Executive summary

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

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2016 for hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- review the prospects for reform across Medicare's payment systems for post-acute care.
- review the status of the MA plans that beneficiaries can join in lieu of traditional FFS Medicare.
- review the status of the plans that provide prescription drug coverage (Part D).

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

We recognize that managing updates and relative payment rates alone will not solve what has been the fundamental problem with Medicare FFS payment systems to date—that providers are paid more when they deliver more services without regard to the value of those additional services. To address that problem directly, two approaches must be pursued. First, payment reforms, such as incentives to reduce excessive hospital readmission rates, need to be implemented more broadly and coordinated across settings. Second, delivery-system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care—such as medical homes, bundling, accountable care organizations, and MA plans—need to be monitored and successful models adopted on a broad scale.

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

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

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

Context for Medicare payment policy

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

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

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

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

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

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

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

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

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

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

These update recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover providers' costs for efficiently delivering care not only help create fiscal pressure on all providers to control their costs but also help create pressure for broader reforms to address what has traditionally been the fundamental problem of FFS payment systems—that providers are paid more when they deliver more services regardless of the value of those additional services. Broader reforms such as bundled payments and accountable care organizations are meant to

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

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

Hospital inpatient and outpatient services

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

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

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

Payment rates also differ for similar patients in acute care hospitals and LTCHs. LTCHs are currently paid much higher rates than traditional acute care hospitals, even for patients who do not require an LTCH's specialized services. To correct this problem, we recommended a new criterion for patients receiving higher level LTCH payments. Chronically critically ill (CCI) patients (defined as those who spent eight or more days in an intensive care unit during an immediately preceding acute care hospital stay) would still qualify for the relatively high LTCH payment rates. (Current law specifies a three-day threshold.) In contrast, non-CCI patients at LTCHs would receive inpatient prospective payment system (IPPS) standard payment rates. The reduction in LTCH rates for non-CCI cases would generate savings that would be transferred to acute care hospitals in the form of higher outlier payments for the most costly CCI cases.

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

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

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

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

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

This package of changes will improve incentives in the system to care for patients in the most appropriate setting and ensure that funding in the acute care hospital systems is adequate to provide high-quality care for Medicare beneficiaries.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services in a variety of settings. In 2013, Medicare paid $68.6 billion for physician and other health professional services. About 876,000 clinicians billed Medicare—573,000 physicians and 303,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

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

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

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

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

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

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

An additional issue is that Medicare's Primary Care Incentive Payment program (PCIP) expires at the end of 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for primary care services provided by eligible primary care practitioners. Allowing the program to expire without replacement could send a poor signal to those primary care practitioners. While Medicare beneficiaries generally have good access to care now, future access could be at risk because of the aging of the population and the health care workforce and because of the increased use of services by the newly insured. The Commission recommends that the additional payments to primary care practitioners should continue; however, they should be in the form of a per beneficiary payment as a step away from the fee-for-service payment approach and toward beneficiary-centered payments that encourage care coordination. The Commission recommends funding the per beneficiary payment by reducing fees for all services in the fee schedule other than PCIP-defined primary care services (those services could be provided by any practitioner, regardless of specialty designation or whether those services accounted for at least 60 percent of the practitioner's allowed charges). Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the PCIP. This method of funding would be budget neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services.

Ambulatory surgical center services

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

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

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

Medicare margin as we do for other provider types to help assess payment adequacy.

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

Outpatient dialysis services

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

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

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

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

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

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

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

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

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

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

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

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

Skilled nursing facility services

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

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

- Access to SNF services remains adequate for most beneficiaries. The number of SNFs participating in the Medicare program is stable. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Available bed days increased slightly. Days and admissions per FFS beneficiary declined between 2012 and 2013, consistent with declines in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services).
- Quality measures show mixed performance. Between 2012 and 2013, the community discharge and readmission measures improved, and the functional change measures were essentially unchanged.
- Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Access to capital was adequate in 2013 and is expected to remain so. Medicare is regarded as a preferred payer for SNF services.
- In 2013, the average Medicare margin was 13.1 percent—the 14th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities, depending on the share of intensive therapy days, facility size, and cost per day. The variations in Medicare margins and costs per day were not attributable to differences in patient demographics. The projected 2015 Medicare margin is 10.5 percent.
- In 2013, about 500 freestanding facilities provided relatively low-cost and high-quality care over 3 consecutive years and had Medicare margins averaging over 20 percent.

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

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

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

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

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid utilization, spending, and non-Medicare (private-pay and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities remained essentially unchanged between 2013 and 2014. In 2013, the average total margin, reflecting all payers and all lines of business, was 1.9 percent. The average non-Medicare margin was –1.9 percent.

Home health care services

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

The indicators of payment adequacy for home health care discussed in Chapter 9 are generally positive.

- Access to home health care is generally adequate: Over 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 97 percent live in a ZIP code with two or more agencies. In 2013, the number of agencies continued to increase, with a net gain of 302 agencies. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers. After years of rapid increases (between 2002 and 2013, the total number of episodes increased by 65 percent), the volume of services declined slightly in 2013. This trend is not surprising because Medicare inpatient admissions, an important source of referrals, have declined.

- Performance on quality measures did not change significantly. The share of beneficiaries reporting improvement in walking increased slightly in 2013, and the share of beneficiaries reporting improvement in transferring declined slightly. The share of beneficiaries hospitalized during their home health spell was 27.5 percent, similar to the rate in prior years.

- Access to capital is a less important indicator of Medicare payment adequacy for home health care because the service is less capital intensive than other health care sectors. The significant number of new agencies in 2013 suggests that adequate capital is available for start-ups.

- For more than a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies averaged 12.7 percent in 2013 and averaged 17 percent between 2001 and 2013. The Commission estimates that the Medicare margin for 2015 will be 10.3 percent.

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

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

Inpatient rehabilitation facility services

IRFs provide intensive rehabilitation services to patients after an injury, illness, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology, as well as prosthetic and orthotic devices. In 2013, Medicare spent $6.8 billion on IRF care provided in about 1,160 IRFs nationwide. About 338,000 beneficiaries had more than 373,000 IRF stays. On average, Medicare accounts for about 61 percent of IRFs' discharges.

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

- Our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand. Between 2012 and 2013, the number of IRFs remained fairly steady at just over 1,160 providers. The average IRF occupancy rate has hovered around 63 percent for the past several years, indicating that capacity is more than adequate to handle current demand for IRF services. Between 2012 and 2013, the number of Medicare cases treated in IRFs was stable at about 373,000 cases.
- All measures of IRF quality that the Commission tracks showed small improvements between 2011 and 2013.
- One major freestanding IRF chain that accounted for almost 40 percent of all freestanding IRFs in 2013 and about a quarter of all IRF discharges have very good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital. The parent institutions of hospital-based IRFs have maintained reasonable access to capital.
- In 2013, the aggregate Medicare margin remained steady at 11.4 percent. Financial performance continues to vary across IRFs, with margins of freestanding IRFs far exceeding those of hospital-based facilities. We project that IRFs' aggregate Medicare margin will be 12.6 percent in 2015.

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

Long-term care hospital services

LTCHs provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals, and its Medicare patients must have an average length of stay greater than 25 days. In 2013, Medicare spent $5.5 billion on care provided in LTCHs nationwide. About 122,000 beneficiaries had roughly 138,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges. Our findings on LTCH payment adequacy are discussed in Chapter 11.

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

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

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

Hospice services

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

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

- The number of hospice providers increased by more than 5 percent in 2013, almost entirely because of growth in the number of for-profit hospices. Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. The proportion of beneficiaries using hospice services at the end of life continued to grow, and average length of stay changed little in 2013.
- At this time, we do not have data to assess the quality of hospice care provided to Medicare beneficiaries. However, the Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014, and hospices have begun to report data on quality measures to CMS.
- Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a 9.6 percent increase in 2013) suggests capital is readily available to for-profit providers. Less is known about access to capital for nonprofit freestanding providers, for whom capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.
- The aggregate Medicare margin was 10.1 percent in 2012, up from 8.8 percent in 2011. The projected margin for 2015 is 6.6 percent.

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

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

The Medicare Advantage program: Status report

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

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

favor either MA or the traditional FFS program. Recent legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of competitive bidding and lower benchmarks has led to either improved efficiency or lower margins that enable MA plans to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

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

Medicare payments to plans for an enrollee are based on the plan's payment rate and the enrollee's risk score. The risk scores are based on diagnoses attributed to the beneficiary during the year before the payment year. To receive the maximum payment, plans have an incentive to ensure that providers record all diagnoses. Analyses have shown that MA plan enrollees have higher risk scores than otherwise similar FFS beneficiaries because of more complete coding. As mandated by the Deficit Reduction Act of 2005, CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding practices. We find that CMS would have to increase the coding adjustment (i.e., lower risk scores) by about 3 percent to make the aggregate level of coding in the FFS and MA programs roughly equal.

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

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

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

Status report on Part D

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

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

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

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

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

Between 2007 and 2013, Part D spending increased from $46.7 billion to $64.9 billion (an average annual growth rate of about 6.7 percent). In 2013, LIS payments continued to be the single largest component of Part D spending, while Medicare's reinsurance payments to plans remained the fastest growing component, at an average annual rate of about 16 percent between 2007 and 2013. Program spending for Part D reflects two underlying trends. First, a large number of patent expirations on widely used brand-name drugs has led to a shift toward use of generics in Part D, with generic drugs accounting for 81 percent of all prescriptions filled in 2012 compared with 61 percent in 2007. Second, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. In 2012, the share of enrollees who incurred spending high enough to reach the catastrophic phase of Part D's benefit decreased slightly. However, the share of high-cost enrollees who filled prescriptions for biologic products rose. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for individual reinsurance and for the LIS.

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

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