIS and non-LIS enrollees, but the difference was more pronounced for the non-LIS enrollees. Between 2010 and 2011, total drug spending for non-LIS enrollees grew by nearly 38 percent compared with slightly less than 15 percent for LIS enrollees (Table 14-12). Growth in prescriptions filled generally followed the changes in the number of high-cost enrollees for both LIS and non-LIS enrollees.

There were some concerns that the manufacturer discounts reducing beneficiary OOP costs for brand-name drugs could affect enrollees' choice of brand

versus generic medications, particularly if beneficiaries expected to have drug spending high enough to put them in the catastrophic phase of the benefit. However, our preliminary analysis of 2011 Part D data does not suggest a noticeable shift toward the use of brand-name medications. Between 2009 and 2011, the average generic use rate among high-cost enrollees increased from 58 percent to 63 percent, with similar increases for both LIS and non-LIS enrollees. For many of the drug classes we analyzed, the generic use rates were unchanged or higher in 2011 compared with 2009 or 2010 for both LIS and non-LIS enrollees.

Should the manufacturer discount count toward the OOP threshold?

Of the roughly 500,000 non-LIS enrollees who reached the catastrophic phase of the benefit in 2011, only 6 percent (about 30,000) met the OOP limit (\$4,550 in 2011) with their actual OOP alone. These enrollees, on average, incurred about \$60,000 in gross spending, with manufacturer discounts covering less than 3 percent of that total (about \$1,600). Their OOP spending averaged about \$5,400, and the remainder (about \$53,000) was covered by the benefit.

(continued next page)

**TABLE
14-11**

Part D spending and utilization by high-cost enrollees, 2009–2011

	2009	2010	2011	Annual percent change	
				2009–2010	2010–2011
Enrollees (in millions)	2.4	2.4	2.6	-0.8%	12.1%
Aggregate utilization					
Gross spending (in billions)	\$29.2	\$31.2	\$37.1	6.8	19.1
Prescriptions (in millions)	264.3	264.3	294.0	0.0	11.2
Average prescriptions per enrollee	111	112	111	0.8	-0.8
Average spending per prescription	\$110	\$118	\$126	6.8	7.1

Note: Growth rates are calculated using figures before rounding is applied.

Source: MedPAC analysis of Part D prescription drug event data.

Effects of PPACA on drug spending and use (cont.)

**TABLE
14-12**

Growth in drug spending and utilization for high-cost enrollees by LIS status, 2009–2011

	2009	2010	2011	Annual percent change	
				2009–2010	2010–2011
Gross spending (in billions)					
LIS enrollees	\$23.9	\$25.5	\$29.3	6.8%	14.9%
Non-LIS enrollees	5.3	5.7	7.8	7.1	37.7
Prescriptions (in millions)					
LIS enrollees	222.0	223.6	242.3	0.7	8.3
Non-LIS enrollees	42.3	40.7	51.7	-3.9	27.2

Note: LIS (low-income subsidy). Growth rates are calculated using figures before rounding is applied.

Source: MedPAC analysis of Part D prescription drug event data.

In contrast, gross spending averaged about \$12,500 among the 475,000 enrollees who met the OOP limit with the combination of their own OOP spending and the manufacturer discounts. If manufacturer discounts were not treated as OOP for the purpose of determining when enrollees met the OOP threshold, they most likely would not have reached the catastrophic phase as quickly, and some likely would not have reached

the catastrophic phase of the benefit in 2011. For these enrollees, manufacturer discounts covered, on average, 13 percent of their gross drug spending (about \$1,600). About 40 percent of the spending (\$2.4 billion) was for drugs filled after the enrollees met the OOP limit, resulting in \$1.9 billion in Medicare's payments for individual reinsurance for these enrollees (80 percent of the \$2.4 billion). ■

payments were and continue to be nontaxable income for employers. Second, employers had been allowed to treat the prescription drug expenses for which they receive the subsidy as a tax-deductible cost of doing business, making these subsidies worth more to the employers than the actual subsidy amounts paid. As of 2013, PPACA no longer allows employers to deduct expenses for which they receive the subsidy.

Per capita spending and use

Between 2007 and 2011, the most recent years for which we have data, the average per capita spending for Part D-covered drugs grew at an average annual rate of 3 percent, or by about 12.5 cumulatively. Growth in average per capita spending slowed in 2010 to about 1.5 percent—a trend consistent with that of general drug costs measured in national health expenditures—but picked up in 2011 (3.2 percent).

Per capita spending for LIS enrollees growing faster than for non-LIS enrollees

Spending for non-LIS enrollees remained relatively flat compared with LIS enrollees (average annual growth rate of 1.8 percent compared with 4.8 percent), resulting in a larger difference in per capita spending between the two groups—from \$145 in 2007 to nearly \$200 per member per month in 2011 (Table 14-13, p. 380). The growth in the number of prescriptions filled by LIS and non-LIS enrollees was comparable during this period, while the change in average price per prescription was not. Between 2007 and 2011, the average price per prescription filled by LIS enrollees grew cumulatively by about 10 percent compared with a decrease of about 2 percent for non-LIS enrollees. The mix of drugs, which may reflect differences in medication needs, can have significant effects on the cost of medications. For example, our analysis of Part D prices shows that the average price of generic products fell

**TABLE
14-13**

Average per capita spending and use per month for Part D-covered drugs, 2007-2011

Part D spending and utilization per enrollee

	Average spending/utilization					AAGR, 2007-2011	
	2007	2008	2009	2010	2011	In dollars	In percent
Average spending							
All Part D	\$212	\$221	\$228	\$231	\$239	\$7	3.0%
By LIS status							
LIS	301	324	339	348	364	16	4.8
Non-LIS	156	159	163	163	167	3	1.8
By plan type							
PDP	239	250	260	265	274	9	3.5
MA-PD	151	162	169	172	178	7	4.2
						Number of prescriptions	
All Part D	3.9	4.1	4.1	4.2	4.3	0.1	2.1%
By LIS status							
LIS	4.6	4.9	5.0	5.1	5.1	0.1	2.6
Non-LIS	3.4	3.6	3.6	3.7	3.8	0.1	2.6
By plan type							
PDP	4.1	4.3	4.4	4.4	4.5	0.1	2.0
MA-PD	3.4	3.6	3.7	3.8	3.9	0.1	3.1

Note: AAGR (average annual growth rate), LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]). Part D prescription drug event (PDE) records are classified into plan types based on the contract identification on each record. For purposes of classifying the 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 according to each plan type and LIS status. Gross drug spending includes all payments to pharmacies, including payments by drug plans, Medicare's LIS, and beneficiary out-of-pocket. Prescriptions are standardized to a 30-day supply.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

by over 40 percent during this period, while the average price of brand products grew by between 40 percent and 60 percent between 2007 and 2011 (see section on Part D prices).

Although the growth in per capita drug spending among MA-PD enrollees was greater than for stand-alone PDP enrollees (4.2 percent compared with 3.5 percent), the average growth was lower for MA-PD enrollees in terms of the dollar increase (\$7 compared with \$9). Despite the higher growth rates observed, average per capita spending for MA-PD enrollees was consistently lower than that for stand-alone PDP enrollees—by around \$90 per member per month.

Part D drug prices

Most plan sponsors do not negotiate drug prices directly with pharmaceutical manufacturers. Instead, sponsors engage in two separate negotiations:

- The first involves pharmacies or a network of pharmacies negotiating the prices the plan will pay the pharmacy for drug ingredient costs and dispensing fees.
- The second involves negotiating the terms under which manufacturers pay retrospective rebates.

Between 2006 and 2011, the average manufacturer rebate as a percentage of total prescription drug costs increased from less than 9 percent to 11.5 percent (Boards of

Trustees 2013). In general, plan sponsors do not receive rebates from manufacturers of generic drugs, which accounted for over three-quarters of the prescriptions dispensed under Part D in 2011. The CMS Office of the Actuary reports that “many brand-name prescription drugs carry substantial rebates, often as much as 20–30 percent” but expects the rebates to decrease as some of the drugs with the highest Part D rebate amounts lose patent protection in the next several years (Boards of Trustees 2013). Plan sponsors tend to use rebate revenues to offset plans’ benefit spending (reducing plan premiums) rather than lowering the price of prescriptions at pharmacies. As a result, drug prices measured in this section do not reflect the outcomes of the rebate negotiations.

Part D plan sponsors have had mixed success at influencing drug prices. They have been successful at encouraging enrollees to use generic alternatives when available (Congressional Budget Office 2010, Office of Inspector General 2007) (see text box, p. 383). Plan sponsors regularly use cost-sharing differentials to encourage enrollees to use lower priced products such as generic drugs and brand-name drugs placed on preferred brand tiers. But sponsors have had less success at controlling the growth in prices for unique drugs and biologic products.

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 from manufacturers but rather the prices sponsors and beneficiaries pay to pharmacies at the point of sale (including ingredient costs and dispensing fees).

Enrollees’ use of generic drugs have kept Part D prices stable

Measured by individual national drug codes (NDCs), Part D drug prices rose between 2006 and 2011 by an average of 29 percent cumulatively (Figure 14-5, p. 382).²⁷ At the same time, Part D sponsors have had success in encouraging enrollees to switch from brand-name drugs to generic substitutes. As measured by a price index that takes this substitution into account, Part D prices grew cumulatively by 3 percent.²⁸

For most drug classes, CMS requires plan formularies to cover—in every therapeutic class and key drug type—at least two drugs that are not therapeutic substitutes, unless only one drug is approved for that class. This policy is intended to allow competition in classes with multiple products while protecting beneficiaries who need a drug

that is the only one available to treat a certain condition. For six drug classes, CMS requires Part D plans to cover “all or substantially all” drugs in the class (protected class). Those classes are antineoplastics, antidepressants, antipsychotics, antiretrovirals, anticonvulsants, and immunosuppressants used by transplant patients.²⁹ Although plans can charge higher cost sharing for drugs in these classes—for example, by placing them on tiers for nonpreferred brands—plans may have limited ability to influence use of these classes of drugs.

As measured by individual NDCs, prices for drugs in the six protected classes showed a trend between 2006 and 2011 similar to that for all Part D drugs, rising by a cumulative 28 percent (Figure 14-5, p. 382). This growth was influenced heavily by two classes of drugs: (1) antidepressant medications, which accounted for about half of the volume in the six classes and had many generics on the market during this period, and (2) anticonvulsants, which accounted for about a quarter of the volume and also had generic alternatives available during the same period.

Our price index for the individual NDCs of antidepressant and anticonvulsant drugs fell by nearly 10 percent and 15 percent, respectively, during the six-year period (data not shown). Growth in the prices for immunosuppressants has 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 increases of over 30 percent for antiretrovirals to increases of nearly 80 percent for antineoplastics.

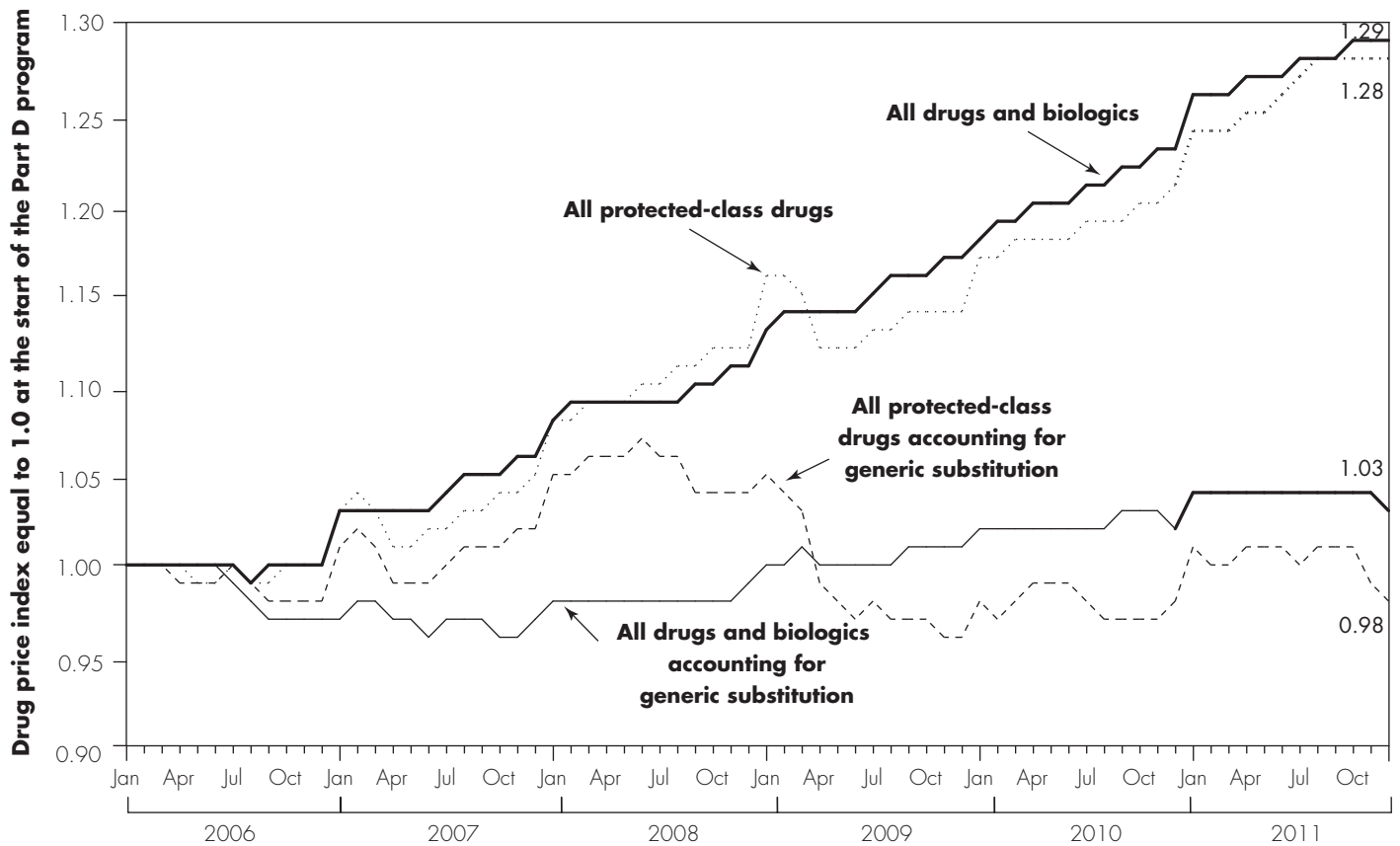
When protected-class drugs were grouped to take generic substitution into account, their prices fell by a cumulative 2 percent over the six-year period. Thus, despite the drugs’ protected status, plan sponsors appeared to have had success at moving enrollees toward generics for these drugs when generic 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 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. As expected, when we measured the price growth for drugs with no generic substitutes (single-source brand-name drugs) separately,

**FIGURE
14-5**

Availability of generics, rather than protected status, was key to slower price growth under Part D, 2006–2011



Note: The price index is a chain-weighted Fisher price index.

Source: Acumen, LLC analysis for MedPAC.

the growth in prices between 2006 and 2011 was much higher—an average of 66 percent cumulatively (Figure 14-6, p. 384). Prices of generic drugs, on the other hand, decreased to about 40 percent of the average prices observed at the beginning of 2006.

National average bid

Under Part D, payments to plans are based on the average of the bids that plan sponsors submit to CMS each year. The bids are intended to reflect the expected costs for a Medicare beneficiary of average health; CMS adjusts payments to plans based on the actual health status of each of the plan’s enrollees. Growth in expected per capita benefit costs for Part D has fluctuated, ranging from nearly 9 percent between 2008 and 2009 to –4 percent between 2011 and 2012. For 2014, the expected costs were

projected to increase by 4 percent (Table 14-15, p. 385). The actual costs of the program may be higher or lower than the prospective payments CMS makes to plans based on the bids.

Plan sponsors expecting lower cost for basic benefits but a much higher cost for reinsurance in 2014

Between 2013 and 2014, national average benefit costs for basic Part D benefits are projected to decrease by nearly 5 percent (Table 14-15, p. 385). During this period, the monthly payment to sponsors (i.e., the direct subsidy component) is projected to decrease by over 10 percent, while the reinsurance component is expected to grow by 20 percent. We have observed a similar trend for the last several years; the expected cost of providing the portion

Generic drug use has increased but varies across enrollees

The use of generic medications has increased over time. According to the Commission’s analysis of the years 2007 to 2011, the overall average generic dispensing rate (GDR) increased from 61 percent to 77 percent (Table 14-14). 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, Medicare Advantage–Prescription Drug (MA–PD) enrollees are more likely to use generic drugs than enrollees in prescription drug plans (PDPs). Between 2007 and 2011, MA–PDs consistently exceeded the GDR for PDPs by about 5 percentage points. Low-income subsidy (LIS) enrollees have had a consistently lower GDR than non-LIS enrollees, and that difference grew between 2007 and 2011 from 2 percentage points to 5 percentage points.

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. Also, there can be differences in

the prescribing behavior of physicians who are part of a managed care organization and those who are not. Some of the difference in GDRs between PDPs and MA–PDs reflects the fact that most LIS enrollees are in PDPs. Since LIS enrollees are more likely to be disabled and tend to have a greater disease burden than non-LIS enrollees, they may have different medication needs. At the same time, because the LIS limits financial liability, some of the difference in the GDRs between LIS and non-LIS enrollees may be due to the difference in the financial incentives they face.

Over 80 percent of beneficiaries with high drug spending receive Part D’s LIS, which pays for cost-sharing amounts above the statutorily set copayment. This subsidy may limit how well plan sponsors can manage drug spending for those individuals—for example, by limiting plans’ ability to use reduced cost sharing to encourage the use of generic drugs when available. 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). ■

**TABLE
14-14**

Generic dispensing rate by plan type and LIS status, 2007–2011

	2007	2008	2009	2010	2011
All Part D	61%	67%	70%	74%	77%
By plan type					
PDP	60	66	69	72	75
MA–PD	66	71	74	77	80
By LIS status					
LIS	60	65	68	71	74
Non-LIS	62	69	72	76	79

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.

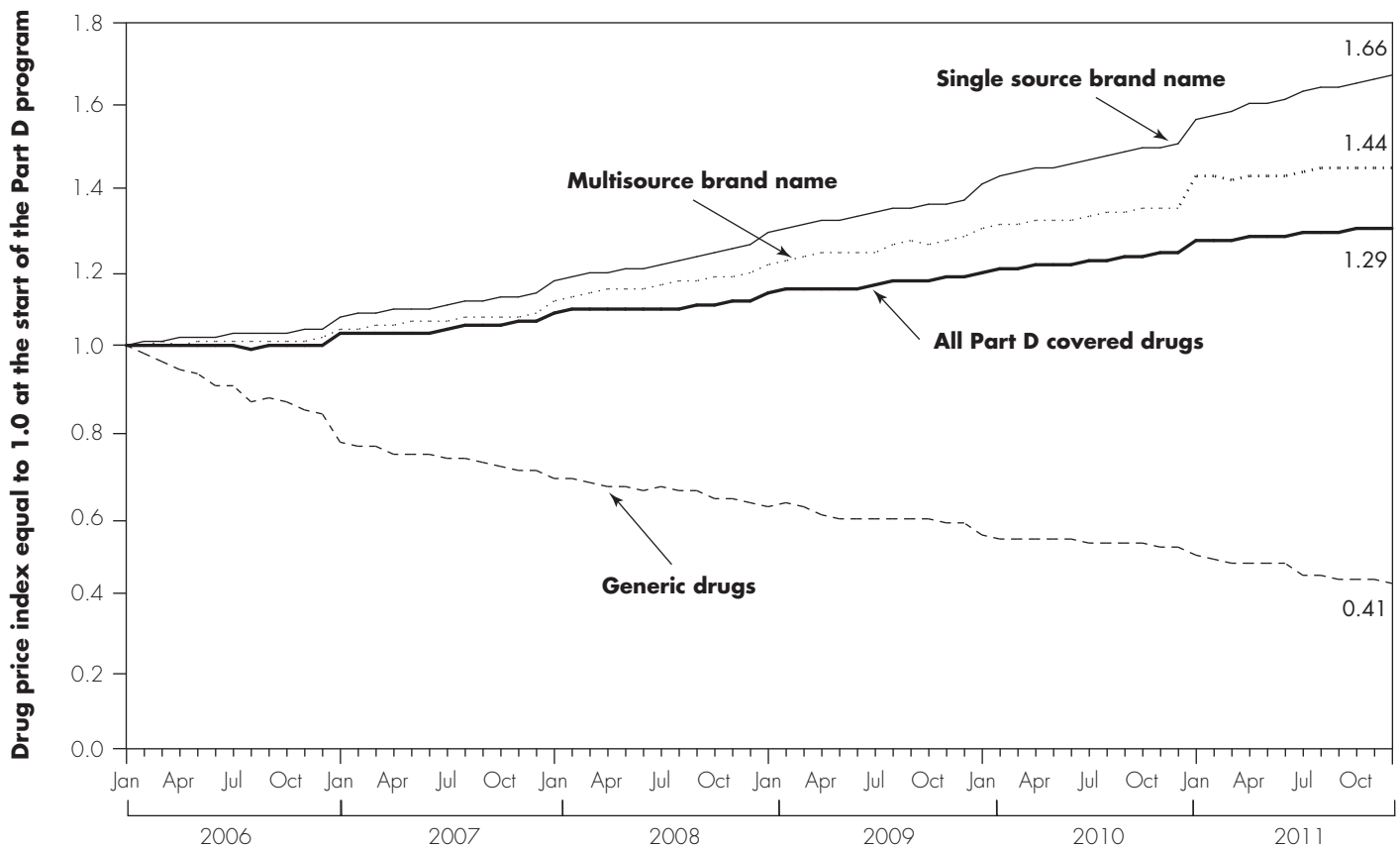
Source: MedPAC analysis of Medicare Part D prescription drug event data and Part D denominator file from CMS.

of the benefit for which sponsors bear the most insurance risk has been decreasing, while the payments for which sponsors bear little or no insurance risk has been growing rapidly (see text box on changing priorities for sharing risk, p. 362).

The higher growth in the reinsurance component of the bid in most years since 2011 may, in part, be due to PPACA’s gradual phase-out of the coverage gap. Part D reconciliation data through 2012 shows a larger net payment from Medicare to plans for the individual

**FIGURE
14-6**

Sustained aggressive price growth under Part D for single-source brand-name drugs



Note: The price index is a chain-weighted Fisher price index. Drug price index is equal to 1.0 at the start of Part D.

Source: Acumen, LLC analysis for MedPAC.

reinsurance in 2011 and 2012, suggesting plans underestimated the amount of spending in the catastrophic phase of the benefit.

In 2014, the base beneficiary premium is \$32.42, an increase of 4 percent from \$31.17 in 2013 (Table 14-15). The actual average monthly premium in 2014 differs from the base beneficiary premium since it depends on the beneficiary's plan choice. The base beneficiary premium reflects the basic portion of the benefit (the portion that does not include premiums for enhanced, or supplemental, benefits). The actual premium paid by individual beneficiaries is higher or lower depending on their selected plan's bid, their income level, and whether they are subjected to Part D's late enrollment penalty.

Quality in Part D

CMS collects quality and performance data for Part D plans to monitor sponsors' operations and help beneficiaries choose among plans. Plan ratings are displayed at www.medicare.gov, with the lowest rated plans 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 overall plan ratings used by the MA program to determine the amount of bonus payments.

CMS relies on several sources for these data—the Consumer Assessment of Healthcare Providers and Systems survey, agency monitoring of plans, data provided

**TABLE
14-15**

National average bid and components of average prospective monthly payments per enrollee for basic coverage, 2009-2014

	2009	2010	2011	2012	2013	2014
Amount in dollars						
National average monthly bid						
Base beneficiary premium	\$30.36	\$31.94	\$32.34	\$31.08	\$31.17	\$32.42
Monthly payment to sponsors	<u>53.97</u>	<u>56.39</u>	<u>54.71</u>	<u>53.42</u>	<u>48.47</u>	<u>43.46</u>
Subtotal	84.33	88.33	87.05	84.50	79.64	75.88
Expected individual reinsurance	<u>34.73</u>	<u>36.92</u>	<u>39.77</u>	<u>37.38</u>	<u>42.60</u>	<u>51.26</u>
Total average benefit cost	119.06	125.25	126.82	121.88	122.24	127.14
Annual percent change						
National average monthly bid						
Base beneficiary premium	8.7%	5.2%	1.3%	-3.9%	0.3%	4.0%
Monthly payment to sponsors	<u>2.6</u>	<u>4.5</u>	<u>-3.0</u>	<u>-2.4</u>	<u>-9.3</u>	<u>-10.3</u>
Subtotal	4.7	4.7	-1.4	-2.9	-5.8	-4.7
Expected individual reinsurance	<u>19.7</u>	<u>6.3</u>	<u>7.7</u>	<u>-6.0</u>	<u>13.9</u>	<u>20.3</u>
Total average benefit cost	8.7	5.2	1.3	-3.9	0.3	4.0

Note: These amounts reflect averages based on bids to provide basic Part D benefits; they do not net out subsequent reconciliation amounts with CMS. They were calculated from bids by plans to provide the defined standard benefit or actuarially equivalent basic benefits, as well as the portion of enhanced Part D coverage attributable to basic benefits. Enrollees in plans with enhanced coverage must pay the full price of benefits that supplement basic coverage. The combination of monthly payments to plans and expected payments for individual reinsurance makes up 74.5 percent of total average monthly benefit costs. Bids are fully weighted by prior year enrollment.

Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2009 through 2014, as well as other data provided by CMS.

by sponsors, and claims information (Centers for Medicare & Medicaid Services 2013c). For 2014, up to 15 metrics are grouped into four domains (Centers for Medicare & Medicaid Services 2013a):

- drug-plan customer service (three measures);
- member complaints, problems getting services, and improvement in the drug plan’s performance (four measures);
- member experience with the drug plan (two measures); and
- patient safety and accuracy of drug pricing (six measures).

The star ratings on Medicare’s web-based Plan Finder for MA-PDs are based on up to 48 measures, including measures that assess the quality of medical services

provided under Part C (i.e., the MA program), in addition to the measures used to assess the quality of prescription drug (Part D) services provided. Since 2012, CMS has put more emphasis on intermediate outcome measures—such as the use of medications 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. CMS aggregates individual scores for each measure (15 for PDPs and 48 for MA-PDs) on the Plan Finder under a 5-star system; 5 stars mean excellent performance, and 1 star reflects poor performance. CMS presents star ratings that combine individual scores in each domain as well as a summary rating that represents overall performance.

For 2014, ratings for both stand-alone PDP and MA-PD sponsors range from 2 stars to 5 stars. Weighted by enrollment, the average star rating among PDP sponsors is

3.04, compared with 3.3 for 2013, and the average among MA–PD sponsors is 3.84, compared with 3.66 for 2013 (Centers for Medicare & Medicaid Services 2013a). Much of the reduction in the average star rating among PDPs is attributable to contracts that are under CMS enrollment sanctions.³⁰ Ratings for contracts (only stand-alone PDPs) that are eligible to receive LIS autoassignments range from 2 stars to 4 stars, with no 5-star plans available. Compared with last year, fewer LIS plans have ratings below 3 stars, indicating potential improvement in quality.

Although star ratings for PDPs and MA–PDs are not directly comparable because the ratings are determined relative to other plans within the same plan type (PDP or MA–PD), the numeric averages that underlie individual measures allow for direct comparison of plan performances for each measure. For example, MA–PD sponsors were more likely to process appeals in a timely manner, and an external review entity was more likely to agree with coverage decisions made by MA–PDs compared with PDPs. MA–PDs were also less likely to use high-risk medications and more likely to follow recommended medication therapy for treating diabetes. PDPs, on the other hand, had fewer complaints from their enrollees and had higher adherence, on average, to medications to treat diabetes, hypertension, and high cholesterol. On other measures, such as members choosing to leave the plan and getting needed medications, the performances were about the same for both PDPs and MA–PDs.

Despite the shift in emphasis from process measures to outcome measures in rating plan quality and performance, we continue to be concerned about the quality of pharmaceutical care received by beneficiaries with multiple medications. They may have medical problems caused or exacerbated by their heavy use of medications (polypharmacy), and they are at increased risk of adverse drug events, drug-drug interactions, and use of inappropriate medications. As mentioned earlier, the current risk-sharing arrangement may limit how aggressively or successfully plan sponsors manage drug utilization for beneficiaries who take many medications (see text box on changing priorities for sharing risk, p. 362).

Part D plans are required to implement medication therapy management programs (MTMPs) to improve the quality of the pharmaceutical care that high-risk beneficiaries receive. However, 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). In a recent evaluation, CMS found low enrollment in the program, with only a minority of enrollees receiving comprehensive medication reviews. Nevertheless, the report found some improvement in medication adherence for those participating in the program (Marrufo et al. 2013). Although the program has the potential to increase the quality of pharmaceutical care provided under Part D, we currently do not have sufficient data to determine how well it is working. We will continue to monitor this program and revisit this issue in the future. ■

Endnotes

- 1 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 generics and brand-name drugs, and (3) reducing the OOP threshold on OOP spending over the 2014 to 2019 period.
- 2 In 2014, the Part D benefit provides coverage of 2.5 percent for brand-name drugs, in addition to the 50 percent discount provided by pharmaceutical manufacturers, reducing the cost sharing for drugs filled during the coverage gap to about 47.5 percent. The cost-sharing amount for brand-name drugs filled during the coverage gap depends on the amount of the dispensing fee charged by a plan since the 2.5 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.
- 3 The amount of total covered drug spending at which a beneficiary meets the annual OOP threshold depends on the existence of other sources of supplemental coverage and the mix of brand-name and generic prescriptions an individual fills during the coverage gap. In 2014, the amount of total drug expenses at the annual OOP threshold of \$6,690.77 is for an individual not receiving Part D's low-income subsidy and without other sources of supplemental coverage, assuming that expenses for brand-name drugs account for 86.2 percent of drug spending in the coverage gap. In 2012, 86.2 percent of spending below the OOP threshold by enrollees who did not receive low-income subsidies was for brand-name drugs.
- 4 Based on CMS's estimate as of October 2013.
- 5 Phone conversation with MAXIMUS on August 20, 2013.
- 6 The prescription drug coverage 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 at least as generous as Part D's basic benefit.
- 7 In 2014, maximum cost-sharing amounts for full-benefit dual-eligible beneficiaries with income at or below 100 percent of the federal poverty level are \$1.20 for generic drugs and \$3.60 for brand-name drugs. The amounts for other full-benefit dual-eligible beneficiaries are \$2.55 for generic drugs and \$6.35 for brand-name drugs. Institutionalized full-benefit dual-eligible beneficiaries do not pay any cost sharing.
- 8 If an employer agrees to provide primary drug coverage to its retirees with an average benefit value that is equal to or greater than Part D (called creditable coverage), Medicare provides the employer with a tax-free subsidy for 28 percent of each eligible individual's drug costs that fall within a specified range of spending. Under PPACA, employers still receive the RDS on a tax-free basis, but beginning in 2013, they can no longer deduct prescription 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).
- 9 The employer group waiver plans provide the standard Medicare Part D prescription drug coverage only to the Medicare-eligible retirees and covered Medicare-eligible dependents of the sponsoring employer.
- 10 Medicare allows plan sponsors to offer two types of plans that have the same average benefit value as the defined standard benefit. The first type, which CMS calls actuarially equivalent, uses the same deductible as the defined standard benefit but has different cost sharing during the plan's initial coverage phase. The second type, called basic alternative, allows insurers to use a lower deductible than the defined standard benefit, different cost sharing, and a modified initial coverage limit. Because they have the same average benefit value as the defined standard benefit, in this chapter, we refer to both types as actuarially equivalent benefits.
- 11 Enhanced benefit plans that include coverage for drugs filled during the gap must provide such coverage beyond what is required by PPACA.
- 12 Under the Part C payment system, which is used to pay MA plans, a portion (between 58 percent and 71 percent in 2013) 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.
- 13 *Prior authorization* refers to requirements for preapproval from a plan before coverage. *Quantity limits* refer to a plan limiting the number of doses of a particular drug covered in a given time period. Under step therapy, plans require the enrollee to try specified drugs before moving to other drugs.
- 14 The amount in controversy (AIC) must be greater than the specified dollar thresholds. For 2014, the AIC thresholds are \$140 and \$1,430 for ALJ and federal district court, respectively (Centers for Medicare & Medicaid Services 2013d).
- 15 At least 90 percent of urban beneficiaries must live within 2 miles of an in-network pharmacy; at least 90 percent of

- suburban beneficiaries must live within 5 miles, and at least 70 percent of rural beneficiaries must live within 15 miles.
- 16 For this analysis, we considered plans as having a preferred network only if the network included both preferred and nonpreferred pharmacies and there was differential cost sharing for the two types. Some plans report having preferred pharmacies in their network, but either they consider all in-network pharmacies as preferred or they have no cost-sharing differential between preferred and nonpreferred pharmacies. Those plans were excluded from this analysis because they did not meet both tests of a preferred network.
 - 17 In a proposed rule published on January 6, 2014, CMS proposes to revise the definition of negotiated prices to require all price concessions from pharmacies to be reflected in negotiated prices. This policy is intended to standardize the reporting of costs and to ensure that plans are in compliance with CMS's regulation requiring that any reduction in cost sharing not increase CMS payments to plans.
 - 18 Preferred and nonpreferred cost-sharing differentials are based on cost-sharing amounts for Region 12 (Alabama–Tennessee region) when available. Some plan offerings have slight differences in cost sharing from region to region. All plans have a specialty tier but none varied cost sharing on the specialty tier.
 - 19 CMS allows a sponsor to offer multiple plans in any given service area only if those offerings are substantially different from one another. In order to be considered “substantially different,” for 2014 plans must have a difference of at least \$21 per month in a beneficiary's expected monthly OOP costs between basic and enhanced plans. If a sponsor is offering two enhanced plans in the same service area, in 2014 the second enhanced plan must have a higher value than the first, with a difference of at least \$18 in a beneficiary's expected monthly OOP costs between the two enhanced plan offerings.
 - 20 The number of LIS benchmark plans (352 PDPs) includes 27 SmartD Rx plans and 31 Silverscript plans that are under CMS sanctions and are therefore not eligible to receive LIS reassignments.
 - 21 E-mail communication with CMS staff, December 4, 2013.
 - 22 The actual cost-sharing amount for brand-name drugs will depend on the amount of the dispensing fee charged by a plan since the 2.5 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.
 - 23 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 5 percent between 2013 and 2014.
 - 24 The share of all formulary generic drugs on nonpreferred tiers among PDPs that use a nonpreferred-generic tier is higher (over 80 percent) when weighted by enrollment.
 - 25 Lower subsidy rates apply to higher income beneficiaries. For more information, refer to the section on premiums.
 - 26 Many high-priced medications are biologics—that is, drug products derived from living organisms. They are often used to treat diseases like cancer, anemia, chronic kidney disease, rheumatoid arthritis, and multiple sclerosis. These products generally have high launch prices, and the lack of competition has made it difficult for both public and private payers to negotiate lower prices with manufacturers.
 - 27 An individual NDC uniquely identifies the drug's labeler, drug, dosage form, strength, and package size. Because each drug often is available in different dosages, strengths, and package sizes, the same drug typically has many different NDCs.
 - 28 For this index, Acumen groups 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.
 - 29 In a proposed rule published on January 6, 2014, CMS proposes to remove three classes—antidepressants, antipsychotics, and immunosuppressants for transplant rejection—from the protected status.
 - 30 As of December 2013, two plans, the SmartD Rx PDPs and the SilverScript PDPs, with a combined enrollment of nearly 3.5 million in 2013, are under CMS sanctions and are banned from accepting new enrollees.

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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 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 2015 to 2017.
- increase payment rates for the acute care hospital inpatient and outpatient prospective payment systems in 2015 by 3.25 percent, concurrent with the change to the outpatient payment system discussed above and with initiating the change to the long-term care hospital payment system.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Abstain: Kuhn

Chapter 4: Physician and other health professional services

The Commission reiterates its standing position on improving Medicare's payments to physicians and other health professionals. See pp. 112–114.

Chapter 5: Ambulatory surgical center services

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2015. The Congress should also require ambulatory surgical centers to submit cost data.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 6: Outpatient dialysis services

6-1 The Congress should not increase the outpatient dialysis payment rate for calendar year 2015.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

6-2 The Congress should direct the Secretary to:

- include a measure that assesses poor outcomes related to anemia in the End-Stage Renal Disease Quality Incentive Program.
- redesign the low-volume payment adjustment to consider a facility's distance to the nearest facility.
- audit dialysis facilities' cost report data.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 7: Post-acute care providers: Steps toward broad payment reforms

The Congress should direct the Secretary to implement common patient assessment items for use in home health agencies, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals by 2016.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 8: Skilled nursing facility services

The Commission reiterates its previous recommendation on updating Medicare's payments to skilled nursing facilities. See text box, p. 204.

Chapter 9: Home health care services

The Congress should direct the Secretary to reduce payments to home health agencies with relatively high risk-adjusted rates of hospital readmission.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Additionally, the Commission reiterates its previous recommendations on improving the home health payment system. See text box, pp. 234–236.

Chapter 10: Inpatient rehabilitation facility services

The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2015.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, 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 2015.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

The Commission's recommendation for long-term care hospital payment reform is included with its acute care hospital update recommendation, Chapter 3.

Chapter 12: Hospice services

The Congress should eliminate the update to the hospice payment rates for fiscal year 2015.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 13: The Medicare Advantage program: Status report

13-1 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.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

13-2 The Congress should include the Medicare hospice benefit in the Medicare Advantage benefits package beginning in 2016.

Yes: Armstrong, Baicker, Butler, Chernew, Christianson, Coombs, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

Chapter 14: Status report on Part D

No recommendations

Acronyms

Acronyms

AAGR	average annual growth rate	CBSA	core-based statistical area
AARP	(formerly) American Association of Retired Persons	CC	complication or comorbidity
ABIM	American Board of Internal Medicine	CCI	chronically critically ill
ACC	American College of Cardiology	CCP	coordinated care plan
ACCF	American College of Cardiology Foundation	CCU	cardiac care unit
ACH	acute care hospital	CDC	Centers for Disease Control and Prevention
ACO	accountable care organization	CEO	chief executive officer
ADL	activity of daily living	CHS	Community Health Systems
AEP	annual election period	CHF	congestive heart failure
AHA	American Hospital Association	CHIP	Children’s Health Insurance Program
AHCA	American Health Care Association	CKD	chronic kidney disease
AHRQ	Agency for Healthcare Research and Quality	CMG	case-mix group
AIC	amount in controversy	CMI	case-mix index
AIDS	acquired immunodeficiency syndrome	CMS	Centers for Medicare & Medicaid Services
AKF	American Kidney Fund	CMS–HCC	CMS–hierarchical condition category
ALJ	administrative law judge	CON	certificate of need
ALOS	average length of stay	COP	condition of participation
AMA	American Medical Association	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
ASC	ambulatory surgical center	CT	computed tomography
ASP	average sales price	DMARD	disease-modifying antirheumatic drug
ASPE	Assistant Secretary for Planning and Evaluation	DME	durable medical equipment
ATRA	American Taxpayer Relief Act of 2012	DRG	diagnosis related group
AV	arteriovenous	DSH	disproportionate share
B–CARE	Bundled Payments for Care Improvement Initiative–Continuity Assessment Record and Evaluation	DSH	disproportionate share hospital
BEA	Bureau of Economic Analysis	D–SNP	dual-eligible special needs plan
BLS	Bureau of Labor Statistics	DVT	deep vein thrombosis
BMI	body mass index	E&M	evaluation and management
BP	blood pressure	EBITDA	earnings before interest, taxes, depreciation, and amortization
<i>C. difficile</i>	<i>Clostridium difficile</i>	ED	emergency department
CAD	coronary artery disease	EEG	electroencephalography
CAH	critical access hospital	EGHP	employer group health plan
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®	EHR	electronic health record
CAHPS®–MA	Consumer Assessment of Healthcare Providers and Systems for Medicare Advantage	EKG	electrocardiogram
CARE	Continuity Assessment Record and Evaluation [tool]	EPS	earnings per share
CBO	Congressional Budget Office	ER	emergency room
		eRx	electronic prescribing
		ESA	erythropoiesis-stimulating agent
		ESI	employer-sponsored insurance
		ESRD	end-stage renal disease

FDA	Food and Drug Administration	IPPS	inpatient prospective payment system
FFS	fee-for-service	IPS	interim payment system
FIM™	Functional Independence Measure™	IRE	independent review entity
FY	fiscal year	IRF	inpatient rehabilitation facility
g/dL	grams per deciliter	IRF-PAI	Inpatient Rehabilitation Facility–Patient Assessment Instrument
GAO	Government Accountability Office	I-SNP	institutional special needs plan
GDP	gross domestic product	IV	intravenous
GDR	generic dispensing rate	KDE	kidney disease education
GI	gastrointestinal	KFF	Kaiser Family Foundation
HAC	hospital-acquired condition	LEP	late enrollment penalty
HCA	Hospital Corporation of America	LEP	limited English proficiency
H-CAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems	LIS	low-income [drug] subsidy
HCBS	home- and community-based services	LOS	length of stay
HCCI	Health Care Cost Institute	LPN	licensed practical nurse
HCFA	Health Care Financing Administration	LTCH	long-term care hospital
HEDIS®	Healthcare Effectiveness Data and Information Set®	LUPA	low utilization payment adjustment
HHA	home health agency	M&A	merger and acquisition
HHS	Department of Health and Human Services	MA	Medicare Advantage
HI	Hospital Insurance (Medicare Part A)	MAC	Medicare appeals council
HIT	health information technology	MACIEs	Medicare Ambulatory Care Indicators for the Elderly
HMO	health maintenance organization	MACPAC	Medicaid and CHIP Payment and Access Commission
HOPD	hospital outpatient department	MA-PD	Medicare Advantage–Prescription Drug [plan]
HOS	Health Outcomes Survey	MAC	Medicare Appeals Council
HPSA	health professional shortage area	MCBS	Medicare Current Beneficiary Survey
HPSP	Health Professionals Scholarship Program	MCC	major complication or comorbidity
HQA	Hospital Quality Alliance	MDS	Minimum Data Set
HQID	Medicare Hospital Quality Incentive Demonstration	MedPAC	Medicare Payment Advisory Commission
HRET	Health Research and Educational Trust	MedPAR	Medicare Provider Analysis and Review [file]
HRR	hospital referral region	MEI	Medicare Economic Index
HRRP	Hospital Readmissions Reduction Program	MEPS	Medical Expenditure Panel Survey
HTN	hypertension	MGMA	Medical Group Management Association
HUD	Department of Housing and Urban Development	MHA	Missouri Hospital Association
HWH	hospital within hospital	MIPPA	Medicare Improvements for Patients and Providers Act of 2008
ICD-9	International Classification of Diseases, Ninth Revision	MLR	medical loss ratio
ICL	initial coverage limit	MMA	Medicare Prescription Drug, Improvement, and Modernization Act of 2003
ICU	intensive care unit	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
IGC	impairment group code	MRI	magnetic resonance imaging
IME	indirect medical education	MRSA	methicillin-resistant staphylococcus aureus
IMRT	intensity-modulated radiation therapy	MS-DRG	Medicare severity–diagnosis related group
IOL	intraocular lens		
IOM	Institute of Medicine		

MS-LTC-DRG	Medicare severity long-term care diagnosis related group	PFFS	private fee-for-service
MSS	medical social services	PFS	physician fee schedule
MTMP	medication therapy management program	PLI	professional liability insurance
N/A	not applicable	POS	provider of services
N/A	not available	PPACA	Patient Protection and Affordable Care Act of 2010
NALTH	National Association of Long Term Hospitals	PPO	preferred provider organization
NAMCS	National Ambulatory Medical Care Survey	PPS	prospective payment system
NASBO	National Association of State Budget Officers	PQRS	Physician Quality Reporting System
NBER	National Bureau of Economic Research	PSI	patient safety indicator
NCQA	National Committee for Quality Assurance	QIO	Quality Improvement Organization [Medicare]
NDC	national drug code	QIP	quality incentive program
NHSN	National Healthcare Safety Network	RAS	renin angiotensin system
NP	nurse practitioner	RDS	retiree drug subsidy
NSAS	National Survey of Ambulatory Surgery	RUG	resource utilization group
NTA	nontherapy ancillary	RVU	relative value unit
NTIOL	new technology intraocular lens	SCHIP	State Children's Health Insurance Program
OACT	Office of the Actuary	SGR	sustainable growth rate
OASIS	Outcome and Assessment Information Set	SMI	Supplementary Medical Insurance (Medicare Part B and Part D)
OECD	Organisation for Economic Co-operation and Development	SNF	skilled nursing facility
OIG	Office of Inspector General	SNP	special needs plan
OMB	Office of Management and Budget	SSI	Supplemental Security Income
OOP	out-of-pocket	SSI	surgical site infection
OPPS	outpatient prospective payment system	SSO	short-stay outlier
OR	operating room	TCM	transitional care management
PA	physician assistant	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
PAC	post-acute care	TEP	technical expert panel
PAC-PRD	Post-Acute Care Payment Reform Demonstration	TTY	teletypewriter
PBP	plan benefit package	TTY/TDD	teletypewriter/telecommunications device for the deaf
PCIP	Primary Care Incentive Payment [program]	U.S.	United States
PD	peritoneal dialysis	USRDS	United States Renal Data System
PDE	prescription drug event	UTI	urinary tract infection
PDP	prescription drug plan	VBP	value-based purchasing [program]
PE	practice expense	VSSO	very short-stay outlier
PE	pulmonary embolism		

More about MedPAC

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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 professor of health economics in 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. Dr. Baicker has served on the faculty of the Department of Public Policy in the School of Public Affairs at the University of California, Los Angeles; the Economics Department at Dartmouth College; and the Center for the Evaluative Clinical Sciences and the Department of Community and Family Medicine at Dartmouth Medical School. 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, 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 and was a member of the Institute of Medicine's Committee on Health Insurance Status and Its Consequences. She received her B.A. in economics from Yale University and her Ph.D. in economics from Harvard University.

Peter W. Butler, M.H.S.A., is a nationally recognized health care executive with more than 30 years of experience in academic medical centers and health care systems. In addition to being president and chief operating officer of Rush University Medical Center in Chicago, IL, Mr. Butler is an associate professor and chairman of the Department of Health Systems Management at Rush University. Before joining Rush, he served as president and chief executive officer at the Methodist Hospital System in Houston and senior vice president and chief administrative officer at the Henry Ford Health System in Detroit. He has chaired the board of University HealthSystem Consortium, the board of the National Center for Healthcare, and the AHA section for Health Care Systems. He has also served on the boards of the Health Research and Educational Trust as well as the Texas and Michigan hospital associations.

Michael Chernew, Ph.D., is the Leonard D. Schaeffer Professor of Health Care Policy in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research activities focus on several areas, most notably the causes and consequences of growth in health care expenditures, geographic variation in medical spending and use, and value-based insurance design. He is a member of the Congressional Budget Office's Panel of Health Advisors and Commonwealth Foundation's Commission on a High Performance Health System. In 2000, 2004, and 2011, he served on technical advisory panels for the Centers for Medicare & Medicaid Services that reviewed the assumptions used by the Medicare actuaries to assess the financial status of the Medicare trust funds. Dr. Chernew is a faculty research fellow of the National Bureau of Economic Research. He coedits the *American Journal of Managed Care* and is a senior associate editor of *Health Services Research*. In 2010, Dr. Chernew was elected to the Institute of Medicine (IOM) of the National Academy of Sciences and served on the IOM Committee on Determination of Essential Health Benefits. Dr. Chernew earned his undergraduate degree from the University of Pennsylvania and a doctorate in economics from Stanford 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.

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 immediate 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.

George N. Miller, Jr., M.H.S.A., has, over the past two decades, managed a series of hospitals, leading financial turnarounds at four of them. Mr. Miller is chief executive officer of CommUnityCare, a network of health centers in Travis County, Texas. Previously, he was the chief executive officer of Okmulgee Memorial Hospital in Okmulgee, OK; the president and chief executive officer of First Diversity Healthcare Group, a national health care consulting firm helping health care organizations improve their operations; and the regional president and chief executive officer of Community Mercy Health Partners and senior vice president of Catholic Health Partners, a hospital chain in the Springfield, OH, area. He has run hospitals in Illinois, Oklahoma, Texas, and Virginia and is a past president of the National Rural Health Association. Mr. Miller has been an adjunct professor for the Master's of Health Care Services Administration for Central Michigan University since 1998. He has an undergraduate degree in business administration from Bowling Green State University and a master of science in health services administration from Central Michigan University.

Mary Naylor, Ph.D., R.N., F.A.A.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. Since 1989, 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

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