

M A R C H 2 0 1 3

**REPORT TO THE CONGRESS**

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# Medicare Payment Policy

**MEDPAC** Medicare  
Payment Advisory  
Commission

# MEDPAC Medicare 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](http://www.medpac.gov).) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

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

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425 Eye Street, NW • Suite 701 • Washington, DC 20001  
(202) 220-3700 • Fax: (202) 220-3759 • [www.medpac.gov](http://www.medpac.gov)





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

Glenn M. Hackbarth, J.D., Chairman  
Michael Chernew, Ph.D., Vice Chairman  
Mark E. Miller, Ph.D., Executive Director

March 15, 2013

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 2013 *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 15 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, such as improving the equity and efficiency of payments for major payment systems used by traditional Medicare, including a summary chapter on a more patient-centered approach to match services and settings to the needs of each patient across post-acute care settings;
- a chapter that updates the trends in enrollment, plan offerings, and payments in Medicare Advantage plans;
- a chapter that provides recommendations on the future of special needs plans within Medicare Advantage; and
- a chapter that updates the trends in enrollment and plan offerings for plans that provide prescription drug coverage.

In this report, we continue to make recommendations 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 this report, in light of our payment adequacy analyses, we recommend no update in 2014 for five fee-for-service payment systems and a 1 percent update for the hospital inpatient and outpatient 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 example, for skilled nursing facilities and home health agencies, we stand by our previous recommendations that would improve payment equity among providers serving different kinds of patients, lower payments over time, improve quality, and improve program integrity.

I would also draw your attention to Appendix B, which addresses a long-standing problem in Medicare: the sustainable growth rate (SGR) system (Medicare's method for updating physician fee schedule services). In this Appendix, we reproduce the Commission's October 2011 letter to the Congress in which we recommended repealing the SGR, replacing it with legislated updates that would no longer be based on an expenditure-control formula, improving equity among primary care and specialty services, and creating incentives to move to more organized health care delivery systems. It is critical for the Congress to act now to resolve the SGR. Delay will not leave the Congress with a better set of choices, providers' frustration with the SGR is increasing, and recent changes in scoring have substantially reduced the cost of repeal.

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

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## **Executive summary**

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## Executive summary

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

- consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product (GDP).
- evaluate payment adequacy and in some sectors make recommendations concerning Medicare FFS payment policy in 2014 for hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice.
- review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- make recommendations on the MA special needs plans.
- review the status of the plans that provide prescription drug coverage.

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Although this report addresses many topics to increase value, its principal focus is the Commission's recommendations on the annual rate updates for Medicare's various FFS payment systems.

We recognize that managing updates and relative payment rates alone will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. To address that problem directly, two approaches must be pursued. First, payment reforms—such as penalties for excessive readmission rates and linking some percentage of payment to quality outcomes—need to be implemented more broadly. Second, delivery system reforms that encourage high quality, better care transitions, and more

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

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

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

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

### Context for Medicare payment policy

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

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

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

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

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

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

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

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

As required by law, the Commission makes payment update recommendations annually for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a prospective payment system (PPS) is changed relative to the prior year. As described in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2013) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2014). As part of the process, we examine payment adequacy for an "efficient" provider to the extent possible. Finally, we make a judgment on what, if any, update is needed.

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

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

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

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

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

## Hospital inpatient and outpatient services

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

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

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

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

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

### **Physician and other health professional services**

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

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

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

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

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

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



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

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

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

### **Ambulatory surgical center services**

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

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

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

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

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

## Outpatient dialysis services

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

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

- Our measures suggest access is good. Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis patients. Between 2009 and 2011, use of dialysis injectable drugs, including erythropoietin-stimulating agents (ESAs), declined. Some of this decline stems from new clinical evidence that found that higher doses of ESAs—the leading class of dialysis drugs—led to increased risk of morbidity and mortality. In addition, some of this decline stems from providers realizing efficiencies under the modernized payment method.
- Dialysis quality has improved over time for some measures, such as use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during dialysis. Other measures, such as rates of hospitalization, suggest that improvements in quality are still needed.
- Access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase.
- Our analysis of Medicare payments and costs is based on 2011 claims data submitted by freestanding dialysis facilities to CMS and 2010 cost report data from freestanding dialysis facilities (the most current data available). We estimate that the Medicare margin for

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

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

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

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

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

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

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

## Skilled nursing facility services

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

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

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

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

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

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

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

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

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

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

### **Home health care services**

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

We find in Chapter 9 that the indicators of payment adequacy for home health care are generally positive.

- Access to home health care is generally adequate: Ninety-nine percent of beneficiaries live in a ZIP code where a Medicare home health agency operates, and 98 percent live in a ZIP code with two or more agencies. The number of agencies continues to increase, with over 700 new agencies and 12,199 total agencies in 2011. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers. In 2011, the volume of services was level, and total payments declined by about 5 percent, or \$1 billion. The decline in payments was attributable to a reduction in the Medicare base rate. The lower spending comes after several years of increases, as total spending between 2002 and 2011 increased by 92 percent. Between 2002 and 2010, the average number of 60-day episodes per

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

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

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

### **Inpatient rehabilitation facility services**

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

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

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

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

### Long-term care hospital services

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

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

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

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

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

### Hospice services

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

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

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

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

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

## The Medicare Advantage program: Status report

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

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

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

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

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

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

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

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

## **Medicare Advantage special needs plans**

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

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

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

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

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

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

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

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

### **Status report on Part D**

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

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

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

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



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

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

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

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



CHAPTER

1

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**Context for Medicare  
payment policy**

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# 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 accounts 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 2011, from 9.2 percent to 17.9 percent. Growth in spending slowed somewhat in 2010 and 2011. Though the causes of this slowdown are debated, the economic downturn beginning in 2008 has likely had an effect on health care spending, since fewer people have insurance and those with insurance may delay care because of cost concerns.

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

## In this chapter

- Growth in health care spending
- Growth in Medicare spending
- Health care and the federal budget
- Changes in the Medicare-eligible population
- Effects of growth in health care spending on individuals and families
- Variation in health care spending suggests inefficiencies
- Conclusion

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

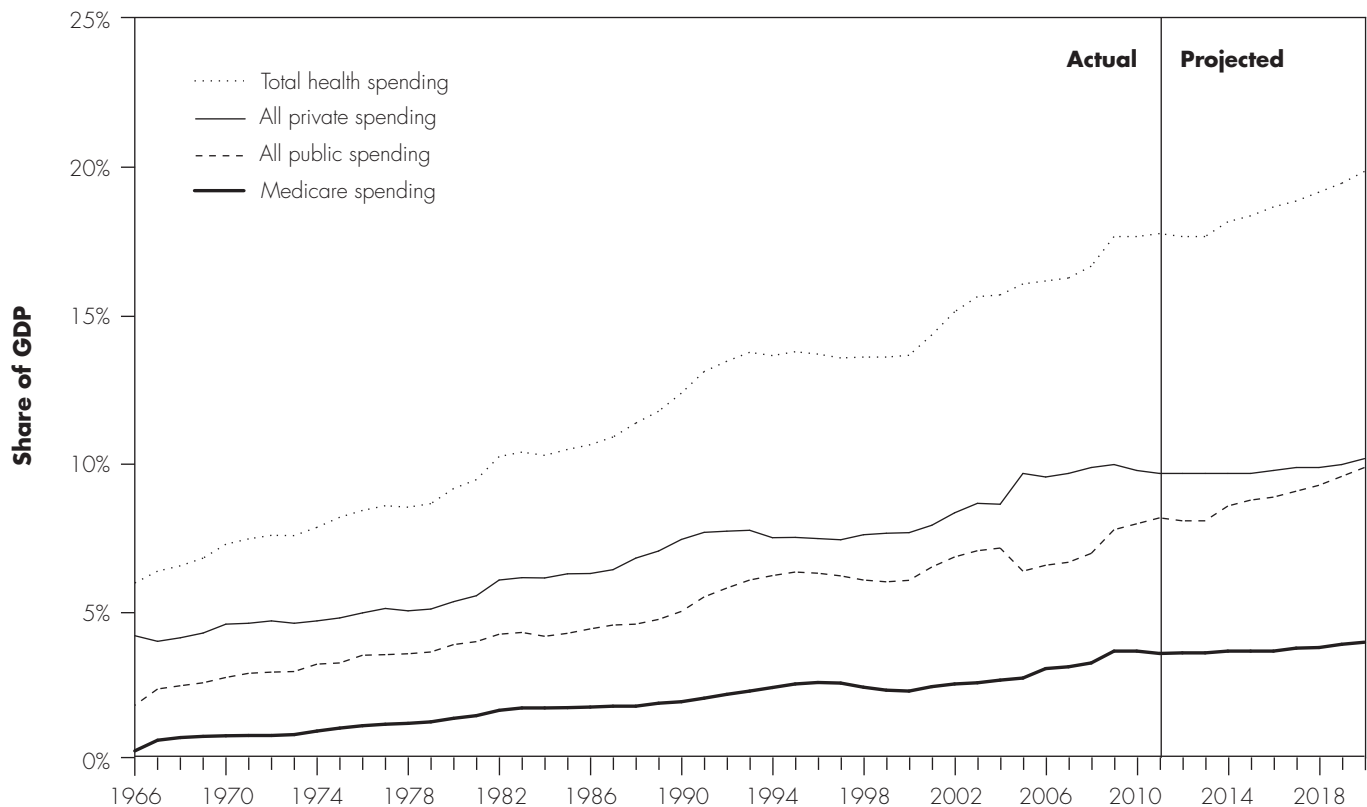
Growth in Medicare spending over the next 10 years is projected to be much smaller than in the past 10 years, while the number of Medicare beneficiaries will grow notably faster as the baby-boom generation ages into the program. The lower growth projections are largely due to policies in the Patient Protection and Affordable Care Act of 2010, including reduced updates of fee-for-service Medicare and lower payments to managed care plans. That said, the Hospital Insurance trust fund is projected to be exhausted by 2024, and the program still faces substantial deficits over the long term. Furthermore, the population aging into the Medicare program will present a new set of challenges since rising obesity levels put this population at a greater risk than previous generations for chronic disease.

There are indications that some share of health care dollars is 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 receive better quality care. In addition, despite higher per capita spending by the United States compared with other developed countries, the United States does not perform as well as these countries in the Organisation for Economic Co-operation and Development's internationally accepted health care quality measures. Finally, while minority Medicare beneficiaries represent a disproportionate share of high-spending beneficiaries, they tend to experience worse health outcomes.

Health care spending and growth in spending put pressure on government, family, and individual budgets. For the Medicare program, this pressure is particularly acute given the outlook for the federal budget and the projected increases in Medicare enrollment. Because the Medicare program pays for just over a fifth of all health care in the United States, it has an important influence on the shape of the health care delivery system as a whole. Therefore, it must pursue reforms that decrease 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). Medicare spending reflects current law, which includes the sustainable growth rate.

Source: Centers for Medicare & Medicaid Services, National Health Expenditures.

**Introduction**

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

- the growth in health 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 spending affects current and future federal and state budgets;
- the effect of growth in health care spending on individuals and families; and
- variation in health spending and quality of care, indicators that suggest health care dollars may be substantially misspent or misallocated.

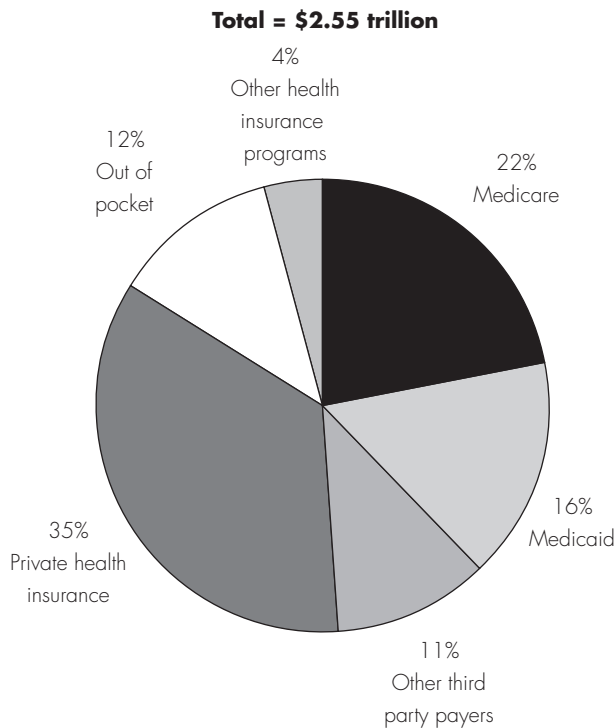
Taken together, these points about the levels and growth of health care spending undergird the Commission’s payment update recommendations and its call for payment reforms.

**Growth in health care spending**

High growth in health care spending significantly affects individuals and families, providers, and payers (public, private, and individual). Much research has been dedicated to evaluating the level of spending and drivers of growth in health spending (see text box on pp. 8–9 for further discussion). The average growth rate of per capita health care spending has annually exceeded that of per capita gross domestic product (GDP) by about 2.6 percentage points since the 1960s. In 2011, health care spending accounted for 17.9 percent of GDP, nearly twice what it was in 1980 (9.2 percent of GDP) (Figure 1-1) (Martin et

**FIGURE 1-2**

**Share of health consumption expenditures, 2011**



Note: "Other health insurance programs" includes Children's Health Insurance Program, Department of Defense, and Department of Veterans Affairs health care.

Source: CMS, National Health Expenditures, 2012.

al. 2012). Nearer term effects of growth in rates of health spending at this level include growth in premiums and out-of-pocket costs that exceed growth in wages and income, pressure on federal and state budgets as well as increased costs to employers, and the projected exhaustion of the Medicare Hospital Insurance trust fund in 2024.

**National health care spending**

In 2011, total U.S. health care spending reached \$2.7 trillion, or roughly \$8,700 per person, of which almost \$2.3 trillion was for personal health care.<sup>1</sup> The largest share of health spending for all payers was for hospital care (\$851 billion, or 37 percent of personal health care) and physician and clinical services (\$541 billion, or 24 percent). A smaller share went to spending on prescription drugs (\$263 billion, or 12 percent of personal health care), nursing home care (\$149 billion, or 7 percent), and home health services (\$74 billion, or 3 percent) (Hartman et al. 2013).

In 2011, spending by private payers, Medicare, and Medicaid accounted for 73 percent of health consumption expenditures, compared with 12 percent by individuals for out-of-pocket spending (Figure 1-2).

**Slowdown in health care spending since 2008**

Growth in health care spending has always matched or outpaced GDP growth. However, national health expenditure (NHE) data show a significant slowdown in health care spending in recent years. In 2009 and 2010, spending grew by 3.8 percent and 3.9 percent, respectively, the two slowest years of growth since NHE data were first tracked in 1960. Continuing this trend, growth was 3.9 percent in 2011, and national health care spending remained at 17.9 percent of GDP for the third year in a row (Hartman et al. 2013). However, this slowed growth (now equal to GDP) follows many years of growth significantly in excess of GDP (Figure 1-3).

Several factors caused the recent slowdown in spending (see text box on spending level and factors attributable to spending growth, pp. 8–9). First, aggregate spending on private health insurance declined because fewer people had insurance and uninsured people generally consume less health care (Newhouse and the Insurance Experiment Group 1993). Second, demand for health care also declined for those who remained insured, as reflected in the slowdown in out-of-pocket spending. However, prices did not slow down to the same extent (Health Care Cost Institute 2012a, Health Care Cost Institute 2012b).

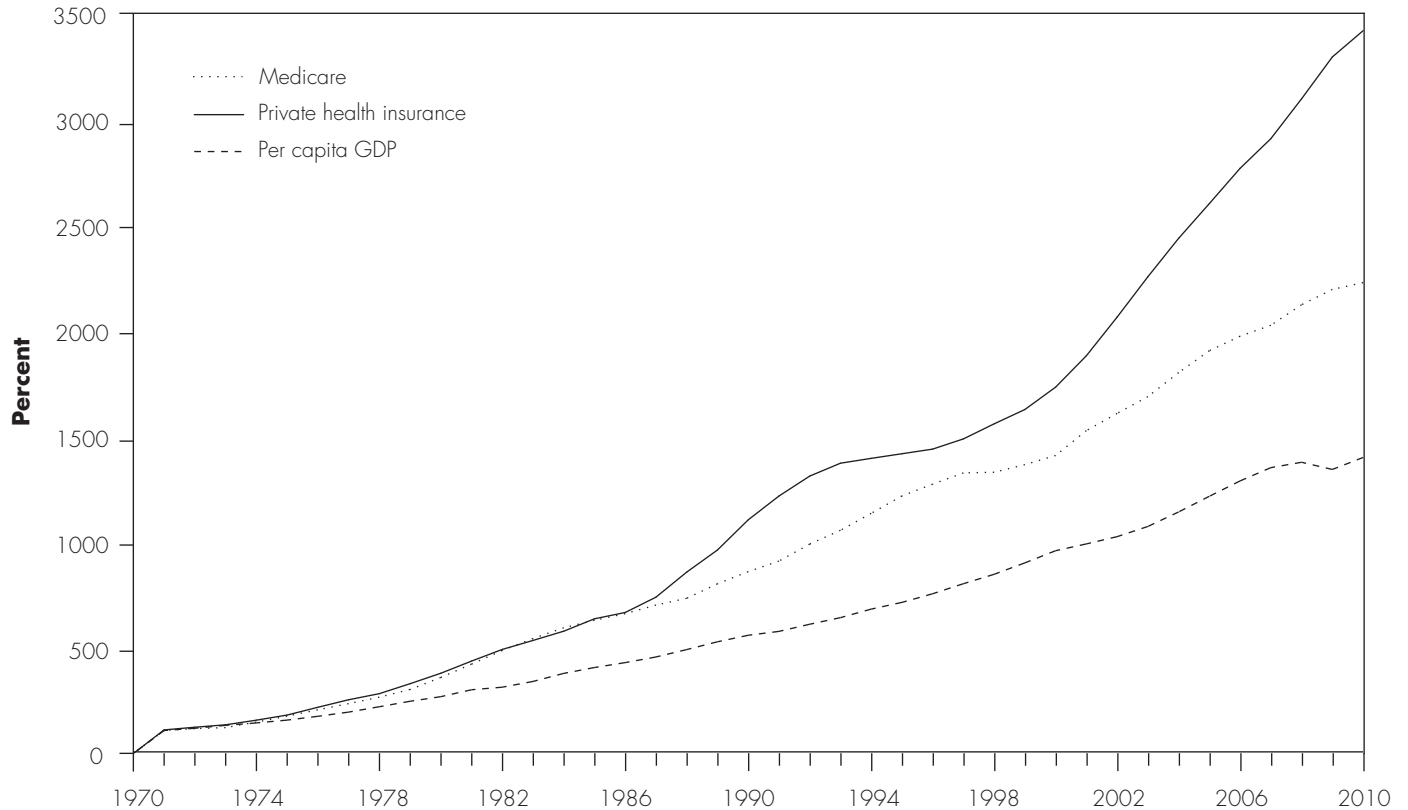
It is unclear whether this slowdown in health care spending is temporary or permanent, though its longevity would have major implications. Growth in health care spending has been shown to put pressure on wages, so if the long-term trend is slowed, it could help buoy wage growth (Auerbach and Kellermann 2011, Baicker and Chandra 2006, Goldman et al. 2005). If the slower growth in spending is temporary, then as the economy recovers, growth in health spending could rebound, which would create additional pressure on federal and state governments, third-party payers, and individuals. Regardless of whether the current slowdown is permanent or temporary, growth in health care spending has always matched or outpaced GDP growth and thus will likely continue to consume a greater share of GDP.

Some health policy analysts argue that the recent slowdown in health spending may be permanent. First, some data show a decline in growth in health care



**FIGURE  
1-3**

**Cumulative growth since 1970 for Medicare and private health insurance per enrollee and for per capita GDP**



Note: GDP (gross domestic product).

Source: Centers for Medicare & Medicaid Services, National Health Expenditures, 2012.

spending that predates the current recession (Roehrig et al. 2012). Second, some evidence exists of a slowdown in the pace of technology in certain sectors (e.g., fewer patents). Third, for many years, rising health care spending as a share of income (personal, state, and federal) has increased the pressure on payers to seek lower cost or more efficient health care (Health Care Cost Institute 2012a, Health Care Cost Institute 2012b, Lowrey 2012, Roehrig et al. 2012).

Other analysts expect that the slowdown may be short lived. Temporary slowdowns of this magnitude are not unprecedented. For example, growth rates in Medicare and private insurance were very low during the late 1990s (because of provider cuts in the Balanced Budget Act of 1997, historically low inflation and medical inflation, and the influence of managed care), but this slowdown was not sustained.

### Projections

The slowdown of growth in health care spending is likely to continue through 2013 because of continuing effects of the economic downturn. Continuing levels of unemployment, moderate recoveries in insurance coverage, and growth in disposable income are expected to continue to depress health spending.

Beginning in 2014, as a result of the Patient Protection and Affordable Care Act of 2010, 10-year projections from NHE data show the uninsured moving onto the rolls of Medicaid and private plans in the new state-based health insurance exchanges. Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) are projected to cover 44 percent of the population by 2020, compared with 34 percent in 2010 (Keehan et al. 2012).

## The level of health care spending and factors attributable to spending growth

National growth in health care spending in general and Medicare spending growth in particular are both driven by five main factors: technology, prices, changes in market structure, health insurance, and changes in demographics and patient characteristics (particularly in income and wealth). Health care spending trends are sensitive to each of these factors, and interaction among factors adds an additional layer of complexity to attributing causes of spending levels, growth, or slowdowns. In addition, the level of health care spending sets the baseline from which growth in spending is built. Thus we mention the level of spending as an aspect of some of the growth factors to note its effect on health spending.

- Technology is credited as having the largest single effect on growth in health care spending (with different studies attributing 38 percent to more than 65 percent of spending growth) (Cutler 1995, Newhouse 1992, Smith et al. 2009). Technology is broadly defined as the introduction, expansion, and diffusion of new interventions or treatments, changes in procedures or processes, or changes in the appropriate treatment population (Ginsburg 2008). In other words, technology includes not only new treatments but old treatments applied to

a different population or for a different purpose than originally intended. Downstream effects of technology include interventions that increase or reduce the use of other treatments (Chernew 2010, Cutler and McClellan 2001) and interventions resulting in higher survival rates for a previously terminal condition (McKinsey Global Institute 2008).

- Prices for health care products and services, both the level and growth, 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. 2003, Anderson et al. 2005, Laugesen and Glied 2011). Prices vary across geographic areas, payers, and providers and are rarely transparent; however, studies consistently cite growth in prices as a leading cause (between 10 percent and 25 percent) of health spending growth (Coakley 2011, Health Care Cost Institute 2012a, Health Care Cost Institute 2012b, Laugesen and Glied 2011).
- Changes in market structure among providers and insurers can affect the level of competition in a

*(continued next page)*

### Growth in Medicare spending

As with growth in national health care spending, Medicare spending growth also slowed between 2009 and 2010, with per beneficiary growth remaining largely flat and total Medicare growth nearly 3 percent. In 2009 and 2010, hospital inpatient admissions declined as did the volume of physician claims. In contrast, spending growth picked up somewhat in 2011 to 6.4 percent overall (2.5 percent due to enrollment growth and 3.8 percent growth in spending per beneficiary).<sup>2</sup>

Areas with notable growth in Medicare spending in 2011 included hospital outpatient services (8.4 percent growth per beneficiary), physician services (4.8 percent growth per beneficiary), and skilled nursing facilities (20.9 percent

growth per beneficiary). Spending on these services was attributable to increases in price, use, or intensity: For example, the rise in spending on skilled nursing facility services was due to a change in the prices paid by Medicare, while increased spending on hospital outpatient services reflected an increase in the number of services provided (Medicare Payment Advisory Commission 2012b).

### Spending for beneficiaries with chronic conditions

The number of beneficiaries with chronic conditions is an important component of Medicare's spending trajectory. Beneficiaries with certain chronic conditions make up a significant share of Medicare's spending. Among

## The level of health care spending and factors attributable to spending growth (cont.)

market and thus affect both the level of spending and spending growth. Hospitals and health insurers alike are increasingly consolidating. Evidence of the effects of provider and insurer consolidation on spending growth reveals a mixed picture for health spending. Markets with provider consolidation may have higher growth in health care spending (Vogt and Town 2006), and providers may obtain market power to negotiate higher payment rates—further advancing the increase in prices (Berenson et al. 2010, Berenson et al. 2012). On the other hand, insurance market concentration can decrease health spending because providers may have less leverage in negotiating prices where insurers are dominant (Moriya et al. 2010).

- Health insurance coverage, paired with a lack of complete information about appropriate treatment or value of interventions, removes 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). Recent studies of Oregon’s experiment in extending Medicaid
- 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. 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 the growth of health spending. ■

coverage by lottery showed that people randomly chosen for Medicaid coverage used services more—an estimated 25 percent more than the uninsured control group (Finkelstein et al. 2010). Given the positive correlation between coverage and use shown by this and other studies, we contend that the declining rate of insurance coverage over the past decade likely slowed the rate of growth in health spending. Factors such as increased cost sharing (deductibles, coinsurance, and copayments), changes in benefit design that encourage patients to seek low-cost care, and increased transparency of information on prices and quality could also have contributed to slower spending growth (Ginsburg 2008).

beneficiaries in the top decile of Medicare spending, nearly half had congestive heart failure, as compared with less than 15 percent in the overall Medicare population, and ischemic heart disease was twice as common. In addition, nearly twice as many individuals in the top decile of Medicare spending had diabetes (Medicare Payment Advisory Commission 2012a).

### Historical trends in chronic disease prevalence

Data reported by the Centers for Disease Control and Prevention from the National Health and Nutrition Examination Survey show mixed results on whether the prevalence of chronic disease has increased over time. For example, between 1997 and 2010, the proportion of individuals over age 65 who reported being told that they had heart disease remained relatively constant, at about

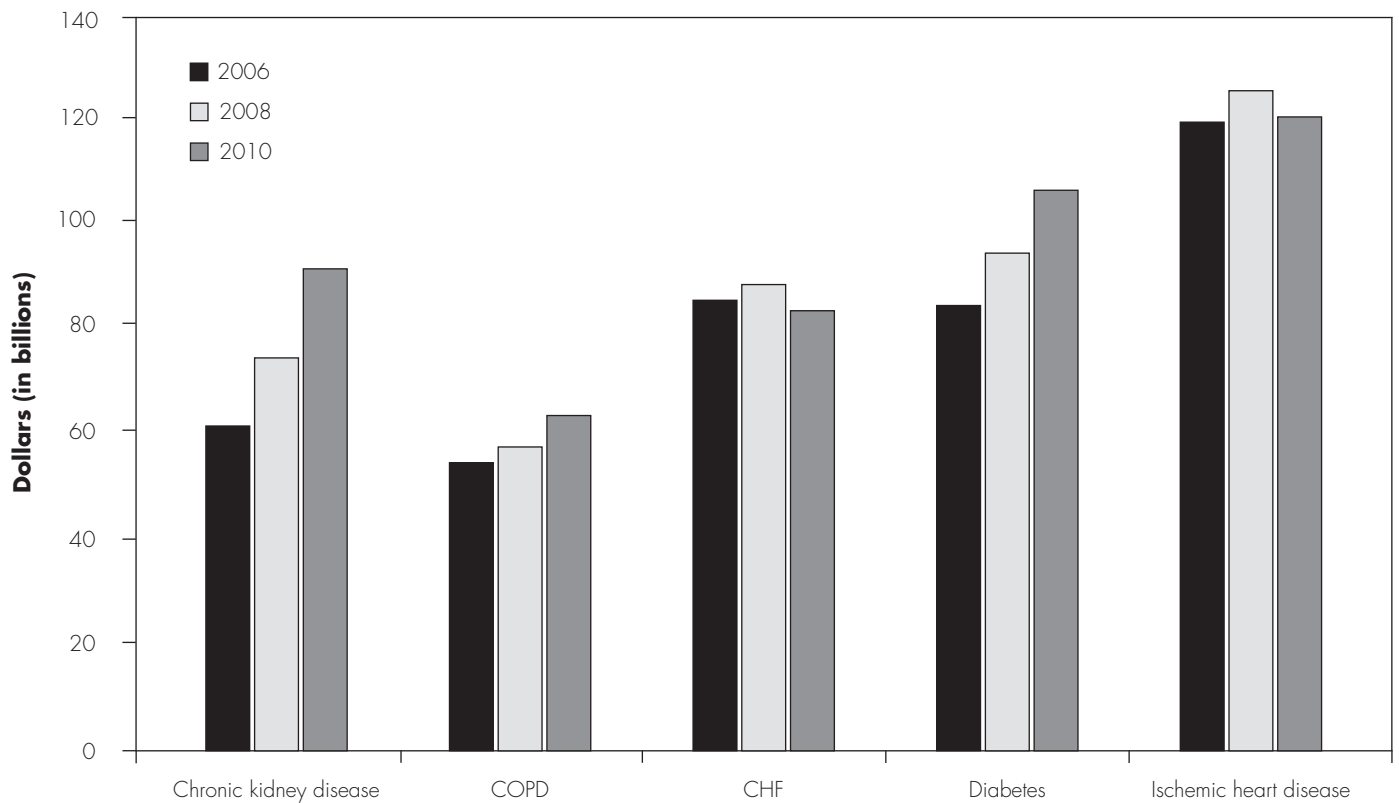
30 percent of the population. In contrast, during the same period, those reporting that they had cancer increased from 14 percent to 18 percent. Between 1988 and 2006, prevalence of diabetes among the Medicare population increased more significantly, from about 20 percent to 26 percent. On the other hand, rates of self-reported health status for individuals over age 65 improved during a similar time frame (1991 to 2010) as fewer beneficiaries (24 percent compared with 29 percent) reported that they were in fair or poor health (Centers for Disease Control and Prevention 2012a).

### Recent patterns in prevalence and spending per beneficiary in Medicare

Medicare spending for beneficiaries with chronic conditions is the function of the prevalence of disease and

**FIGURE  
1-4**

**Medicare spending on selected chronic conditions, 2006–2010**



Note: COPD (chronic obstructive pulmonary disorder), CHF (congestive heart failure). Only includes full-year fee-for-service enrollees. Beneficiaries may be included in more than one column.

Source: Beneficiary Annual Summary file.

**TABLE  
1-1**

**Prevalence of disease among Medicare beneficiaries**

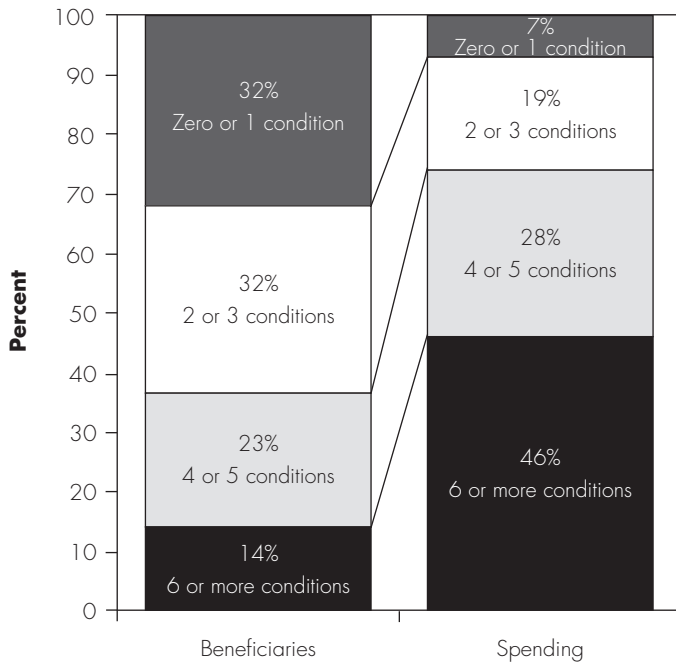
Condition	2006	2008	2010
<b>Chronic conditions</b>			
Chronic kidney disease	9%	11%	13%
Chronic obstructive pulmonary disease	10	10	10
Congestive heart failure	15	15	11
Diabetes	25	26	27
Ischemic heart disease	31	31	25
<b>Acute conditions</b>			
Acute myocardial infarction	1	1	1
Atrial fibrillation	7	7	7
Hip fracture	1	1	1
Stroke/transient ischemic attack	4	4	4

Note: Beneficiaries may be included in more than one category. Disease definitions based on Chronic Condition Data Warehouse definitions.

Source: MedPAC analysis of the Beneficiary Annual Summary files.

**FIGURE 1-5**

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



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

Source: Centers for Medicare & Medicaid Services. *Chronic conditions among Medicare beneficiaries. Chartbook: 2012 edition.*

the growth in spending per beneficiary with that disease. For example, spending on beneficiaries with chronic kidney disease and diabetes grew fastest among the major chronic conditions (Figure 1-4). The rise in spending for these two conditions is due to both rising spending per beneficiary (2 percent to 4 percent per year) and the prevalence of disease.

Spending on beneficiaries with congestive heart failure and ischemic heart disease remained relatively steady over time, but this spending is the function of a decline in the prevalence of those conditions, not a slowdown in spending per beneficiary. For other chronic diseases, the prevalence was relatively stable (Table 1-1).<sup>3</sup>

**Share of beneficiaries with multiple chronic conditions**

Beneficiaries who have multiple chronic conditions account for a greater share of Medicare spending than those with a single chronic condition or none. For example, in 2010, beneficiaries with six or more chronic conditions constituted only about 14 percent of the Medicare population but accounted for over 40 percent of Medicare spending (Centers for Medicare & Medicaid Services 2012). In contrast, those beneficiaries with zero or one chronic condition—about a third of the population—accounted for 7 percent of total Medicare spending (Figure 1-5).

Other research finds that the number of multiple chronic conditions reported by beneficiaries has increased over the past 10 years: A study assessing self-reported health status stated that 45 percent of individuals over age 65 reported having 2 or more of 9 chronic conditions, up from a third 10 years before (Centers for Disease Control and Prevention 2012a). Between 2000 and 2010, the rate of multiple chronic conditions among respondents ages 45 to 64 also grew from 16 percent to 21 percent, raising concern about those newly enrolling in Medicare.

The aging of Medicare beneficiaries will magnify trends in the prevalence of multiple chronic conditions. In general, older beneficiaries are more likely to have multiple chronic conditions (Table 1-2). In about 10 years, distribution of Medicare beneficiaries will shift upward in age. If

**TABLE 1-2**

**Percentage of Medicare FFS beneficiaries by number of chronic conditions, 2010**

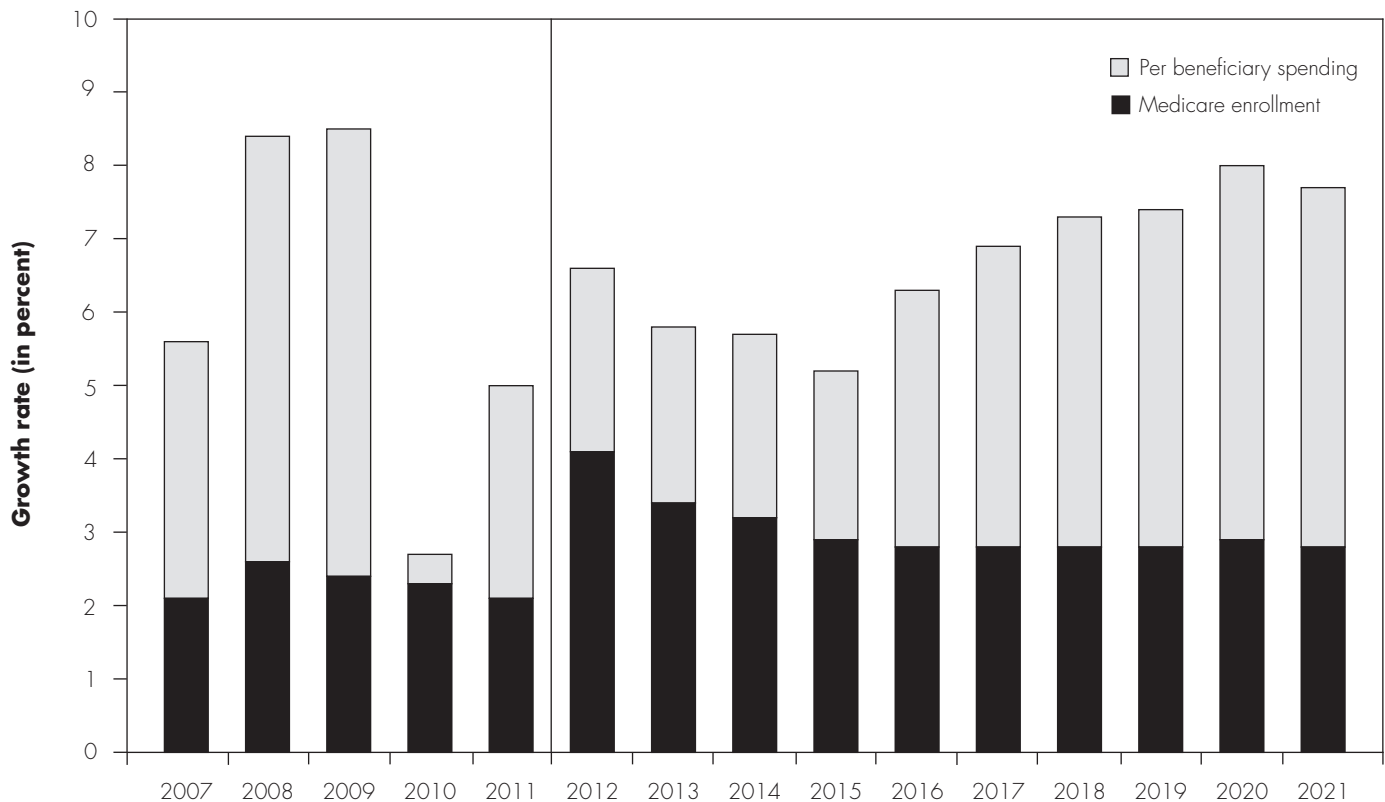
Number of chronic conditions	Age (in years)			
	Less than 65	65 to 74	75 to 84	85+ years
0 to 1	47%	37%	23%	17%
2 to 3	28	34	33	29
4 to 5	17	20	27	29
6 or more	9	9	18	25

Note: FFS (fee-for-service). Number of chronic conditions is based on counts of 15 selected conditions using the Chronic Condition Data Warehouse definitions. Totals may not sum to 100 percent due to rounding.

Source: Centers for Medicare & Medicaid Services. *Chronic conditions among Medicare beneficiaries. Chartbook: 2012 edition.*

**FIGURE  
1-6**

**Historical and projected growth rates for Medicare enrollment and per beneficiary spending**



Note: Assumes the sustainable growth rate formula is replaced with a 1 percent update.

Source: 2012 annual report of the Boards of Trustees of the Medicare trust funds.

the current pattern holds, the relatively older Medicare population may increase the number of beneficiaries needing treatment for multiple chronic conditions.

**Medicare spending over the next 10 years**

The Medicare Trustees project that Medicare spending will grow at an average annual rate of about 6.8 percent over the next 10 years, consisting of 3.9 percent per beneficiary growth and 2.9 percent enrollment growth (Figure 1-6), assuming that physician fees are updated by 1 percent per year starting in 2013, instead of the payment reductions mandated by the sustainable growth rate (SGR) formula. The Trustees also project that demand for health care (reflected by increases in both the units and intensity of service) will increase when the economic recession abates

(Boards of Trustees 2012) (See online Appendix 1-A at <http://www.medpac.gov> for further detail on Medicare spending trends).<sup>4</sup>

The Trustees predict that enrollment in Medicare Advantage (MA), which is Medicare’s managed care alternative under Part C of Medicare law, will peak in 2012 as payment reductions prescribed in the Patient Protection and Affordable Care Act of 2010 begin to have an impact on MA plans. By 2018, once the payment changes to the MA program are fully phased in, the Trustees estimate that about 17 percent of beneficiaries will remain on MA plans. Beneficiaries rejoining traditional fee-for-service Medicare will likely be in low-cost areas, slightly depressing fee-for-service costs (Boards of Trustees 2012).

## Medicare program spending and funding

Medicare's spending covers acute and post-acute care, ambulatory care, and prescription drugs (Table 1-3). The Medicare program is funded by premiums and cost sharing, payroll taxes, general revenue, and other sources (Table 1-4). General revenue alone accounts for 42 percent of Medicare's revenue (and consists of about 17 percent of all income taxes collected by the government) (Congressional Budget Office 2012).

- **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, starting in 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 Medicare's Supplementary Medical Insurance benefit**, which covers outpatient hospital

**TABLE 1-3**

**Medicare spending, 2011**

	Dollars (in billions)
<b>Total</b>	<b>\$549</b>
Inpatient hospital	133
Medicare Advantage	124
Physician fee schedule	68
Prescription drugs	67
Other Part B services	48
Outpatient hospital	35
Skilled nursing facilities	33
Home health	20
Hospice	15
Administration	8

Note: Individual dollar amounts may not sum to total due to rounding.

Source: 2012 annual report of the Boards of Trustees of the Medicare trust funds.

### Long-run Medicare projections

The Trustees project that by 2085, Medicare's share of GDP will increase from 3.7 percent today to 6.7 percent (see text box for a description of 2011 program financing and spending). Under an alternative set of assumptions—

**TABLE 1-4**

**Sources of Medicare revenue, 2011**

	Dollars (in billions)
<b>Total</b>	<b>\$530</b>
General revenue	223
Payroll taxes	196
Premiums	69
Interest from HI trust fund	15
Taxation of Social Security benefits	15
Transfers from states	7
Other	5

Note: HI (Hospital Insurance).

Source: 2012 annual report of the Boards of Trustees of the Medicare trust funds.

services and ambulatory care as well as some home health care under certain circumstances. Part B is financed through beneficiary premiums and general revenue. Since 2011, Medicare collects a fee from pharmaceutical manufacturers that also funds Part B.

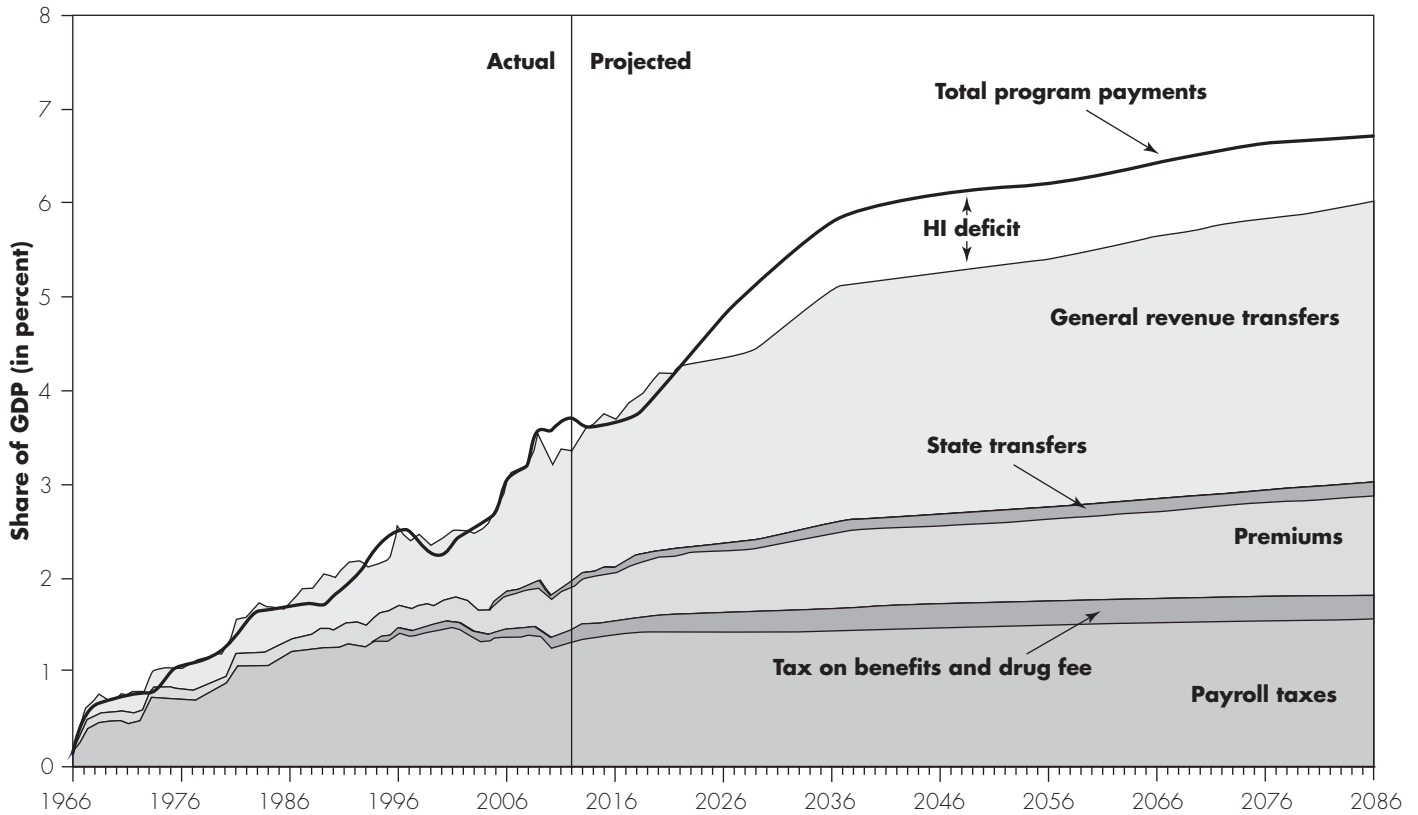
- **Part C is the Medicare Advantage (MA) program**, which contracts with private plans to offer Part A and Part B services. The MA program is funded through beneficiary premiums and transfers from Part A and Part B.
- **Part D is Medicare's Supplementary Medical Insurance benefit for outpatient pharmaceuticals**, which is financed through beneficiary premiums and general revenue.

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 in Part D. ■

including an override of the SGR cuts, 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

**FIGURE  
1-7**

**Medicare's long-term financing challenge**



Note: GDP (gross domestic product), HI (Hospital Insurance). 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 fee" refers to a tax on manufacturers and importers of brand-name prescription drugs, which is credited to the Part B trust fund.

Source: 2012 annual report of the Boards of Trustees of the Medicare trust funds.

of Trustees 2012). Part B spending alone is expected to grow from 1.5 percent of GDP in 2011 to 4.4 percent of GDP in 2080 under these alternative assumptions (Shatto and Clemens 2012).

The Hospital Insurance trust fund currently runs an annual deficit (i.e., currently pays more in benefits than it collects in revenues), and the trust fund assets are projected to be exhausted by 2024. A large share of Medicare's financing is projected to come from general revenues (Figure 1-7). As Medicare becomes more dependent on general revenue, there will be fewer resources available to finance other priorities and greater pressure to reduce spending or increase revenues.

## Health care and the federal budget

Because general revenues finance a large share of Medicare, its fiscal sustainability is tightly linked to that of the overall federal budget and vice versa. Between 2013 and 2035, Medicare's share of the nation's GDP will increase from 3.7 percent to 5.4 percent. This high growth rate reflects rising enrollment and increases in per beneficiary spending (Boards of Trustees 2012).

Over the next 10 years, growth in Medicare spending is projected to increase by about 70 percent, split about equally between enrollment (35 percent) and per beneficiary spending (35 percent) (Boards of Trustees



**TABLE  
1-5****Historical and projected annual growth rates  
for major components of the federal budget**

	<b>2002-2011 actual growth rates</b>	<b>2012-2021 projected growth rates</b>
Medicare	9.2%	6.0%
Medicaid	7.2	8.9
Social Security	5.4	5.7
Medicare, Medicaid, and Social Security	5.9	6.4
Other mandatory spending	7.0	-0.2
Defense	8.0	0.6
Nondefense discretionary	5.9	0.0
Net interest	3.2	11.4
Nominal GDP	4.0	4.8
Population growth	0.9	0.9

Note: GDP (gross domestic product). All figures are nominal and based on the Congressional Budget Office's (CBO's) March 2012 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: CBO March 2012 baseline, Bureau of Economic Analysis.

2012). These projections include reductions in provider payments under the SGR formula; if the SGR fee reductions do not take effect, per beneficiary spending growth will be higher.

The population shift over the next 30 years from working-age individuals to individuals in retirement will reshape government spending and revenues. A larger share of the population will be of retirement age and proportionately fewer people will be of working age, paying the taxes that support Medicare, Social Security, and Medicaid.

Table 1-5 illustrates the trends in federal spending. Spending for Medicare, Medicaid, and Social Security is projected to grow by 6.4 percent on average over the next 10 years. In contrast, the current projections for other parts of the budget—defense, nondefense discretionary spending, and other mandatory spending—are projected to grow between 0 percent and 1 percent per year under the mandatory caps and sequester established in the Budget Control Act of 2011.

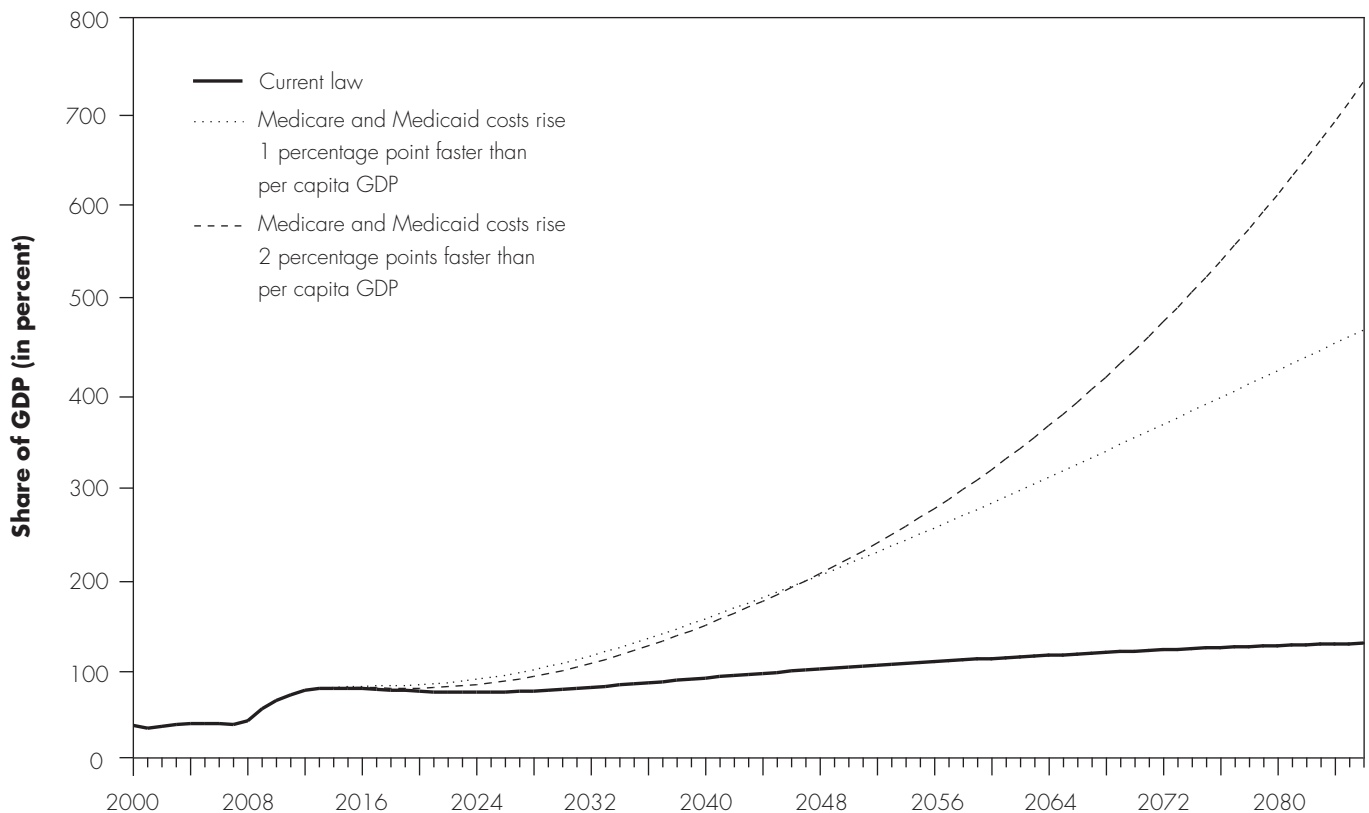
Taking population growth into account, no part of the budget is projected to grow in nominal terms over the next 10 years—except for Medicare, Medicaid, Social Security, and net interest payments. These four parts of the budget, together with other health spending, are projected to total

over 16 percent of GDP within 10 years. When defense spending is added, the total nears 19 percent of GDP. In contrast, total government revenues over the past 40 years have averaged around 18.5 percent of GDP.

### Federal debt and deficits

The federal government was projected to run a deficit of \$1.2 trillion in 2012, and debt held by the public is now projected to be 70 percent of GDP by the end of 2012 (Congressional Budget Office 2012). The debt burden has grown dramatically over the last few years, from 40 percent of GDP in 2008.

The role of growth in health care spending in the federal budget is also significant. Because Medicare and Medicaid, along with Social Security, are the only parts of the budget projected to grow in real terms over the coming years, the budget projections are extremely sensitive to the rate of growth in health care spending. For example, if the current-law projections of Medicare and Medicaid per beneficiary spending remain at or around the GDP growth rate through 2085, as projections from the Office of Management and Budget and the Congressional Budget Office assume, the federal debt and deficit will remain relatively steady. If, however, the rate of growth in health care spending is higher—for example, at GDP

**FIGURE  
1-8****Debt as a share of GDP**

Note: GDP (gross domestic product).

Source: Department of Treasury, *Financial Report of the United States*.

plus 1 percent, the federal fiscal picture looks much worse. This increase would happen if, for example, use of health care is much higher than expected, the Congress makes legislative changes to increase provider payments, or cost-control mechanisms such as the SGR formula do not take effect (Figure 1-8).

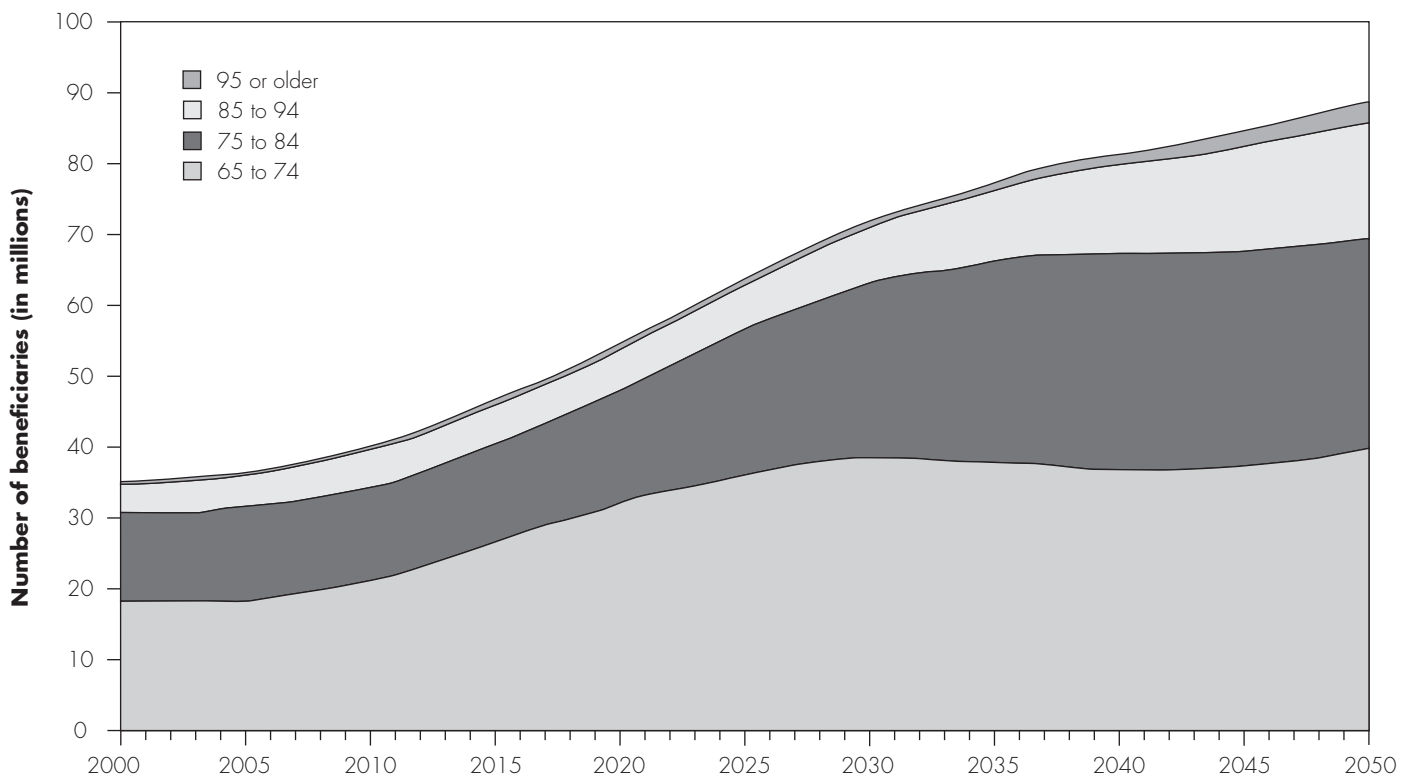
### Medicaid dominates many states' fiscal outlooks

While Medicaid is their largest source of federal revenues, states spent about 17 percent of their own general revenues on Medicaid in fiscal year 2011—the second largest portion of states' general revenues (National Governors Association and National Association of State Budget Officers 2012, Smith et al. 2011). In 2011, Medicaid covered 68 million people, and CHIP covered an additional 7 million; together they accounted for over

\$400 billion in state and federal spending (Medicaid and CHIP Payment Access Commission 2012). Since the economic downturn of 2008, Medicaid enrollment has expanded considerably. The number of individuals covered will increase again in 2014 when participating states implement the Medicaid expansion provision under the Patient Protection and Affordable Care Act of 2010 (National Governors Association and National Association of State Budget Officers 2012). Likewise, state resources will be increasingly diverted to cover the costs of the Medicaid program. In June 2011, enhanced federal matching rates for Medicaid from the American Recovery and Reinvestment Act of 2009 expired (Smith et al. 2011). Further, while the expansion in Medicaid enrollment will be paid mostly by the federal government, those federal subsidies will diminish beginning in 2019 (Vestal 2012).

**FIGURE  
1-9**

**Age of the Medicare population**



Source: Census Bureau population projections.

## Changes in the Medicare-eligible population

The Medicare population is projected to grow by a third within the next 10 years as the baby-boom generation ages into Medicare eligibility. With this expansion, the new Medicare population will differ in key ways from the current one. First, the population will be younger and more racially and ethnically diverse. Second, the covered individuals may have a different burden of chronic conditions or diseases. Finally, the newly eligible will likely have had a different experience of insurance coverage through employers because of market changes in the past few years.

### Age and demographic changes

The average age of Medicare beneficiaries will slightly decline as the baby-boom generation ages into Medicare coverage. This trend will continue through the next decade

when nearly a third of all Medicare beneficiaries will be between the ages of 65 and 69. However, around the middle of the next decade the average age of Medicare beneficiaries will rapidly increase as a function of increasing longevity in combination with the baby-boom retirement. For example, by 2050 it is projected that there will be nearly 3 million people over the age of 95 (Figure 1-9).

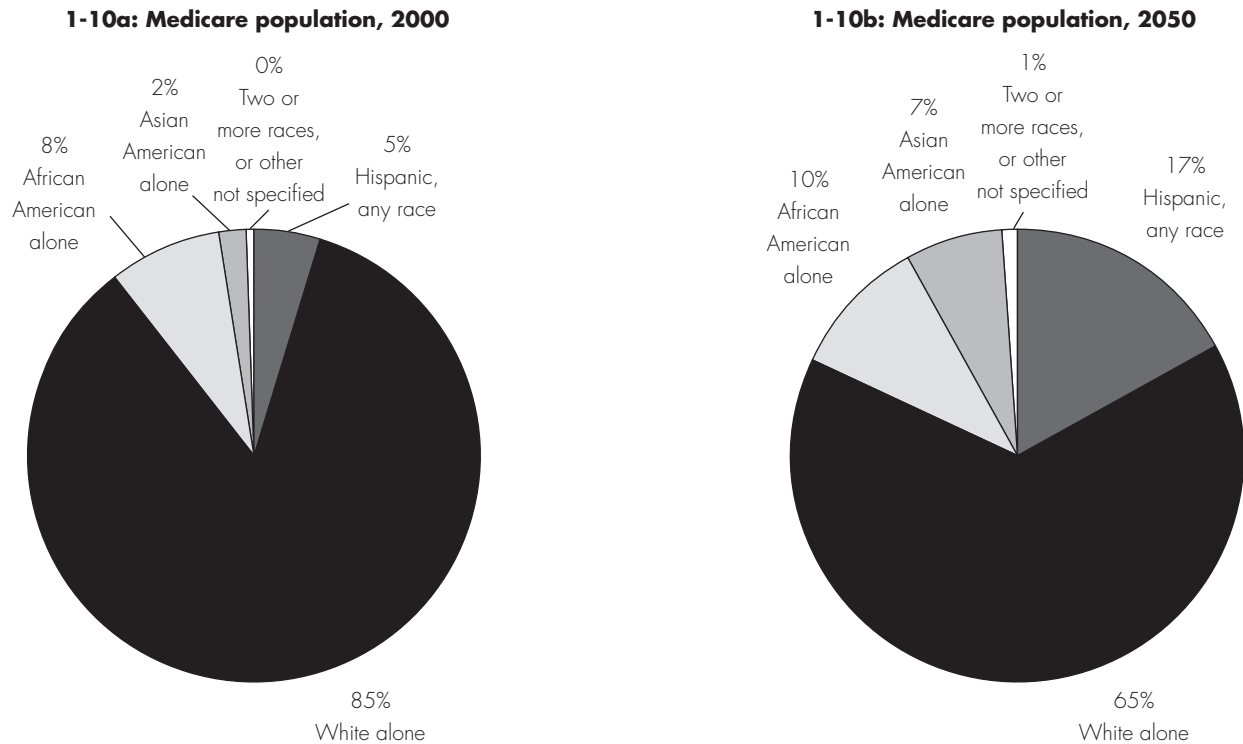
Over the longer term, the Medicare population will become racially and ethnically more diverse, with increasing numbers of Hispanic, African American, and Asian American beneficiaries. In particular, the proportion of Medicare beneficiaries identifying as Hispanic or Latino is projected to grow nearly 10-fold over the next 40 years (Figure 1-10, p. 18).

### Disease burden

Compared with the current Medicare population, the baby-boom generation will bring a different set of health

**FIGURE  
1-10**

**Demographics of the Medicare population will change over time**



Source: Census Bureau population projections.

challenges to Medicare. The prevalence of obesity has rapidly increased in the last two decades, and this trend is expected to continue (Robert Wood Johnson Foundation 2012). New Medicare beneficiaries will more likely be overweight or obese and will have been overweight or obese for longer than current beneficiaries, beginning in their thirties and forties. The prevalence of obesity could heighten the risk of chronic diseases (such as heart disease, stroke, type 2 diabetes, and certain cancers), difficulties with mobility and activities of daily living, and disabilities (Centers for Disease Control and Prevention 2012b, Leveille et al. 2009). Between 2000 and 2030, the number of Americans with chronic conditions is expected to increase by 37 percent (Anderson 2010).

Chronic conditions, both related and unrelated to obesity, are more prevalent among minority populations, an additional concern for Medicare considering the changing demographics of the beneficiary population and the

persistent disparities in quality of care. Likewise, obesity is especially prevalent among minority populations, including almost half of African Americans and 40 percent of Hispanics (Centers for Disease Control and Prevention 2012b, Flegal et al. 2012).

**Insurance coverage**

Changes in the private insurance market may have an effect on new Medicare beneficiaries' familiarity with different types of products and their expectations about costs. For example, over 19 percent of the currently employed population is in a high-deductible plan, which has been widely available only since 2005 (Kaiser Family Foundation and Health Research and Educational Trust 2012). In addition, premiums of employer-sponsored coverage have grown rapidly—premiums for family coverage have grown by 30 percent since 2007 and have nearly doubled since 2002 (Kaiser Family Foundation and Health Research and Educational Trust 2012).

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## Effects of growth in health care spending on individuals and families

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The persistent and aggressive growth of health care spending has a major effect not just on payers and public programs but on individuals and households. Growth of spending in health care has exceeded growth in the economy since the 1960s. Income gains have been negated over the last 10 years because of growth in health care spending and the economic recession. Such high costs have not only wiped out income growth for people of all ages but also pose financial challenges and provoke anxiety for individuals and families as resources are diverted to health spending and away from investments or retirement savings.

### Income growth offset by rising health care spending

Growth in health care spending has the most direct impact on individuals and beneficiaries, those who are exposed to rising spending in both premium increases and at the point of service. Some evidence points to health care spending (including rising premiums, out-of-pocket costs, and taxes for health care) as a main roadblock to growth in family income (Auerbach and Kellerman 2011). For those individuals with health insurance, the increase in premiums has far outweighed increases in average wages. In addition, between 2010 and 2011, median household income fell 1.5 percent in nominal terms to \$50,054 (DeNavas-Walt et al. 2012).

Annual premium growth for private health insurance has ranged from 5 percent to 15 percent over the last 10 years (Kaiser Family Foundation and Health Research and Educational Trust 2012). And while there is some variation across states, the affordability of health insurance has declined—in 2008, employer premiums on average accounted for more than 18 percent of family median income in 18 states, up from just 3 states meeting that threshold in 2003 (Schoen et al. 2009).

About a quarter of Americans report that they have had difficulty paying medical bills in the past year, and roughly 60 percent have forgone or delayed seeking medical care to avoid the hefty costs (including 77 percent of those who report being in poor health) (Kaiser Family Foundation 2012).

Medicare beneficiaries are not exempt from the financial challenges of ever-growing out-of-pocket costs (Figure

1-11, p. 20). In 2010, premiums and cost sharing for Part B and Part D consumed 27 percent of the average Social Security benefit. By 2030, the Medicare Trustees estimate that out-of-pocket costs will consume 36 percent of Social Security benefits (Potetz et al. 2011). Growth in total cost sharing for Medicare beneficiaries is projected to continue to outpace the growth in Social Security benefits, which constitutes 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).

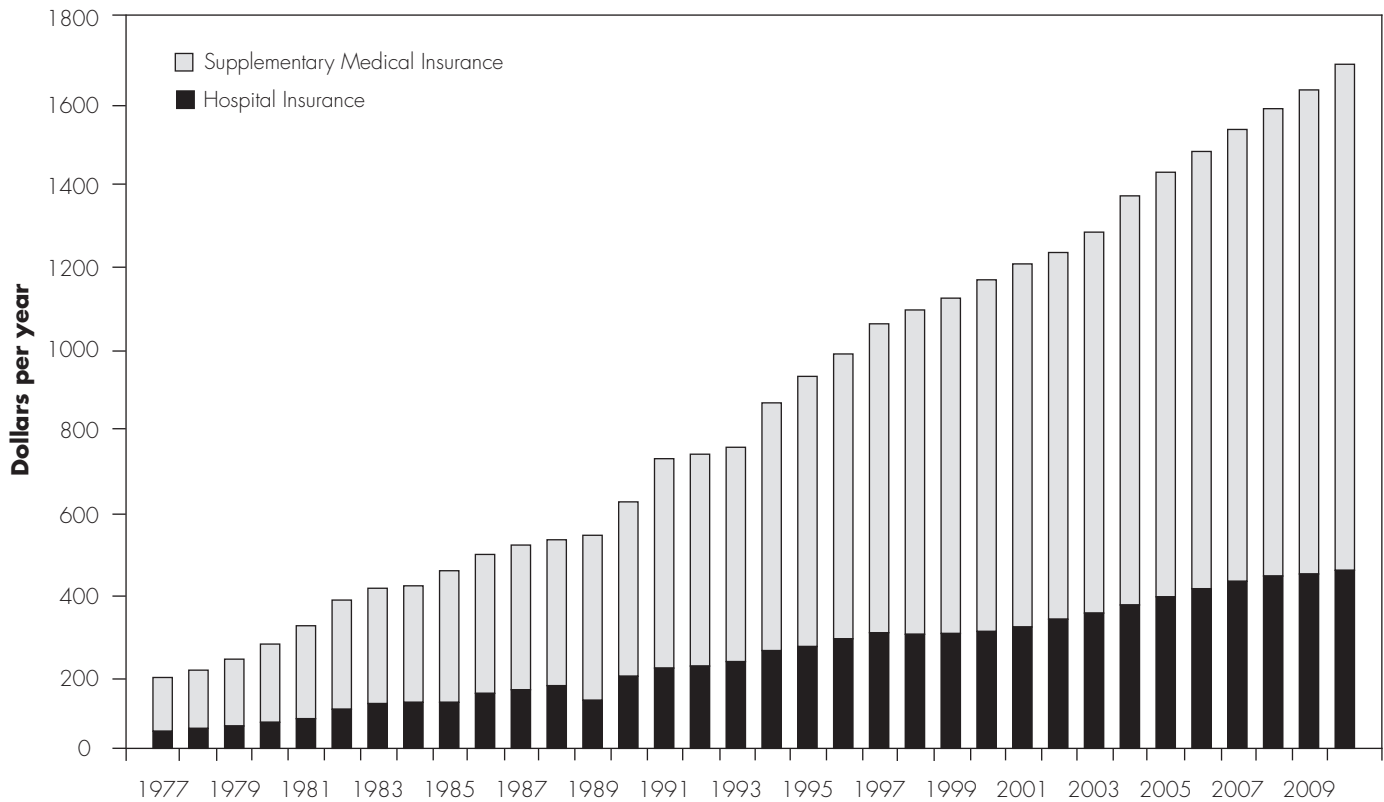
Despite these challenges, Medicare beneficiaries experience greater stability from guaranteed insurance benefits than adults under the age of 65. Adults age 65 or older are less likely to report trouble paying for health care (17 percent). Relative to privately insured adults under 65, fewer seniors report skipping care due to cost concerns (43 percent compared with 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, though a small share of the Medicare population (about 2 percent) report trouble finding a new primary care physician or a specialist (see Chapter 4).

### Lasting effects of the economic downturn

In addition to rising health care spending, the recent economic downturn has depreciated the value of assets and caused more financial insecurity for Medicare beneficiaries and for adults approaching Medicare eligibility (ages 45 to 64). Adults in this age group experienced a notable increase in unemployment during the recent recession, similar to those in most other age groups (Bureau of Labor Statistics 2012). A quarter of respondents ages 50 to 59 in a 2010 RAND survey 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 and thus are more likely to participate in the labor force after they turn 65. The Bureau of Labor Statistics has reported that the share of adults over age 65 in the labor force has steadily increased since the mid-1990s (Bureau of Labor Statistics 2008a). This trend is projected to continue since the number of workers between the ages of 65 and 74 is predicted to increase by 83 percent between 2006 and 2016 (Bureau of Labor Statistics 2008b), potentially affecting the number of beneficiaries with employer-sponsored coverage.

**FIGURE  
1-11**

**Cost-sharing burden for Medicare beneficiaries**



Source: CMS, Medicare and Medicaid Statistical Supplement, 2011.

**Variation in health care spending suggests inefficiencies**

Evidence suggests that some spending on health care in the United States does not improve the population's 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 by the supply of providers (Fisher et al. 2003a, Fisher et al. 2003b, Medicare Payment Advisory Commission 2011b, Zhang et al. 2010, Zuckerman et al. 2010). Likewise, the level of health care spending in the United States consistently exceeds that of comparable countries (Organisation for Economic Co-operation and Development 2012). Evidence also points to a decline in the marginal value of the health care dollar, particularly for the elderly (Cutler et al. 2006),

suggesting that some health spending does not equate to better health. Finally, though quality of care is broadly improving, disparities in health care delivery remain, and racial and ethnic minorities continue to experience worse health outcomes. These variations suggest opportunities for systemic reforms to encourage spending that improves health outcomes and that achieves higher quality and higher value care.

**Wide variation in spending on and use of care**

Researchers have documented wide variations in the use of health care services and the spending on such services by geographic areas. The observed variation is so wide that it cannot be fully explained by differences in disease burden or severity or by the supply of care and caregivers (Fisher et al. 2003a, Fisher et al. 2003b, Medicare Payment Advisory Commission 2011b, Zuckerman et al. 2010).

In 2011, the Commission reported significant variation in the use of services among comparable Medicare patient populations. 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 health status, a 30 percent gap in service use remained between the 90th percentile and 10th percentile of areas. Variation in service use for 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).

While 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, they were not necessarily more satisfied with their care, nor did they realize better health outcomes (Baicker and Chandra 2004, Fisher et al. 2003a, Fisher et al. 2003b). This level of variance in spending and service use across the country with no added benefit to patient experience or quality of care prompts questions about the efficiency of health care spending, as well as significant concerns about fraud and abuse.

In addition to regional variation, differences can be found across member countries in the Organisation for Economic Co-operation and Development (OECD). As measured by per capita spending, share of GDP spent on health care, or spending adjusted for purchasing power, U.S. spending levels are well above the average of OECD countries (Organisation for Economic Co-operation and Development 2012). Evidence indicates that while use of health services tends to be similar for developed economies, the United States' higher spending levels are attributable to the nation's significantly higher prices for health services and products (Anderson et al. 2003, Laugesen and Glied 2011, White 2007). At the same time, other OECD countries appear to obtain similar or better outcomes (Anderson and Squires 2010, Docteur and Berenson 2009).

## Value of health care

Considering the wide variation in service use and spending that does not correspond to significant differences in health outcomes, health system analysts have questioned the comparative value of health services. 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 indicators like mortality); however, the value of health care spending seems to have decreased over time, 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, Redberg 2011, Welch 2012). Spending on such services does not improve health and indeed may expose patients to unnecessary medical and financial risk. Likewise, relative to a less expensive and proven intervention, such services may provide a lower value to the patient and to the public or private insurer paying the increasingly expensive bills.

## 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 physician access survey, the Commission noted that minorities more frequently report access problems (see Chapter 4). Second, beneficiaries in racial and ethnic minorities or with low income are more likely to seek care from providers of poorer quality (Bach et al. 2004, Jha et al. 2007). Third, though quality of care is broadly improving across racial and ethnic groups, age groups, and income groups, minorities continue to experience worse health outcomes compared with their nonminority counterparts (Agency for Healthcare Research and Quality 2012).

This discrepancy is 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 kidney disease, which is a fast-growing share of the Medicare population, the rate of hospital admissions for short-term complications is significantly higher for African

Americans than for other racial and ethnic groups, and all non-White racial groups have higher rates of end-stage renal disease due to diabetes than Whites alone (Agency for Healthcare Research and Quality 2011).

Differences in medical literacy (the individual's ability to understand medical instructions and communicate with doctors and other staff) further compound disparities in the prevalence of chronic disease. The proportion of individuals having below-basic medical literacy is significantly higher for Hispanics (over 33 percent), African Americans (25 percent), and Native Americans/Alaskan Natives (25 percent) than for Whites (9 percent) and Asian/Pacific Islander groups (13 percent) (Kutner et al. 2006). Noting that minorities tend to seek care from poorer quality providers, the Commission recommended that, when allocating federal resources dedicated to quality improvement organizations, the Secretary should prioritize supporting low-performing providers. Such a policy could lead to improved outcomes for racial and ethnic minority beneficiaries (Medicare Payment Advisory Commission 2011a).

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## Conclusion

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The level and growth of health spending as a share of the economy mean that an ever-increasing amount of economic activity and gain will 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 put 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. This interaction between public and private payers means that 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 growth rates 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 like 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

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- 1 Personal health care is a category used in the national health expenditure data that excludes investment and public health activities, for example.
- 2 These figures are based on calculations of the total benefit payments and total enrollment from the Trustees Reports 2009–2012. Other ways to calculate per beneficiary or per enrollee spending use variations such as excluding Medicare Advantage beneficiaries and spending, measuring spending as a share of Part A beneficiaries, or adjusting for age and gender. The figures reported in this chapter make no such adjustments.
- 3 Caveats to this analysis are that it does not measure severity and could be subject to coding bias (if more clinicians have an incentive to code a diagnosis, it will appear that the prevalence of disease increased even though the underlying prevalence has not changed). The definitions of chronic disease prevalence follow CMS’s Chronic Condition Data Warehouse definitions: <http://www.ccwdata.org/index.htm>.
- 4 The growth rate of beneficiary enrollment in 2012 shown in Figure 1-6 is due to the spike in birth rates in 1947.

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CHAPTER

2

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

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# 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 prospective 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 (2013) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year—2014). As part of the process, we examine payment adequacy for 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 make update recommendations in 10 FFS sectors: hospital inpatient and outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care agency, inpatient rehabilitation facility, long-term care hospital, and hospice. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates any prior year assumptions using the most

## In this chapter

- Are Medicare payments adequate in 2013?
- What cost changes are expected in 2014?
- How should Medicare payments change in 2014?
- 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 the efficient provider could create fiscal pressure on all providers to control their costs and also help create pressure for broader reforms to address 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—that is, the development of more integrated and value-oriented health care systems.

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



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. Necessary 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' ability to control; and
- considering the need for annual payment updates and other policy changes.

Our general approach to developing payment policy recommendations attempts, first, to make enough funding available to ensure that payments are adequate to cover the costs of efficient providers; and second, to improve payment accuracy among services and providers. Together, these two steps should maintain Medicare beneficiaries' access to high-quality care while creating financial pressure on providers to make better use of taxpayers' and beneficiaries' resources.

In the first step, our goal is to judge payment adequacy based on the performance of efficient providers in a sector, as required by our charter. 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 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 2012, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2010). We also continue to analyze efficient providers in the skilled nursing facility (SNF) sector. We have found that some SNFs have considerably lower costs than others and substantially better quality (Medicare Payment Advisory Commission 2011). This year we identify efficient home health agencies (HHAs), and we plan to extend our efficient-provider analysis to inpatient rehabilitation facilities (IRFs) and other sectors as data and resources permit.

To help determine the appropriate level of aggregate funding for a given payment system in 2014, we first

consider whether payments are adequate for providers in 2013. 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 2013. We then consider how providers' costs will change in 2014. Taking these factors into account, we then determine how Medicare payments for the sector in aggregate should change in 2014.

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 SNF prospective payment system (PPS) that make it less financially desirable to treat medically complex patients than patients who only need therapy.

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 2014 with current law to understand the implications for providers, beneficiaries, 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.

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## **Are Medicare payments adequate in 2013?**

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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 2013

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, 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' willingness to serve beneficiaries and beneficiaries' opinions about their access to physician care. 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 or lower priced equipment could increase 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 HHAs 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 the definition of the benefit. 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, on the other hand, 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 the hospital outpatient department (HOPD) sector 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. In 2008, for example, CMS substantially increased the number of surgical procedures covered under the ambulatory surgical center (ASC) payment system. As a result, the volume of services per FFS beneficiary for those services grew rapidly over the next several years. 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. In fact, undesirable outcomes (e.g., unnecessary complications) may result in additional payments, and sectors with more-than-adequate payments may have little incentive to improve quality. For the past several years, the Commission has recommended a fundamental change to create incentives in Medicare FFS payment systems to reward better quality, and the program has recently begun to carry out quality-based payment policies in a number of sectors.

## Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and capabilities for patient care. Widespread inability to access capital throughout a sector may in part reflect the adequacy of Medicare payments (or, in some cases, 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, need fewer 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 ASCs) 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.

The past few years have seen dramatic changes in financial markets. In late 2008, because of the extraordinary conditions in the credit market, access to capital was

driven almost entirely by factors other than the adequacy of Medicare payment, and markets essentially froze. In 2009, liquidity began to return, and credit markets now appear to have returned to more normal conditions under which access to capital depends on a borrower's individual circumstances and creditworthiness.

## Medicare payments and providers' costs for 2013

For most payment sectors, we estimate Medicare payments and providers' costs for 2013 to inform our update recommendations for 2014.

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 2012 and 2013 to our base data (2011 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2013. To estimate 2013 costs, we consider the rate of input price inflation 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 complementarities of 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 payments for other distinct units of the hospital, such as SNFs, are governed by payment rates for those payment systems.

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 our intent is not to ensure 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 the case-mix adjustment of the payment unit, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Information about the extent to which 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 that was supposed to result in more accurate payments. 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 of comparable product.

To assess whether reported costs reflect the costs of efficient providers, we examine recent trends in the average cost per unit of output, 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). 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.

In contrast, in the hospital sector, for example, some have suggested that 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. (See the hospital chapters in our 2009, 2010, and 2011 March reports for a more complete discussion of the relation between cost pressure and Medicare margins.)

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 the growth in 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 sum, 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.

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## **What cost changes are expected in 2014?**

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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 above 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.

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## **How should Medicare payments change in 2014?**

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

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 the 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 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 recommendations 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 Medicare 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 sectors**

A beneficiary can sometimes receive a similar service in different sectors. Depending on which sector 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 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 sectors. Putting this principle into practice requires that the definition of services in the sectors 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. Those differences create opportunities for Medicare and beneficiary savings, if the sector with lower payments sets the level for all sectors. 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 or other professional 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 sectors that are defined similarly and to determine whether patients have the same characteristics.

Last year, 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 sectors. E&M office visits are defined similarly in both sectors. In addition, because the coding for the service incorporates a specific length of time (e.g., 15 minutes), patient characteristics are accounted for. That is, a more complex patient in either sector would have a longer office visit than a less complex patient. Our recommendation set 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). The Commission will continue to study other services that are provided in multiple sectors 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.

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### **Payment adequacy in context**

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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 the long-term trend 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 of federal spending. Slowing the increase in Medicare outlays is important. Medicare's rising costs are projected to exhaust the Hospital Insurance trust fund and significantly burden taxpayers. 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

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**Hospital inpatient and  
outpatient services**

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

- 3** The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.

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

# Hospital inpatient and outpatient services

## Chapter summary

From 2010 to 2011, Medicare payments per fee-for-service beneficiary for inpatient and outpatient services in acute care hospitals (ACHs) grew by 1.6 percent. The 4,800 ACHs paid under the Medicare prospective payment system and critical access payment system received \$158 billion for roughly 10 million Medicare inpatient discharges and 181 million outpatient services.

## Assessment of payment adequacy

To evaluate whether aggregate payments were adequate, we consider beneficiaries' access to care, changes in the volume of services provided, hospitals' access to capital, quality of care, and the relationship of Medicare's payments to the average cost of caring for Medicare patients. In addition to examining the costs of the average provider, we compare Medicare payments with the costs of relatively efficient hospitals.

**Beneficiaries' access to care**—Access measures include the capacity of providers and changes in the volume of services over time. These measures were positive for the period reviewed.

- **Capacity and supply of providers**—The number of hospitals and the range of services offered both continue to grow.
- **Volume of services**—From 2004 to 2011, outpatient services per beneficiary grew 34 percent and inpatient admissions declined by 8

## In this chapter

- Are Medicare payments adequate in 2013?
- How should Medicare payments change in 2014?

percent due to two factors. First, services continued to shift from inpatient to outpatient settings. Second, hospitals increasingly billed for outpatient services that had previously been billed as services provided in physicians' offices. For example, physician evaluation and management (E&M) visits billed as outpatient services increased by 7 percent in 2010 and 8 percent in 2011. Similarly, outpatient echocardiograms increased by 18 percent in 2011. In 2012, the Commission recommended equalizing E&M payment rates between physicians' office and hospital settings. This change would remove the financial incentive to shift E&M visits from lower cost office visits to higher cost outpatient visits (Medicare Payment Advisory Commission 2012c).

***Quality of care***—Quality continues to improve on most measures. Hospitals reduced 30-day mortality rates across five prevalent clinical conditions and readmission rates improved slightly from 2008 to 2011. A penalty for above-average readmission rates started in fiscal year 2013. However, it is too soon to know if the penalty will stimulate greater reductions in readmissions.

***Providers' access to capital***—Access to capital is good due to strong hospital earnings in recent years and low interest rates. Hospitals' level of construction spending remains stable at \$26 billion per year, with a slight decline in bond offerings.

***Medicare payments and providers' costs***—The overall hospital Medicare margin declined from -4.5 percent in 2010 to -5.8 percent in 2011. The margin declined primarily because CMS reduced inpatient payment rates in 2011 to recover overpayments in 2008 and 2009 due to documentation and coding changes. The result was a slight decline in inpatient payment rates in 2011 and a decline in inpatient revenues. Overall margins declined only 1.3 percentage points in part because of temporary payments for health information technology and other policy changes that increased payments by over \$2 billion in 2011. We project that margins in 2013 will remain roughly equal to 2011 levels. We expect payment rates to grow more slowly than costs and we expect an increase in supplemental Medicare payments to hospitals that achieve meaningful use of electronic medical records, resulting in Medicare margins remaining at roughly -6 percent from 2011 through 2013.

***Efficient providers***—While Medicare payments are currently less than costs for the average hospital, a key question is whether current Medicare payments are adequate to cover the costs of efficient hospitals. To explore this question, we examined financial outcomes for a set of hospitals that consistently perform relatively well on cost, mortality, and readmission measures. We find that Medicare payments

covered the fully allocated costs of the median efficient hospital, which generated a 2 percent Medicare margin in 2011.

The inpatient payment update recommendation is based on four factors. First, updates must be restrained to maintain pressure to control costs. Second, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. Third, hospitals changed their documentation and coding in response to the introduction of Medicare severity–diagnosis related groups in 2008, and the effect of these documentation and coding changes on payments needs to be offset. Fourth, while hospitals’ aggregate Medicare margin is projected to remain at roughly –6 percent, the set of relatively efficient hospitals had a median overall Medicare margin of 2 percent. Balancing these factors, we recommend increasing payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. In other words, all else being equal, the per case payment a hospital receives in 2014 should be 1 percent higher than it was in 2013. For inpatient services, CMS should use the difference between the 2014 statutory update and the recommended 1 percent increase to offset the costs to the Medicare program from changes in hospitals’ documentation and coding.

Despite negative overall Medicare margins, the Commission also recommends a 1 percent increase in outpatient rates in 2014 for three reasons: First, pressure to constrain costs should be maintained. Second, outpatient volume has grown significantly, by more than 4 percent. Third, hospital outpatient payment rates are already substantially higher than payment rates for similar services in other sectors. This difference in payment rates has contributed to a shift in the site of care from less expensive settings to the hospital setting. Any higher increase in hospital outpatient rates would exacerbate this problem. ■



**TABLE  
3-1**

**Growth in Medicare inpatient and outpatient spending**

<b>Hospital services</b>	<b>2006</b>	<b>2010</b>	<b>2011</b>	<b>Average annual change 2006-2010</b>	<b>Change 2010-2011</b>
<b>Inpatient services</b>					
Total FFS payments (in billions)	\$107	\$117	\$117	2.2%	0.1%
Payments per FFS beneficiary	3,065	3,373	3,340	2.4	-1.0
<b>Outpatient services</b>					
Total FFS payments (in billions)	28	37	41	7.2	10.4
Payments per FFS beneficiary	863	1,178	1,285	8.1	9.1
<b>Inpatient and outpatient services</b>					
Total FFS payments (in billions)	135	154	158	3.3	2.5
Payments per FFS beneficiary	3,928	4,550	4,624	3.7	1.6

Note: FFS (fee-for-service). Reported hospital spending includes all hospitals covered by Medicare’s inpatient prospective payment system as well as critical access hospitals. Maryland hospitals are excluded. Fiscal year 2011 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 2010, the number of FFS beneficiaries declined over that time because of the shift of beneficiaries to the Medicare Advantage program. The number of FFS beneficiaries increased slightly from 2010 to 2011. To calculate payments per beneficiary, we identified populations of beneficiaries eligible for inpatient (Part A) and outpatient (Part B) coverage and excluded enrollees in Maryland.

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

**Background**

Acute care hospitals (ACHs) provide Medicare beneficiaries with inpatient care for the diagnosis and treatment of acute conditions and manifestations of chronic conditions. They also provide ambulatory care through outpatient departments (OPDs) 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 2011, Medicare paid ACHs approximately \$117 billion for fee-for-service (FFS) inpatient care and \$41 billion for FFS outpatient care (Table 3-1). Acute inpatient and outpatient services represented more than 92 percent of Medicare FFS spending on ACHs. From 2010 to 2011, Medicare inpatient spending per FFS beneficiary—including spending at critical access hospitals (CAHs)—decreased by 1 percent, and outpatient spending per FFS beneficiary grew 9.1 percent. The decline in inpatient payments reflects a shift in the site of services to OPDs

and a slight decline in inpatient payment rates from 2010 to 2011.

**Medicare’s payment systems for inpatient and outpatient services**

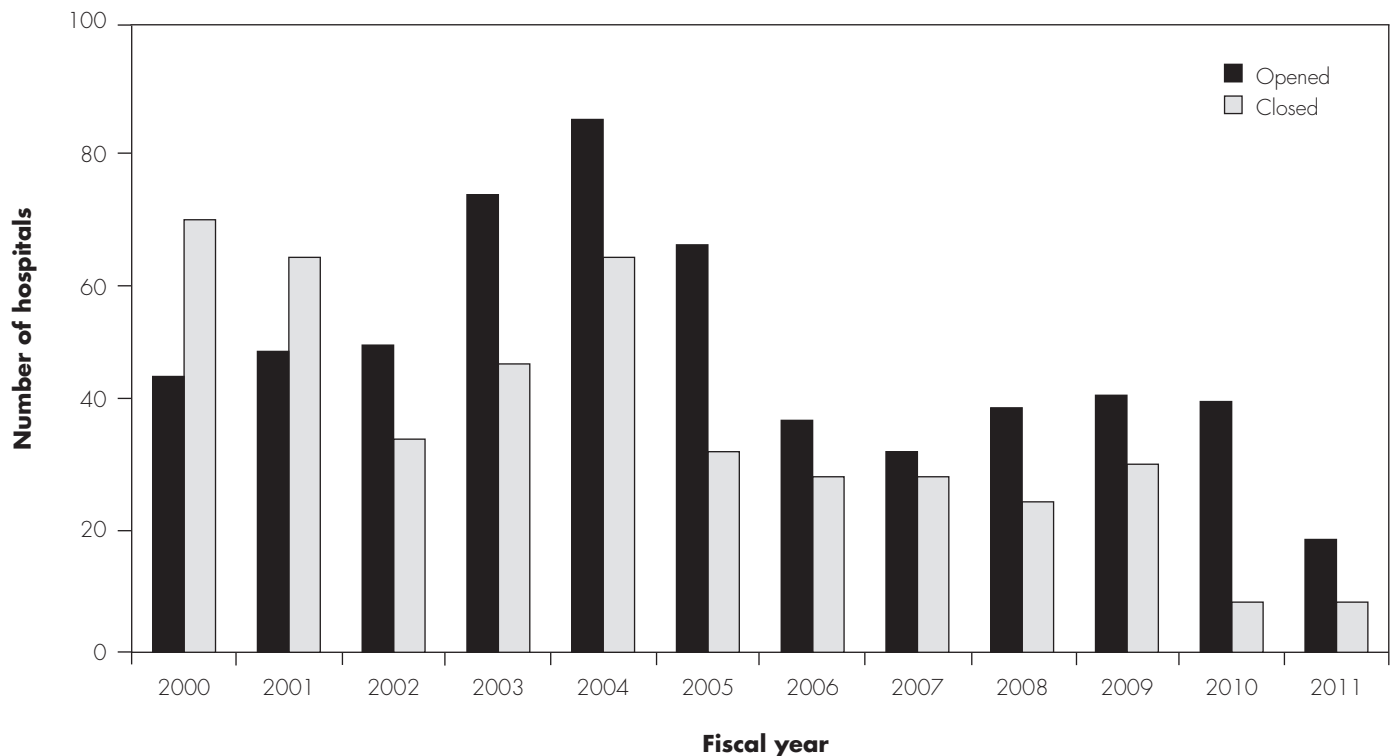
Medicare’s inpatient prospective payment system (IPPS) and its outpatient prospective payment system (OPPS) have a similar basic structure. Each has a base rate modified for the differences in type of case or service, as well as geographic differences in wages. However, each PPS has different units of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

**Acute inpatient payment system**

Medicare’s IPPS pays ACHs a predetermined amount for most admissions. 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 differences in area wages, and adjustments are made for hospitals that train residents or serve large numbers of low-income patients. Payment rates are updated annually.

**FIGURE  
3-1**

**More hospitals opened than closed in the last 10 years**



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.

To set inpatient payment rates, CMS uses a clinical categorization system called Medicare severity–diagnosis related groups (MS–DRGs). The MS–DRG system (which replaced the prior DRG system in 2008) classifies patient cases in one of 750 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 DRG (no CC, a nonmajor CC, or a major CC). A more detailed description of the acute IPPS, including payment adjustments, can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_hospital.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_hospital.pdf).

**Hospital outpatient payment system**

The OPSS pays hospitals a predetermined amount per service. CMS assigns each outpatient service to one of approximately 850 ambulatory payment classification (APC) groups. Each APC has a relative weight based on its median cost of service compared with the median cost of a midlevel clinic visit. A conversion factor translates

relative weights into dollar payment amounts. A more detailed description of the OPSS can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_OPD.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_OPD.pdf).

**Are Medicare payments adequate in 2013?**

To judge whether payments for 2013 are adequate to cover the costs that 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 on Medicare patients remain negative for most hospitals.



## Beneficiaries' access to care: Access remained positive, as hospital capacity generally grew over the period reviewed

We assess beneficiaries' access to care by tracking the number of hospitals participating in the Medicare program, the proportions of hospitals offering certain specialty services, and the volume of services received. In general, we find that access to hospital services is good and has expanded from the previous year.

### More hospitals opened than closed

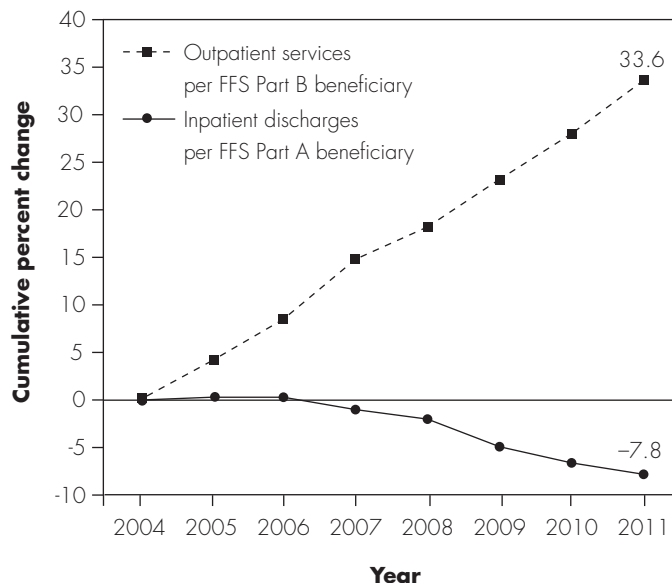
In 2011, 18 ACHs opened and 8 closed (Figure 3-1). For the 10th consecutive year, hospital openings exceeded closings.<sup>1</sup> Overall, approximately 4,800 short-term ACHs participated in the Medicare program in 2011. Of them, 1,329 were CAHs (Flex Monitoring Team 2012).

Hospitals that entered the Medicare program in 2011 were generally the same size as those that left the program. The 18 hospitals that entered the program in 2011 had 98 beds on average, representing approximately 1,800 new acute care beds. All but two of these hospitals opened in urban areas, and slightly more than half were nonprofit hospitals. Four of the hospitals that entered the program opened in Florida, three opened in California, and the remaining hospitals were dispersed across the country. In earlier years, many new entrants appeared to be specialty hospitals, but in 2011 most were small or midsized hospitals offering a slightly broader range of services. This shift reflects the new rules enacted in 2010 as part of the Patient Protection and Affordable Care Act of 2010 (PPACA), which prohibited physicians from referring patients to new physician-owned hospitals in which they were investors.

The eight hospitals that exited the program in 2011 were similar in size and geographic location. With an average size of 85 beds, the exit of these hospitals amounted to roughly 700 closed acute care beds. Six closures occurred in urban locations and two in rural locations. For most of these facilities, we observed a decline in their total (all-payer) margins over each of the last three years, which were less than -10 percent in one or more of the years between 2008 and 2010. These hospitals had an average inpatient occupancy rate of 37 percent, significantly lower than the national average of approximately 60 percent. Although the shares of Medicaid patients varied across each of these hospitals over their last three years of service, their share of Medicaid inpatient admissions generally increased. In addition, hospitals that closed were

**FIGURE 3-2**

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



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

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

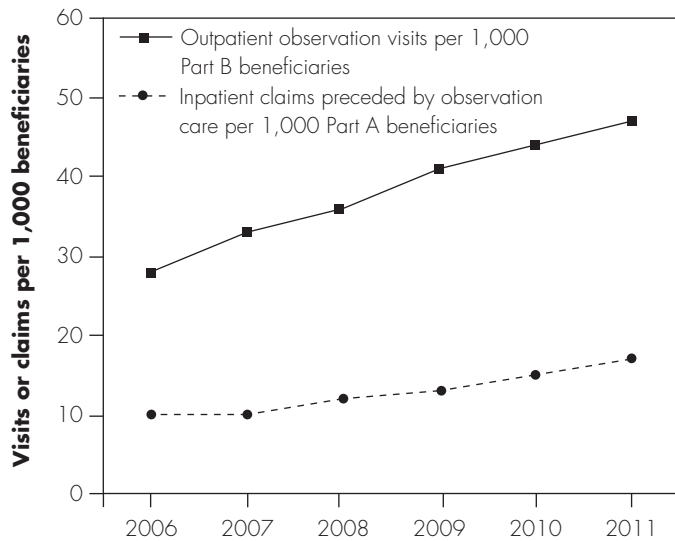
located an average of six miles from the nearest hospital, and the average occupancy rate of that hospital was typically 15 to 20 percentage points higher.

### Volume of services: Inpatient declines as outpatient grows

The shift of services from the inpatient to the outpatient setting continued in 2011. To examine changes in volume in the two settings, we used the number of admissions per FFS beneficiary as an indicator of inpatient volume and the number of services per beneficiary to measure outpatient volume. In 2011, Medicare inpatient admissions per FFS beneficiary declined 1.3 percent per Part A beneficiary and had a cumulative reduction of 7.8 percent from 2004 to 2011 (Figure 3-2).<sup>2</sup> The decline in inpatient admissions occurred while outpatient volume increased by 4.4 percent per Part B beneficiary from 2010 to 2011 and by 33.6 percent cumulatively from 2004 to 2011. This shift in the site of service from inpatient to outpatient settings occurred across all types of insurance (American Hospital Association 2011). In particular, surgeries shifted from inpatient to outpatient settings. From 2010 to 2011,

**FIGURE  
3-3**

**Number of Medicare outpatient observation visits and inpatient claims preceded by observation care per 1,000 beneficiaries increased from 2006 to 2011**



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

hospital surgical discharges declined 3.8 percent per beneficiary, compared with a decline in medical discharges of less than 0.5 percent per beneficiary. From 2005 to 2011, inpatient surgical discharges declined nearly 17 percent per beneficiary, or 3 percent per year, compared with the decline in inpatient medical discharges of 7 percent per beneficiary, or 1 percent per year.

The rate of decline in inpatient discharges also differed depending on the location and size of the hospital. While inpatient discharges declined in the aggregate, a more rapid decline occurred in small rural hospitals from 2005 to 2011. For the same cohort of hospitals over this period, inpatient discharges declined 7 percent at urban hospitals and 18 percent at rural hospitals. The drop in inpatient discharges was most pronounced for the smallest rural hospitals (those with less than 100 beds), declining approximately 21 percent.

As services shifted from inpatient to OPDs, hospital inpatient occupancy rates declined. From 2006 to 2010, the average hospital bed occupancy rate declined slightly from 64 percent to 62 percent despite a decrease during this period in the number of available beds, from 2.8 beds to 2.7 beds per 1,000 people.<sup>3</sup> Occupancy rates vary widely across markets, suggesting that the level of

excess capacity varies by market. For example, in 2010 Washington State had 1.8 beds per 1,000 people and an average occupancy of 69 percent in Seattle. By contrast, West Virginia had an average 4.0 beds per 1,000 people and an average occupancy of 50 percent in Charlestown. Nationally, the decline in occupancy rates suggests that, on average, there is no need to expand the number of hospital beds despite population growth.

The volume of observation visits is increasing. Between 2006 and 2011, observation visits increased from 28 visits per 1,000 Part B beneficiaries to approximately 47 visits per 1,000, a nearly 65 percent increase in visits over the period (Figure 3-3).<sup>4</sup> It appears that at least some of these outpatient observation visits would have been short inpatient stays in the past; during the corresponding time period (2006 to 2011), the number of inpatient stays lasting one day declined by more than 15 percent. Despite the reduction in one-day stays, the average Medicare length of inpatient stay declined between 2006 and 2011 from 4.9 days to 4.7 days due to a decline in longer inpatient stays. Over the same period, the number of inpatient claims preceded by an observation visit, which is bundled with inpatient claims, increased from approximately 10 claims to 17 claims per 1,000 Part A beneficiaries, a 70 percent increase.

**Services shift from physicians' offices to outpatient departments**

Another factor contributing to the growth of outpatient services is the shift in services from a freestanding physician's office to an office that is deemed part of a hospital's OPD. For example, evaluation and management (E&M) visits per beneficiary in hospital OPDs grew by 7 percent from 2009 to 2010 and 8 percent from 2010 to 2011, compared with a 1 percent decline in these visits at physicians' offices between 2009 and 2011. Growth was particularly strong in cardiac testing in outpatient departments. Echocardiograms (APCs 269, 270, and 697) per beneficiary grew by 18 percent, and other cardiac imaging (APCs 377 and 398) grew by 14 percent. In contrast, from 2010 to 2011, services in physicians' offices fell by 7 percent for echocardiograms and 13 percent for other cardiac imaging. The increase in volume of these three services together represented 24 percent of the increase in OPD service volume. This shift in service volume toward OPDs is consistent with the financial incentives in the current payment system. For example, compared with rates in physicians' offices, Medicare payment rates for E&M visits are 80 percent

**TABLE  
3-2**

**Shares of hospitals offering specific services, 2005–2010**

Type of service	Urban		Rural	
	Percentage of hospitals in 2010	Percentage point change from 2005 to 2010	Percentage of hospitals in 2010	Percentage point change from 2005 to 2010
<b>High-tech services</b>				
Robotic surgery	36%	22	2%	1
PET or PET/CT scanner	60	10	16	4
MRI	93	3	85	9
<b>Core services</b>				
Palliative care	54	9	22	2
Indigent care clinic	37	9	11	4
Orthopedics	87	5	60	8
Open heart surgery	48	5	4	1
Cardiac catheterization	63	4	7	0
Oncology	76	1	39	2
Geriatrics	53	1	32	-1
Trauma center	46	1	37	4
<b>Post-acute services</b>				
Skilled nursing	35	-6	43	-3
Home health	61	-3	56	-5

Note: PET (positron emission tomography), CT (computed tomography). The American Hospital Association’s annual survey generally has overall response rates of more than 80 percent, but response rates vary by line of service.

Source: American Hospital Association annual surveys of hospitals.

higher and echocardiograms are over 70 percent higher when billed as outpatient services, even after adjusting for differences in packaging. In 2010, the Medicare program and beneficiaries paid hospitals \$1.3 billion more than they would have if OPD rates were set equal to physicians’ office rates for E&M and echocardiograms; in 2011, the difference was \$1.5 billion due to the shift in site of care for these services toward OPDs.

The Commission has expressed concern that higher payment rates in OPDs may induce hospitals to acquire physician practices and deem these practices part of the OPD. The result is that care is being shifted from a lower to a higher cost site of care without any identifiable improvement in quality. For that reason, the Commission recommended equalizing payment rates for E&M services (Medicare Payment Advisory Commission 2012c). By equalizing payment rates across sectors, hospitals will still be rewarded if their physician–hospital integration reduces inpatient costs, improves quality, or results in a bonus

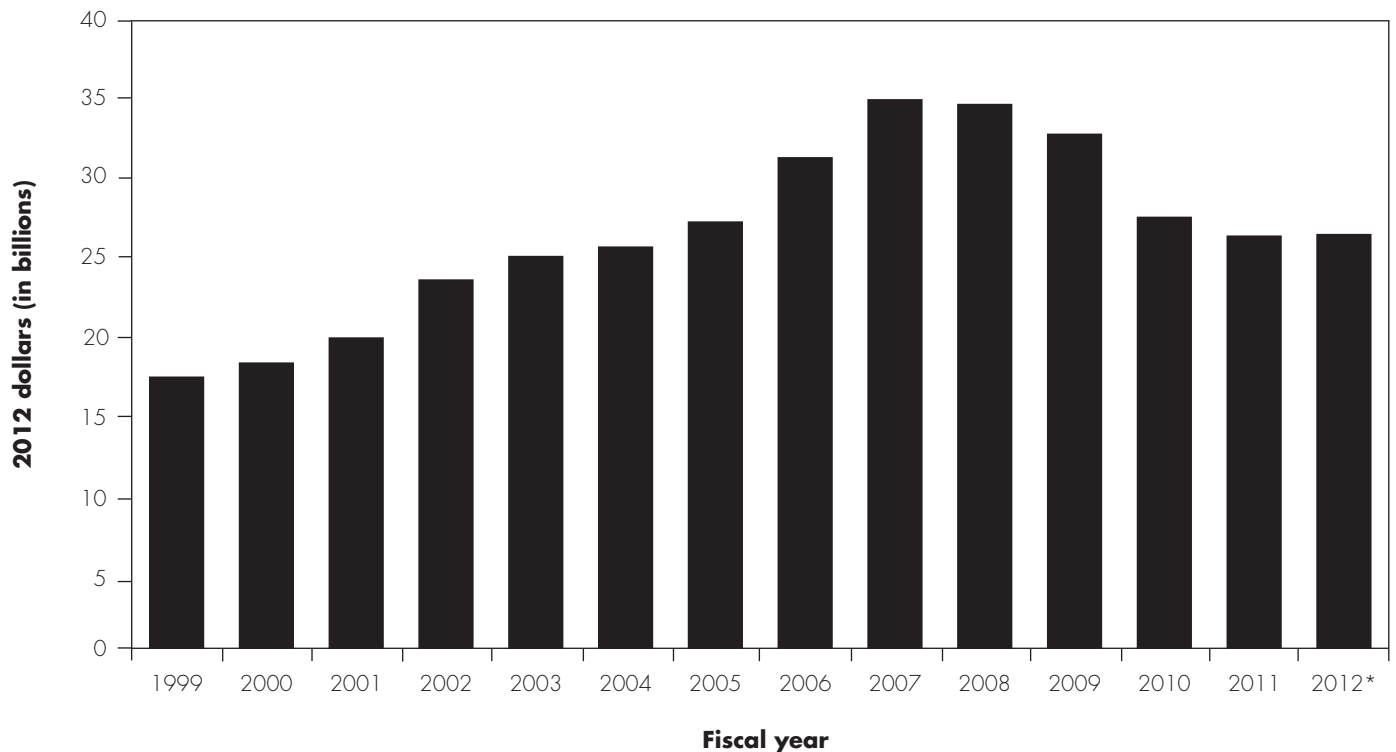
through Medicare’s value-based performance incentives. But hospitals would not be rewarded purely for changes in corporate structure that do not change patient care.

**Breadth of services continues to grow**

Hospitals have continued to expand the scope of services they offer. Our analysis of 50 specialized hospital services from 2005 to 2010 found that the share of hospitals and their affiliates providing these services increased for most services.<sup>5</sup> New technologies such as robotic surgery and positron emission tomography scan services were among those that grew most rapidly. Core hospital services—such as trauma care, cardiac services, and oncology—generally were offered by more hospitals in 2010 than in 2005. Post-acute care was the only type of service for which the share of hospitals offering this service declined by more than 1 percent. Rural hospitals tended to offer fewer services but have been expanding their imaging and orthopedic surgery offerings (Table 3-2). (The change from 2009 to 2010 was

**FIGURE  
3-4**

**Hospital construction spending remains strong**



Note: Spending is for nonfederal hospital construction and inflated to September 2012 dollars using McGraw-Hill's construction cost index.  
\*Data for 2012 are an annualized estimate based on data for the first five months of 2012.

Source: Census Bureau. <http://www.census.gov/const/www/c30index.html>.

similar to the average change over the five-year period (not shown in table).

**Access to capital remains positive**

Overall, the hospital industry has strong access to bond markets. Interest rates across the various classes of bonds on tax-exempt debt decreased significantly in 2012. As of November 12, 2012, the interest rate on double-A tax-exempt 30-year hospital bonds was 3.75 percent. In mid-November of 2010 and 2011, interest rates for similarly classified bonds were approximately 5.0 percent (Cain Brothers 2012).

The dollar value of hospital construction projects in the United States remained steady in 2011 and the first half of 2012. Hospital construction spending increased steadily from 1999 to 2005, followed by a four-year period of heavy construction spending from 2006 to 2009 (Figure 3-4). During that period, construction spending peaked in 2007, reaching approximately \$35 billion. By 2011,

spending moderated but remained at relatively high levels, exceeding \$26 billion. Construction spending in 2012 is also estimated to exceed \$26 billion. These findings are consistent with what Moody's Investment Service noted concerning a slight increase in the median capital spending ratio—1.2 times depreciation in 2011 compared with 1.1 times depreciation in 2010. This suggests that hospitals are spending slightly more than would be necessary to replace aging existing facilities (Moody's Investors Service 2012). Given that construction has continued at a stable rate, there appears to be adequate access to capital.

**Hospital industry consolidation increased**

Hospital industry consolidation has increased in recent years, indicating that hospital systems still see acquisitions of other hospitals as a good use of their capital. In 2011, the hospital sector saw 90 separate merger and acquisition (M&A) deals, and as a part of these deals, 156 individual hospitals were acquired (Irving Levin Associates Inc.

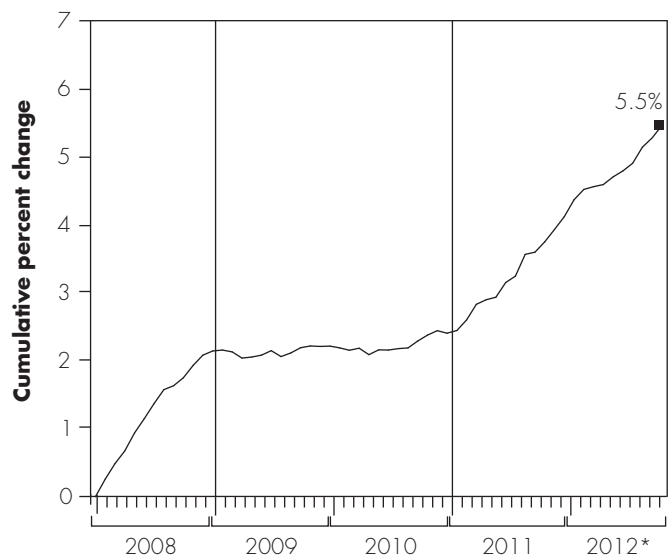
2012).<sup>6</sup> Both the number of deals and the number of hospitals involved in the 2011 deals represent a marked increase from 2009 and 2010. For the third consecutive year, most of these hospital deals involved regional hospital systems acquiring either smaller local hospital systems or small independent hospitals. However, in 2011, large national hospital systems became more active once again in making hospital acquisitions. In 2011, 41 percent of hospital M&A deals involved regional systems acquiring hospitals or other systems. In 33 percent of deals, national hospital systems were the acquirers; in 16 percent, hospitals were acquiring other individual hospitals; and in 14 percent, private equity firms were the acquirers.<sup>7</sup> Similar to 2010, in 2011, most acquired hospitals were small, having 160 or fewer inpatient beds, and the majority of deals involved for-profit entities acquiring nonprofit facilities. The acquisitions in 2011 reflected a long-standing trend of consolidation in the industry, which could affect prices insurers pay in the non-Medicare market (Gaynor and Town 2012). In 2012, the merger trend continued, with the merger of the Trinity and Catholic Healthcare East systems forming an 82-hospital system.

### Hospital employment growth indicates growing capacity

The hospital industry continues to grow, with hospital employment increasing. Hospital industry employment is trending upward again after two years of slower growth. Bureau of Labor Statistics (BLS) employment data reveal that the number of individuals employed by hospitals increased 5.5 percent over the last five years (January 2008 to November 2012), adding 320,000 jobs (Figure 3-5). Overall, BLS estimates that as of November 2012, hospitals employed over 6.2 million individuals. During the last four-plus years, the rate of growth in hospital employment varied in three general periods. In the first period, from January 2008 to January 2009, hospital employment increased approximately 2 percent. In the second period, from January 2009 to January 2011, employment growth slowed to less than 1 percent over the two years. This period started during the nation's recession. In the third period, from January 2011 to November 2012, hospital employment accelerated again, increasing more than 3 percent. While the hospital industry has added jobs in recent years, an increase in the number of individuals employed by a given industry may not translate to an improvement in economic efficiency (Baicker and Chandra 2012).

**FIGURE 3-5**

**Hospital employment grew at beginning and end of five-year period**



Note: \*Data through November 2012.

Source: Bureau of Labor Statistics.

According to data from a separate BLS survey that best corresponds to the four-year period described above, growth in employment varied among hospital occupations. From 2007 to 2011, the occupations that experienced the largest increases in hospital employment were physical and social scientists (25 percent), physician assistants (22 percent), computer and math science occupations (18 percent), management occupations (14 percent), pharmacists (13 percent), and imaging technicians (11 percent). A handful of occupations experienced an overall decline in hospital employment. The employment of licensed practical nurses and licensed vocational nurses declined by 18 percent (31,000 fewer); however, the number of registered nurses (RNs) increased by nearly 10 percent (148,000 more RNs). Hospitals also trimmed the number of social workers, office staff, food service staff, and various clinician support occupations such as nursing aides and orderlies. Yet data from the American Hospital Association (AHA) describe a steady increase over the last decade in the number of physicians employed by hospitals, and anecdotal sources suggest this trend has increased rapidly in more recent years. The AHA reported a 35 percent increase from 2007 to 2010 in the number

of physicians employed directly by a consistent cohort of hospitals over that time period.

### **Quality of care: Overall, quality indicators show improvement**

Our analysis of several inpatient quality indicators (IQIs) shows generally positive trends. We use five of the IQIs developed and maintained by the Agency for Healthcare Research and Quality (AHRQ) to measure in-hospital and 30-day postdischarge mortality rates (Agency for Healthcare Research and Quality 2007a). We also analyze six of the AHRQ patient safety indicators (PSIs), which measure the frequency of potentially preventable adverse events that can occur during an inpatient stay, such as the development of postoperative blood clots or deaths from treatable surgical complications (Agency for Healthcare Research and Quality 2007a, Agency for Healthcare Research and Quality 2007b). To assess sector-wide quality trends, we calculate risk-adjusted rates for these measures across all IPPS hospitals for a rolling four-year period and determine whether there was a statistically significant change in each rate from the first year to the fourth year. We use the IQIs and PSIs that AHRQ has concluded have the strongest base of clinical and statistical evidence (Agency for Healthcare Research and Quality 2009a). We calculate the IQIs and PSIs using Medicare Provider Analysis and Review inpatient hospital data files for 2008 through 2011 and version 4.1b of the AHRQ mortality and PSI software (Agency for Healthcare Research and Quality 2009b).

### **Most in-hospital and 30-day mortality rates declined**

In-hospital and 30-day postdischarge mortality rates, as measured by the AHRQ IQIs, declined by a statistically significant amount for four of the five conditions we monitor. From 2008 through 2011, risk-adjusted in-hospital and 30-day mortality rates declined by a statistically significant amount for acute myocardial infarction (AMI), congestive heart failure, stroke, and pneumonia, as measured by AHRQ methods. The in-hospital and 30-day mortality rate for patients admitted with hip fracture also declined but not by a statistically significant amount.

### **Patient safety indicators improved**

Rates improved from 2008 to 2011 for five of the six PSIs we analyzed, including iatrogenic pneumothorax, postoperative respiratory failure, postoperative pulmonary embolism or deep-vein thrombosis, postoperative wound

dehiscence, and accidental puncture or laceration. The PSI that did not improve from 2008 to 2011 was the rate of deaths among surgical inpatients with treatable serious complications. Caution should be used in interpreting all the reported PSI rates. The PSIs measure rates of very rare events, and it is difficult to detect statistically significant changes in these indicators. In addition, AHRQ and other researchers have found that changes over time in providers' coding practices and variations among providers in how patient safety events are captured and reported can affect the accuracy and reliability of some of the PSIs (Agency for Healthcare Research and Quality 2007a, Agency for Healthcare Research and Quality 2007b, Agency for Healthcare Research and Quality 2009a, Rosen et al. 2012). Nonetheless, we monitor sector-level trends in selected PSIs as indicators, though not definitive evidence, of increases and decreases in rates of harm to patients resulting from their medical care that can be avoided if providers adhere to known clinical safety practices.

### **Readmission rates have improved slightly following public reporting**

The Commission recommended implementation of a readmissions policy in June 2008 because avoidable readmissions represent poor outcomes for beneficiaries and unnecessary costs to the Medicare program. CMS began to publicly report readmission rates in 2009. In addition, a penalty for high AMI, pneumonia, and heart failure readmissions started in fiscal year 2013, creating further pressure for hospitals to reduce readmission rates. From 2009 to 2011, potentially preventable readmission rates decreased 0.7 percentage point. The full effect of the readmission policy will not be known until after the readmission penalty takes effect in 2013.

The benefits of reducing readmissions accrue to both the beneficiary and the Medicare program. The benefits for the patient can include improved care in the hospital, more help with transitioning to other settings, better care coordination outside the hospital, and avoiding unnecessary subsequent hospital stays. The benefit to the Medicare program has two parts: savings from the avoided readmissions plus any revenue from penalties on hospitals with excessive readmission rates. The current policy has penalties of about \$300 million in 2013 (0.2 percent of total payments), whereas potential savings from reducing avoidable readmissions is much higher. For example, a 20 percent decline in potentially preventable

readmissions (from 12.3 percent to 9.8 percent) would reduce readmission spending by more than \$2.5 billion.

While readmission rates have improved, research suggests further progress can be made. For example, Silow-Carroll and colleagues cited improving the process within the hospital to reduce complications in order to indirectly prevent readmissions (Silow-Carroll et al. 2011). Other strategies include scheduling follow-up visits, reconciling medications before discharge, and using case managers for complex cases (Jack et al. 2009, Kanaan 2009). Better transition planning and execution reduce readmissions by encouraging and facilitating communication among providers, as well as encouraging patient education and self-management (Naylor et al. 2011). In patients with low cognitive function or poor health literacy, these efforts are bolstered by a postdischarge plan that is comprehensible to both patient and caregiver, in addition to the guidance of a health coach (Chugh et al. 2009, Parry and Coleman 2010). Efforts in the hospital setting can be made in conjunction with coordination across the post-acute care sector. Interventions by pharmacists, home health nurses, and skilled nursing facilities may prevent further hospitalizations after the patient has been discharged (Bellone et al. 2012, Kanaan 2009).

While the current financial incentive to reduce readmissions is a clear improvement over the past when hospitals had a financial disincentive to take action to reduce readmission rates, refinements to the readmission policy will eventually be needed as the program matures. Future revisions to the policy should be designed to maintain or increase the average hospital's incentive to reduce readmissions, increase the share of hospitals that have an incentive to reduce readmissions, make penalties a constant multiple of the costs of readmissions, and continue to generate savings that are at least equal (budget neutral) to current policy (Medicare Payment Advisory Commission 2012a). The Commission plans to discuss issues with the current readmission policy in future analyses.

### **Value-based incentive payments**

In an effort to move from purely paying for volume toward paying for value, Medicare has begun to publicly report quality metrics and (starting in 2013) to adjust hospital payments based on a series of quality metrics. As mandated by PPACA, the value-based purchasing (VBP) program started in fiscal year 2013. For the first year of the VBP program, CMS will reduce all DRG payments

to about 3,100 participating PPS hospitals by 1 percent of base inpatient payments. The funds will be used to create a pool of funds from which value-based (i.e., performance-based) incentive payments will be made. CMS estimates that this payment redistribution will total \$850 million in fiscal year 2013. As required by law, the VBP program must be budget neutral, meaning that the total amount of withheld payments must be redistributed to hospitals participating in the VBP program.

In 2013, each hospital's performance score will be based on 12 process measures and 1 patient experience measure; in fiscal year 2014, CMS will add one clinical process measure and three outcome measures (condition-specific mortality rates) to the VBP program. The Commission has expressed concern regarding the relatively low weight (25 percent) assigned to outcomes (Medicare Payment Advisory Commission 2012a). Given some of the concerns regarding coding and process measures as well as the importance of outcomes, a stronger emphasis on outcomes may be warranted.

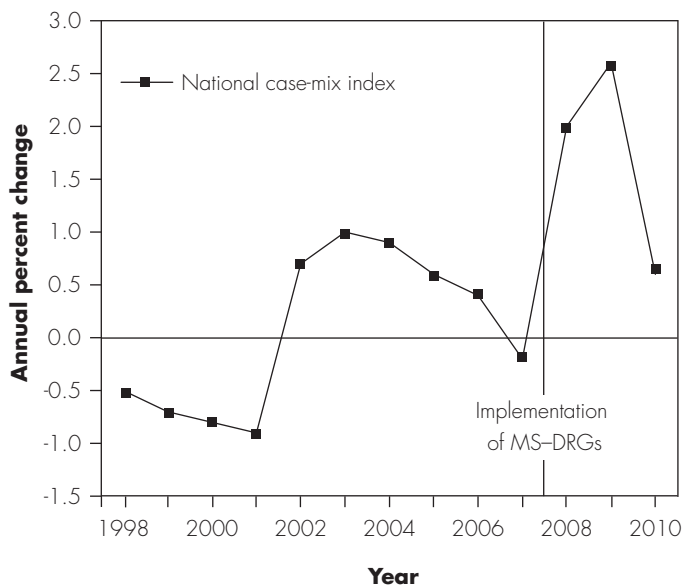
While quality as measured by process, patient safety, and outcomes has been improving, some have questioned whether financial incentives affect quality any more than public reporting alone. For example, the 260 hospitals that participated in the CMS/Premier pay-for-performance demonstration improved their performance by an amount equal to the 780 control hospitals that were involved only in CMS's public reporting (Werner et al. 2011). In addition, other work shows that the downward trajectory in central catheter-associated bloodstream infections was not affected by a 2008 change in Medicare policy that stopped allowing these cases to count as a complication that would increase DRG rates (Lee et al. 2012). However, in this case, because other comorbidities and complications almost always exist, the magnitude of this penalty was minimal. It may take several years of observation to determine if the financial incentives in the current VBP program generate greater improvements than were observed when these quality metrics were subject only to public reporting. It is also possible that greater incentives are needed for certain changes (such as reducing readmissions that generate revenue for hospitals) than are needed for other changes (such as reducing central-line infections that generate additional costs for hospitals).

### **Medicare payments and providers' costs**

In assessing payment adequacy, the Commission also considers the estimated relationship between Medicare

**FIGURE  
3-6**

**After implementation of MS-DRGs,  
the change in reported case mix  
was more than twice the  
rate in previous years**



Note: MS-DRG (Medicare severity–diagnosis related group).

Source: MedPAC analysis of inpatient prospective payment system hospital inpatient claims in the final-rule Medicare Provider Analysis and Review (MedPAR) files for fiscal years 1997–2009 and the proposed-rule MedPAR file for fiscal year 2010, from CMS. Case-mix indexes (CMI) are based on the diagnosis related group grouper, relative weights, and transfer policies in effect for each fiscal year. Claims for hospitals designated as critical access hospitals as of December 31, 2010, were excluded from the CMI for all years.

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, 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 revenue-generating services hospitals provide 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 when 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 costs presents challenges. By combining data for all major 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.

Our hospital update recommendation applies to hospital inpatient and outpatient payments. Payments for the other distinct units of the hospital, such as SNFs, are addressed by our update recommendations for those payment systems, which apply to both hospital-based and freestanding providers.

### Medicare payment changes

Growth in Medicare hospital payments per discharge under the IPPS depends primarily on three factors: (1) annual payment updates, (2) changes in reported case mix, and (3) policy changes that are not implemented in a budget-neutral manner. In 2011, IPPS hospitals received a 2.3 percent payment update to operating rates, case mix grew by 0.5 percent, and the low-volume adjustment substantially increased payments to rural hospitals. However, these increases were largely offset by a 2.9 percent downward adjustment implemented in 2011 to recover overpayments in 2008 and 2009 that stemmed from changes in documentation and coding of clinical diagnoses (see below). The net effect was that the average per case payment rate increased by 0.7 percent from 2010 to 2011. While the average was 0.7 percent, rural hospitals received a 3.0 percent increase, and small hospitals with under 50 beds received an 8.1 percent increase because of a temporary low-volume adjustment discussed below. This low-volume increase initially expired at the end of fiscal year 2012 but was extended through the end of fiscal year 2013 by the American Taxpayer Relief Act of 2012.

**Corrections for past documentation and coding changes decreased rate increases for 2011 and 2012** Medicare implemented MS-DRGs in 2008, which gave hospitals an opportunity to increase their payments by changing their coding practices. Analyses by both CMS and the Commission have concluded that the increases in case mix reported from 2008 through 2010 (2.0 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 (Figure 3-6) (Medicare Payment Advisory Commission 2010b). This finding explains how hospitals could record high growth in case mix from 2008 to 2010 without a corresponding increase in cost growth (Table 3-3). We estimate that documentation and coding changes led to more than \$6 billion of additional payments in 2008 and 2009, which CMS recovered through a temporary reduction in hospital payments in 2011 and 2012. Hospital payment rates increased in fiscal year 2013 by 2.7 percent when the two-year temporary reductions expired.<sup>8</sup> For a more detailed description of this issue, see the Commission’s comment letter on the 2012 proposed rule, June 17, 2011, at [http://www.medpac.gov/documents/06172011\\_FY12IPPS\\_MedPAC\\_COMMENT.pdf](http://www.medpac.gov/documents/06172011_FY12IPPS_MedPAC_COMMENT.pdf).

**Reported case mix increased by 0.5 percent** In fiscal year 2011, the reported case mix for Medicare patients in hospitals increased by 0.5 percent. Case-mix growth has slowed over time as the effects of documentation and coding changes have diminished. It is not clear the extent to which the reported growth of case mix in 2011 represents increases in patient severity and to what extent it represents continued changes in coding. Given the small magnitude of case-mix change, we have not performed the analysis done in prior years to categorize this change in reported case mix.

**Policy change: Low-volume adjustments temporarily increased rural hospital payments** PPACA instituted a temporary low-volume payment adjustment that initially applied to fiscal year 2011 and fiscal year 2012 payments to hospitals with fewer than 1,600 Medicare discharges that are more than 15 road miles from another hospital. Hospitals with 200 or fewer Medicare discharges received a 25 percent payment add-on to their IPPS payments. The add-on declined linearly from 25 percent to 0 percent for hospitals with 1,600 Medicare discharges. The temporary low-volume adjustment added \$380 million to low-volume hospitals’ payments and helped to increase rural hospital inpatient payments by 3.0 percent in 2011, compared with a 0.4 percent increase for urban hospitals. Smaller rural hospitals saw the biggest percentage increases; rural hospitals with fewer than 50 beds saw Medicare payments per case rise by 8.1 percent. This temporary adjustment applied mostly to rural hospitals and will remain in effect through fiscal year 2013, when it will be replaced by the original empirically based low-volume adjustment—a 25 percent

**TABLE 3-3**

**Cost growth slowed close to input price inflation after 2008**

Cost measure	Annual cost growth				
	2007	2008	2009	2010	2011
Inpatient costs per admission	4.3%	5.5%	2.9%	2.0%	2.8%
Outpatient costs per service	5.6	5.1	4.8	0.1*	2.7
Weighted average	4.5	5.4	3.3	1.6	2.8
Input price inflation	3.4	4.3	2.6	2.1	2.6

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 by hospital staff, including costs for inpatient, outpatient, skilled nursing facility, inpatient rehabilitation, and home health services.  
\*Outpatient cost growth was 1.7 percent if we adjusted for complexity of services provided. Input price inflation reflects a weighted average of the hospital operating and capital market baskets.

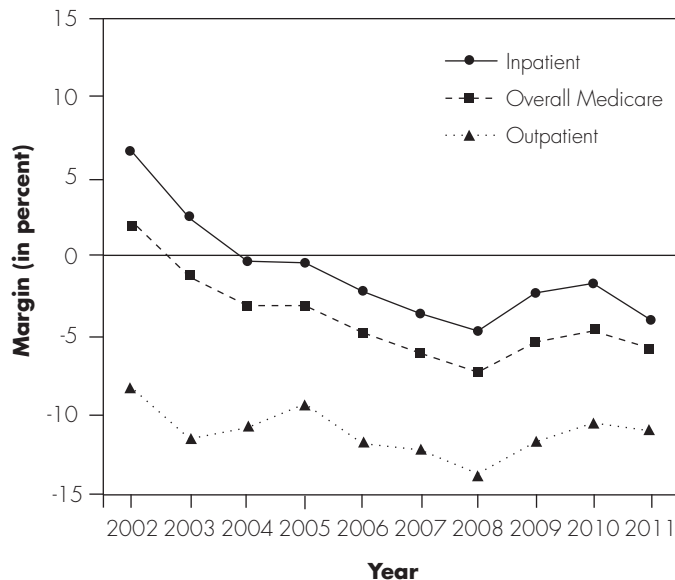
Source: MedPAC analysis of Medicare hospital cost reports and claims files.

add-on to hospitals with fewer than 200 total discharges that are more than 25 miles from the nearest hospital.

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

Following a period of rapid cost growth from 2002 to 2008, a combination of low input price inflation and financial uncertainty has resulted in relatively slow hospital cost growth. From 2009 through 2011, Medicare inpatient costs per case continued to rise at rates close to underlying input price inflation, growing by 2.9 percent in 2009, 2.0 percent in 2010, and 2.8 percent in 2011—cumulatively just 0.4 percentage point faster than input price inflation (the hospital market basket index) during this period. While cost growth ticked up slightly in 2011 from a more than 10-year low in 2010, it still remained lower than the growth rates experienced through most of the 2000s, when hospital cost growth averaged 1 or more percentage points faster than the hospital market basket increase. Our analysis also shows that growth in outpatient costs per service rose at close to input price inflation, rising by 2.7 percent in 2011 (Table 3-3).

The lower cost growth from 2009 through 2011 was partly due to lower input price inflation facing hospitals, reflecting lower general economy-wide inflation for goods and services and slower wage growth. Compensation costs

**FIGURE  
3-7****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), and inpatient psychiatric and rehabilitation services, plus graduate medical education.

Source: MedPAC analysis of Medicare cost reports.

for hospital workers, for example, grew by less than 2.5 percent in each year from 2009 through 2012. These increases are the smallest ones in hospital compensation costs in more than a decade (Bureau of Labor Statistics, <http://www.bls.gov/web/eci/echistrynaics.pdf>). Hospitals may also have tried to control cost growth in response to the recession and the financially difficult year they had in 2008, when the industry experienced historically low total all-payer margins (1.8 percent) and had steep declines in their balance sheets.

Lower cost growth could also be the result of shifting more expensive surgical patients to an outpatient setting. Although the reported inpatient case mix increased, after accounting for documentation changes, inpatient case mix declined slightly as some high-cost surgical services shifted from the inpatient setting to outpatient settings. Growth in cost per unit of outpatient services was 0.1 percent in 2010 (Table 3-3, p. 55). However, this reflects

the decline in outpatient service mix as physicians' office visits (a relatively inexpensive service) increased as a share of overall outpatient services. Without this change in service mix, outpatient cost growth would have been 1.7 percent in 2010.

This lower cost growth, however, is not uniform across provider groups. In 2011, smaller hospitals had higher cost growth. This higher growth could be in response to higher revenues associated with two temporary policies: the low-volume adjustment and the temporary low-spending county payment. Rural hospitals with fewer than 50 beds, for example, saw inpatient payments per case increase by 8.1 percent in 2011 but also had much higher cost growth—7.3 percent per case.

**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 PPS. The overall Medicare margin trended downward from 1997 through 2008.<sup>9</sup> However, from 2008 to 2010, the overall Medicare margin went up from -7.3 to -4.7 percent, largely due to documentation and coding changes and lower cost growth. In 2011, it declined to -5.8 percent as CMS started to recover past overpayments (Figure 3-7). Both inpatient and outpatient margins improved in 2010 but declined in 2011 as cost growth exceeded payment growth. The overall Medicare margin is dominated by inpatient and outpatient services, which, when combined, represent 92 percent of hospitals' Medicare revenues.

**2011 Medicare margins by hospital type**

We further examined the overall aggregate Medicare margin by hospital type. In 2011, the -3.2 percent overall Medicare margin for rural PPS hospitals was higher than the -6.2 percent margin for urban hospitals (Table 3-4). Smaller rural hospitals saw the greatest improvement in their overall Medicare margins. Between 2010 and 2011, overall margins increased from -2.5 percent to 0.9 percent for rural hospitals in the bottom quartile of inpatient volume. This improvement is likely temporary, however, as many of these hospitals received

a combination of low-volume and other temporary payments that they will not receive in fiscal year 2014.

Overall Medicare margins at for-profit hospitals remained above those at nonprofit hospitals. In 2011, for-profit hospitals' overall Medicare margins were -1.0 percent compared with -7.2 percent at nonprofit hospitals. Both Medicare inpatient and outpatient margins are higher on average in for-profit hospitals.

In 2011, the overall Medicare margin was -2.4 percent for major teaching hospitals (Table 3-4). Major teaching hospitals have higher overall Medicare margins than the average IPPS hospitals, in large part due to the extra inpatient payments they receive through the indirect medical education and disproportionate share (DSH) adjustments. A Commission analysis shows that both of these adjustments provide payments that substantially exceed the estimated effects that teaching intensity and service to low-income patients have on hospitals' average cost per admission. 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 Medicare margins on average, -8.3 percent in 2011.

Three sets of temporary payments increased revenues for many hospitals: the revised low-volume adjustment, the low-spending county payment add-on, and special payments for health information technology. In 2011, we estimate that these payments added over \$2 billion to hospital revenues. This extra revenue likely contributed to some of the improvement in the margins for many facilities. If these temporary revenues were not included, the overall Medicare margin would have stood at -6.7 percent rather than the -5.8 percent we are reporting. For hospitals to maintain their Medicare margins when the health information technology payments expire in 2016, they will need to constrain cost growth below the growth in input price inflation.

### Medicare margins are expected to remain steady through 2013

In 2013, we project margins will remain roughly equal to 2011 levels. Inpatient and outpatient payments rates are expected to increase by roughly 3 percent to 4 percent, and case mix is expected to continue to increase slightly. Costs are expected to grow by 5 percent to 6

**TABLE  
3-4**

### Overall Medicare margins by hospital group

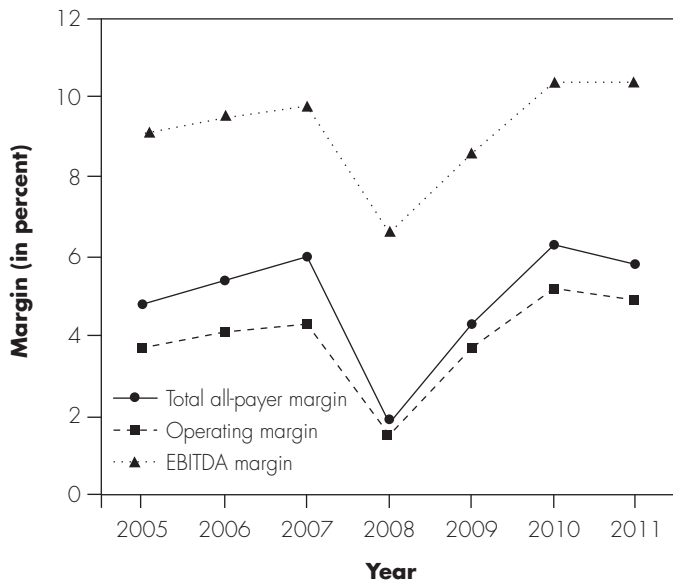
Hospital group	2007	2008	2009	2010	2011
All hospitals	-6.1%	-7.3%	-5.4%	-4.7%	-5.8%
Urban	-6.2	-7.5	-5.5	-4.9	-6.2
Rural					
Excluding CAHs	-5.2	-6.0	-4.6	-2.8	-3.2
Including CAHs	-3.6	-4.1	-3.1	-1.8	-1.8
Nonprofit	-7.0	-8.5	-6.7	-5.9	-7.2
For profit	-3.5	-2.8	-0.2	-0.1	-1.0
Government*	N/A	N/A	N/A	N/A	N/A
Major teaching	-0.2	-2.1	-0.8	-0.5	-2.4
Other teaching	-6.5	-7.5	-5.4	-4.7	-5.4
Nonteaching	-9.4	-10.3	-8.1	-7.2	-8.3

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, as well as CAHs where indicated. A margin is calculated as payments minus costs, divided by payments; margins are based on Medicare-allowable costs. Overall Medicare margins cover acute inpatient, outpatient, hospital-based skilled nursing facility (including swing bed), home health, and inpatient psychiatric and rehabilitation services, plus graduate medical education. The rural margins are shown with and without 1,300 CAHs, which are paid 101 percent of costs for inpatient and outpatient services. The margins without CAHs illustrate the profitability of rural hospitals paid prospective payment system rates; 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 file.

percent over two years, which is roughly in line with input price inflation. Therefore, we expect payment rates to grow roughly 2 percent more slowly than costs. However, we also expect an increase in supplemental Medicare payments to hospitals that achieve meaningful use of electronic medical records. These temporary supplemental payments will contribute to Medicare margins remaining at roughly -6 percent from 2011 through 2013.<sup>10</sup>

The projection of -6 percent depends upon hospitals maintaining their rate of cost growth at the rate of input price inflation. It is uncertain whether hospitals will be under sufficient pressure to maintain that level of growth in cost given the strong growth in all-payer profitability that has occurred in recent years. In the past, we have seen cost growth accelerate when hospitals are under less pressure to constrain costs.

**FIGURE  
3-8****Hospitals' financial performance  
has been improving after  
poor performance in 2008**

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

Source: MedPAC analysis of Medicare hospital cost reports.

**Total (all-payer) profitability of hospitals recovered after 2008 because of restrained cost growth and strong growth in private-payer payment rates**

Hospitals' total (all-payer) profit margins are an indicator of how much financial pressure hospitals are under to control costs. Total (all-payer) margins for hospitals increased to 6.0 percent in 2007 (Figure 3-8). Following this relatively high all-payer profitability, cost growth was high in 2008 (5.5 percent), as many hospitals started the year with little pressure to constrain costs. However, the picture changed rapidly in September 2008 with the collapse of the bond and stock markets. In part due to investment losses, total all-payer margins in 2008 fell to 1.8 percent, the lowest level in more than two decades. Operating margins fell, investment income declined dramatically, some defined-benefit pension plans needed larger contributions from their hospital sponsors, and the economic outlook was uncertain. This situation created financial pressure to constrain costs. In response, hospitals pulled back from the unsustainable levels of capital expenditures and cost growth seen in 2007 and 2008 to more moderate levels from 2010 through 2012. As capital

and wage growth slowed, cost growth slowed in 2010 to the lowest level recorded in more than 10 years, reflecting both slowing input price growth and hospitals' efforts to constrain cost growth. For the first time in 10 years, cost growth slowed to near the rate of input price inflation. All-payer profit margins rose because of increases in private-payer rates in the range of over 6 percent per year (roughly double cost growth in recent years), which more than offset slower growth in Medicare payments (Health Care Cost Institute 2012).

Cost growth may start to increase in response to the rebound in hospitals' total all-payer margin, which climbed back to roughly 6 percent in 2010 and 2011 (Figure 3-8). This 6 percent is roughly the peak level of margins achieved in more than 20 years. In addition, cash flow—as measured by earnings before interest, taxes, depreciation, and amortization—held steady at 10.4 percent in 2011, showing that 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 depended on its financial resources (Medicare Payment Advisory Commission 2012c). In general, in periods when hospitals were under pressure because of managed care pressures or contractions in the economy, cost growth per admission grew slowly. In periods when profit margins were high, cost growth per admission grew more rapidly.

**Hospital-level financial pressure and hospital costs**

The effect of financial pressure on hospital 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 2006 to 2010. 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 profit margins of more than 5 percent. We found that hospitals under high pressure from 2006 to 2010 ended up with lower costs

per admission in 2011 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 2011b).

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 costs per case that were roughly 8 percent lower than the national median for all 2,893 IPPS hospitals with available data. Because of their lower costs, hospitals under pressure generated a median overall Medicare profit margin of 4 percent, which is 9 percentage points above the national median.
- *Low pressure = high cost:* The 59 percent of hospitals that were under a low level of financial pressure had median standardized costs per case that were 4 percent above the national median. Because of higher costs, they generated a median Medicare profit margin of -10 percent, which is 5 percentage points below the national median.
- *Recent cost growth is similar:* Both low-pressure and high-pressure hospitals have constrained cost growth to about 3 percent per year from 2009 to 2011. This growth is roughly the rate of input price inflation. The similar rate of cost growth for the two groups suggests that most hospitals under financial pressure have been so for many years, and the differential between costs and margins for the two groups has remained constant.
- *For profits have different incentives:* For-profit hospitals tended to keep their median standardized 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, but 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 often generated profits treating Medicare patients in 2011. The next question is whether a 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 IQIs), readmission rates (3M potentially preventable readmissions), standardized inpatient costs per case, hospitals' payer mix, and the annual level of overall FFS Medicare service use per capita 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 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. 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 service use per FFS beneficiary. This method reduces the chance that a hospital would appear to have low unit costs of service simply because it is in an area with a high volume of low-cost discharges that could have been treated on an outpatient basis.

We further restricted the population of hospitals studied by removing the 10 percent of hospitals with the smallest shares of Medicaid patients. This process reduces the likelihood of including hospitals solely 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 from 2008 to 2010. We then examined the performance of the two hospital groups in fiscal year 2011.

Hospitals were identified as relatively efficient if they met four criteria every year of the 2008 to 2010 period:

- Risk-adjusted mortality levels were in the best two-thirds of all hospitals.

**TABLE  
3-5**

**Performance of efficient hospitals relative to the national average**

Relative performance measure	Type of hospital	
	Relatively efficient during 2008-2010	Other hospitals
Number of hospitals	297	1,864
Share of hospitals	14%	86%
<b>Historical performance, 2008-2010 (percent of national median)</b>		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	84%	103%
Readmission rates (3M)	95	101
Standardized cost per admission	90	102
<b>Performance metrics, 2011 (percent of national median)</b>		
Risk-adjusted:		
Composite 30-day mortality (AHRQ)	87%	103%
Composite 30-day readmission (3M)	95	101
Standardized cost per discharge	90	102
Percent of patients highly satisfied, 2011 (H-CAHPS®)	69	67
Median:		
Overall Medicare margin, 2011	2%	-6%
Non-Medicare margin, 2011	5	7
Total (all-payer) margin, 2011	4	4
Median occupancy, 2011	63%	57%

Note: AHRQ (Agency for Healthcare Research and Quality), H-CAHPS® (Hospital Consumer Assessment of Healthcare Providers and Systems). "Relative" refers to the median of 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 admission by the share of discharges in that particular hospital. We removed hospitals with low Medicaid patient loads (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) because of concerns that socioeconomic conditions and aggressive treatment patterns could influence unit costs and outcomes.

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

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

The objective is to identify hospitals that have consistently performed at an above-average level on at least one measure (cost or quality) and that have 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 2008 to 2010** Of the 2,161 hospitals that met our screening criteria, 297, or about 14 percent, were found to be relatively efficient during the 2008 to 2010 period. The set of relatively efficient providers was a diverse array of hospitals, including large teaching hospitals and smaller rural hospitals. Roughly 19 percent of teaching hospitals, 11 percent of nonteaching hospitals, 9 percent of rural hospitals, 15 percent of urban hospitals, 10 percent of proprietary hospitals, and 15 percent of nonprofit hospitals were in the group of relatively efficient providers. Teaching and urban hospitals are overrepresented because they often have lower than

average mortality rates, in part due to their higher volume of patients. While 63 percent of for-profit hospitals in our sample had below-average costs, only 40 percent had below-average mortality, and 37 percent had below-average readmissions. The net result is that for-profit hospitals are one-third less likely to be in our relatively efficient category (10 percent of for profits vs. 15 percent of nonprofits), even though they tend to be low-cost providers. This result illustrates how efficiency reflects more than the cost of care. 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 for the 2008 to 2010 period according to the three measures by reporting the group's median performance divided by the median for the set of 2,130 hospitals in our analysis (Table 3-5). The median efficient hospital's relative risk-adjusted 30-day mortality rate from 2008 through 2010 was 84 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 16 percent better than the national median. The median readmission rate for the efficient group was 5 percent below the national median. Standardized cost per admission for the efficient group was 10 percent below the national median.

**Historically strong performers had lower mortality and readmissions in 2011** The composite mortality level for the efficient group was 13 percent below the national median in 2011. In addition, the efficient group's risk-adjusted 30-day readmission rate was 5 percent lower than the national median. The efficient group also performed slightly better than other hospitals on patient satisfaction. The share of patients who were highly satisfied was 69 percent of those treated in the efficient group, compared with 67 percent in the comparison group.

**Historically strong performers continued to have lower costs in 2011** Hospitals that were low-cost and low-mortality providers from 2008 through 2010 continued to have lower costs in 2011. The median standardized Medicare cost per admission 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 -6 percent. Among the relatively efficient hospitals, 57 percent had positive

overall Medicare margins, compared with 31 percent for other hospitals. The distribution of Medicare margins for the efficient hospitals ranged from -5 percent to 8 percent at the 25th percentile and 75th percentile, respectively. For the comparison group, the distribution of Medicare margins was -16 percent to 2 percent at the 25th percentile and 75th percentile, respectively. Part of the relatively efficient group's higher profitability is explained by higher hospital occupancy: The relatively efficient hospitals had roughly 10 percent higher occupancy (63 percent for the efficient group vs. 57 percent for the others). Pressure to constrain costs could also play a role in efficiency; among the relatively efficient hospitals, 50 percent were under high or medium financial pressure to constrain their costs compared with 40 percent for the other hospitals.

### **2014 payment policies will differ significantly from 2011**

By 2014, there will be several significant changes in Medicare payment policy, including changes to incentive payments for electronic health records (EHRs) and scheduled reductions in Medicare DSH payments that are tied to expected decreases in the numbers of uninsured individuals. In addition, starting in 2013, a small offset to updates will occur because of the enactment of a readmission penalty and the expiration of certain special payments directed at rural hospitals, as discussed below. Therefore, we expect payments to rise faster than the update in 2012 but then start to rise more slowly than the current law update from 2013 onward due to policy changes that reduce payments to hospitals.

### **EHR Incentive Program increases Medicare payments from 2011 through 2016**

The Medicare EHR Incentive Program was enacted in the Health Information Technology for Economic and Clinical Health (HITECH) Act, part of the American Recovery and Reinvestment Act of 2009. Hospitals that have met the EHR requirements received a total of roughly \$300 million in EHR payments in fiscal year 2011 and \$2.5 billion in fiscal year 2012 because of an increase in hospitals meeting the meaningful-use criteria. We expect payments to rise to roughly \$3 billion in 2013 and then start to decline each year until the program ends in 2016. While only 31 percent of hospitals had received their first payment by the end of fiscal year 2012, 81 percent of hospitals (3,955 of 4,855) had registered to participate in the Medicare EHR Incentive Payment Program by the end of fiscal year 2012 and are expected to receive EHR payments in future years.<sup>11</sup> As part of the HITECH

Act, the EHR Incentive Program also includes a nearly equivalent Medicaid EHR Incentive Program, with its own set of provider eligibility criteria and incentive payment amounts.<sup>12</sup>

### **Changes to Medicare DSH policy in 2014 will eventually lower Medicare payments to hospitals**

In 2011, Medicare paid roughly \$11 billion in DSH payments to IPPS hospitals, which represents 7 percent of all Medicare payments to short-term ACHs. DSH payments are supplementary inpatient payments given to hospitals with high shares of low-income patients. For purposes of computing DSH payments, the low-income patient share is defined as the sum of two ratios: the share of Medicare patients on Supplemental Security Income (SSI) plus the share of Medicaid days relative to all inpatient days.

The original justification for Medicare DSH payments was that low-income Medicare patients were thought to be more expensive in ways that were not accounted for by the original DRG system. By 2011, the Commission and other researchers concluded that, at most, 25 percent of the DSH payments were empirically justified by the higher Medicare costs at hospitals treating low-income patients (Medicare Payment Advisory Commission 2007a, Nguyen and Sheingold 2011).

Some have argued that DSH payments should continue in order to assist hospitals that serve low-income patients because of their higher non-Medicare uncompensated care burdens. However, in 2007 the Commission noted that DSH payments were not well targeted at hospitals with high uncompensated care costs (Medicare Payment Advisory Commission 2007a). Because at most 25 percent of DSH payments were empirically justified as covering higher Medicare costs and DSH payments were poorly targeted at hospitals with high uncompensated care costs, the Congress made several changes in the DSH payments as part of PPACA. The key changes scheduled to take place in fiscal year 2014 are:

- DSH payments will be reduced to 25 percent of what they would have been under prior DSH formulas.
- The remaining 75 percent of the pool of DSH dollars will be divided into two parts:
  - One part will be used to create a pool of dollars to pay for uncompensated care at hospitals. We expect CMS to define uncompensated care as non-Medicare bad debts and charity care, as in

current Medicare cost reports. Each hospital will receive a share of the uncompensated care pool proportionate to its share of all IPPS hospitals' uncompensated care costs.

- The remainder of the DSH pool will be retained by the Medicare trust fund as savings. For every 1 percent decline in the rate of uninsurance among those under 65 years of age, the share of the DSH pool allocated to uncompensated care will decline by 1 percent, and that decline will be retained by the Medicare program.
- The amount of uncompensated care is expected to decline as the subsidized insurance exchanges become operational in 2014 and states expand Medicaid eligibility.

The change in aggregate Medicare payments to hospitals from new DSH payments and payments from the uncompensated care pool will depend on two key factors. First, PPACA will expand eligibility for Medicaid in 2014, which will result in a larger DSH pool. The Congressional Budget Office (CBO) has estimated that Medicaid enrollment will expand by roughly 20 percent under PPACA.<sup>13</sup> If this estimate holds, Medicaid inpatient days are expected to expand by roughly 20 percent.<sup>14</sup> The expansion of Medicaid days will result in a larger pool of DSH dollars because DSH is based on the share of Medicare patients on SSI plus the share of non-Medicare inpatient days that are Medicaid days.

Second, the rate of uninsurance is expected to decline, which will shrink the share of the DSH pool allocated to uncompensated care and will increase the savings for the trust fund. The current policy is designed to decrease Medicare payments to hospitals for uncompensated care as the number of uninsured declines. As more people gain insurance through expanded Medicaid coverage or through the exchanges, the amount of money available for uncompensated care payments to hospitals declines.

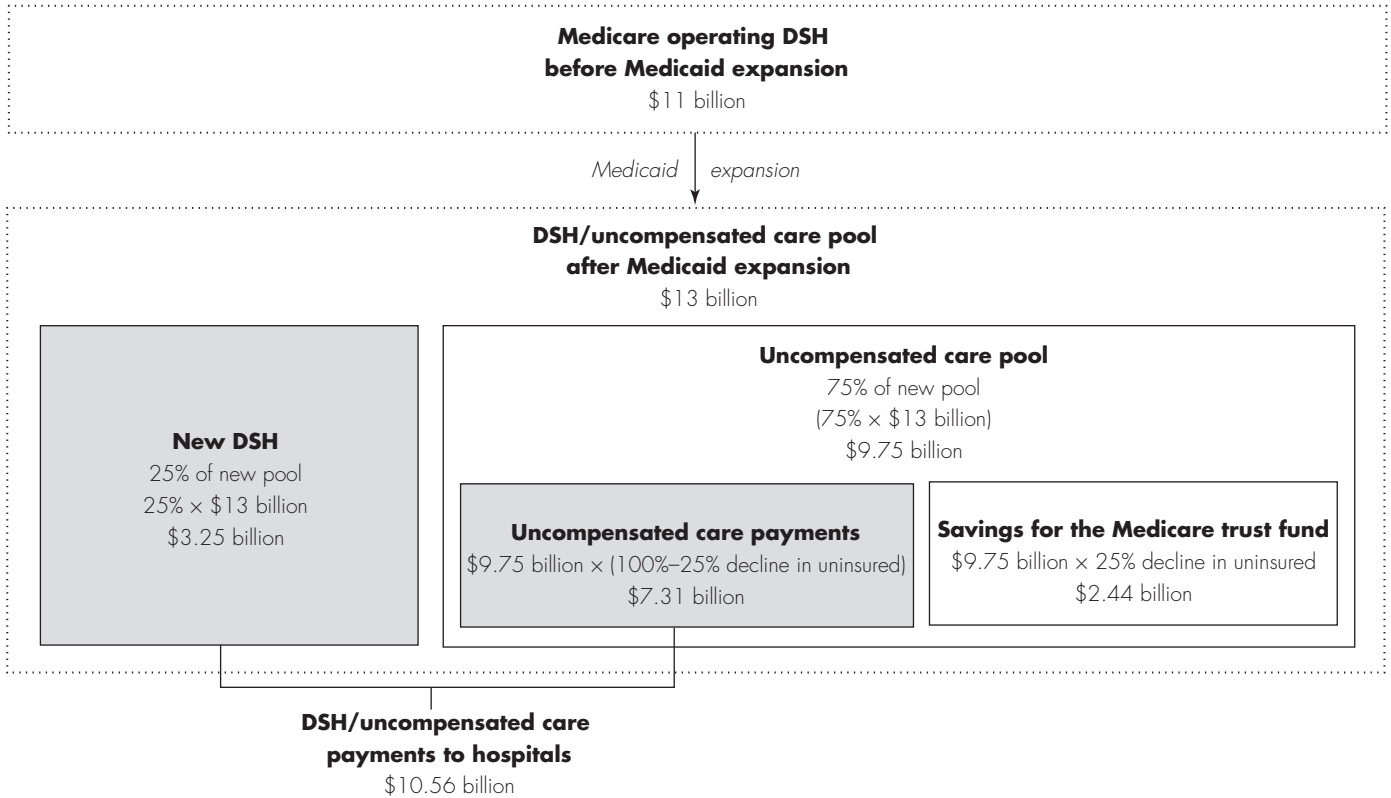
It is difficult to predict the net change in Medicare payment to hospitals from these two factors (decreasing DSH payments and increasing uncompensated care payments) because of factors that introduce uncertainty into the computation. For example, some states may not expand their Medicaid eligibility, and the share of low-income individuals who will use the exchanges is uncertain. For these reasons, we have conducted a sensitivity analysis of how DSH payments will change with changes in Medicaid enrollment and the uninsured.



**FIGURE  
3-9**

**Illustration of DSH payment changes under new 2014 payment policy**

- Key assumptions:**
- A 20 percent increase in Medicaid patients and inpatient days
  - A 25 percent decline in the rate of uninsured



- Net effects on hospital payments under illustrative scenario**
- Starting level of DSH payments \$11 billion
  - +\$2 billion in payments due to 20 percent expansion of Medicaid
  - –\$2.44 billion in payments due to 25 percent reduction in uninsured
  - Projected \$10.56 billion in DSH/uncompensated care payments to hospitals
  - If the rate of uninsurance declines further, payments will decline further.

Note: DSH (disproportionate share hospital). Computations were made using 2011 Medicare payment rates and 2011 cases to isolate the effect of policy changes.

Source: MedPAC simulation using Congressional Budget Office estimates of the rate of uninsurance.

Given a 20 percent increase in Medicaid enrollment and a 25 percent decline in the rate of the uninsured (as CBO estimated for 2014), we estimate that the net amount of payments to hospitals under the DSH and uncompensated care policies would decline by about \$0.44 billion in 2014 (Figure 3-9).<sup>15</sup>

In the future, if the insurance exchanges are successful and more people become insured, payments will decline

significantly. For example, if Medicaid enrollment expanded by 25 percent and the number of uninsured individuals fell by 50 percent (as CBO estimated for 2017), the pool of dollars going to hospitals would decline by roughly \$2.3 billion, or 1.5 percent of all Medicare payments. In general, as the rate of the uninsured declines, Medicare payments for uncompensated care will decline. We expect hospitals' uncompensated care costs to decline

as Medicaid expands, the new insurance exchanges are established, and the penalties for being uninsured go into effect.

### **Other inpatient policy changes**

CMS and the Congress made a variety of policy changes affecting the acute IPPS for fiscal year 2012, fiscal year 2013, and future years. Among these changes are the series of adjustments for increases in payments due to hospitals' changes in medical record documentation and coding and several PPACA-mandated policy changes.

In 2009, CMS completed its implementation of MS-DRGs and cost-based relative weights. CMS and the Commission concur that hospitals responded to the financial incentives of the MS-DRG system by changing medical record documentation and diagnosis coding, which resulted in assignment of cases to higher weighted MS-DRGs. This change in assignments increased payments without an accompanying increase in resources used and thus resulted in unintended increases in payments.

Analyses by both CMS and the Commission found that changes in documentation and coding increased annual payments by 5.4 percent by 2009, resulting in a total of \$6 billion in extra payments to hospitals in 2008 and 2009. To correct for rates being 5.4 percent too high, CMS adjusted payments downward by a total of 5.4 percent (0.6 percent in 2008, 0.9 percent in 2009, 2.0 percent in 2012, and 1.9 percent in 2013). CMS also made a temporary 2.9 percent adjustment in 2011 and 2012 to recover past overpayments in 2008 and 2009.

In addition, CMS estimated that payments increased by another 0.8 percent in 2010 because of hospitals' continuing changes in documentation and coding. These changes raised hospitals' payments in 2011 and 2012 and will continue to raise payments in 2013 and into the future until CMS makes an offsetting adjustment. Our analysis finds that an adjustment of between -0.6 percent and -0.8 percent is needed to offset the effect of 2010 changes in documentation and coding. CMS has stated it will consider adjusting 2014 inpatient payment rates downward by as much as an additional 0.8 percent to account for the changes in 2010 (Centers for Medicare & Medicaid Services 2012). Our analysis also finds that the documentation and coding led to overpayments of more than \$11 billion during 2010 through 2012. The American Taxpayer Relief Act of 2012 mandates that

CMS recover the \$11 billion by lowering inpatient rates paid to hospitals from 2014 through 2017.

PPACA mandated several policy changes that affect inpatient hospital payments for fiscal year 2012, fiscal year 2013, and fiscal year 2014:

- PPACA mandated a series of reductions in Medicare payment rates to hospitals. For fiscal year 2013, the payment update is projected to be 1.8 percent (equal to the market basket rate increase of 2.6 percent, reduced by a 0.1 percentage point budget adjustment as well as by the projected 10-year moving average of nonfarm multifactor productivity for the period ending in fiscal year 2013 (0.7 percentage point)). The current projected inpatient update for 2014 starts in October 2013 and is forecast to equal 1.8 percent (2.6 percent projected market basket - 0.5 percent for productivity - 0.3 percent for budget adjustments). The projected outpatient update starts three months later, in January 2014, and is forecast to equal 2.0 percent (2.7 percent projected market basket - 0.4 percent for productivity - 0.3 for budget adjustments). These forecasts will be updated as new market basket and productivity data become available.
- In fiscal year 2013, the VBP program will redistribute a pool of dollars equal to 1 percent of inpatient DRG payments (\$850 million in fiscal year 2013) to hospitals based on their overall performance on a set of quality measures. The size of the VBP redistribution pool is mandated to increase 0.25 percentage point each year, reaching a maximum of 2 percent of DRG payments in fiscal year 2017.
- Also beginning in fiscal year 2013, the Hospital Readmissions Reduction Program will reduce payments to hospitals that have higher than expected risk-adjusted readmissions. The current readmission penalty formula is complex, but in essence the penalty is computed as the product of a hospital's adjusted cost of excess readmissions and a multiplier (see p. 53 for further discussion of the readmission policy). The net effect on industry-wide Medicare payments is equivalent to roughly -\$300 million, or a 0.2 percent reduction in overall Medicare payments. Each individual hospital's penalty is capped at 1 percent of base inpatient operating payments in

2013, 2 percent in 2014, and 3 percent in 2015 and thereafter.

- PPACA mandated the expansion of the low-volume adjustment policy for fiscal year 2011 and fiscal year 2012. This policy was intended to provide additional payments to rural hospitals that have a low volume of Medicare (not all-payer) inpatient discharges and are 15 miles or more from the nearest IPPS hospital. We estimate that the expansion of the low-volume adjustment increased payments to rural hospitals by approximately \$380 million in fiscal year 2011 and \$365 million in fiscal year 2012. We have determined that the program is not well targeted and provides payments in excess of amounts that can be empirically justified based on past studies of the relationship between volume and cost. We discussed the problems with this policy in detail in our report on rural health care (Medicare Payment Advisory Commission 2012b). The program was originally scheduled to expire at the end of 2012 but was extended through 2013 as part of the American Taxpayer Relief Act of 2012 (ATRA).
- PPACA authorized the creation of the low-spending county hospital payment policy for fiscal year 2011 and fiscal year 2012. This policy provides additional payments to hospitals in counties with relatively low levels of Medicare spending per beneficiary. In both years, approximately 400 hospitals qualified for the additional payments and, as mandated, shared the fixed pool of dollars available (\$150 million in fiscal year 2011 and \$250 million in fiscal year 2012). We are not aware of any empirical support for this policy. The program expired at the end of fiscal year 2012.
- The “rural floor” policy (which actually sets a floor for urban hospitals) specifies that a state’s urban areas cannot have a lower wage index than its rural areas. We are not aware of any empirical support for this policy, which implicitly assumes that rural areas always have wages that are equal to or below wages in urban areas. To pay for the additional payments that some hospitals receive due to the rural floor, PPACA mandated that the Secretary of Health and Human Services (HHS) enact a national budget-neutrality factor. For example, when the rural Nantucket Cottage Hospital deactivated its critical access hospital status, thus becoming the only rural IPPS hospital in Massachusetts, it set the rural floor for all of Massachusetts’s hospitals at the wages paid

in Nantucket, a high-cost community. This change yielded an estimated \$274 million in extra payments to 60 urban hospitals in Massachusetts, a nearly 9 percent increase in inpatient payments. These extra payments were offset by lowering payments to other IPPS hospitals across the country by up to 0.5 percent. The Commission recommended eliminating these special wage index adjustments and adopting a new wage index system to avoid geographic inequities that can occur due to current wage index policies (Medicare Payment Advisory Commission 2007b).

In addition to PPACA-derived hospital payment policies, one non-PPACA policy, the Medicare-Dependent Hospital (MDH) program, will expire at the end of fiscal year 2013. It was scheduled to expire at the end of 2012 but was extended through 2013 by ATRA. As part of the MDH program, eligible hospitals can receive an additional payment to augment their standard IPPS payments if they are rural, if they have fewer than 100 beds, and if at least 60 percent of the inpatient days or discharges are covered under Medicare Part A. The program helps small hospitals but is not well targeted, as we discussed in our recent report on rural health care (Medicare Payment Advisory Commission 2012b). We estimate that the MDH program provided over \$120 million in additional payments to primarily rural hospitals in fiscal year 2012.

Prior to 2013, Medicare paid different rates for two alternative forms of stereotactic radiosurgery. ATRA equalized these rates by bringing the price of the higher cost procedure down to the price of the lower cost procedure in urban areas. CBO estimated that will reduce payments by roughly \$40 million per year.

### **Outpatient payments**

Outpatient policy changes for rural hospitals change our projections of margins for fiscal year 2013. First, through 2012, sole-community hospitals and other rural hospitals with 100 or fewer beds received hold-harmless outpatient payments. Payment rates for these hospitals were based on the higher of the current outpatient PPS rates or the hospital’s historic payment-to-cost ratio applied to its current reported outpatient costs. As of January 2013, these adjustments expired, which resulted in a decline in outpatient payments for some rural hospitals. Second, for 2013, CMS has decided to pay for separately paid drugs and biologicals at a rate of each drug’s average sales price (ASP) plus 6 percent. In 2012, CMS had paid for separately paid drugs at a rate of ASP plus 4 percent. To maintain budget neutrality in the OPPS, the increased

rates for separately paid drugs result in lower rates for all other services.

## How should Medicare payments change in 2014?

Each year, we provide update recommendations for services covered by Medicare's inpatient operating and outpatient prospective payment systems.<sup>16</sup> These recommendations apply only to acute care inpatient and outpatient services; updates for services provided in hospital-owned rehabilitation, home health, skilled nursing, and psychiatric units are based on separate recommendations for those types of Medicare services.

### Statutory update: Payment rates will be updated by the hospital market basket minus adjustments for productivity and budgetary factors

For both the acute IPPS and the OPPOS, the statutory update for fiscal year 2014 equals the projected increase in the hospital operating market basket index minus an adjustment equal to the HHS Secretary's forecast of the 10-year average productivity growth nationwide and a -0.3 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 2013, when the inpatient update takes place, is 2.6 percent, and the productivity forecast is 0.5 percent. The resulting projected statutory inpatient update on October 2013 is 1.8 percent (2.6 percent - 0.5 percent - 0.3 percent). CMS's latest forecast for January 2014, when the outpatient update takes place, is 2.7 percent, and the forecast for productivity is 0.4 percent. Therefore, the forecast statutory outpatient update is 2.0 percent (2.7 percent - 0.4 percent - 0.3 percent). The final update may differ because input prices and productivity estimates will change twice before the final updates are published in 2013.

CMS adjusted prior payment rates to correct for documentation and coding changes that took place in 2008 and 2009. In addition, CMS has stated that it still needs to reduce inpatient rates to account for further documentation and coding changes hospitals made in 2010. The Commission stated that an adjustment of between 0.6 percent and 0.8 percent is needed to correct

for coding changes from 2010 that will otherwise result in overpayments in the future (Medicare Payment Advisory Commission 2011a). The Commission also recommended in our March 2012 report that an adjustment be made to recover over \$11 billion in past overpayments that occurred from 2010 through 2012. In ATRA, the Congress authorized CMS to recover the \$11 billion from 2014 through 2017. The Secretary of HHS has authority with respect to the timing of the recoveries. If the recoveries were done equally over the four years, payments would be reduced by roughly 2.4 percent per year. This process would result in lower inpatient payment rates in 2014 than in 2013.

### RECOMMENDATION 3

**The Congress should increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.**

### RATIONALE 3

The Commission balanced several factors in reaching its inpatient update recommendation. First, updates must be constrained to maintain pressure on the industry to contain costs. There is a concern that high overall profit margins may lead hospitals to reduce their focus on cost control. Second, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. Third, hospitals' documentation and coding changes in 2010 resulted in excessive payment rates from 2010 through 2013. The Medicare program has not recovered these overpayments. In addition, the update must be lowered to prevent further overpayments in 2014. Fourth, while relatively efficient hospitals roughly broke even caring for Medicare patients in 2011, most hospitals have negative overall Medicare margins (-5.8 percent in 2011 and a projected -6 percent in 2013). Balancing these factors, the Commission recommends increasing the payment rate from 2013 to 2014 by 1 percent. The difference between the current statutory update (projected to be 1.8 percent) and the 1 percent recommended update would be used for two purposes: first to prevent future overpayments in 2014, and second to recover past overpayments from 2010, 2011, 2012, and 2013. The pace of the Commission's recommended recoveries of overpayments is slower than that of current

law, but this slower pace is necessary to ensure that base payments in 2014 are 1 percent higher than in 2013 after all adjustments. Because the policy environment is fluid, we want to be clear: The recommendation should be interpreted as a net increase in per case payments to hospitals in 2014 relative to 2013. That is, when all policy changes affecting base payments are made (i.e., recovery of overpayment due to documentation and coding changes, prevention of future overpayments, and the sequester), the net increase in payment should be 1 percent.

For outpatient services, the Commission also recommends a 1 percent increase in payment rates. On the one hand, growth in the volume of outpatient services has been strong, suggesting that the statutory outpatient update (2 percent) is too high. In addition, there has been particularly strong growth in the volume of services such as evaluation and management visits and cardiac imaging services for which hospital payment rates exceed those in competing physicians' offices by a wide margin. On the other hand, overall Medicare margins are negative, suggesting a positive update is appropriate. A 1 percent update would balance these two considerations and help limit the disparity in payment rates between services provided in outpatient departments and payment rates for the same services provided in other sectors. The Commission

maintains, as in previous years, that Medicare should try to pay similar amounts for similar services, taking into account differences in the quality of care and the relative risks of patient populations.

## IMPLICATIONS 3

### Spending

- This recommendation would increase Medicare spending relative to the scheduled updates by between \$750 million and \$2 billion in 2014 and by \$5 billion to \$10 billion over the next five years. While the reduced update for outpatient services reduces spending, slowing the pace of recoveries due to documentation and coding increases spending and more than offsets the outpatient savings. Note that the Secretary has discretion in how to make the recoveries during the four-year window. Our spending implications assume that the overpayments are recouped in equal amounts in each of the four years.

### Beneficiary and provider

- The 1 percent increase in payment rates is adequate to allow hospitals to continue caring for Medicare beneficiaries. The recommendation will increase payments to providers but should not materially affect beneficiary access to care or the financial viability of providers. ■

## Endnotes

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- 1 From 2002 to 2011, 479 hospitals entered the Medicare program and 301 exited. The count of hospital openings and closings is estimated from the raw count of hospitals participating in the Medicare program by excluding hospitals that changed ownership in the same year, obtained a new Medicare provider number, or converted to a different type of hospital.
- 2 The decline in inpatient discharges was based on a consistent cohort of approximately 4,300 hospitals in each year. In addition, these data represent the raw change in volume rather than case-mix-adjusted volume change.
- 3 Occupancy rate reflects the ratio of the hospital industry's inpatient beds occupied by all patients designated as inpatients, those in outpatient observation status, and post-acute patients who are occupying inpatient swing beds to the total inpatient beds available to be staffed. Swing beds are those that can be used for acute or post-acute care.
- 4 In 2011, CMS processed nearly 1.5 million outpatient observation claims and nearly 610,000 inpatient claims that were preceded by observation care. In 2006, CMS processed nearly 920,000 outpatient observation claims and nearly 350,000 inpatient claims that were preceded by observation care.
- 5 The share of hospitals and their affiliates providing each service was calculated as the share of hospitals indicating availability of the services within the hospital, network, system, or joint venture.
- 6 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 of M&A deals that occur each year because of the decentralized nature of market activity in this field.
- 7 Regional hospital systems are defined as those possessing multiple hospitals in one state or in multiple contiguous states. National hospital systems are defined as those that possess multiple hospitals in noncontiguous states.
- 8 The net increase of 2.7 percent results from several adjustments: the market basket (+2.6 percent), less a productivity adjustment (-0.7 percent), less a budget adjustment (-0.1 percent), less an adjustment to prevent further overpayments due to documentation and coding changes (-1.9 percent), plus the expiration of the 2.9 percent temporary downward adjustment that was in effect during fiscal year 2011 and fiscal year 2012 to recover past overpayments in fiscal year 2008 and fiscal year 2009.
- 9 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, Medicare inpatient rehabilitation, as well as special payments for health information technology and the low-spending county payments.
- 10 The -6 percent projection does not factor in any effect of the sequestration that may or may not occur in 2013.
- 11 In its July 2012 report to the Congress concerning CMS's EHR Incentive Payment Program, the Government Accountability Office reported that as many as 4,855 hospitals were eligible to receive payments as part of this program. For hospitals that are not deemed meaningful users by 2015, their market basket update will be reduced 25 percent in 2015, 50 percent in 2016, and the 75 percent maximum in 2017 and beyond. For CAHs that are not deemed meaningful users by 2015, Medicare payments will be reduced from 101 percent of reasonable costs to 100.66 percent of costs in 2015 and then reduced a third of a percentage point for two more years until reaching the maximum of a 1 percent reduction in 2017. In other words, CAH payments will go no lower than 100 percent of reasonable costs. We expect the vast majority of PPS hospitals and a large share of CAHs to adopt EHRs and avoid the penalties.
- 12 Medicaid EHR incentive payments to hospitals equaled approximately \$2 billion in fiscal year 2012.
- 13 This 20 percent estimate takes into account the Supreme Court ruling of 2012, which allows states to choose not to expand their Medicaid rolls without losing their other Medicaid dollars.
- 14 We expect the newly insured to have a roughly similar number of inpatient days per capita compared with those currently on Medicaid. In survey data from the Massachusetts expansion of health care coverage, the health status reported by newly covered individuals was similar to that of individuals on Medicaid. In the lottery-based expansion of Medicaid in Oregon, the initial number of Medicaid days per capita for the newly insured was less than 1 standard deviation point higher than for the existing Medicaid population (Finkelstein et al. 2011, McCormick et al. 2012).
- 15 The 20 percent increase in Medicaid enrollment reflects CBO estimates for 2014, taking into consideration the Supreme

Court decision in the summer of 2012. Earlier estimates by CBO and others projected a greater expansion of Medicaid. CBO projected a 25 percent decline in uninsured in 2014, rising to 50 percent by 2017. The administration has projected greater reductions in the number of uninsured. The payments in 2014 will hinge on what data CMS uses to determine the rate of uninsurance. The lack of current data on uninsurance may cause CMS to use either 2013 data or projections of 2014 uninsurance rates to provide interim payments and then reconcile the DSH and uncompensated care payments after data on the uninsured become available. Currently, CMS

provides interim DSH payments based on projections and then reconciles after actual Medicaid and SSI share data for the year become available.

- 16 Our update recommendations focus on inpatient operating payment rates and payment rates for outpatient services (which encompass both operating and capital costs of outpatient services). The Secretary of Health and Human Services makes a separate evaluation of updates to per discharge payment rates for inpatient capital costs.

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CHAPTER 4

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**Physician and other health  
professional services**

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

*(The Commission reiterates its previous recommendations on improving Medicare's payments to physicians and other health professionals. See Appendix B, pp. 371–392.)*

# Physician and other health professional services

## Chapter summary

In 2011, Medicare paid \$68 billion for physician and other health professional services, 12 percent of total Medicare spending. About 850,000 clinicians billed Medicare—550,000 physicians, with the balance consisting of nurse practitioners and other advanced practice nurses, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and health professionals under a fee schedule, and total payments are limited by the sustainable growth rate (SGR) formula. Because of years of volume growth exceeding the SGR limits and legislative and regulatory overrides of negative updates, fees for physicians and other health professionals will decline by about 25 percent in January 2014, according to the Congressional Budget Office.

## 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.

**Beneficiaries' access to care**—Overall, beneficiary access to physicians and other health professional services is stable and similar to access for privately insured individuals ages 50 to 64. Seventy-seven percent of beneficiaries reported that they never had to wait longer than they wanted for a routine visit,

## In this chapter

- Repeal of the SGR: Urgent and should protect access, break the link between updates and expenditures, and be fiscally responsible
- Are Medicare fee-schedule payments adequate in 2013?
- How should Medicare payments change in 2014?

and 84 percent reported that they never had to wait longer than they wanted for an illness or injury visit. A greater share of beneficiaries continues to report a big problem finding a primary care doctor than do beneficiaries seeking a specialist. This pattern is similar among individuals ages 50 to 64 with private insurance. The Commission continues to be concerned about access to primary care physicians, given the Commission's aim to transform Medicare from a fee-driven payment model to one that encourages the delivery of efficient, high-quality care.

- **Capacity and supply of providers**—The supply of primary care providers and specialists per beneficiary remained constant from 2009 through 2011; the supply of advanced practice nurses, physician assistants, and other providers grew. One study found that 83 percent of primary care physicians (excluding pediatrics) and 91 percent of specialists accept new Medicare patients (Decker 2012).
- **Volume of services**—The volume of physician and other health professional services grew 1.0 percent per fee-for-service beneficiary in 2011, although growth rates varied across type of service. Evaluation and management services increased 2.0 percent; other procedures increased 1.9 percent; and tests increased 0.8 percent. Imaging and major procedures had negative growth rates of –1.0 percent and –1.1 percent, respectively. In addition, there is geographic variation in initial and repeated diagnostic tests across the country.

**Quality of care**—A few measures of ambulatory care quality between the periods of 2008 to 2009 and 2010 to 2011 improved slightly, a few worsened slightly, and the majority of measures did not change.

**Medicare payments and providers' costs**—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 relatively constant at 82 percent. CMS currently projects that the percentage change in the Medicare Economic Index, a measure of the change in providers' costs, will be 2.3 percent in 2014.

### **Repeal of the sustainable growth rate is urgent**

The Commission's deliberations regarding payment updates for physicians and other health professionals are driven by concerns with the SGR, which links physician fees to volume growth. The SGR has called for negative updates for every year since 2002, and every year since 2003 the Congress has provided a short-term override of the negative payment updates. On January 2, 2013, the President signed a bill that delayed the reduction in fees under the SGR for calendar year 2013. The Commission laid out its findings and recommendations for moving forward

from the SGR system in its October 2011 letter to the Congress (Appendix B, pp. 371–392).

First, the SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it. Second, temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may cause anxiety among beneficiaries. Third, the SGR is inequitable; it neither rewards health professionals who restrain volume nor punishes those who prescribe unnecessary services (Alhassani et al. 2012). Fourth, while the Congressional Budget Office’s most recent budget projection has reduced the cost of repealing the SGR, the budget score is volatile, and the cost of SGR repeal will likely continue to grow, creating pressure to repeal it now. The Commission presented a set of recommendations to eliminate the SGR and replace it with a set of fee-schedule updates, improve the accuracy of physician payments, and encourage movement into risk-bearing accountable care organizations. If the Congress wishes to fund the SGR repeal entirely out of Medicare, it would require spending offsets across Medicare.

The Commission reiterates two points from our letter. First, the need to repeal the SGR is urgent. Deferring repeal of the SGR will not leave the Congress with a better set of choices: The cost will likely increase and the array of new payment models is unlikely to change. While our latest access survey does not show significant deterioration at the national level, the Commission is concerned about access, particularly for primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare, a large cohort of physicians is nearing retirement age, and SGR fatigue is increasing. Second, repeal of the SGR should adhere to the following principles: The link between fee-schedule expenditures and annual updates is unworkable, beneficiary access to care must be protected, and proposals to replace the SGR must be fiscally responsible. ■





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## Background

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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 nearly 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 2011, payments totaled \$68 billion, about 12 percent of Medicare spending. Between 2000 and 2011, Medicare's spending per beneficiary for physician and other fee-schedule services grew 74 percent. In 2010, 97 percent of beneficiaries received at least one physician service, and Medicare paid for nearly 1 billion services.

Medicare pays for physician and other health professionals using a fee schedule, which includes payment rates for about 7,000 separate billing codes. For each service, CMS assigns three weights: the amount of 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.<sup>1</sup>

Under current law, the conversion factor is governed by the sustainable growth rate (SGR) formula. The SGR limits the aggregate growth in payments to physicians and other health professionals, with allowances for changes in input prices, enrollment in traditional fee-for-service (FFS) Medicare, the volume of services provided under the fee schedule relative to gross domestic product growth, and changes in law and regulation. The SGR has called for negative updates for every year since 2002, and every year since 2003 the Congress has provided a short-term override of the negative payment updates. On January 2, 2013, the estimated 27 percent payment cut to physician fees under the SGR was overridden until the end of calendar year 2013.

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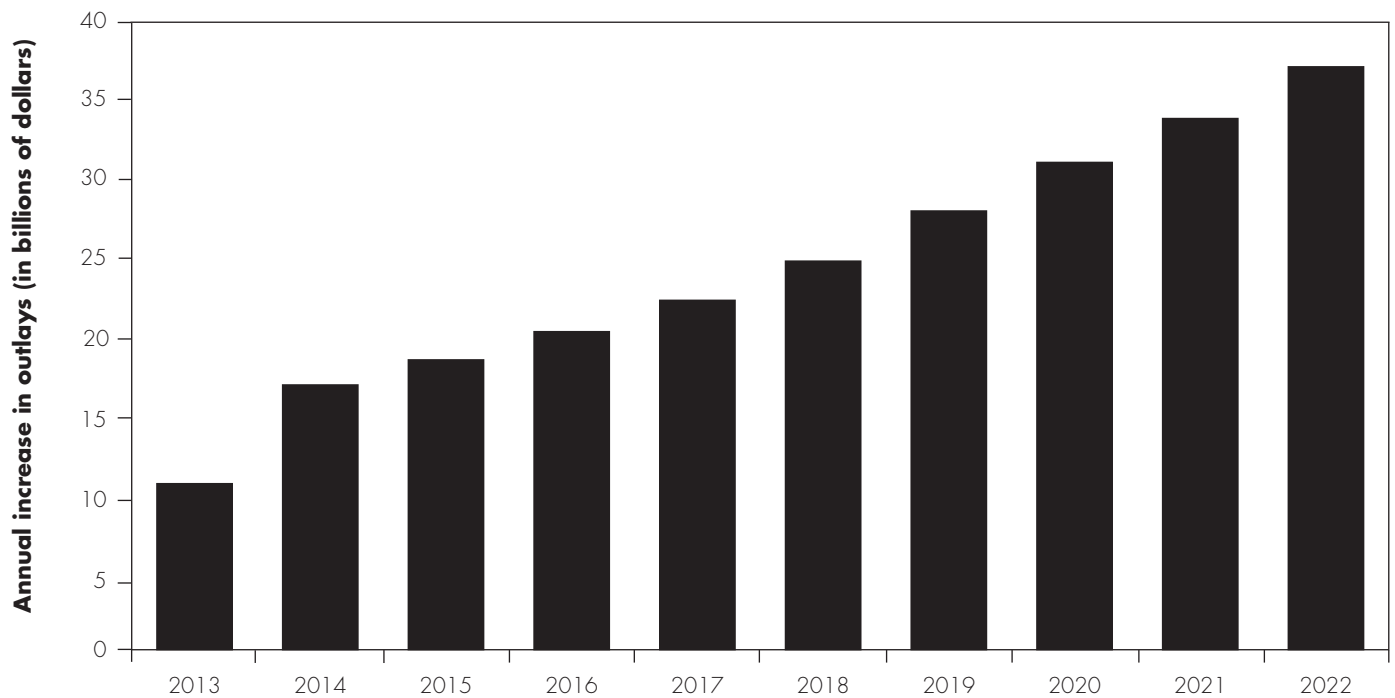
## Repeal of the SGR: Urgent and should protect access, break the link between updates and expenditures, and be fiscally responsible

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The SGR has led to significant frustration among providers and beneficiaries. In addition, the short-term overrides have led to an administrative burden for providers and CMS due to holding of claims, delays in submission of claims, and reprocessing of claims. Moreover, while some physicians and other health professionals contribute to the inappropriate volume growth that has resulted in large payment adjustments through the SGR, others have restrained volume. But the SGR cannot differentiate between physicians who restrain volume and physicians who do not restrain volume (Alhassani et al. 2012). Given the significant accumulation in spending that must be recouped under the SGR, repealing it has a very high budgetary cost—in the range of \$250 billion to \$300 billion over 10 years. Given the fiscal climate facing the government, proposals to permanently repeal or fix the SGR have not been enacted.

The Commission laid out its findings and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress (see Appendix B, pp. 371–392). The Commission stated that the SGR is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. First, the SGR system, which ties annual updates to cumulative expenditures, has failed to restrain volume growth and may have exacerbated it. Any restraint on updates disproportionately burdens physicians and other health professionals in specialties with less ability to generate volume. Second, temporary, stop-gap fixes to override the SGR undermine the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may cause anxiety among beneficiaries. Third, the cost of SGR repeal continues to grow, creating pressure to repeal it now.

The Commission's recommendations included four components. First, the SGR should be repealed, severing the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission outlined a 10-year path of legislated updates, including updates for primary care services that are different from those for other services.<sup>2</sup> Second, CMS should collect data to improve payment accuracy and identify overpriced services within the fee schedule. Third, the Medicare

**FIGURE  
4-1****CBO estimates of increase in outlays under freeze in payment updates for services of physicians and other health professionals, 2013–2022**

Note: CBO (Congressional Budget Office).

Source: Congressional Budget Office 2012.

program should encourage movement from FFS into risk-bearing accountable care organizations (ACOs) by creating greater opportunities for shared savings. Fourth, repeal of the SGR should be fiscally responsible. In exercising its prerogatives, the Congress could decide to fund repeal entirely within Medicare, or it could consider other options. While the Commission has not recommended funding repeal entirely within Medicare, doing so would require spending offsets across Medicare. Specifically, in addition to a freeze in the payment rates for primary care and a reduction in payment rates for all other physicians, it would include offsets in other provider sectors—such as hospital, skilled nursing facility, home health, and others—and higher out-of-pocket costs for beneficiaries.

Further details on the Commission’s position on repeal of the SGR are in our October 2011 letter. However, we emphasize several points:

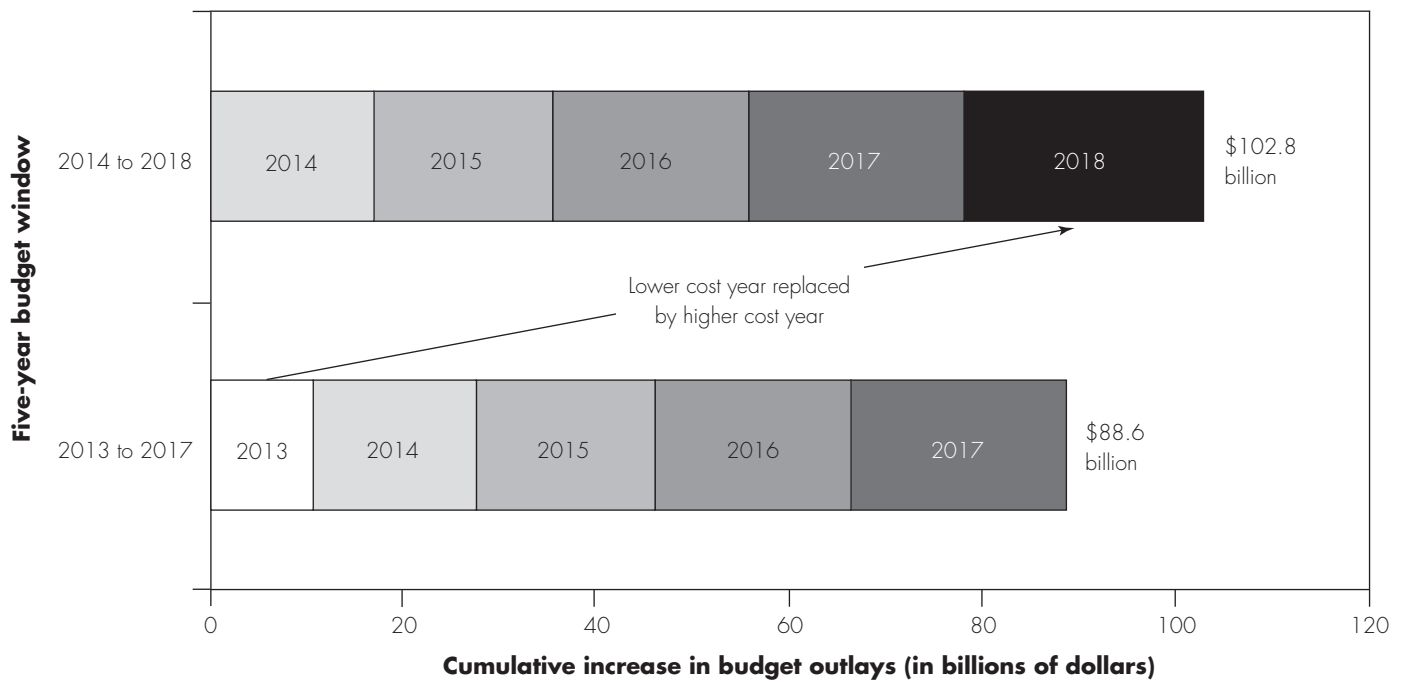
- Repeal is urgent. Delay will not provide more favorable options, and repeal becomes more costly over time.
- Beneficiary access must be preserved.

- The physician fee schedule must be rebalanced to achieve equity of payments between primary care and other services.
- Pressure on FFS must encourage movement toward new payment models and delivery systems.
- Repeal of the SGR must be fiscally responsible.

In order to assist the Congress, the Commission outlined a menu of options that could constrain the cost of repeal (e.g., conversion-factor reductions) and a set of offsets (e.g., provider reductions and increases in beneficiary cost sharing). While the Commission has not endorsed every one of these items individually or as a package, they do exceed the likely cost of SGR repeal. Nonetheless, this list illustrates that funding repeal entirely within Medicare would present the Congress with some difficult choices. If, however, the Congress decides that all of the cost will not be borne within Medicare, it could enact smaller conversion-factor reductions, fewer provider reductions, and smaller increases in beneficiary cost sharing. The Congress could also choose to phase in such changes by, for example, ramping up conversion-factor reductions

**FIGURE  
4-2**

**Cost of SGR repeal increases each year with growth in enrollment and service volume**



Note: SGR (sustainable growth rate).

Source: MedPAC analysis of Congressional Budget Office annual estimates of increases in budget outlays under the option of replacing the SGR with 0 percent updates through 2018.

over time to encourage movement of physicians and other health professionals into alternative models of payment and delivery of care.

**Repeal is urgent**

Although our latest access survey does not show significant deterioration at the national level, the Commission is nonetheless concerned about access. The balance between supply and demand is tight in many markets and problems could surface, particularly in primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare, a large cohort of physicians is nearing retirement age, and SGR fatigue is increasing. We do not predict abrupt changes in the national access picture, but we cannot rule them out either.

Deferring repeal for one or two years will not leave the Congress with a better set of choices. First, the cost of repeal will only increase as enrollment and the volume of services per beneficiary increase. The cost increases are apparent in the Congressional Budget Office estimates of the cost of replacing the SGR with a freeze in the fee schedule’s conversion factor for 10 years (Figure 4-1).

Under this option, the cost of replacing the SGR results in annual increases in outlays that rise from \$10.6 billion in 2013 to \$37.2 billion in 2022.

In turn, the budget score for repealing the SGR continues to rise as a result of these yearly increases if there is a delay in repeal of the SGR. For example, a 10-year freeze in the conversion factor would total \$88.6 billion for 2013 to 2017 (Figure 4-2). By contrast, delaying the freeze one year (to 2014) would result in a score of \$102.8 billion for 2014 through 2018, an increase of 16 percent. The increase occurs because—with the one-year shift in the budget window—delaying action would replace the lowest cost year (2013) with the highest cost year (2018).

A second argument against deferring repeal of the SGR is that delay will not give the Congress better options. The array of new payment models to choose from is unlikely to change materially in the near term, and such models—when available—are unlikely to produce significant impacts on utilization in the short term. Meanwhile, ACOs will remain the principal alternative payment mechanism. If past pilots and demonstrations are any indication, we are not likely to

**TABLE  
4-1**

**Most aged Medicare beneficiaries and older privately insured individuals had good access to physician care, 2008–2012**

Survey question	Medicare (age 65 or older)					Private insurance (age 50–64)				
	2008	2009	2010	2011	2012	2008	2009	2010	2011	2012
<b>Unwanted delay in getting an appointment:</b> 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?”										
<b>For routine care</b>										
Never	76% <sup>a</sup>	77% <sup>a</sup>	75% <sup>a</sup>	74% <sup>ab</sup>	77% <sup>a</sup>	69% <sup>ab</sup>	71% <sup>a</sup>	72% <sup>a</sup>	71% <sup>a</sup>	72% <sup>a</sup>
Sometimes	17 <sup>a</sup>	17 <sup>a</sup>	17 <sup>a</sup>	18 <sup>a</sup>	17 <sup>a</sup>	24 <sup>ab</sup>	22 <sup>a</sup>	21 <sup>a</sup>	21 <sup>a</sup>	21 <sup>a</sup>
Usually	3 <sup>a</sup>	2 <sup>a</sup>	3 <sup>a</sup>	3	3	5 <sup>ab</sup>	3 <sup>a</sup>	4 <sup>a</sup>	4	3
Always	2	2	2	2 <sup>a</sup>	2 <sup>a</sup>	2 <sup>b</sup>	3	3	3 <sup>a</sup>	3 <sup>a</sup>
<b>For illness or injury</b>										
Never	84 <sup>a</sup>	85 <sup>a</sup>	83 <sup>a</sup>	82 <sup>b</sup>	84 <sup>a</sup>	79 <sup>a</sup>	79 <sup>a</sup>	80 <sup>a</sup>	79	80 <sup>a</sup>
Sometimes	12 <sup>a</sup>	11 <sup>a</sup>	13 <sup>a</sup>	14 <sup>a</sup>	12 <sup>a</sup>	16 <sup>a</sup>	17 <sup>a</sup>	15 <sup>a</sup>	17 <sup>a</sup>	16 <sup>a</sup>
Usually	1	2	2	2	2	2	2	2	2	2
Always	1 <sup>a</sup>	1	1 <sup>a</sup>	1	1 <sup>a</sup>	2 <sup>a</sup>	2	2 <sup>a</sup>	1	2 <sup>a</sup>
<b>Not accessing a doctor for medical problems:</b> “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 <sup>a</sup>	7 <sup>ab</sup>	8 <sup>a</sup>	8 <sup>a</sup>	8 <sup>a</sup>	12 <sup>a</sup>	11 <sup>a</sup>	12 <sup>a</sup>	11 <sup>a</sup>	11 <sup>a</sup>
<b>Looking for a new doctor:</b> “In the past 12 months, have you tried to get a new...?” (Percent answering “Yes”)										
Primary care doctor	6	6	7	6	7	7	8	7	7	7
Specialist	14 <sup>a</sup>	14 <sup>a</sup>	13 <sup>a</sup>	14 <sup>a</sup>	13 <sup>a</sup>	19 <sup>a</sup>	19 <sup>a</sup>	15 <sup>ab</sup>	16 <sup>a</sup>	18 <sup>a</sup>
<b>Getting a new physician:</b> 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...”										
<b>Primary care physician</b>										
No problem	71	78	79 <sup>a</sup>	65	72	72	71	69 <sup>a</sup>	68	75
Percent of total insurance group	4.6	5.0	5.2	3.6	4.7	4.8	5.4	4.8	4.5	5.0
Small problem	10	10	8	12	14	13	8	12	16 <sup>b</sup>	9
Percent of total insurance group	0.6	0.6	0.5	0.7	0.9	0.9	0.6	0.8	1.1	0.6
Big problem	18	12 <sup>a</sup>	12	23 <sup>ab</sup>	14	13	21 <sup>a</sup>	19	14 <sup>a</sup>	15
Percent of total insurance group	1.1	0.8	0.8	1.3	0.9	0.9	1.6	1.3	0.9	1.0
<b>Specialist</b>										
No problem	88	88	87 <sup>a</sup>	84	87	83	84	82 <sup>ab</sup>	86	86
Percent of total insurance group	12.8	12.5	11.0	12.1	11.7	15.5	16.1	12.6	13.9	15.6
Small problem	7	7	6 <sup>a</sup>	8	6	9	9	11 <sup>ab</sup>	8	7
Percent of total insurance group	1.0	1.0	0.8	1.1	0.7	1.7	1.7	1.8	1.3	1.2
Big problem	4	5	5	7	7	7	7	6	6	7
Percent of total insurance group	0.6	0.7	0.7	1.0	0.9	1.4	1.3	1.0	1.0	1.2

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) were 3,000 in 2008 and 4,000 in 2009 to 2012. Overall sample sizes for individual questions varied.

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

<sup>b</sup> Statistically significant difference from 2012 within the same insurance coverage category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted in 2008, 2009, 2010, 2011, and 2012.

have meaningful results on bundling and medical homes within two years.

In considering budget packages to improve the government's fiscal picture, the Congress often looks to Medicare for savings. If those savings are applied to deficit reduction and the SGR remains in place, it will become more difficult to offset the cost of replacing the SGR one or two years from now. At that point, the only option for dealing with an even larger score for SGR repeal may be to add it to the deficit, which may be unpalatable after much effort to get the deficit down.

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***Editor's note:** After production of this chapter was finalized, the Congressional Budget Office released new, substantially lower estimates of the costs of freezing updates and eliminating the SGR. These estimates are lower largely because they assume lower rates of service volume growth. While the Congressional Budget Office is projecting lower volume growth in the near term, the history of volume growth is highly volatile—in the 1980s per capita volume growth ranged from at least 3.7 percent to 9.7 percent, in the 1990s the range was from -0.7 percent to 3.4 percent, and from 2001 to 2011 it ranged from 1.0 percent to 5.6 percent. These new estimates do not change the Commission's recommendation for SGR repeal—instead they underscore the need for action now. Repeal is now less costly than it has been for many years, and it could be accomplished—depending on how the Congress decides to finance it—with less burden on physicians, other providers, beneficiaries, and taxpayers.*

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## **Repeal should adhere to certain principles**

The Commission's principles for moving forward from the SGR are as follows:

- the link between cumulative fee-schedule expenditures and annual conversion-factor updates is unworkable and should be eliminated,
- beneficiaries' access to care must be protected, and
- proposals to replace the SGR must be fiscally responsible.

It is the Congress's prerogative to decide how to replace the SGR in a way that is fiscally responsible. Our October 2011 letter outlined options for the Congress to consider if it were to decide that the cost of SGR repeal must be fully offset within Medicare. The Commission struck a balance by coupling, first, a freeze or decreases in fees for physicians and other health professionals with, second,

reductions for other providers and increases in beneficiary cost sharing. Much of the discussion about our letter since we submitted it has been focused on the magnitude of the cuts in the fee-schedule conversion factor. However, the magnitude of the cuts presented was driven by the assumed need to offer a budget-neutral package. If the Congress were to opt not to finance repeal fully out of Medicare, those cuts could be reduced.

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## **Are Medicare fee-schedule payments adequate in 2013?**

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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 are positive or neutral.

### **Beneficiaries' access to care: Generally stable with few reported problems**

We review a range of beneficiary access measures, including our own beneficiary survey, other beneficiary surveys, physicians' willingness to accept Medicare beneficiaries, and results from our beneficiary and physician focus groups. In general the share of beneficiaries in 2012 reporting good access to care and satisfaction with their care is consistent with prior years. The Commission's patient survey finds that beneficiaries have generally stable access to physician services.

Every year, the Commission sponsors a telephone survey of Medicare beneficiaries and privately insured individuals ages 50 to 64. This year, the survey was administered to 4,000 respondents in each group and oversampled minority beneficiaries to increase statistical power. The goal in surveying both Medicare beneficiaries and near-elderly enrollees in private insurance is to assess whether issues reported by Medicare beneficiaries are unique to the Medicare population or due to trends in health care delivery system wide. This year's survey was fielded in summer and fall 2012.

Overall, we find that beneficiaries' access to physician services is stable and similar to (or better than) access among privately insured individuals (Table 4-1). Higher shares of Medicare beneficiaries report that they are very or somewhat satisfied with their care (88 percent) compared with those with private insurance (84 percent) (not shown). Most beneficiaries report they are able to obtain timely

**TABLE  
4-2**
**Medicare beneficiaries had better or similar access to physicians compared with privately insured individuals, but minorities in both groups reported problems more frequently, 2012**

Survey question	Medicare (age 65 or older)			Private insurance (age 50-64)		
	All	White	Minority	All	White	Minority
<b>Unwanted delay in getting an appointment:</b> 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?"						
<b>For routine care</b>						
Never	77% <sup>a</sup>	78% <sup>a</sup>	77% <sup>a</sup>	72% <sup>a</sup>	73% <sup>a</sup>	70% <sup>a</sup>
Sometimes	17 <sup>a</sup>	17 <sup>a</sup>	15 <sup>a</sup>	21 <sup>a</sup>	21 <sup>a</sup>	22 <sup>a</sup>
Usually	3	3	3	3	3	3
Always	2 <sup>a</sup>	2 <sup>a</sup>	2 <sup>a</sup>	3 <sup>a</sup>	3 <sup>a</sup>	5 <sup>a</sup>
<b>For illness or injury</b>						
Never	84 <sup>a</sup>	84 <sup>a</sup>	82	80 <sup>a</sup>	80 <sup>a</sup>	78
Sometimes	12 <sup>a</sup>	12 <sup>a</sup>	14	16 <sup>a</sup>	17 <sup>a</sup>	15
Usually	2	1	2	2	2	2
Always	1 <sup>a</sup>	1	1 <sup>a</sup>	2 <sup>a</sup>	2 <sup>b</sup>	4 <sup>ab</sup>
<b>Not accessing a doctor for medical problems:</b> "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 <sup>a</sup>	8 <sup>a</sup>	9	11 <sup>a</sup>	11 <sup>a</sup>	11
<b>Looking for a new doctor:</b> "In the past 12 months, have you tried to get a new...?" (Percent answering "Yes")						
Primary care physician	7	7 <sup>b</sup>	5 <sup>b</sup>	7	7	7
Specialist	13 <sup>a</sup>	15 <sup>ab</sup>	8 <sup>ab</sup>	18 <sup>a</sup>	19 <sup>ab</sup>	13 <sup>ab</sup>
<b>Getting a new physician:</b> 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..."						
<b>Primary care physician</b>						
No problem	72	70	76	75	77	67
<i>Percent of total insurance group, by race</i>	4.7	5.0	3.6	5.0	5.2	4.6
Small problem	14	13	16	9	8	13
<i>Percent of total insurance group, by race</i>	0.9	0.9	0.8	0.6	0.5	0.9
Big problem	14	15	8	15	13	20
<i>Percent of total insurance group, by race</i>	0.9	1.1	0.4	1.0	0.8	1.4
<b>Specialist</b>						
No problem	87	88	81	86	88 <sup>b</sup>	77 <sup>b</sup>
<i>Percent of total insurance group, by race</i>	11.7	13.1	6.6	15.6	17.1	10.3
Small problem	6	6	4 <sup>a</sup>	7	5 <sup>b</sup>	14 <sup>ab</sup>
<i>Percent of total insurance group, by race</i>	0.7	0.9	0.4	1.2	1.0	1.8
Big problem	7	6 <sup>b</sup>	15 <sup>b</sup>	7	6	9
<i>Percent of total insurance group, by race</i>	0.9	0.9	1.2	1.2	1.2	1.3

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. Overall sample size for each group (Medicare and privately insured) was 4,000 in 2012. Sample sizes for individual questions varied.

<sup>a</sup> Statistically significant difference between the Medicare and privately insured populations in 2012 (at a 95 percent confidence level).

<sup>b</sup> Statistically significant difference by race within the same insurance category in 2012 (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys, conducted in 2012.

appointments for routine care, illness, or injury, and most beneficiaries are able to find a new doctor without a problem. However, beneficiaries seeking a specialist were more likely to report that they had no problem finding a doctor than beneficiaries seeking a primary care doctor.

### **Most beneficiaries are able to see their doctors when they want to**

The results from the 2012 survey are consistent with prior years in finding that most beneficiaries were able to see their doctors in a timely manner. The share of beneficiaries seeking a routine care appointment that reported that they never had to wait longer than they wanted was 77 percent; 84 percent of beneficiaries seeking an illness or injury appointment reported that they never had to wait longer than they wanted. These shares were significantly higher than the respective 72 percent and 80 percent shares of the privately insured population that never had to wait longer than they wanted for a routine or illness appointment.

Among the 12 percent of Medicare respondents who had to wait longer than they wanted for an illness or injury appointment, 7 percent took the later appointment date, 2 percent went to the emergency room, and 2 percent went to a walk-in clinic. Although the share of African American beneficiaries who reported that they had to wait longer for an illness or injury appointment was not greater than for other beneficiaries, a greater share reported that they went to the emergency room instead (5 percent) than did non-Hispanic White beneficiaries (2 percent).

**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, 0.9 percent of all Medicare beneficiaries reported that they had a big problem finding a new primary care doctor, as did the share of Medicare beneficiaries (0.9 percent) who reported that they had a big problem finding a new specialist. However, among those beneficiaries looking for a new doctor, it continues to be the case that a larger share of those looking for a new primary care doctor report problems than those seeking a new specialist.

The rates of individuals with private insurance reporting a big problem finding a doctor were similar to the rates for Medicare beneficiaries: Among respondents ages 50 to 64 covered by private insurance, 1 percent had a big problem finding a primary care doctor, and 1.2 percent reported that they had a big problem finding a specialist.

A greater share of minority beneficiaries reported that they had a big problem accessing specialty care (1.2 percent) than non-Hispanic White beneficiaries (0.9 percent) (Table 4-2). Minority beneficiaries have reported problems obtaining specialty care in our surveys in prior years as well.

Overall, we do not find significant problems with beneficiary access to physicians and other health professional services, but certain areas or populations may face problems with access to care, and beneficiaries may face specific issues finding certain specialties (see text box, p. 86, for a discussion of the health professional shortage area payment adjustment). To help supplement our survey, we conduct beneficiary focus groups in different geographic areas to assess more localized access issues. While the overall share of beneficiaries having a problem finding a new doctor is small (0.9 percent of the Medicare population report big problems finding a new primary care doctor and 0.9 percent report big problems finding a new specialist), 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 higher among privately insured individuals and some groups** A lesser share of Medicare beneficiaries (8 percent) than privately insured individuals (11 percent) reported that they had a health problem that they should have seen a doctor about but did not. Hispanic beneficiaries were more likely than non-Hispanic White beneficiaries to report the reason they did not see a doctor when they thought they should have was because they could not find a doctor who would treat them. Rural beneficiaries were more likely than urban beneficiaries to report that the reason they did not see a doctor when they thought they should have was that they could not get an appointment soon enough.

**Urban and rural analyses** Overall, the survey finds no significant differences in access between urban and rural beneficiaries, although there are some differences. Most urban (78 percent) and rural beneficiaries (76 percent) never had to wait longer than they wanted to for routine care; the shares were greater for illness or injury appointments (84 percent for urban, 83 percent for rural beneficiaries; see online Appendix 4-A, available at <http://www.medpac.gov>).

Among Medicare beneficiaries, 1.0 percent of urban and 0.7 percent of rural beneficiaries reported that they had a big problem finding a new primary care physician, and 1.0 percent of urban and 0.4 percent of rural beneficiaries

## Payment adjustments for health professional shortage areas

One policy in the Medicare program to improve access to physician and other health professional services in areas where problems arise is the bonus payment made to physicians practicing in health professional shortage areas (HPSAs). Physicians delivering care in a primary care HPSA are paid 10 percent above the payment amount for all fee-schedule services they provide. Psychiatrists practicing in a mental health HPSA may also receive a 10 percent adjustment to the fee-schedule amount.

Two other temporary payment adjustments are in place from 2011 through 2016 that add to the permanent HPSA bonus. First, primary care practitioners who meet certain criteria (specialty and practice patterns) receive a 10 percent increase in payment for selected fee-schedule services. And second, surgical services delivered in a primary care HPSA are eligible for a 10 percent adjustment to the fee-schedule amount. These adjustments are both in addition to the permanent HPSA bonus.

The Health Resources and Services Administration oversees the HPSA designation, which was designed to measure the scarcity of physicians and other health professionals. The Medicare HPSA payment adjustment has been in place since 1991, with generally only minor adjustments. In 2010, the Congress established a negotiated rule-making committee to design a new method of establishing geographic-based health care scarcity areas (such as the HPSA), but the committee did not reach consensus (Babitz et al. 2011).

Over the coming analytic cycle, the Commission plans to review the HPSA and other targeted payments designed to improve access to ambulatory services in areas that are underserved. The Commission's work could include reviewing HPSAs and other similar policies; the geography, demography, and service use of beneficiaries living in these areas; the profile of physicians receiving HPSA payments; the type of services they deliver; and the effects of these policies. ■

reported that they had a big problem finding a new specialist. However, none of these differences between urban and rural beneficiaries was statistically significant. Rural beneficiaries were statistically more likely to report that they always waited longer than they wanted to for an appointment for regular or routine care, although the rates were low (4 percent of rural beneficiaries vs. 1 percent of urban beneficiaries).

**Some beneficiaries see advanced practice nurses for their primary care** Consistent with findings in prior years, about 30 percent of beneficiaries reported that they saw a physician assistant or nurse practitioner for some or all of their primary care. A slightly greater share of privately insured individuals (36 percent) than Medicare beneficiaries (30 percent) reported that they saw a physician assistant or nurse practitioner for some or all of their primary care. It continues to be the case that twice the share of rural Medicare beneficiaries report that they see advanced practice nurses for all or most of their primary care versus beneficiaries in urban areas.

### **Beneficiary focus groups have similar findings**

For a number of years, the Commission has contracted with NORC to conduct beneficiary and physician focus

groups in certain geographic locations. In 2012, the focus groups took place in New York City and Greenville, South Carolina. These sites were chosen in part because beneficiaries there reported through the Consumer Assessment of Healthcare Providers and Systems survey that they had higher than average difficulty finding new physicians. This year, focus group participants included Medicare beneficiaries, Medicare beneficiaries dually eligible for Medicaid, and primary care physicians.

Nearly all beneficiaries in our focus groups reported that they had a regular source of care, and most reported that they could see that provider in a reasonable amount of time. Some reported that their providers would schedule them to see another physician or provider in the practice if their own physician could not see them in a timely way, and beneficiaries seemed generally comfortable with this approach. Most beneficiaries reported that if they were seeking a new primary care physician, they were able to find one who took new Medicare patients, although occasionally they reported difficulty because of some physicians' stated policy of not accepting Medicare patients or provider network restrictions. However, the focus groups consisting of dual-eligible beneficiaries reported more trouble finding a new primary care



physician. Some physicians reported that they were less willing to see Medicaid patients than Medicare patients and that they were also less willing to see dual-eligible beneficiaries.

Beneficiaries were also generally able to find specialty care, although for many years beneficiaries in our focus groups have reported problems finding certain specialists (dermatology and psychiatry). Beneficiaries seeing a specialist regularly reported that follow-up visits were generally easy to obtain but that their doctor may not accept a new Medicare patient if they referred a friend. Some primary care physicians in the focus groups also reported that they had difficulty referring patients to certain specialists—the physicians would have to call the specialists themselves or rely on favors to obtain the specialty referral. Physician and beneficiary focus groups both reported that specialists were more likely than primary care physicians not to take certain types of insurance.

The physician focus groups also found that most physicians were willing to take Medicare patients, although some reported that they would take only current patients who had aged into Medicare or that they would limit the number of new Medicare beneficiaries when their practice got crowded. Physicians who did not take insurance (including Medicare) reported that the reasons they did not take insurance were significant paperwork burdens, low reimbursement rates, or both.

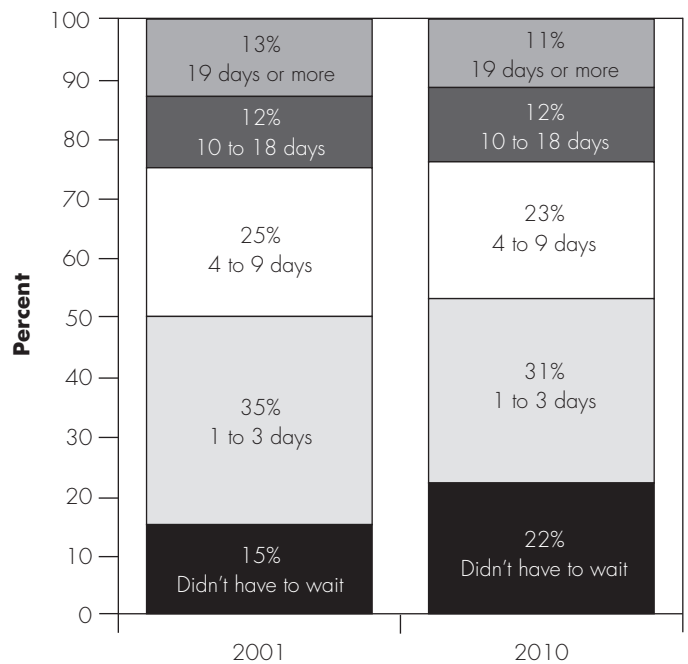
### Other national patient surveys show comparable results for access to care

In addition to the Commission’s survey and focus groups, other surveys assessing access for Medicare beneficiaries have similar findings:

- An analysis of the 2010 Medicare Current Beneficiary Survey (MCBS) finds that 95 percent of beneficiaries had a usual source of medical care—74 percent go to a doctor’s office and 12 percent see a doctor at a clinic. Five percent of beneficiaries reported that they had trouble getting needed care, and 9 percent of beneficiaries reported that they did not see a doctor when they thought they should have. Consistent with the focus group findings, respondents in the MCBS who are dually eligible for Medicare and Medicaid were more likely to report that the reason they did not see a doctor was because they had trouble finding one who would treat them. The MCBS also tracks the share of beneficiaries reporting that they were able to see a physician within a specified amount of time. In

**FIGURE 4-3**

**Half of all Medicare beneficiaries seeking an appointment with a physician were able to see one within three days, 2001 and 2010**



Note: Intervening years did not show significant differences. Data exclude beneficiaries residing in institutions. Totals may not sum to 100 percent due to rounding.

Source: Medicare Current Beneficiary Survey.

2010, about half of all Medicare beneficiaries seeking an appointment with a provider were able to see one within three days (Figure 4-3). This figure was similar to that reported in 2001. In addition, the share of beneficiaries reporting that they did not wait at all for an appointment increased from 15 percent in 2001 to 22 percent in 2010.

- The Consumer Assessment of Healthcare Providers and Systems for Medicare FFS, another survey of FFS beneficiaries, found in 2011 that 89 percent of respondents were always or usually able to schedule timely appointments for routine care, and 92 percent were always or usually able to schedule timely appointments for specialty care. In addition, 91 percent of respondents reported that over the last six months they were able to get care for an injury or illness as soon as needed.
- A 2012 study of both Medicare and nonelderly respondents conducted by the Commonwealth

**TABLE  
4-3**

**Physicians and other health professionals billing Medicare, 2009–2011**

Year	Physicians				Advanced practice nurses and physician assistants		Other health professionals	
	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				
2009	161,411	3.8	363,836	8.5	103,344	2.4	155,406	3.6
2010	165,565	3.8	372,269	8.5	113,232	2.6	164,881	3.8
2011	169,640	3.8	379,411	8.5	123,959	2.8	172,129	3.8

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.

Source: Medicare claims data for 100 percent of beneficiaries and the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

Fund found that elderly Medicare beneficiaries had fewer problems with access to care than privately insured individuals, individuals with Medicaid, or individuals with Medicare entitlement based on a disability. Twenty-three percent of elderly Medicare beneficiaries reported that they had experienced access problems due to cost—such as not filling a prescription, not getting needed specialist care, skipping a recommendation or follow-up, or having a medical problem but not seeing a physician—but the rates were significantly higher for privately insured individuals (37 percent) and Medicaid enrollees (41 percent) (Davis et al. 2012). Elderly Medicare beneficiaries were more likely to report that they had a medical home and to rate their quality of care highly. However, the study did find higher rates of access problems and dissatisfaction with care among disabled Medicare beneficiaries, a finding consistent with earlier surveys (Davis et al. 2012).

- An analysis of the 2010 National Health Interview Survey found that beneficiaries were more likely to report having a usual source of care (between 94 and 97 percent, depending on the presence and type of supplemental coverage), compared with 89 percent in the under-65 privately insured population. In addition, Medicare beneficiaries were more likely to report having a doctor’s office as their usual source of care (rather than a clinic) than were privately insured individuals or Medicare beneficiaries who were also Medicaid eligible (Centers for Disease Control and Prevention 2012).

**Physician surveys show that providers are generally willing to accept Medicare beneficiaries**

Another measure of beneficiary access to physician services is the willingness of providers to accept new Medicare patients. An analysis of the National Ambulatory Medical Care Survey found that in 2009 and 2010, 73 percent of primary care physicians reported that they would accept new Medicare patients.<sup>3</sup> This number was slightly lower than the rate 10 years ago (75 percent) and lower than the rate reported for patients with private insurance (89 percent). Among specialists, 90 percent reported that they would accept new Medicare patients, also slightly lower than the rate 10 years earlier (Hing and Schappert 2012).

Another study using the same survey but a different sampling frame and more recent data (2011) found similar shares of office-based physicians accepting new Medicare patients—83 percent for primary care (when pediatricians were excluded) and 91 percent for other specialties (Decker 2012). Finally, the American Medical Association’s 2012 National Health Insurer Report Card—which assesses payment accuracy, timeliness, and transparency in payment—found that, overall, Medicare performed as well as or better than other large insurers (American Medical Association 2012).

**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, whether physicians and other health

professionals are participating providers, and whether these providers take assignment (which means that they accept Medicare’s payment as payment in full). Other trends that may have implications for beneficiaries’ access to physician services are the number of physicians or other professionals who choose to opt out of the Medicare program and trends in retainer-based practices, which charge an additional fee for enhanced services or access.

**Supply of physicians and other health professionals billing Medicare has kept pace with enrollment growth**

Our analysis of Medicare FFS claims data for 2009 to 2011 shows that the number of physicians and other health professionals providing services to Medicare beneficiaries kept pace with growth in the beneficiary population (Table 4-3). First, considering 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. Similarly, the ratio of physicians in other specialties remained constant at 8.5 per 1,000. Meanwhile, the number of advanced practice nurses and physician assistants billing Medicare increased faster than enrollment, growing between 2009 and 2011 from 2.4 per 1,000 to 2.8 per 1,000. The number of other health professionals billing Medicare—such as chiropractors and physical therapists—also grew faster than enrollment during the same period, from 3.6 per 1,000 to 3.8 per 1,000.

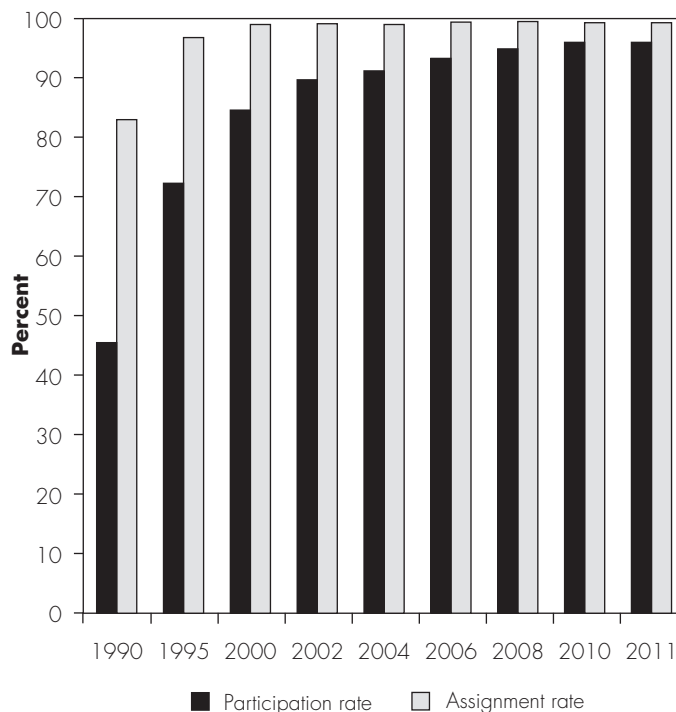
**Most physicians and other professionals are part of Medicare’s participating provider program, and most claims are taken on assignment**

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; Figure 4-4). Participating providers agree to take assignment for all claims, which means they accept the fee-schedule amount as payment in full. 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 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

**FIGURE 4-4**

**Medicare participation and assignment rates continue to be high**



Note: “Participation rate” is the percentage of physicians and other health professionals with signed Medicare participation agreements among those in Medicare’s registry. Participation agreements require the provider to accept assignment (i.e., accept Medicare’s fee-schedule rate as payment in full) for all services provided to Medicare beneficiaries. Participation agreements do not require physicians to accept new Medicare patients. “Assignment rate” is the percentage of allowed charges paid on assignment.

Source: Ways and Means Greenbook (2004) and CMS Data Compendium.

payment (80 percent of the payment amount). Balance billing and nonparticipating providers are relatively rare in Medicare, although some specialties are more likely to balance bill than others. Among all physician specialties, oral surgeons and chiropractors have the lowest rates of participation (Centers for Medicare & Medicaid Services 2012c). Chiropractors, in particular, account for about 10 percent of all balance billing, far exceeding their share of total Medicare spending (charges are only 0.6 percent of fee-schedule spending). Among geographic regions, North Dakota, South Dakota, Idaho, Wyoming, Arizona, and the District of Columbia have the lowest rates of participating providers (Centers for Medicare & Medicaid Services 2012c).

**Medicare’s payment adjustments** Once the total fee-schedule payment amount for a service is determined, the Medicare program may make adjustments based on a

provider's characteristics, geographic location, or type of care delivered. The payment adjustment for care delivered in a health professional shortage area is discussed in the text box (p. 86).

Providers who enter into participating provider agreements with Medicare receive 100 percent of the fee-schedule amount. Providers who do not enter into these agreements are paid 95 percent of the fee-schedule amount and may choose to take assignment. Nurse practitioners billing independently are paid 85 percent of the fee-schedule amount.

Qualifying physicians and other health professionals participating in the Physician Quality Reporting System (PQRS) received a 1 percent bonus on all Medicare services in 2011 and a 0.5 percent bonus in 2012 through 2014. Starting in 2015, physicians not satisfactorily reporting PQRS measures will be subject to a penalty of 1.5 percent, and the 2015 adjustment will be based on participation in PQRS in 2013. In 2010, the last year for which CMS has reported complete data on PQRS utilization, 24 percent of just over 1 million eligible professionals (or 244,145 individuals) participated in PQRS (Centers for Medicare & Medicaid Services 2012a).

The value-based payment modifier for physicians will take effect in 2015; it adjusts physicians' payments based on the cost and quality of care they provide. In 2015, the payment modifier will apply to groups of more than 100 physicians. Groups who do not satisfactorily report under the PQRS will receive a penalty of 1 percent under the modifier.

The electronic health record (EHR) incentive program makes payments to physicians who adopt EHRs and demonstrate their use in specific ways. Up to \$44,000 over five years is available per physician. Starting in 2015, physicians who do not satisfy the EHR criteria will face a financial penalty of 1 percent of their fees. In 2012, most physicians who did not use a qualified electronic prescribing system received a 1 percent reduction in fees.

**Few physicians and other health professionals opt out of the Medicare program, although the number has grown** Physicians and other health professionals can choose to opt out of the Medicare program by signing an affidavit with Medicare. Those choosing to opt out cannot receive any reimbursement from Medicare, either directly or indirectly, for any Medicare patient they see. Opt-out physicians must enter into a private contract

with a Medicare beneficiary in order to deliver care to them. The private contract must meet certain standards set out in regulations, including stating 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. A study conducted in 2004 found that the specialty with the highest number of opt-out physicians was psychiatry, and the Department of Health and Human Services' Office of Inspector General (OIG) reported in 2012 that the number of physicians opting out every year appears to have increased between 2006 and 2010 (Buczko 2004–2005, Wright 2012). In its report, OIG noted that CMS does not regularly publish data on the number of physicians opting out, nor do the data appear to allow for tracking physicians over time (i.e., whether they rejoin the Medicare program at a later date). These types of data, if available, could provide an important indicator of physician satisfaction with the Medicare program.

**Retainer-based practices are still rare but can raise issues regarding compliance with Medicare regulations** The development of retainer-based physician practices may also have implications for Medicare, and the Commission contracted for a study of these practices in 2010. Retainer-based physician practices charge a monthly or annual fee for each patient. In return for the fee, the patient is offered additional services, such as greater access to the physician (through limited patient panels), extended patient hours or easier weekend access, longer appointments, or extra services. The Commission-sponsored report found about 750 retainer-based practices nationwide (Hargrave et al. 2010). Under current Medicare rules, providers may not charge beneficiaries additional fees for covered Medicare services. OIG's roadmap for new physicians explicitly states that any additional charges must be for non-Medicare-covered services (Office of Inspector General 2012).

### **Small increase in volume growth**

We analyze annual changes in use of services as another indicator of payment adequacy, but we caution that interpreting such data is complex because of factors unrelated to Medicare's pricing of services. For example, decreases in volume could signify price inadequacy if physicians are reluctant to offer such services based on their Medicare payment. However, our evidence indicates that volume decreases are more likely due to other factors, such as general practice pattern changes or concerns about radiation exposure. For example, the volume of

coronary artery bypass grafting has been declining as other interventions substitute for the procedure. Increases in volume may signal overpricing if physicians favor certain services because they are relatively profitable, but other factors—including population changes, disease prevalence, changes in Medicare benefits, shifts in the site of care, technology, and beneficiaries' preferences—can also explain volume increases. As an example, procedures for injecting pharmacological agents into the eye have increased in volume in recent years as therapies have emerged for treating macular degeneration. Another confounding factor is that the volume of services sometimes increases when payment rates decline (Codespote et al. 1998). The possibility of such a response—known as a behavioral or volume offset—makes it particularly difficult to interpret volume increases by themselves as an indicator of payment adequacy.

For this year's analysis of volume change, we used claims data for 2006, 2010, and 2011; identified the services furnished by physicians and other professionals billing under Medicare's physician fee schedule; and calculated two measures of change in service use. First, we calculated growth in the units of service per beneficiary. Second, we calculated growth in the volume of services per beneficiary. Volume equals units of service multiplied by each service's relative value unit (RVU) from the physician fee schedule. The result is that change in 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 from, for example, X-rays to higher complexity computed tomography (CT) scans. We used RVUs for 2011 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.<sup>4</sup> 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 situation, we focus the discussion below—when considering changes in service use before 2010—on the change in units of service, and we 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 grew 1.0 percent in 2011 (Table 4-4, p. 92). Among broad categories of service, growth rates were positive at 2.0 percent for evaluation and management (E&M), 1.9 percent for other procedures, and 0.8 percent for tests. Imaging and major procedures had negative growth rates, -1.0 percent and -1.1 percent, respectively.

### **Imaging decreases amid concerns about appropriateness**

Despite decreases in 2011 and 2010, use of imaging services remained much higher than a decade ago (Figure 4-5, p. 93). Cumulative growth in the volume of imaging from 2000 through 2009 totaled 85 percent, compared with a cumulative decrease in imaging volume in 2010 and 2011 of less than 4 percent. The growth in imaging volume from 2000 through 2009 was exceeded only by the 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:

- 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). Sophisticated technology, while able to detect disease, can also have costs such as exposure to radiation, adverse effects of treatment, and proliferation of false-positive results.
- In a study for the Commission documenting trends in services furnished 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 conclude that it is unlikely that these services were underutilized in 1999 and express doubt that there was a clinical justification for a threefold increase in nuclear stress testing and a twofold increase in echocardiography. They also note 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  
4-4****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 2011 allowed charges
	Average annual 2006-2010	2010-2011	Average annual 2006-2010	2010-2011	
<b>All services</b>	<b>1.7%</b>	<b>0.8%</b>	<b>N/A%</b>	<b>1.0%</b>	<b>100.0%</b>
<b>Evaluation and management</b>	<b>0.8</b>	<b>0.9</b>	<b>N/A</b>	<b>2.0</b>	<b>45.1</b>
Office visit—new and established	0.9	0.6	N/A	1.8	24.8
Inpatient visit—hospital and nursing facility	0.3	1.0	N/A	1.5	15.5
Emergency room visit	1.7	3.4	3.5	4.6	3.1
Hospital visit—critical care	6.0	5.0	7.5	5.0	1.4
Home visit	4.8	2.8	6.3	2.7	0.4
<b>Imaging</b>	<b>1.0</b>	<b>0.6</b>	<b>1.3</b>	<b>-1.0</b>	<b>12.6</b>
Advanced—CT: other	3.9	2.1	3.2	1.2	1.8
Standard—nuclear medicine	-3.3	-3.6	-3.7	-9.8	1.6
Echography—heart	1.4	-0.3	1.8	-3.7	1.3
Advanced imaging—MRI: other	0.4	2.4	-0.7	0.9	1.3
Standard—musculoskeletal	0.5	0.9	0.0	0.2	1.0
Echography—other	5.7	5.6	7.3	4.2	0.9
Imaging/procedure—other	4.7	-6.4	9.9	-2.3	0.7
Standard—breast	2.9	4.2	2.5	3.3	0.7
Advanced—MRI: brain	-0.8	1.9	-3.7	-1.1	0.6
Advanced—CT: head	3.0	2.6	2.1	0.8	0.5
Standard—chest	-0.8	-0.6	-1.4	-1.2	0.5
Echography—abdomen and pelvis	2.2	1.9	2.8	1.6	0.5
<b>Major procedures</b>	<b>1.1</b>	<b>-1.4</b>	<b>2.4</b>	<b>-1.1</b>	<b>7.5</b>
Cardiovascular—other	-0.7	-3.8	3.4	-3.5	1.8
Orthopedic—other	6.4	-0.7	7.6	2.3	1.1
Knee replacement	2.1	-3.6	2.8	-3.4	0.5
Coronary angioplasty	-3.8	-5.2	-3.6	-5.2	0.4
Explore, decompress, or excise disc	3.0	1.8	5.2	2.7	0.3
Coronary artery bypass graft	-7.1	-8.0	-7.1	-8.3	0.3
Hip replacement	2.3	2.0	3.2	2.5	0.3
Hip fracture repair	-1.6	-0.5	-1.3	-0.5	0.3
<b>Other procedures</b>	<b>4.2</b>	<b>2.1</b>	<b>3.3</b>	<b>1.9</b>	<b>22.6</b>
Skin—minor and ambulatory	1.8	-1.5	N/A	-0.5	4.5
Outpatient rehabilitation	8.6	5.2	9.3	6.7	3.4
Radiation therapy	-1.0	1.2	2.5	3.2	2.3
Minor—other	2.2	-0.2	2.2	1.0	2.1
Cataract removal/lens insertion	-0.7	-1.2	-0.3	-1.1	1.6
Minor—musculoskeletal	2.4	2.3	2.4	2.4	1.4
Eye—other	11.6	11.7	4.4	6.4	1.0
Colonoscopy	-2.1	0.3	-2.0	0.5	0.9
Upper gastrointestinal endoscopy	0.9	1.1	1.6	1.2	0.5
Cystoscopy	-0.2	0.7	-0.1	0.1	0.4
<b>Tests</b>	<b>0.6</b>	<b>1.0</b>	<b>3.4</b>	<b>0.8</b>	<b>5.1</b>
Other tests	-0.1	0.6	1.9	-0.3	1.9
Electrocardiograms	0.1	-0.5	1.0	-0.7	0.5
Cardiovascular stress tests	-4.0	-3.2	-3.3	-8.0	0.3

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 2011. For billing codes not used in 2011, 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 2006, office visits and inpatient visits include, respectively, office and inpatient consultations. Skin procedures volume is not reported for 2006 to 2010 due to a change in coding of Mohs procedures that prevented assignment of RVUs for these services in 2006.

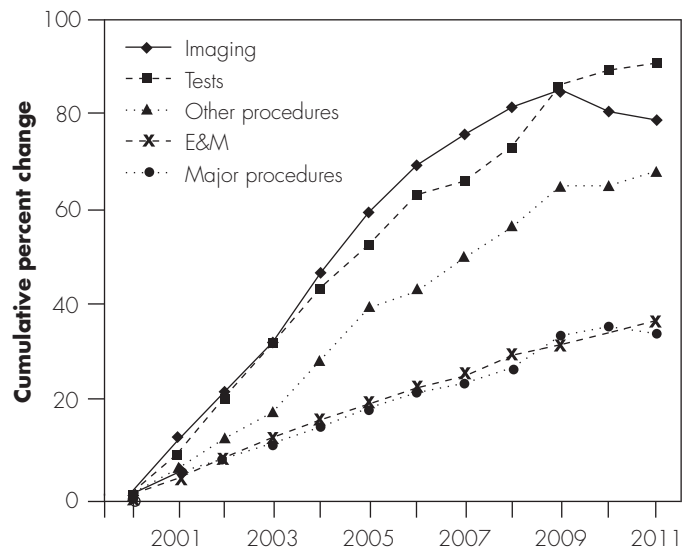
Source: MedPAC analysis of claims data for 100 percent of Medicare beneficiaries.

- Another study for the Commission considered the extent to which certain diagnostic services are repeated when furnished for Medicare beneficiaries (Welch et al. 2012). The list of services included three imaging services: echocardiography, imaging stress tests, and chest CT. Given the lack of research on this topic, the first aim of the project was to document the extent to which services are repeated at given intervals, such as within one year after an initial service. 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 is determining testing thresholds. One reason to study repeat testing is that it is a risk factor for overdiagnosis, which occurs when individuals are diagnosed with conditions that will never cause symptoms or death (Welch et al. 2011). In addition, 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 raise spending.

- The ABIM Foundation has a Choosing Wisely initiative under way to help physicians and patients have conversations about the overuse of tests and procedures and support physicians' efforts to help patients make smart and effective choices about their care (ABIM Foundation 2012).
- 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, "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).

**FIGURE 4-5**

**Growth in volume of practitioner services, 2000–2011**



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 1.7 percent and the 2010 to 2011 growth rate of 2.0 percent.

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

- 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 both physicians' offices and hospitals. 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 furnished in either a nonfacility setting, such as a professional's office, or a facility setting, such as a hospital. As discussed in this report's chapter on hospital inpatient and outpatient

**TABLE  
4-5****Change in cardiac imaging units of service per beneficiary, 2010-2011**

Type of imaging	Hospital outpatient department	Professional office
Echocardiography	17.6%	-7.2%
Nuclear cardiology	13.6	-12.9

Note: Echocardiography includes services in ambulatory payment classifications (APCs) 0269, 0270, and 0697. Nuclear cardiology includes services in APCs 0377 and 0398.

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

services, there has been a shift in billing for some services from professionals' offices to hospitals. In 2011 compared with 2010, the number of echocardiograms per beneficiary furnished in hospital outpatient departments went up by 17.6 percent, but the number furnished in professionals' offices went down by 7.2 percent (Table 4-5). Similarly, from 2010 to 2011, the number of cardiac nuclear medicine studies per beneficiary furnished in hospital outpatient departments went up by 13.6 percent, while the number furnished in professionals' offices went down by 12.9 percent. These changes in billing patterns are consistent with reports of an increase in cardiologists' practices that are owned by hospitals (American College of Cardiology 2012).

This shift has implications for changes in the volume of services. RVUs used in measuring volume are higher for services billed in a nonfacility setting, such as a professional's office, than in a facility setting, such as a hospital.<sup>5</sup> Specifically, practice expense RVUs are higher for services furnished in nonfacility settings than for services furnished in facility settings to account for higher practice costs incurred when services are furnished in nonfacility settings. In turn, measures of service volume decrease when there is a shift in billing patterns from higher RVU nonfacility settings to lower RVU facility settings.

Much of the 1.0 percent decrease in the volume of imaging services is due to decreases in units of service for two cardiovascular services: nuclear medicine and echocardiography. The more important factor, however, is the shift in setting for these services from the nonfacility setting to the facility setting. If these two types of services

are excluded from the calculations, the change in the volume of imaging services from 2010 through 2011 would be an increase of 0.5 percent.

**Quality of care: Most ambulatory care measures were stable or improved, although declines occurred for some measures**

A set of quality indicators called the Medicare Ambulatory Care Indicators for the Elderly (MACIEs) was developed by the Commission with input from a group of clinicians to assess the quality of care delivered by physicians and other health professionals. The MACIEs measure 38 types of clinically indicated acute and follow-up care for beneficiaries diagnosed with certain chronic or acute conditions (see online Appendix 4-B, available at <http://www.medpac.gov>). We assess these quality measures for FFS beneficiaries based on changes between two time periods, 2008 to 2009 and 2010 to 2011. Between these periods, 12 indicators improved, 20 indicators were statistically unchanged, and 6 indicators worsened. Both the increases and decreases in quality were modest.

The rate of beneficiaries with a breast cancer diagnosis who received a chest X-ray at initial diagnosis declined, as did breast cancer screening and mammography surveillance. We see a similar trend in the private market, as measured in the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>), which assesses quality measures for commercial insurers. In the HEDIS measures, the rates of breast cancer screening for individuals under 65 enrolled in HMOs and preferred provider organizations (PPOs) also fell slightly, after peaking in 2009. This trend may be due to ongoing discussions regarding the frequency and efficacy of breast cancer screening (Bleyer and Welch 2012).

The MACIEs also include six measures of potentially avoidable hospitalizations and emergency department visits for beneficiaries with five chronic diseases: coronary artery disease, congestive heart failure, diabetes, hypertension, and chronic obstructive pulmonary disease. Among the six measures (two for diabetes—short-term and long-term complications), one worsened (hospitalization for hypertension) and the rest were statistically unchanged.

**Medicare payments and providers' costs**

Because physicians 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 looks at whether Medicare's fee schedule and FFS payment system encourage differences in physicians' compensation across specialties. The third is a measure of input prices for physicians and other health professionals—the Medicare Economic Index (MEI).

### **Ratio of Medicare payments to private insurer payments is steady**

Since 1999, 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. For 2011, we find little change from the results reported for 2010. In 2011, Medicare's payments for physician and other health professional services were 82 percent of commercial rates for PPOs, and the rate for 2010 was 81 percent. This analysis uses 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, our Medicare fees include bonuses or penalties that Medicare pays as part of the claim. Our findings on access to care for Medicare beneficiaries and privately insured individuals suggest that Medicare's lower fees on average have less effect on access than other systemic trends or local factors.

### **Compensation differences between primary and specialty care**

The Commission remains concerned that the fee schedule and the nature of FFS payment leads 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 of 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 (and therefore their revenue from Medicare) more easily, while other specialties, particularly those that spend most of their time providing E&M services, have limited ability to increase their volume. This situation can also lead to the compensation differences between primary care and specialty care.

An analysis published on the *Health Affairs* website reviewed the argument that if commercial payers used Medicare and Medicaid payment rates, the lower rates would cause financial instability for physicians. The author found that pay for orthopedists—net of expenses—

would fall from \$541,000 under the current payer mix to \$411,000 if commercial insurers paid Medicare fees. The author asserts that the argument has more validity for primary care physicians. In the data source the author uses, net pay for primary care physicians was \$189,000, whereas if commercial insurers paid Medicare fees, primary care physicians would net \$137,000 (Rickert 2012).

This finding is similar to that of a Commission-contracted study of compensation by specialty (Medicare Payment Advisory Commission 2012). Income for physicians in broad specialty categories was calculated using the Medicare fee schedule—as if all of the physician's workload consisted of Medicare patients. While these simulated physician earnings were about 17 percent lower than they were under the current mix of payers, the most striking finding was the persistence of the primary care–specialty care gap in earnings (\$254,000 vs. \$305,000), even under the Medicare fee schedule. Specifically, the nonsurgical, procedural group (\$445,000) and the radiology group (\$460,000) had simulated annual earnings that were more than twice those for the primary care group (\$207,000).

The Commission will continue to review ways of addressing the primary care–specialty care income differences. Methods could include targeted add-on payments to the fee schedule (such as a primary care payment adjustment), additional payments for primary care offices that become patient-centered medical homes (see text box, pp. 96–97), or payment for primary care services through larger bundled or capitated payment models.

### **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.<sup>6</sup> CMS's current forecast is that the percentage change in the MEI will be 2.3 percent in 2014 and 2.8 percent without the productivity adjustment (Centers for Medicare & Medicaid Services 2012b). Medicare's total payments to physicians and other health professionals have increased faster than both the MEI and updates to the fee schedule's conversion factor (Figure 4-6, p. 98). From 2000 through 2011, the updates rose at a cumulative rate of 9 percent, while the MEI rose at a cumulative rate of 26 percent. Over the same period, however, Medicare per beneficiary spending for physician and other health professional services increased by 74 percent. Growth in volume accounts for the difference between the fee-schedule

## The patient-centered medical home

The patient-centered medical home (PCMH) is a primary care model that aims to improve patient outcomes by adopting a patient-centered rather than disease-centered approach, with the aim of improving quality of care, lowering costs, and improving the patient experience (Agency for Healthcare Research and Quality 2012). The concept began in pediatrics in the late 1960s to better document a patient's medical record, but it was not until recently that PCMH has been redefined as a model of primary care delivery for adult patients as well as children. In June 2008, the Commission wrote that the essential functions of a PCMH are to provide primary care, conduct care management, use health information technology for active clinical decision support, have a formal quality improvement program, maintain 24-hour patient communication and rapid access, keep up-to-date records of beneficiaries' advance directives, and maintain a written understanding with each beneficiary designating the provider as a medical home (Medicare Payment Advisory Commission 2008).

In 2007, the American Academy of Family Physicians, the American Academy of Pediatrics, the American College of Physicians, and the American Osteopathic Association produced their Joint Principles of the Patient-Centered Medical Home. Regarding the medical home concept, they stressed the importance of each patient having a consistent personal physician, a physician-directed team of health professionals, and a "whole person orientation" of care. This means that the physician is responsible for providing "care for all stages of life: acute care; chronic care; preventive

services; and end of life care" (Patient-Centered Primary Care Collaborative 2007).

Because of its basis in pediatric primary care, many of the oldest and most advanced PCMH programs are state-run Medicaid care management programs. Since 2008, the National Academy for State Health Policy has supported 16 states to implement and evaluate PCMH programs. They found that the most successful states tailored the definition of "medical home" to their local experience; used changes in payment to facilitate care coordination; minimized the administrative burden of implementing a medical home; based qualification and evaluation on national models that translate medical home principles into concrete, measurable expectations; and addressed the antitrust issues that arise when multiple payers collaborate (Kaye et al. 2011).

Examples of these models include Community Care of North Carolina, which works on improving care transitions for the state's Medicaid population by including pharmacists in efforts to coordinate care, facilitating access to medical records, and using nonphysician care managers (Trygstad et al. 2011). In Maryland and Montana, the multipayer PCMH program facilitates coordinated care by including a shared savings component in the program to give physicians incentive to participate (Kaye et al. 2011). Blue Cross Blue Shield of Michigan (BCBSM) identifies 12 "domains of function" to improve care and evaluates and reimburses practices for achieving them (BlueCross BlueShield of Michigan 2012).

*(continued next page)*

updates and spending growth. Aggregate Medicare payments to practices from this spending growth are a function of volume growth and fee-schedule updates.

### How should Medicare payments change in 2014?

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. We find that, in general, all measures are positive or neutral.

Beneficiary access to physician and other health professional services continues to be good. Medicare beneficiaries generally have better overall access than privately insured individuals ages 50 to 64. However, more beneficiaries seeking a primary care doctor report a big problem than beneficiaries seeking a specialist,

## The patient-centered medical home (cont.)

Earlier this year, the Urban Institute reviewed 10 different accreditation tools to evaluate the processes by which PCMHs receive recognition. The most widely used assessment tool was the Physician Practice Connections<sup>®</sup>–Patient-Centered Medical Home produced by the National Committee for Quality Assurance (NCQA) in 2008 and revised in 2011. Most assessment surveys seem to agree that qualification for PCMH status should require an emphasis on care coordination, health information technology, quality measurement, and patient engagement. Other more innovative considerations include the PCMH's adherence to current law, the presence of a contract acknowledging the practice–patient relationship, the capacity to provide basic care services, business practices and management, and continuity of care by the same physician over time (Burton et al. 2012).

Despite the analysis of these tools that accredit PCMHs, little work has been published to date regarding the programs' success at improving outcomes and reducing costs. Because the PCMH model as it is currently defined is only about five years old, many evaluations are still in progress. Another challenge is that many of the programs considered medical homes predate the official definition of PCMH, and thus variation and uncertainty exist in terms of what PCMHs are able to accomplish (Agency for Healthcare Research and Quality 2012).

Preliminary results from BCBSM's initiative suggest that participation in a PCMH can reduce emergency department visits, reduce the use of radiology services, and increase the use of generic drugs as opposed to brand names (BlueCross BlueShield of Michigan 2012). UPMC Health Plan recently reported lower

medical and pharmaceutical costs and reduced readmissions and emergency department visits as a result of its PCMH (Rosenberg et al. 2012). But there is no evidence as to whether these results can be replicated or scaled.

The Agency for Healthcare Research and Quality (AHRQ) finds that while many evaluations did not meet rigorous methodological standards and thus could not offer statistically significant data, some positive evidence has emerged from PCMH programs around the country. The PCMH model seems to improve process and outcome measures of quality and lead to a more favorable patient experience, but the effect on cost is still unclear. Ultimately, AHRQ concluded that the evidence in favor of PCMH is still weak and that a longer term study is required.

Three demonstrations in the Centers for Medicare and Medicaid Innovation will support practices to become PCMHs that serve Medicare beneficiaries. These demonstrations share some features of state-sponsored programs, such as shared savings and technical assistance to achieve NCQA recognition. CMS will conduct an analysis of the demonstrations' success (Centers for Medicare & Medicaid Services 2011).

Several barriers exist to widespread adoption of PCMHs: Physicians must become comfortable with a practice structure that incorporates nonphysician health professionals and is reimbursed in ways other than fee-for-service. Also, PCMH requires a level of collaboration and communication for which Medicare payment structures have not yet created incentives (Agency for Healthcare Research and Quality 2012, Nutting et al. 2012). ■

which continues to be of concern to the Commission. Other beneficiary access surveys have consistent findings. The number of physicians per beneficiary has remained 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 has also grown.

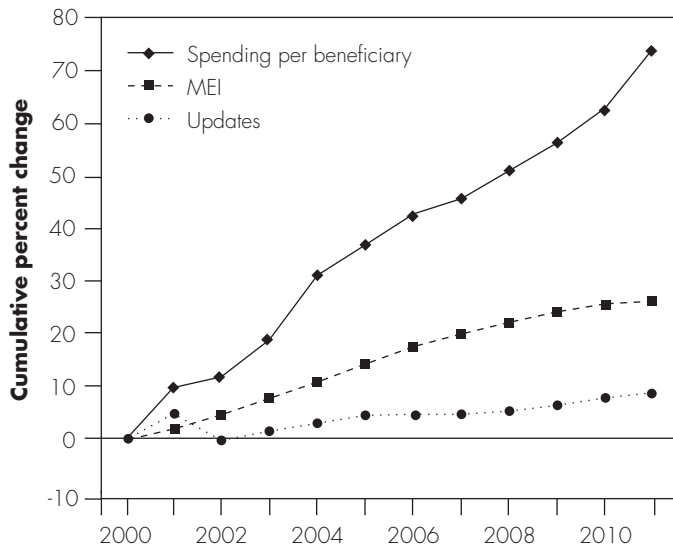
The volume of physician and other health professional services grew 1.0 percent per beneficiary in 2011, but

growth rates varied across groups of services. E&M services increased 2.0 percent, other procedures increased 1.9 percent, and tests increased 0.8 percent. Imaging and major procedures had negative growth rates of –1.0 percent and –1.1 percent, respectively. Imaging procedures declined, in part, from some cardiovascular imaging shifting from physicians' offices to hospital outpatient departments.

Ambulatory care quality assessed for FFS beneficiaries based on changes between two time periods showed slight

**FIGURE  
4-6**

**Volume growth has caused spending to increase faster than input prices and updates, 2000-2011**



Note: MEI (Medicare Economic Index). The MEI measures the changes in the market basket of input prices for physician and other health professional services.

Source: 2012 annual report of the Boards of the Medicare trust funds and Office of the Actuary 2012.

improvement in a few measures and slight declines in a few others. Between the periods 2008 through 2009 and 2010 through 2011, 12 indicators improved, 20 indicators were statistically unchanged, and 6 indicators worsened. With a few exceptions, the increases and decreases were modest. Input prices for physicians and other health professionals are projected to be 2.3 percent in 2014 (including a productivity adjustment).

An overarching issue affecting our deliberations is the SGR system. The Commission laid out its findings, principles, and recommendations for moving forward from the SGR system in its October 2011 letter to the Congress (see Appendix B, pp. 371-392). Repeal of the SGR should follow the Commission's principles—eliminating the link between cumulative fee-schedule expenditures and annual conversion-factor updates, protecting beneficiary access to care, and having the Congress replace the SGR in a way that is fiscally responsible.

Although our latest access survey does not show significant deterioration at the national level, the Commission is nonetheless concerned about access. The balance between supply and demand is tight in many markets and problems could surface, particularly in primary care. The Medicare population is increasing as members of the baby-boom generation become eligible for Medicare, a large cohort of physicians is nearing retirement age, and SGR fatigue is increasing. We do not predict abrupt changes in the national access picture, but we cannot rule them out either.

For these reasons, the Commission reiterates the urgent need to repeal the SGR as detailed in the set of parameters for how the SGR could be repealed in our October 2011 letter to the Congress. Deferring repeal for one or two years will not provide the Congress with a better set of choices. On the contrary, delaying action makes the cost of repeal that much larger, given the projected continuing increases in volume and intensity. A second argument against deferring repeal of the SGR is that the array of new payment models to choose from is unlikely to change materially in the near term. ■

## Endnotes

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- 1 For further information, see the Commission's *Payment Basics: Physician services payment system* document, available at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_Physician.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_Physician.pdf).
- 2 For primary care, payment rates would be frozen at their current levels. For all other services, there would be reductions in the fee schedule's conversion factor in each of the first three years and then a freeze in the conversion factor for the subsequent seven years.
- 3 The study authors refer to "generalist" physicians, but they include the specialty types included in a primary care definition, so we use "primary care" here instead.
- 4 CMS changed the policy on billing for consultations with the rationale that the relaxation of consultation documentation requirements over time had brought the effort involved in consultations to levels comparable to those of visits.
- 5 When a service is furnished in a facility setting, there is a payment under a payment system such as the outpatient prospective payment system—separate from the payment under the physician fee schedule—to account for facility costs.
- 6 The MEI measures the weighted average annual price change for various inputs used by physicians and other health professionals to provide services.

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CHAPTER

5

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**Ambulatory surgical  
center services**

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## 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 2014. The Congress should also require ambulatory surgical centers to submit cost data.

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

# Ambulatory surgical center services

## Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient surgical services to patients who do not require an overnight stay after surgery. In 2011,

- ASCs served 3.4 million fee-for-service (FFS) Medicare beneficiaries, an increase of 0.9 percent from 2010;
- there were 5,344 Medicare-certified ASCs, an increase of 1.8 percent (92 ASCs) from 2010; and
- Medicare combined program and beneficiary spending on ASC services was \$3.4 billion, an increase of 2.2 percent per FFS beneficiary from 2010.

## Assessment of payment adequacy

Our results indicate that beneficiaries' access to ASC services is at least adequate, as most of 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 2011 than in previous years.

**Beneficiaries' access to care**—Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC care has generally been adequate.

## In this chapter

- Are Medicare payments adequate in 2013?
- How should Medicare payments change in 2014?

- ***Capacity and supply of providers***—From 2006 through 2010, the number of Medicare-certified ASCs grew by an average annual rate of 3.6 percent. However, the growth slowed to 1.8 percent in 2011. The relatively slow growth may reflect the substantial revision of the ASC payment system in 2008 (see online Appendix A from Chapter 2C of our March 2010 report at [http://www.medpac.gov/chapters/Mar10\\_Ch02C\\_APPENDIX.pdf](http://www.medpac.gov/chapters/Mar10_Ch02C_APPENDIX.pdf)), and investors may have been responding to the large changes in payment rates that occurred under that revision. In addition, Medicare payment rates for most ambulatory surgical services have become much higher in hospital outpatient departments (HOPDs) than in ASCs—for 2013, the Medicare rates are 78 percent higher in HOPDs than in ASCs. This payment difference may have led some ASC owners to sell their facilities to hospitals. Finally, 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 2006 through 2010, the volume of services per beneficiary grew by an average annual rate of 5.7 percent; in 2011, volume increased by 1.9 percent.

***Quality of care***—Although CMS has established a program for ASCs to submit quality data, ASCs did not begin doing so until October 2012. Consequently, we do not have sufficient data to assess ASCs’ quality of care.

***Providers’ access to capital***—Because the number of ASCs has continued to increase, they appear to have adequate access to capital.

***Medicare payments and providers’ costs***—From 2006 through 2010, Medicare payments per FFS beneficiary increased at an average annual rate of 5.1 percent but slowed to 2.2 percent in 2011. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to assist in assessing payment adequacy. ■

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## Background

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An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient surgical 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. About one-quarter of ASCs in 2008 were jointly owned by physicians and hospitals (Medical Group Management Association 2009). 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 3,600 surgical procedures under the ASC payment system. Physicians who perform procedures in ASCs or other facilities receive separate payment for their professional services under the physician fee schedule (PFS). About 90 percent of ASCs have at least one physician owner (Medical Group Management Association 2009). Physicians who perform surgeries in ASCs they own receive a share of the ASC's facility fees in addition to their professional fees. 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 payments 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\\_12\\_ASC.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_ASC.pdf)). The ASC payment system is also partially linked to the PFS. The ASC system underwent substantial revisions in 2008 (see online Appendix A from Chapter 2C of our March 2010 report at [http://www.medpac.gov/chapters/Mar10\\_Ch02C\\_APPENDIX.pdf](http://www.medpac.gov/chapters/Mar10_Ch02C_APPENDIX.pdf)). The most significant changes included a substantial increase in the number of surgical procedures covered under the ASC payment system, 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 have been 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. Thus, ASC spending does not change over time because of changes in the OPPS relative weights. In 2013, this adjustment reduced the ASC relative weights by 6.8 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 \$42.92 in 2013. The ASC conversion factor is lower than the OPPS conversion factor (\$71.31 in 2013).

The ASC conversion factor is less than the OPPS conversion factor for two reasons. First, CMS set the initial ASC conversion factor for 2008 so that total ASC payments under the revised payment system would equal what they would have been under the previous payment system. 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, and the Commission has recommended that CMS collect ASC cost data. These data should be used 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 that 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.<sup>1</sup> The Commission has been investigating payment rate differences across multiple ambulatory settings, including ASCs, HOPDs, and physicians' offices (Medicare Payment Advisory Commission 2012).

The ASC payment system generally parallels the OPPS in terms of which ancillary services are paid separately and which are packaged into the payment of the associated surgical procedure. 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 OPPS,
- brachytherapy sources implanted during a surgical procedure,
- all pass-through and non-pass-through drugs that are paid for separately under the OPPS when provided as part of a covered surgical procedure, and
- devices with pass-through status under the OPPS.<sup>2</sup>

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 increase could partially offset reduced spending and cost sharing.

Although we do not have recent ASC cost data that would allow us to quantify the cost difference 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 ASC costs are, on average, lower than HOPD costs (Government Accountability Office 2006).<sup>3</sup> 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).<sup>4</sup> Average times were also higher in HOPDs than in ASCs for specific diagnoses, such as cataract, benign neoplasm of the colon, and intervertebral disc disorders.

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## Are Medicare payments adequate in 2013?

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To address whether payments for the current year (2013) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2014), 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 revenue from the Medicare program. Unlike our assessments of other provider types, we could not use quality data in our analysis because ASCs have only recently begun to submit information on quality measures. Moreover, we cannot examine Medicare payments relative to providers' costs because CMS does not require ASCs to submit cost data.<sup>5</sup> Finally, we caution that the effect of Medicare payments on the financial health of ASCs is limited because, on average, Medicare spending accounts for only about 17 percent of an ASC's overall revenue (Medical Group Management Association 2009).<sup>6</sup>

Our results show that 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 payment rates are at least adequate.

### **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 convenience and efficiency relative to HOPDs—the provider type with the greatest overlap of services with ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs; for physicians, ASCs may offer more control over their work environment, customized surgical environments, and specialized staff. In addition, Medicare has lower payment rates and beneficiaries generally have lower copayments 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 pp. 113–115).

## Differences in types of patients treated in ambulatory surgical centers and hospital outpatient departments

There is evidence that ambulatory surgical centers (ASCs) treat different types of patients than hospital outpatient departments (HOPDs). Our analysis of Medicare claims from 2011 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 dual eligible), beneficiaries who are eligible because of disability (under age 65), and beneficiaries who are age 85 or older (Table 5-1).<sup>7</sup> 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, and the relatively high percentage of African Americans who have HOPDs or emergency departments as their usual source of care (Centers for Medicare & Medicaid Services 2012a).

In addition, we found that patients treated in HOPDs were, on average, more medically complex than patients treated in ASCs, as measured by differences in average patient risk scores. We used risk scores from the CMS-hierarchical condition categories (CMS-HCC) risk-adjustment model used in Medicare Advantage to measure patient severity.<sup>8</sup> 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). We used 100 percent of Medicare claims from 2010 to maximize the number of cases and combined services into ambulatory payment classification (APC) groups. 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.

**TABLE 5-1**

**Medicare patients treated in ASCs differ from patients treated in HOPDs, 2011**

Characteristic	Percent of beneficiaries	
	ASC	HOPD
Medicaid status		
Not Medicaid	85.8%	76.6%
Medicaid	14.2	23.4
Race/ethnicity		
White	87.9	83.9
African American	6.9	10.4
Other	5.2	5.7
Age		
Under 65	14.5	22.0
65 to 84	78.4	67.3
85 or older	7.1	10.7
Sex		
Male	42.3	44.0
Female	57.7	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, 2011.

We also compared average patient risk scores within each APC.<sup>9</sup> 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. Table 5-2 (p. 110) shows the average risk scores in each setting for the 10 APCs with the highest ASC volume in

(continued next page)

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

2011. Risk scores were significantly higher in HOPDs than in ASCs for 3 of the top 10 APCs (Table 5-2).

There is a limitation to using risk scores to predict the relative cost of providing a specific service: Risk scores predict patients' relative costliness across the full range of health care services, but they do not necessarily indicate that a patient who has a high risk score will be more costly for a specific service. Despite this limitation, we use CMS-HCC risk scores as a proxy for patient severity because we do not have comparable cost data for HOPDs and ASCs that would allow us to directly evaluate the impact of patient severity on the cost of individual services. In prior work, the Commission has used risk scores from the full HCC model to compare patient severity in HOPDs and ASCs (Medicare Payment Advisory Commission 2003).

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 2012). In Pennsylvania, Medicaid patients accounted for 4.7 percent of ASCs' diagnostic and surgical procedures in 2011, compared with 12.0 percent of HOPDs' procedures.<sup>10</sup> Commercially insured and Medicare patients represented a higher share of ASC procedures than HOPD procedures (87.3 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 accounted for 3.9 percent of total visits to freestanding ASCs in 2006, compared with 8.1 percent of total visits to hospital-based surgery centers.<sup>11</sup>

(continued next page)

**TABLE  
5-2**

**Comparison of average patient risk scores in HOPDs and ASCs for 10 most frequently provided ASC procedure groups, 2010**

Procedure group (APC)	Average patient risk score		Percent of total ASC volume
	HOPD	ASC	
Cataract procedure with IOL insert	1.24	1.19	19.8%
Lower GI endoscopy	1.22*	1.08	15.7
Level III nerve injections	1.34	1.33	13.9
Level I upper GI procedures	1.54	1.36	11.0
Laser eye procedures	1.33	1.28	5.5
Level I nerve injections	1.37	1.35	4.8
Colorectal cancer screening: Colonoscopy	1.00*	0.90	2.7
Level II nerve injections	1.37	1.28	2.2
Level I arthroscopy	1.00*	0.89	1.5
Level III repair and plastic eye procedures	1.37	1.30	1.5
Total			78.7

Note: HOPD (hospital outpatient department), ASC (ambulatory surgical center), APC (ambulatory payment classification), IOL (intraocular lens), GI (gastrointestinal). Services are combined into APC groups.

\*Difference between average HOPD risk score and average ASC risk score is statistically significant ( $p < 0.05$ ). Risk scores were calculated using the CMS-hierarchical condition categories risk-adjustment model used in Medicare Advantage to measure patient severity. These risk scores predict beneficiaries' relative costliness based on diagnoses from the prior year and demographic information.

Source: MedPAC analysis of 100 percent carrier standard analytic file, 2010.



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

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 2012a). If a patient has an HOPD or ED as his usual source of care, physicians may be more likely to refer the patient to an HOPD for surgical care than they would patients who have a usual source of care in another setting. ■

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

The number of Medicare-certified ASCs increased substantially from 2006 through 2008 but has grown more slowly since then. From 2006 through 2008, the number of Medicare-certified ASCs increased by 5.1 percent per year on average. During this period, an average of 318 new facilities entered the program each year, while an average of 79 closed or merged with other facilities. However, the growth rate decelerated to 2.2 percent in 2009 and 1.8

percent in both 2010 and 2011 (Table 5-3). This slower growth continued into 2012, as the number of ASCs increased by 0.3 percent to 5,359 during the first three quarters of 2012 (an annual growth rate of 0.4 percent).

Several factors might explain the relatively slow growth from 2009 through the first three quarters of 2012:

- The economy is experiencing a sluggish recovery after the economic downturn that began in the fall of 2008, which has dampened demand for physicians' services

**TABLE 5-3**

**Number of Medicare-certified ASCs grew by 17 percent, 2006–2011**

	2006	2007	2008	2009	2010	2011
Number of centers	4,567	4,838	5,045	5,157	5,252	5,344
New centers	328	345	281	218	189	153
Exiting centers	89	74	74	106	94	61
Net percent growth in number of centers from previous year	5.5%	5.9%	4.3%	2.2%	1.8%	1.8%

Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of Provider of Services file from CMS, 2011.

**TABLE  
5-4****Most Medicare-certified ASCs  
are urban and for profit**

ASC type	2006	2011
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, 2011.

and elective surgeries (Deutsche Bank 2012b, Kaiser Family Foundation 2011, Keehan et al. 2012).

- 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 78 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).
- There may be limited opportunities to develop new facilities because most physicians who perform procedures in ASCs are already affiliated with an ASC (Cain Brothers 2011).
- Physicians are increasingly choosing to be employed by hospitals rather than work in an independent practice (Berenson et al. 2012, Mathews 2012, Pettypiece 2012). Physicians employed by hospitals are more likely to provide ambulatory surgical services in their 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 2006 through 2011, the number of ASC operating rooms increased at almost the same rate as the number of ASCs (3.0 percent per year vs. 3.2 percent per year). The mean number of operating rooms per ASC decreased slightly from 2.8 to 2.7, although the median number of operating rooms per facility was 2 in both years.

ASCs are concentrated geographically. As of 2011, Maryland had the most ASCs per fee-for-service (FFS) beneficiary, followed by Idaho, Washington, and Georgia; each state had more than 30 ASCs per 100,000 FFS beneficiaries with Part B coverage. Vermont had the fewest ASCs per FFS beneficiary, followed by West Virginia, Kentucky, and New York; each state had fewer than 6 per 100,000 FFS beneficiaries.<sup>12</sup> In addition, in 2011, most Medicare-certified ASCs were for profit and located in urban areas, a pattern that has not changed over time (Table 5-4). 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. However, Medicare payments are not a substantial source of revenue for ASCs, on average (Medical Group Management Association 2009). Other factors have also likely influenced the long-term growth in the number of Medicare-certified ASCs:

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings.
- ASCs may offer patients greater convenience than HOPDs in terms of better locations, the ability to schedule surgery more quickly, and shorter waiting times.
- For most procedures covered under the ASC payment system, beneficiaries' copayments are lower in ASCs than in HOPDs.<sup>13</sup>
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.
- Unlike physicians who perform surgery in HOPDs, 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 professional fees.

## Number of services grew from 2006 to 2011

We examined growth in the number of ASC surgical services provided per FFS beneficiary. From 2006 through 2010, the volume of surgical services per FFS beneficiary increased by an average of 5.7 percent per year and by 1.9 percent in 2011 (Table 5-5).

The 2008 revision of the ASC payment system substantially increased the number of covered services. We evaluated the effect of the increase by breaking down the growth in service volume from 2010 through 2011 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 2011. Our analysis indicates that services newly covered after 2007 grew by 3.9 percent in 2011, and services covered in both 2007 and 2011 grew by 1.7 percent in 2011 (Table 5-5).<sup>14</sup> The most commonly provided services that were newly covered after 2007—which also showed strong growth in other ambulatory settings—include trabeculectomy by laser eye surgery, arthrocentesis by aspiration or injection of a major joint or bursa, and intravitreal injection of a pharmacological agent.

Although newly covered services had strong growth in 2011, the services that have historically contributed the most to overall volume continued to constitute a large share of the total in 2011. For example, cataract removal with intraocular lens insertion had the highest volume in both 2007 and 2011, accounting for 20 percent of volume in 2007 and 18 percent in 2011. Moreover, 19 of the 20 most frequently provided services in 2007 were among the 20 most frequently provided in 2011 (Table 5-6, p. 114). For these 20 services, volume per FFS beneficiary increased by an average of 1.7 percent per year from 2007 through 2011. However, these 20 services accounted for a smaller share of total ASC volume in 2011 than in 2007 (67.8 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 2006 and 2010, but trend has stalled

Although the growth of services provided in ASCs from 2006 to 2010 may reflect the migration of procedures from HOPDs to ASCs, this trend appears to have stalled. We compared volume growth from 2006 through 2011 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 2006, as the inclusion of services covered in the OPSS in 2006 that became covered in the ASC payment system after 2006 would have biased the results.

**TABLE 5-5**

## Volume of ASC services per FFS beneficiary has continued to grow

Time period	Average annual volume growth per FFS beneficiary
2006 through 2010	5.7%
2010 through 2011	1.9
Services covered in both 2007 and 2011	1.7
Services newly covered after 2007	3.9

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

Source: MedPAC analysis of 5 percent carrier standard analytic files, 2006, 2007, 2010, and 2011.

From 2006 through 2010, the number of ASC-covered surgical services per FFS beneficiary grew by 5.8 percent per year in ASCs and by 0.1 percent in HOPDs, which suggests that these surgical services may have migrated from HOPDs to ASCs during that period. In 2011, however, surgical services increased at a lower rate in ASCs than in HOPDs (1.8 percent vs. 3.8 percent).

Although surgical volume growth was higher in HOPDs than ASCs in 2011, there is no strong evidence of a shift of services from ASCs to HOPDs. For example, the 22 most frequently provided ASC services—represented by Healthcare Procedure Coding System codes—constitute about 70 percent of ASC volume. None of these services shows strong evidence of a shift from ASCs to HOPDs in 2011, such as a large decline in the volume provided in ASCs and a large increase in HOPDs. Outside of the 22 most frequently provided ASC services, some services have declined in ASCs but increased in HOPDs. For example, nerve procedures decreased by 3.7 percent in ASCs in 2011 and increased by 10.1 percent in HOPDs.<sup>15</sup> However, other types of procedures increased in ASCs and decreased in HOPDs. For example, the category of services that includes Level II through Level V repair and plastic eye surgeries increased by 5.1 percent in ASCs in 2011 and decreased by 7.0 percent in HOPDs.<sup>16</sup> A factor that may have contributed to the higher volume growth of procedures in HOPDs in 2011 is a shift of services from physicians' offices to HOPDs, as hospital employment of physicians has increased.

Other data also suggest that the migration of services from HOPDs to ASCs has stalled. In Pennsylvania, ASCs' share

**TABLE  
5-6**

**Most frequently provided ASC services in 2011 were similar in 2007**

Surgical service	2007		2011	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	19.9%	1	17.0%	1
Upper GI endoscopy, biopsy	7.9	2	8.0	2
Diagnostic colonoscopy	5.9	3	3.6	8
Colonoscopy and biopsy	5.5	4	5.7	3
After cataract laser surgery	5.4	5	3.9	6
Lesion removal colonoscopy, snare technique	4.8	6	4.4	4
Injection spine: lumbar, sacral (caudal)	4.3	7	3.6	7
Injection foramen epidural: lumbar, sacral	3.1	8	4.1	5
Injection paravertebral: lumbar, sacral add on*	2.9	9	1.9	11
Injection paravertebral: lumbar, sacral*	1.9	10	2.2	9
Lesion removal colonoscopy, biopsy forceps or bipolar cautery	1.7	11	1.0	19
Colon cancer screen, not high-risk individual	1.7	12	1.4	14
Injection foramen epidural add on	1.6	13	2.1	10
Upper GI endoscopy, diagnosis	1.5	14	1.2	16
Colorectal screen, high-risk individual	1.4	15	1.8	12
Cystoscopy	1.3	16	1.1	18
Destruction paravertebral nerve, add on	1.1	17	1.6	13
Revision of upper eyelid	0.9	18	0.9	20
Cataract surgery, complex	0.9	19	1.3	15
Injection spine: cervical or thoracic	0.9	20	0.9	21
Total	74.6		67.8	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal).  
\*The description of these services changed in 2010 to include imaging guidance.

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

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 did not change between 2009 and 2011 (Pennsylvania Health Care Cost Containment Council 2012).

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 2006 through 2011, the proportion of these procedures provided in ASCs increased from 65 percent to 71 percent. Meanwhile, the payment rate for these procedures in 2011 was \$951 in ASCs compared with \$1,691 in HOPDs. Medicare's portion of this payment was \$761 in ASCs and \$1,195 in HOPDs, while the beneficiary's copayment was

\$190 in ASCs and \$496 in HOPDs. Moreover, ASCs offer patients additional advantages over HOPDs, such as more convenient locations and shorter waiting times.

However, we must be attentive to the fact that most ASCs have some degree of physician ownership, and this ownership could give physicians an incentive to perform more surgical services than they would if they provided outpatient surgery only in HOPDs. This additional volume could partially offset the effect of lower 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 nonowning physicians (Hollingsworth et al. 2010, Mitchell 2010, Strobe et al. 2009). One study, using a proxy measure of physician ownership of ASCs in Florida, found that physicians who invested in ASCs increased their volume of four common surgical procedures in all settings more

**TABLE  
5-7****Medicare payments to ASCs have grown, 2006–2011**

	2006	2007	2008	2009	2010	2011
Medicare payments (billions of dollars)	\$2.8	\$2.9	\$3.1	\$3.2	\$3.3	\$3.4
Medicare payments per FFS beneficiary	\$85	\$89	\$97	\$102	\$104	\$106
Percent change per FFS beneficiary from previous year	8.6%	5.0%	8.1%	5.3%	2.0%	2.2%

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.

rapidly than nonowning physicians (Hollingsworth et al. 2010).<sup>17</sup> 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 procedures (Hollingsworth et al. 2011, Koenig and Gu 2013). The first study, which was limited to Florida, found that the volume of colonoscopy and upper gastrointestinal endoscopy in ambulatory settings increased at faster rates 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 2011, although at a slower rate than in previous years (Table 5-3, p. 111). 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 OPPIs, and the increase in physician employment by hospitals. In 2008, the average payment rate for most services provided in ASCs was 62.6 percent of what would have been paid in HOPDs. This percentage fell to 56.5 in 2011. 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 only publicly traded ASC chain—Amsurg—continues to acquire new ASCs, which indicates that it has sufficient access to capital. During the third quarter of 2012, for example, the company announced its intention to acquire 15 new facilities (it currently has over 220 facilities) (Deutsche Bank 2012a). We caution, however, that this chain represents only 4 percent of all Medicare-certified ASCs, so its experience may not represent the entire ASC sector.

### **Medicare payments: Payments have increased rapidly**

In 2011, ASCs received about \$3.4 billion in Medicare payments and beneficiaries' cost sharing (Table 5-7). Spending per FFS beneficiary increased by an average of 5.1 percent per year from 2006 through 2010 and by 2.2 percent in 2011. CMS increased the ASC conversion factor by 0.2 percent in 2011. Annual changes in spending on ASC services can be affected by the amount of spending on new technology intraocular lenses (NTIOLs) because the number of NTIOLs that are eligible for

## 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). CMS should also publicly report quality measurement results to help consumers compare quality among facilities. CMS established a Quality Reporting Program for ASCs that requires them to submit quality data beginning in October 2012; ASCs that do not submit data will have their annual update reduced by 2 percentage points in 2014. However, Medicare payments to ASCs would not be adjusted based on the provider's actual performance on quality measures. CMS currently lacks the statutory authority to implement a VBP program for ASCs.

The Commission supports the quality data reporting program for ASCs 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.**

The current quality reporting 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, and the measure set should primarily focus on clinical outcomes, as Medicare's central concern should be improving outcomes across all ASCs and over time. The program should also include some clinical process, structural, and patient experience measures. Several of these indicators are already being reported through the ASC Quality Reporting Program, but other measures need to be developed, such as a surgical site infection (SSI) indicator and a patient experience measure. An ASC VBP program should reward ASCs for improving care and exceeding quality benchmarks. In addition, funding for the VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program.

CMS should consider incorporating the following outcome measures into an ASC VBP program:

- patient fall in the ASC;
- patient burn;
- wrong site, wrong side, wrong patient, wrong procedure, wrong implant;

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separate payment changes from year to year. Therefore, we also examined the change in Medicare spending on surgical services provided in ASCs excluding spending on NTIOLs. In 2011, per capita spending on surgical services increased 2.6 percent. Per capita spending on surgical services newly covered after 2007 increased 4.5 percent, and spending on surgical services covered in both 2007 and 2011 increased 2.6 percent.

### How should Medicare payments change in 2014?

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

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

- hospital transfer or admission after an ASC procedure, whether the patient is transferred directly to the hospital from the ASC or admitted to the hospital after returning home from an ASC procedure; and
- SSI rate.

The first three outcome measures listed above are patient safety indicators identified by the National Quality Forum as “serious reportable events,” which are defined as errors in medical care that are clearly identifiable and measurable, usually preventable, serious in their consequences for patients, and indicate a problem in a health care facility’s safety systems. ASCs have begun reporting these claims-based measures 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 outcome measures listed above (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 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 a composite measure 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.

Because measures of patient experience provide information on patients’ perceptions of access to care and how well their providers communicate with them, the Commission supports the development of a survey to measure patients’ perceptions of their ASC care. We recognize that scores on a patient experience measure may be similar across facilities because ASCs usually provide low-risk procedures to patients who tend to be less complex than patients treated in hospital outpatient departments. If patient experience scores turn out to be similar across all ASCs, CMS could assign this measure less weight in determining an ASC’s overall performance. ■

facilities, Medicare does not require ASCs to submit cost data. We also do not yet have information on the quality of care in ASCs because they did not begin submitting quality data to CMS until October 2012. The Commission has recommended that Medicare 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).

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 or an ASC-specific market basket should be developed. As discussed in the text box on pp. 118–119, 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 2012b).

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

## 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. We found that ASCs' cost structure is different from that of hospitals and physicians' 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 probably 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 physicians' offices, such as medical equipment, medical supplies, building-related expenses, clinical staff, administrative staff, and malpractice insurance.

We used ASC cost data from the GAO survey to compare the distribution of ASC costs with the distribution of hospital costs (derived from the hospital market basket) and physician practice expenses (derived from the practice expense portion of the MEI). Our March 2010 report has more details on the method (Medicare Payment Advisory Commission 2010b). Although the GAO data are not sufficient for comparing

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mechanism could be annual surveys of a random sample of ASCs with mandatory response. CMS conducted cost surveys of a sample of ASCs in 1986 and 1994, and the Government Accountability Office conducted a survey of ASC costs in 2004. Another approach would be to require all ASCs to submit streamlined cost reports on an annual basis.

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

- total costs for the facility;
- Medicare unallowable costs (e.g., entertainment, promotion, and bad debt);
- 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);
- total Medicare payments; and
- total Medicare visits (this information would enable CMS to validate the cost data with Medicare claims data).



## Revisiting the ambulatory surgical center market basket (cont.)

each category of costs across settings, they suggest that ASCs have a different cost structure from hospitals and physicians' 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 physicians' 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 physicians' offices provide a significant number of imaging, tests, 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 2012b). 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 nine 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 2010b, Medicare Payment Advisory Commission 2011, Medicare Payment Advisory Commission 2012). 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. ■

In addition to the information described above, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (e.g., legal, accounting, and billing services). CMS should use this information to examine the cost structure of ASCs and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed.

CMS increased the ASC conversion factor by 0.2 percent in 2011, 1.6 percent in 2012, and 0.6 percent in 2013. The update for 2013 was based on a projected 1.4 percent increase in the CPI-U, minus a 0.8 percent deduction for multifactor productivity growth, as mandated by

the Patient Protection and Affordable Care Act of 2010 (PPACA).<sup>18</sup>

### Update recommendation

In recommending an update to the ASC conversion factor for 2014, the Commission balanced the following objectives:

- maintain beneficiaries' access to ASC services;
- pay providers adequately;
- hold down the burden on the beneficiaries, workers, and firms who finance Medicare;
- maintain the sustainability of the Medicare program by appropriately restraining spending on ASC services;

- keep providers under financial pressure to constrain costs; and
- require ASCs to submit cost data.

In balancing these goals, the Commission concludes that the ASC update for 2014 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 2014. The Congress should also require ambulatory surgical centers to submit cost data.**

### RATIONALE 5

On the basis of our payment adequacy indicators, the importance of maintaining financial pressure on providers to constrain costs, and the lack of ASC cost and quality data, we believe that ASC payment rates should not be increased for 2014. The indicators of payment adequacy for which we have information are positive: The number of Medicare-certified ASCs continues to grow, as does beneficiaries' use of ASC services, and ASCs have adequate access to capital. Therefore, although we do not have cost and quality data, the indicators we have suggest that payments have been at least adequate.

As we have stated in prior reports, it is vital that CMS begin collecting cost data from ASCs without further delay. The lack of such data for ASCs is one reason why our recommended update for ASCs is lower than that for HOPDs (1.0 percent for 2014) (Chapter 3 of this report). Cost data would enable the Commission to examine the

growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of efficient providers, which would help inform decisions about the ASC update. Such data are also needed to analyze whether an alternative input price index would be an appropriate proxy for ASC costs or an ASC-specific market basket should be developed.

### IMPLICATIONS 5

#### Spending

- CMS has decided to increase ASC payment rates by 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 2014 is 1.9 percent, and the forecast of productivity growth for 2014 is 0.4 percent, resulting in a projected update of 1.5 percent for 2014 (IHS Global Insight 2012). However, we recommend that the update be eliminated. Therefore, relative to the statutory update, 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 would 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

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- 1 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 relative weight in one year and the PFS rate the next year (or vice versa).
- 2 ASCs and HOPDs receive the same amount for drugs that are paid for separately under the OPPS and for pass-through devices.
- 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, Idaho, Washington, 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 CMS–HCC 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 We dropped APCs that did not have any ASC volume.
- 10 These data are based on 266 ASCs and 165 hospitals.
- 11 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).
- 12 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. The 12 states with the lowest number of ASCs per FFS beneficiary all have CON laws, while only 4 of the 10 states that have the highest number of ASCs per beneficiary have CON laws. Among these four states, Maryland and Georgia have exceptions in their CON requirements for ASCs that make it easier to establish new ASCs.
- 13 By statute, the copayment for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,184 in 2013). The ASC payment system does not have the same limitation on copayments, and for a few services the ASC copayment exceeds the inpatient deductible. In these instances, the ASC copayment exceeds the OPPS copayment.
- 14 Our analysis of service volume in 2011 included surgical procedures only, as nearly all these procedures had Current Procedural Terminology codes in the range 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 2011.
- 15 Nerve procedures are represented by APCs 220 and 221.
- 16 This group of services is represented by APCs 239 through 242.
- 17 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.
- 18 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 2012b). Nevertheless, CMS is mandated to subtract multifactor productivity growth from the increase in the CPI–U.

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CHAPTER

6

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**Outpatient dialysis services**

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

- 6** The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2014.

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



# Outpatient dialysis services

## Chapter summary

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2011, about 365,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from about 5,600 dialysis facilities. For most facilities, 2011 is the first year that Medicare paid them using a modernized prospective payment system that includes, in the payment bundle, certain dialysis drugs and ESRD-related clinical laboratory tests that facilities and clinical laboratories previously received in separate payments. Medicare expenditures in 2011 for all outpatient dialysis services in the modernized payment bundle were \$10.1 billion. Controlling for changes in the items and services included in the bundle, we estimate that payments increased about 1 percent between 2010 and 2011.

## Assessment of payment adequacy

Our payment adequacy indicators for outpatient dialysis services are generally positive.

**Beneficiaries' access to care**—Measures include examining the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services.

## In this chapter

- Are Medicare payments adequate in 2013?  
.....
- How should Medicare payments change in 2014?  
.....

- **Capacity and supply of providers**—Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis patients.
- **Volume of services**—Between 2009 and 2011, the number of FFS dialysis beneficiaries and dialysis treatments grew at similar rates (3 percent and 4 percent, respectively). Between 2009 and 2011, use of injectable dialysis drugs—including erythropoiesis-stimulating agents (ESAs)—declined. Some of this decline stems from new clinical evidence that higher doses of ESAs—the leading class of dialysis drugs—led to increased risk of morbidity and mortality; as a result, in 2011, the Food and Drug Administration recommended using more conservative doses of ESAs. In addition, some of this decline stems from providers realizing efficiencies under the modernized payment method.

**Quality of care**—Dialysis quality has improved over time for some indicators, such as use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during dialysis. Other indicators, such as rates of hospitalization, suggest that improvements in quality are still needed.

**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 providers’ costs is based on 2011 claims data submitted by freestanding dialysis facilities to CMS and 2010 cost report data from freestanding dialysis facilities (the most current data available). We estimate that the Medicare margin for outpatient dialysis services was between 2 percent and 3 percent in 2011 and project that the Medicare margin will be between 3 percent and 4 percent in 2013. This projection reflects statutory payment updates in 2012 and 2013 and regulatory changes by CMS, including the small payment reductions due to Medicare’s quality incentive program in both years. ■

## Dialysis treatment choices

**D**ialysis 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. Different types of hemodialysis and PD are available.

Most dialysis patients travel to a facility to undergo hemodialysis three times per week, although hemodialysis can also be done in the patient's home. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient's blood. Based on recent clinical findings, there has been 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 hemodialysis that patients experience when prescribed a thrice weekly regimen 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; it 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 manually (continuous ambulatory peritoneal dialysis (CAPD)) or using a machine (continuous cycler-assisted peritoneal dialysis (CCPD)). With CAPD, patients typically undergo four exchanges during the day; with CCPD, dialysis is typically administered while patients sleep.

Each dialysis method has advantages and disadvantages; no one type of dialysis is best for everyone. People choose one type of dialysis over another for many reasons, including quality of life and personal preferences, patients' awareness of different treatment methods, and physician training and recommendation. Some patients switch from one method to another when their conditions or needs change. Although most dialysis patients undergo in-center dialysis, home dialysis should remain a viable option because it offers several advantages to those patients who are able to dialyze at home, including increased patient satisfaction and health-related quality of life. See online Appendix 6-A to this chapter (available at <http://www.medpac.gov>) for discussion of the use of more frequent hemodialysis and home dialysis by Medicare beneficiaries. ■

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## Background

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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 (see text box). Because of the limited number of kidneys available for transplantation and variation in patients' suitability for transplantation, 70 percent of ESRD patients undergo dialysis. 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.

In 2011, about 365,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from about 5,600 dialysis facilities.<sup>1</sup> For most facilities, 2011 is the first year that Medicare paid them using a modernized prospective payment system (PPS) that includes, in the payment bundle, dialysis drugs for which facilities previously received separate payments and services for which other providers (such as clinical laboratories), not dialysis facilities, previously received separate payments. In 2011, Medicare expenditures for all outpatient dialysis services, including items and

**TABLE  
6-1**

**Characteristics of FFS  
dialysis beneficiaries and  
program eligibility, 2011**

	<b>Percent of all FFS dialysis beneficiaries</b>
Age (in years)	
Under 45	12%
45-64	38
65-74	25
75-84	19
85+	7
Sex	
Male	54
Female	46
Race	
White	50
African American	36
All others	14
Residence, by type of county	
Urban	81
Rural micropolitan	11
Rural, adjacent to urban	5
Rural, not adjacent to urban	3
Frontier	1
Medicare as the secondary payer	9
Dually eligible for Medicaid	47
No supplemental insurance	8*
Prescription drug coverage status	
Enrolled in Part D	72
Coverage through employers that receive RDS	9
Coverage through other creditable sources	8
No creditable coverage	11
LIS	58

Note: FFS (fee-for-service), RDS (retiree drug subsidy), LIS (low-income subsidy). Urban areas contain a core area with a population of 50,000 or more; "rural micropolitan" areas contain at least one cluster of between 10,000 and 50,000 people; "rural, adjacent to urban" are counties that are adjacent to urban areas and do not have a city of 10,000 people in the county; and "rural, not adjacent to urban" are rural counties that are not adjacent to urban areas and do not have a city of 10,000 people. "Frontier" counties have six or fewer people per square mile. Having dual eligibility for Medicaid and having Medicare as the secondary payer are not mutually exclusive. Totals may not sum to 100 percent due to rounding. \*2010 estimate.

Source: Data compiled by MedPAC from 2011 claims submitted by dialysis facilities to CMS, the 2011 CMS denominator file, and the 2010 Medicare Current Beneficiary Survey.

services that Medicare paid to other providers in prior years, were \$10.1 billion.

The 1972 amendments to the Social Security Act extended Medicare benefits to people with ESRD who are eligible for Social Security benefits, including those under age 65 years. 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 the spouse or dependent child of an eligible beneficiary.<sup>2</sup>

Most dialysis patients are enrolled in the Medicare program. According to CMS's 2011 renal facility survey, about 96 percent of all dialysis patients are covered by Medicare.<sup>3</sup> Most Medicare dialysis beneficiaries (about 87 percent) have FFS Medicare. In 2011, there were about 365,000 Medicare FFS dialysis beneficiaries. About 13 percent of Medicare dialysis beneficiaries were enrolled in Medicare Advantage (MA) plans (United States Renal Data System 2012). The statute prohibits enrollment of individuals with ESRD in MA plans.<sup>4</sup> However, beneficiaries who are enrolled in a managed care plan before ESRD diagnosis are permitted to remain in the plan after they are diagnosed. In 2000, the Commission recommended that the Congress lift the bar prohibiting ESRD beneficiaries from enrolling in MA (Medicare Payment Advisory Commission 2000).

Compared with all Medicare enrollees, FFS dialysis beneficiaries are disproportionately younger and African American. Nearly three-quarters of them are under 75 years old and 36 percent are African American (Table 6-1). About 89 percent are enrolled in Part D plans or have other sources of creditable drug coverage. In 2011, about 85,000 FFS dialysis beneficiaries were new to dialysis, and nearly half (46 percent) of them were under age 65 and thus entitled to Medicare based on ESRD (with or without disability).<sup>5</sup>

Between 2000 and 2010, the rate of new ESRD cases increased on average by 0.1 percent per year (Table 6-2) (United States Renal Data System 2012).<sup>6</sup> This growth rate masks two distinct trends. Between 2000 and 2006, with the exception of Native Americans, the rate of new ESRD cases increased across all demographic groups. By contrast, between 2006 and 2010, the rate of new ESRD cases, with the exception of young individuals (19 years or younger) and older individuals (85 years or older), declined across all demographic groups. Between 2000

**TABLE  
6-2****Rate of new cases of end-stage renal disease, 2000–2010**

	Rate per million population			Average annual percent change		
	2000	2006	2010	2000–2006	2006–2010	2000–2010
All	343.7	362.0	347.8	0.9%	-1.0%	0.1%
Age (in years)						
0–19	14.2	14.4	15.5	0.2	1.8	0.9
20–44	120.1	129.3	127.6	1.2	-0.3	0.6
45–64	613.7	619.8	580.9	0.2	-1.6	-0.5
65–74	1,410.9	1,432.9	1,367.7	0.3	-1.2	-0.3
75–79	1,756.2	1,877.2	1,826.2	1.1	-0.7	0.4
80–84	1,778.9	2,011.0	1,956.9	2.1	-0.7	1.0
85+	1,203.5	1,518.3	1,535.8	3.9	0.3	2.5
Sex						
Male	413.5	453.0	441.3	1.5	-0.7	0.7
Female	289.6	291.5	275.2	0.1	-1.4	-0.5
Race						
White	259.5	280.5	275.3	1.3	-0.5	0.6
African American	993.6	1,004.8	924.0	0.2	-2.1	-0.7
Native American	663.9	486.2	465.2	-5.1	-1.1	-3.5
Asian American	379.2	395.3	388.6	0.7	-0.4	0.2

Source: United States Renal Data System 2012.

and 2010, compared with all other demographic groups, the average annual rate of new ESRD cases grew fastest among older individuals (85 years or older) at 2.5 percent per year.

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 2012). The proportion of patients with higher levels of residual kidney function steadily increased from 3.4 percent in 1996 to 16.0 percent in 2010. 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).<sup>7</sup>

To inform patients with chronic renal failure about their renal care options, there is increasing interest in the use of a shared decision-making process that includes patients, their families, caregivers, and physicians. Shared decision making is the process by which a health

care provider communicates personalized information to patients about the risks and benefits of available treatment options, and patients communicate their values and the relative importance they place on benefits and harms. The goal of shared decision making is to improve patients' knowledge of their condition and ensure they have a realistic perception of care outcomes to enable them to make decisions with their physicians that reflect their values and preferences. Information is conveyed in part through patient decision aids that facilitate patients' discussions with their physicians by providing evidence-based objective information on all treatment options for a given condition. Such a process has the potential to help patients with chronic kidney disease understand all available ESRD care options (such as home and in-center dialysis, transplantation, and palliative care) and how each care option affects their quality of life. The American Board of Internal Medicine's "Choosing Wisely" campaign includes the use of a shared decision-making process when initiating dialysis as an opportunity for improving care (ABIM Foundation 2012). The Renal

Physicians Association has published a clinical practice guideline directed at physicians for using a shared decision-making process for initiation of and withdrawal from dialysis (Renal Physicians Association 2010).

To help pay for Part A and Part B cost sharing, most FFS dialysis beneficiaries have private or other public coverage that supplements the Medicare benefit package. According to data from the Medicare Current Beneficiary Survey and the denominator file, among FFS dialysis beneficiaries:

- About 8 percent lack any supplemental insurance.
- Forty-seven percent are dually eligible for Medicare and Medicaid.
- About half receive insurance from private or other government sources (the latter two categories are not mutually exclusive).

According to data from Medicare's denominator file, Medicare is the secondary payer (for Part A and Part B) for 9 percent of FFS dialysis beneficiaries who are insured by an employer group health plan (EGHP) at the time they are diagnosed with ESRD. If an EGHP covers a beneficiary at the time of ESRD diagnosis, it is the primary payer for the first 33 months of care (as long as the individual maintains the EGHP coverage). EGHPs include health plans that beneficiaries were enrolled in through their own employment or through a spouse's or parent's employment before becoming eligible for Medicare due to ESRD.

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 furnish 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 physician and facility services. Physicians and practitioners are paid a monthly capitated payment for outpatient-dialysis-related management services. The monthly payment amount varies based on the number of visits provided each month, the age of the dialysis beneficiary, and whether the beneficiary is receiving dialysis in a facility or at home.<sup>8</sup> Dialysis facilities, beginning in 2011, are paid under a modernized prospective payment method intended to cover all ESRD-related services on a per treatment basis. While this chapter focuses on Medicare's payments to facilities, it

is important to recognize that facilities and physicians collaborate to care for dialysis beneficiaries.

### **In 2011, CMS paid most dialysis facilities under a modernized PPS**

To improve provider efficiency, Medicare began in 2011 to phase in a modernized PPS for dialysis facilities. The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) broadened the payment bundle to include dialysis drugs, laboratory tests, and other ESRD-related items and services that were previously separately billable. MIPPA also required CMS to implement a pay-for-performance program beginning in 2012. 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 and by linking payment to quality. The modernized bundled rate is designed to encourage facilities to furnish care more efficiently by reducing incentives inherent in the former payment method to overutilize drugs, tests, and other services.

Like the previous method, the new one pays facilities for a single dialysis treatment by using a prospective payment. However, the new payment method differs from the former one in the following ways: it (1) uses a broader payment bundle, (2) sets payment using a greater number of beneficiary-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 furnish. The Commission's *Payment Basics* provides more information about Medicare's former and new methods for paying for outpatient dialysis services (available at [http://medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_dialysis.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_12_dialysis.pdf)).

Under the modernized PPS, facilities are paid a single, case-mix-adjusted payment for each dialysis treatment, which is intended to cover all ESRD-related services, including injectable drugs and clinical laboratory services that were previously separately billable. In 2013, the base prospective payment is \$240.36 per treatment. For dialysis facilities that are paid under a four-year transition to the new payment method, in 2013, 75 percent of their payment is based on the new payment method and 25

percent of their payment is based on the former payment method.<sup>9</sup>

### **First-year experience under new dialysis payment method**

According to data from CMS (the 2013 impact file) and the Commission's analysis of 2011 claims submitted by dialysis facilities to CMS, most dialysis facilities (about 93 percent) elected to be paid under the modernized PPS instead of the four-year transition. A greater proportion of freestanding facilities (95 percent) than hospital-based facilities (67 percent) elected to be paid under the modernized payment method. Both of the large dialysis organizations, which account for about two-thirds of all dialysis treatments furnished, elected to be paid under the modernized payment method.

We have identified three issues concerning implementation of the modernized payment method that we intend to monitor: (1) use of dialysis drugs, (2) the low-volume adjuster, and (3) outlier payments.

#### **Use of dialysis drugs**

As discussed on p. 136, the use of injectable dialysis drugs declined between 2010 and 2011. Some of this decline stems from new clinical evidence that found that higher doses of erythropoiesis-stimulating agents (ESAs)—the leading class of dialysis drugs—led to increased risk of morbidity and mortality, which led to the change in the ESA label in June 2011 by the Food and Drug Administration (FDA). In addition, some of this decline stems from providers realizing efficiencies under the modernized payment method. Under the prior payment method, providers had few incentives to control the costs of items and services for which they received separate payments (Medicare Payment Advisory Commission 2003).

#### **Low-volume adjuster**

Low-volume facilities meeting CMS's definition are paid an 18.9 percent adjustment to the base payment rate to account for the higher costs they incur.<sup>10</sup> CMS defined a low-volume facility based on the number of Medicare and non-Medicare treatments furnished in each of the three years before the payment year. Our analysis of 2011 claims data found that some facilities receiving the low-volume adjustment may be near other dialysis facilities. We found that of the roughly 330 facilities that received the low-volume payment adjustment in 2011, about 25 percent were within 1.7 miles of the next facility and 42

percent were within 5 miles of another facility. Medicare and dialysis beneficiaries might be better served by an adjuster that targets low-volume facilities that are not in close proximity to another facility. Only low-volume facilities that are necessary to maintain access—those located in isolated areas—should receive enhanced payment.

#### **Outlier payments**

Under the modernized payment method, a facility is eligible for outlier payments for services that were previously separately billable, including dialysis drugs. To implement the outlier adjustment in a budget-neutral fashion, CMS reduced the base payment rate by 1 percent to account for the proportion of estimated total payments expected to be made as outlier payments (Centers for Medicare & Medicaid Services 2010). However, according to CMS: (1) in 2011, about 0.3 percent of the 1 percent outlier pool was paid out to facilities; and (2) the 1 percent outlier pool was not achieved in 2011 because of the decline in utilization of outlier services associated with implementation of the modernized payment method (Centers for Medicare & Medicaid Services 2012b).<sup>11</sup> To address this issue, for payment year 2013, the agency updated the factors used to calculate outlier payments to reflect more current (2011) utilization data.

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### **Are Medicare payments adequate in 2013?**

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To address whether payments for 2013 are adequate to cover the costs that efficient providers incur and how much providers' costs will change in the update year (2014), we examine several indicators of payment adequacy. We assess beneficiaries' access by examining the capacity of dialysis providers and changes over time in the volume of services furnished, 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 dialysis beneficiaries.
- Some improvements in quality have occurred.

**TABLE  
6-3**

**Increasing number and capacity of freestanding, for-profit, and chain organizations**

	2011				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	
					2006–2011	2010–2011	2006–2011	2010–2011
All	42.0	5,560	98,603	18	4%	3%	4%	3%
	<b>Percent of total</b>							
Freestanding	92%	90%	92%	18	5	3	5	4
Hospital based	8	10	8	14	–2	–3	–2	–4
Residence, by type of county								
Urban	84	78	82	19	4	3	4	3
Rural micropolitan	11	14	12	16	3	1	4	3
Rural, adjacent to urban	3	5	4	13	4	3	5	3
Rural, not adjacent to urban	2	3	2	12	4	2	4	3
Frontier	0.3	0.6	0.3	10	1	3	3	9
For profit	85	84	85	18	5	4	5	4
Nonprofit	15	16	15	16	–1	–3	0.1	–2
Affiliated with any chain	87	82	85	18	5	4	5	4
Affiliated with 1 of 2 largest chains	66	62	64	18	4	5	4	5
Not affiliated with any chain	13	18	15	16	–1	–2	–1	–1

Note: FFS (fee-for-service). “Urban” areas contain a core area with a population of 50,000 or more; “rural micropolitan” areas contain at least one cluster of between 10,000 and 50,000 people; “rural, adjacent to urban” are counties that are adjacent to urban areas and do not have a city of 10,000 people in the county; and “rural, not adjacent to urban” are rural counties that are not adjacent to urban areas and do not have a city of 10,000 people. “Frontier” counties have six or fewer people per square mile.

Source: Compiled by MedPAC from the 2006, 2010, and 2011 Dialysis Compare database from CMS and 2011 claims submitted by freestanding and hospital-based dialysis facilities to CMS.

- Provider access to capital is sufficient.
- The 2011 Medicare margin is estimated at 2 percent to 3 percent, and the 2013 Medicare margin is projected at 3 percent to 4 percent.

**Beneficiaries’ access to care: Indicators continue to be favorable**

Our analysis of access indicators—including the capacity of providers to meet beneficiary demand and changes in the volume of services—shows that beneficiaries’ access to care remains favorable.

**Supply has kept pace with patient demand**

From 2006 to 2011, the number of facilities and their capacity to furnish care, as measured by dialysis

treatment stations, each increased by 4 percent annually (Table 6-3). During this period, the capacity of facilities that were freestanding, for profit, and affiliated with a chain organization grew by 5 percent per year. By contrast, annual growth in the capacity of facilities that are hospital based, nonprofit, and not affiliated with a chain decreased or remained about the same (–2 percent, 0.1 percent, and –1 percent, respectively). Between 2006 and 2011, the capacities of urban and rural facilities grew at similar rates. Trends in supply between 2010 and 2011 are generally similar to those between 2006 and 2011.

Growth in the number of dialysis stations and dialysis patients suggests that provider capacity kept up with demand for care between 2006 and 2011. During this period, the number of all dialysis patients (those in FFS



Medicare, in MA, and not eligible for Medicare) and dialysis treatment stations increased by 4 percent per year. Annual growth in the number of treatment stations was faster than the 2 percent average annual growth in the number of FFS dialysis beneficiaries between 2006 and 2011.

### **Providers of outpatient dialysis services**

In 2011, there were nearly 5,600 dialysis facilities in the United States (Table 6-3). Since the late 1980s, for-profit, freestanding facilities have provided the majority of dialysis treatments (Rettig and Levinsky 1991). In 2011, freestanding facilities furnished 92 percent of FFS treatments and for-profit facilities furnished about 85 percent. The share of facilities that are for profit and freestanding increased from 66 percent of all facilities in 1996 to nearly 85 percent in 2011. In 2011, the distribution of facilities located in urban and rural areas is generally consistent with where FFS dialysis beneficiaries live.

Chain organizations dominate this sector, which has seen significant industry consolidation. In 2005 and 2006, the four largest dialysis chains merged into two chains (referred to as the two largest dialysis organizations). Before the mergers (in 2004), the largest two organizations accounted for 37 percent of all facilities; after the mergers (in 2007), the largest two accounted for nearly 60 percent of all facilities.

In addition to operating most dialysis facilities in 2011, the two largest dialysis organizations are 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 furnish vascular access services; provide ESRD-related disease management services; and 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 specific groups of Medicare dialysis beneficiaries are disproportionately affected by facility closures. Using claims submitted by facilities to CMS and CMS's Dialysis Compare database and the ESRD facility survey, the analysis compares the characteristics

of beneficiaries treated by facilities that closed in 2010 with those in facilities that furnished dialysis in 2010 and 2011.

On net, between 2010 and 2011, the number of dialysis treatment stations, a measure of providers' capacity, increased by 3 percent. Compared with facilities that treated beneficiaries in both years, facilities that closed in 2010 (nearly 90 units) were more likely to be hospital based and nonprofit, which is consistent with long-term trends in supply (as shown in Table 6-3). Closed facilities were smaller, as measured by the number of dialysis treatment stations, than facilities in business in 2010 and 2011 (12 stations vs. 18 stations). Closures did not disproportionately affect rural areas; 21 percent of closed facilities were located in rural areas while 22 percent of facilities in business both years were located in rural areas.

Our analysis of dialysis beneficiaries' demographic characteristics found that a greater proportion of African American FFS dialysis beneficiaries were treated at facilities that closed in 2010 than at facilities that remained open both years (43 percent compared with 38 percent). However, fewer than 1 percent of African Americans (about 1,700 beneficiaries) were affected by closures. Closed facilities and facilities in business both years had similar shares of the elderly and beneficiaries dually eligible for Medicare and Medicaid. There is no evidence that beneficiaries have been unable to obtain care at other facilities. For example, African Americans continued to obtain care from the two largest dialysis chains. In both 2010 and 2011, about 40 percent of beneficiaries served by these two providers were African American.

### **Volume of services**

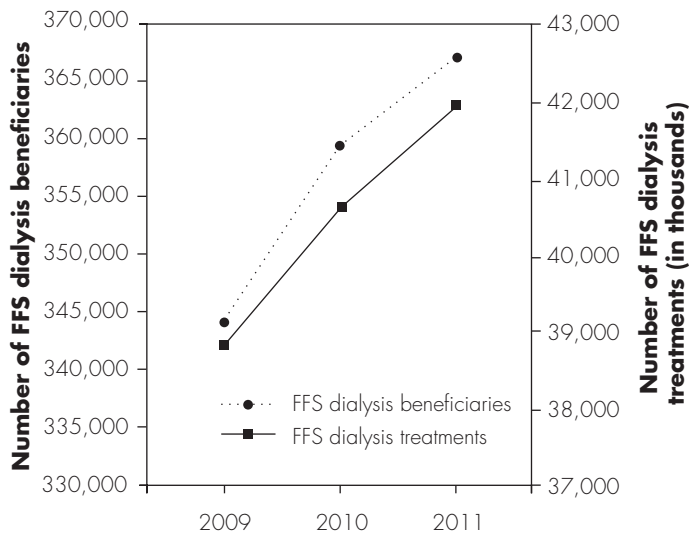
To assess changes in the volume of dialysis services, we examined recent trends in the number of dialysis treatments furnished to beneficiaries and in the use of injectable drugs administered during dialysis.

### **Trends in number of dialysis treatments furnished**

Between 2009 and 2011, dialysis treatments grew at an average annual rate that kept pace with growth in the number of FFS dialysis beneficiaries (Figure 6-1, p. 136). During this period, the number of dialysis treatments grew at an average rate of 4 percent per year, while the number of dialysis beneficiaries grew at an average rate of 3 percent per year.

**FIGURE 6-1**

**Growth in the number of FFS dialysis beneficiaries matches growth in the number of FFS dialysis treatments, 2009–2011**



Note: FFS (fee-for-service).

Source: MedPAC analysis of 2009–2011 claims submitted by dialysis facilities to CMS.

**Trends in use of injectable dialysis drugs** Figure 6-2, which examines changes in the use of erythropoietin (the leading dialysis drug in terms of spending under the prior payment method) shows that the mean weekly dose per week per beneficiary remained fairly steady in 2009. In 2010, per beneficiary use of erythropoietin began to decline. We reported last year that between 2009 and 2010, the mean weekly erythropoietin dose furnished per beneficiary declined by 1.4 percent (Medicare Payment Advisory Commission 2012).

Between 2010 and 2011, the mean weekly erythropoietin dose declined by 15 percent (Figure 6-2). Some of this decline stems from new clinical evidence showing that higher doses of erythropoietin were associated with increased morbidity and mortality. On the basis of this new clinical evidence, in 2007 the FDA included a “black box warning” on ESA drug labels and in 2011 changed the drug’s labeling information to reflect more conservative dosing guidelines. (Food and Drug Administration 2011).<sup>12</sup> In addition, some providers realized efficiencies under the new payment method.

Because CMS set the 2011 payment rate on a per treatment basis and based the rate on 2007 utilization data, we examined changes in the utilization per treatment with erythropoietin and the three leading dialysis drug therapeutic classes.<sup>13</sup> Regarding changes in erythropoietin use, we found that the average units per treatment declined from about 5,700 units in 2007 to 5,200 in 2010 and further to about 4,000 units in 2011. All told, units per treatment declined by nearly 30 percent between 2007 and 2011.

To measure utilization for each drug class, we multiplied the number of units of a drug furnished by the average price that Medicare paid for these drugs in 2011. On a per treatment basis, utilization of ESAs and injectable iron and vitamin D agents was 25 percent lower in 2011 than in 2007. Most of the decline in the use of these three drug classes occurred between 2010 and 2011 rather than between 2007 and 2010. We found that the use of these three drug classes declined by 6 percent per treatment between 2007 and 2010 and by 20 percent per treatment between 2010 and 2011. In each year, most of the decline was driven by the decline in ESA use per treatment.

Use, by drug class, on a per treatment basis changed as follows:

- Between 2007 and 2010, injectable iron and vitamin D agents increased by 9 percent and 1 percent per treatment, respectively, while ESAs decreased by 9 percent per treatment.
- Between 2010 and 2011, use of all three drug classes declined: injectable iron by 7 percent, vitamin D agents by 14 percent, and ESAs by 23 percent per treatment.
- Between 2007 and 2011, use of injectable iron agents increased by 1 percent per treatment, while use of vitamin D agents and ESAs declined by 13 percent and 30 percent, respectively. The modest increase in use of injectable iron stems from increased use in late 2010 and then decreased use in the last two quarters of 2011. Compared with the final quarter of 2007, utilization declined for all three drug classes in the final quarter of 2011 overall by 32 percent, for injectable iron by 12 percent, for vitamin D agents by 15 percent, and for ESAs by 37 percent.

Other researchers have also found declining use of dialysis drugs since implementation of the modernized payment method. The Government Accountability Office (GAO)

measured utilization in dollars by multiplying the number of units per beneficiary of a drug administered in a given quarter by the price Medicare paid for these drugs in the first quarter of 2011. GAO found that in 2011, utilization of ESAs, injectable vitamin D drugs, and injectable iron drugs was 23 percent lower per beneficiary, on average, than it was in 2007 and that this decline was driven largely by a decline in ESA utilization (Government Accountability Office 2012). GAO also reported that from the third quarter of 2010 through the end of 2011, ESA utilization per beneficiary declined by about 30 percent.

The United States Renal Data System (USRDS) also found declining use of dialysis drugs. Among facilities opting into the new payment method, USRDS found a 16 percent decline in the weekly ESA dose per beneficiary between the third quarter of 2010 and the second quarter of 2011. USRDS also found that between the third quarter of 2010 and the second quarter of 2011, among facilities opting into the modernized payment method, mean weekly intravenous iron dose per beneficiary fell by 4 percent and mean weekly intravenous vitamin D dose per beneficiary fell by 12 percent (United States Renal Data System 2012).

### Quality of care: Some measures show progress, others need improvement

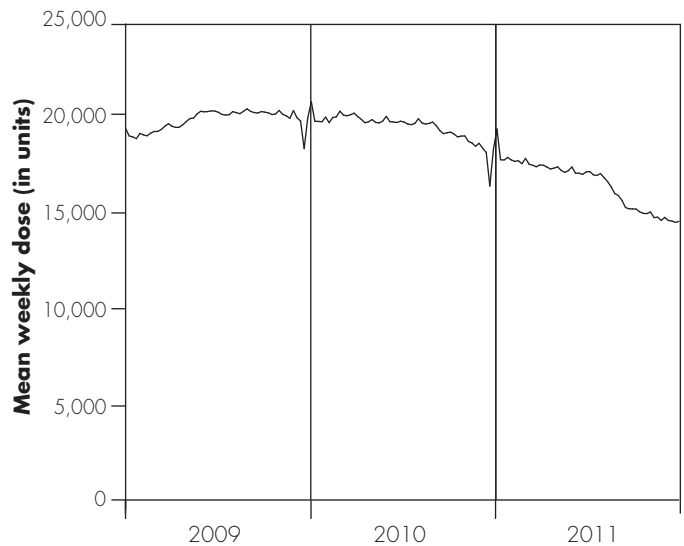
The Commission uses clinical performance and patient outcome measures to assess quality of care furnished to dialysis patients. This year, we also looked at changes in key quality indicators since CMS implemented the modernized payment method. This analysis uses data from CMS, USRDS, and ESRD networks (CMS's contractors that conduct quality improvement activities and other functions).<sup>14</sup>

We found the following trends in quality during the most recent five-year period for which data are available:

- The proportion of patients receiving adequate dialysis remains high, and improvements have been made in use of the recommended type of vascular access for hemodialysis patients, anemia management, and management of patients' nutritional status.
- Rates of mortality, although high, have declined; hospitalization rates remain high and relatively unchanged; 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.

**FIGURE 6-2**

**Mean erythropoietin dose per dialysis beneficiary per week, 2009-2011**



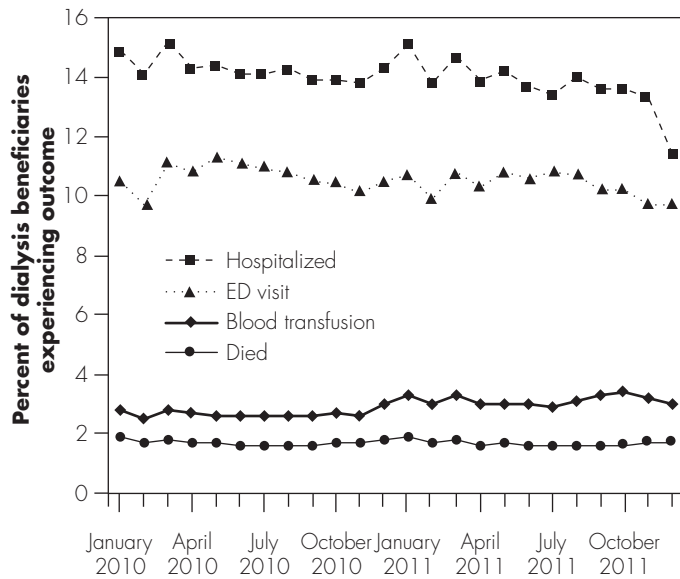
Source: MedPAC analysis of claims submitted by freestanding facilities to CMS, 2009-2011.

Changes in the quality of care between 2010 and 2011, the first year of the modernized payment method, include the following:

- Compared with 2010, monthly rates of beneficiaries who died, were hospitalized, or went to the emergency department in 2011 remained relatively steady.
- With regard to anemia, there was a small increase in the number of dialysis beneficiaries receiving blood transfusions and a large increase in the number of beneficiaries with lower hemoglobin values. This finding is not surprising given the decline in use of ESAs between 2010 and 2011.

### Five-year trends in dialysis quality

The conclusions of this year's assessment of changes in quality are consistent with those in last year's report. Between 2007 and 2011, the proportion of patients receiving adequate dialysis (a measure of the effectiveness of the dialysis treatment in removing waste products from the body) remained high (Table 6-4, p. 139). According to this measure, 97 percent of hemodialysis patients and 91 percent of peritoneal dialysis patients received adequate dialysis. Also during this period, increasing proportions of

**FIGURE  
6-3****Changes in key outcomes for  
dialysis beneficiaries, 2010–2011**

Note: ED (emergency department). Data are compiled on a monthly basis by CMS.

Source: Centers for Medicare & Medicaid Services 2012a.

dialysis patients had their anemia under control (i.e., had a mean hemoglobin between 10 grams per deciliter of blood (g/dL) and 12 g/dL). For hemodialysis patients, use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during dialysis—improved during the period. For most patients, an arteriovenous (AV) fistula is considered the best long-term vascular access for hemodialysis because it provides adequate blood flow, lasts a long time, and has a lower complication rate than other types of access (AV grafts and catheters) (National Institute of Diabetes and Digestive and Kidney Diseases 2008).<sup>15</sup> The goal of Fistula First—CMS’s quality improvement initiative that promotes use of AV fistulas—is for 66 percent of all hemodialysis patients to have an AV fistula.

Between 2007 and 2011, there was a small increase in the proportion of patients achieving the mean serum albumin level (a marker used to identify nutritional concerns) that equals or exceeds the recommendation of the National Kidney Foundation.<sup>16</sup> Recently, some providers have begun to furnish oral nutritional supplements to dialysis beneficiaries. In July 2009, the Office of Inspector General of the Department of Health and Human Services, in

an advisory opinion, said it would not subject such an arrangement to civil monetary penalties or administrative sanctions. Clinical indicators related to the management of bone and mineral disorders, a frequent comorbidity of kidney failure, have remained steady during this period.

In general, the five-year trends in rates of mortality, hospitalization, and access to kidney transplantation suggest that improvements in dialysis quality are still needed. Between 2006 and 2010, although overall adjusted mortality rates decreased across all race and age groups, rates remained high. Overall rates of hospitalization remained steady at about two admissions per dialysis patient per year. There was a modest decline in the 30-day rates of rehospitalization for dialysis patients overall and for cardiovascular, infection, and vascular access index admissions. We looked at several measures that examine access to kidney transplantation because it is widely considered the best treatment option for ESRD patients (Eggers 1988, Kasiske et al. 2000, Laupacis et al. 1996, Ojo et al. 1994). Between 2006 and 2010, the proportion of dialysis patients accepted on the kidney transplant waiting list modestly increased from 16.3 percent to 17.5 percent (Table 6-4). During the same period, overall rates of kidney transplantation decreased from 4.8 per 100 dialysis patient years to 3.9 per 100 dialysis patient years. Rates declined for all race groups. Online Appendix 6-B to this chapter (available at <http://www.medpac.gov>) summarizes issues related to the distribution of kidney transplantation across the ESRD population.

**Effect of new payment method on dialysis quality**

Data from CMS suggest that the modernized method, while affecting anemia management, has not substantially affected rates of mortality, inpatient admission, and emergency department use.

Compared with 2010, the proportion of dialysis beneficiaries in 2011 who died, were hospitalized, or used the emergency department either remained the same or modestly declined (Figure 6-3) (Centers for Medicare & Medicaid Services 2012a). Regarding indicators of anemia management, there was a small increase in the proportion of dialysis beneficiaries receiving blood transfusions, a large increase in those with lower hemoglobin values, and a large decrease in those with higher hemoglobin values. As shown in Figure 6-3, the proportion of beneficiaries (in a given month) receiving a blood transfusion ranged from 2.5 percent to 3.0 percent in 2010 and from 2.9 percent to 3.4 percent in 2011. As shown in Table 6-4, between 2010

**TABLE  
6-4**

**Dialysis clinical indicators and outcomes continue to improve for some measures**

<b>Outcome measure</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>
<b>Percent of in-center adult hemodialysis patients:</b>					
Receiving adequate dialysis (Kt/V ≥ 12)	94%	95%	95%	95%	97%
<b>Anemia measures:</b>					
Mean hemoglobin 10–12 g/dL	49	57	62	68	74
Mean hemoglobin ≥ 12 g/dL*	45	37	32	25	12
Mean hemoglobin < 10	6	6	6	7	14
Dialyzed with an AV fistula	47	50	53	56	59
Nutritional status	34	35	35	39	42
Phosphorus and calcium management	46	45	46	47	48
<b>Percent of adult peritoneal dialysis patients:</b>					
Receiving adequate dialysis	89%	88%	89%	89%	91%
<b>Anemia measures:</b>					
Mean hemoglobin 10–12 g/dL	48	52	57	58	61
Mean hemoglobin ≥ 12 g/dL*	45	39	33	31	21
Mean hemoglobin < 10	7	9	10	11	18
Nutritional status	20	19	18	20	21
Phosphorus and calcium management	46	45	47	47	47
	<b>2006</b>	<b>2007</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>
<b>Annual mortality rate per 100 dialysis patient years:*</b>					
All	20.0%	19.2%	18.5%	18.0%	17.3%
White	21.6	20.7	20.0	19.5	18.9
African American	18.1	17.3	16.5	16.0	15.2
Other	14.8	14.1	13.7	13.4	12.6
45–64 years	16.3	15.6	14.9	14.5	13.9
65–74 years	26.4	25.1	24.3	23.8	23.1
75+ years	40.2	39.1	37.8	36.9	35.8
<b>Inpatient admission rate per dialysis patient:*</b>					
All	1.9	1.9	1.9	1.9	1.9
White	1.9	1.9	1.9	1.9	1.9
African American	2.0	2.0	2.0	1.9	1.9
Native American	1.8	1.7	1.7	1.8	1.7
Asian American	1.4	1.4	1.4	1.3	1.4
45–64 years	1.9	1.8	1.8	1.8	1.8
65–74 years	1.9	1.9	1.9	1.8	1.9
75+ years	2.1	2.0	2.1	2.0	1.9
<b>Percent of discharges that were rehospitalized within 30 days:*</b>					
All	N/A	35.8%	N/A	35.9%	33.4%
Cardiovascular (index hospitalization)	N/A	37.5	N/A	37.6	34.5
Infection (index hospitalization)	N/A	33.7	N/A	33.8	31.0
Vascular access (index hospitalization)	N/A	31.7	N/A	31.1	29.3
<b>Percent of prevalent dialysis patients wait-listed for a kidney:</b>					
All	16.3%	16.8%	17.0%	17.3%	17.5%
White	15.2	15.7	15.9	16.2	16.5
African American	16.7	17.3	17.5	17.7	17.9
Native American	14.5	15.1	15.5	14.9	15.0
Asian American	25.2	25.6	25.7	25.7	25.6
<b>Renal transplant rate per 100 dialysis patient years:</b>					
All	4.8	4.4	4.2	4.1	3.9
White	5.6	5.1	4.8	4.6	4.3
African American	3.2	3.0	2.9	2.9	2.9
Native American	4.5	4.2	4.2	4.8	4.1
Asian American	6.2	3.8	3.7	3.5	3.8

Note: Kt/V (dialyzer urea clearance x dialysis time/urea volume), g/dL (grams/deciliter), N/A (not available), AV (arteriovenous). "Other" includes Asian Americans and Native Americans. Data on dialysis adequacy, use of fistulas, and anemia management represent percent of patients meeting CMS's clinical performance measures. United States Renal Data System adjusts data by age, gender, race, and primary diagnosis of end-stage renal disease.  
\* Lower values indicate higher quality.

Source: Compiled by MedPAC from the 2010 and 2011 National Elab Reports, 2002–2009 Elab Trends Report, Fistula First 2012, and United States Renal Data System 2012.

and 2011, the proportion of adult hemodialysis patients with hemoglobin levels less than 10 g/dL increased from 7 percent to 14 percent, while the proportion of adult hemodialysis patients with hemoglobin levels greater than 12 g/dL declined from 25 percent to 12 percent. Hemoglobin levels less than 10 g/dL are often associated with lower use of ESAs, while hemoglobin levels greater than 12 g/dL are often associated with higher use of ESAs. The clinical indicator measuring the management of bone and mineral disorders remained at about the same level between 2010 and 2011.

### **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 2011 and 2012. For example:

- In 2012, DaVita completed its acquisition of HealthCare Partners, which runs medical groups and physician networks in California, Florida, and Nevada; has 700 employed physicians and a network of 8,300 independent doctors; and is one of the Pioneer Accountable Care Organizations (ACOs) and is in the ACO Pilot Project for People covered by Anthem Blue Cross, for roughly \$4.4 billion.
- In 2011, DaVita purchased a company that owns two dialysis centers in Germany and manages two others.
- In February 2012, Fresenius completed the acquisition of Liberty Dialysis and Renal Advantage, which is expected to add annual revenues of around \$700 million and 201 clinics.
- In 2011, Fresenius acquired American Access Care Holdings, which operates 28 freestanding outpatient clinics for procedures such as fistulas and grafts, for \$385 million.
- In November 2012, Renal Ventures Management LLC, which operates 36 dialysis facilities, created a division of vascular access centers that are intended to open in 2013.
- In October 2012, a new dialysis provider, Corva Clinics LLC, and a private equity firm acquired the assets of Innovative Renal Care.

- In December 2011, Ambulatory Services of America acquired Renal CarePartners. Once the acquisition is complete, Ambulatory Services of America will operate 62 facilities.

These current trends in the profit status and consolidation among dialysis providers suggest that the dialysis industry is attractive to for-profit providers and that there are efficiencies and economies of scale in providing dialysis care. The attractiveness of these ventures is suggested by the statement from a midsized dialysis chain that new clinics become “EBITDA (earnings before interest, taxes, depreciation, and amortization) positive” within an average of 12 months of opening (American Renal Holdings 2011).

Finally, in 2012, Berkshire Hathaway, Inc., a multinational conglomerate holding company, increased its investment in one of the largest dialysis providers (Seeking Alpha 2012). Such an investment suggests the financial attractiveness of the company and the positive economics associated with provision of dialysis services.

### **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 2011 and examined trends in spending during the past five-year period. We also reviewed evidence about providers' costs. Because of delays by CMS in processing the 2011 cost reports of freestanding dialysis facilities, the latest and most complete data available on freestanding providers' costs are from 2010.

### **Medicare payments for outpatient dialysis services**

For most facilities, 2011 is the first year of the modernized PPS that includes, in the payment bundle, injectable dialysis drugs, laboratory tests, and supplies and other services for which facilities previously received separate payments. The modernized bundle also includes items and services for which other providers, not dialysis facilities, received separate payments in prior years. These items and services include (1) laboratory tests that physicians ordered in caring for dialysis beneficiaries (and clinical laboratories furnished), (2) durable medical equipment and supplies for some home dialysis beneficiaries, and (3) the oral equivalent of injectable dialysis drugs (calcitriol, doxercalciferol, paricalcitol, and levocarnitine). CMS

estimated that these items and services account for about 3.8 percent of the total payment per treatment (Centers for Medicare & Medicaid Services 2010).

Excluding items and services that Medicare paid other providers (not dialysis facilities) to furnish in prior years, we estimate that in 2011, Medicare expenditures were about \$9.6 billion, an increase of about 1 percent compared with 2010 spending levels. After those items and services were included in the new payment bundle, Medicare expenditures totaled \$10.1 billion. Freestanding facilities accounted for 92 percent of the spending total (about \$9.3 billion in 2011).

Between 2007 and 2009, per capita annual spending increased by an average of 1.7 percent per year, partly due to increasing use of injectable dialysis drugs (Figure 6-4). Between 2009 and 2010, spending per beneficiary decreased by 0.5 percent. The decline in per beneficiary spending in 2010 was primarily due to the lower volume of ESAs furnished to beneficiaries in 2010.

Excluding services furnished by other providers in prior years, we estimate that, in 2011, dialysis spending averaged about \$26,600 per FFS dialysis beneficiary (Figure 6-4), a 0.3 percent increase from 2010. The change in total per beneficiary spending between 2010 and 2011 also reflects the MIPPA-mandated 2 percent reduction in total ESRD spending and a transitional budget-neutrality adjuster of 3.1 percent to the base payment rate that CMS implemented between January and March 2011.

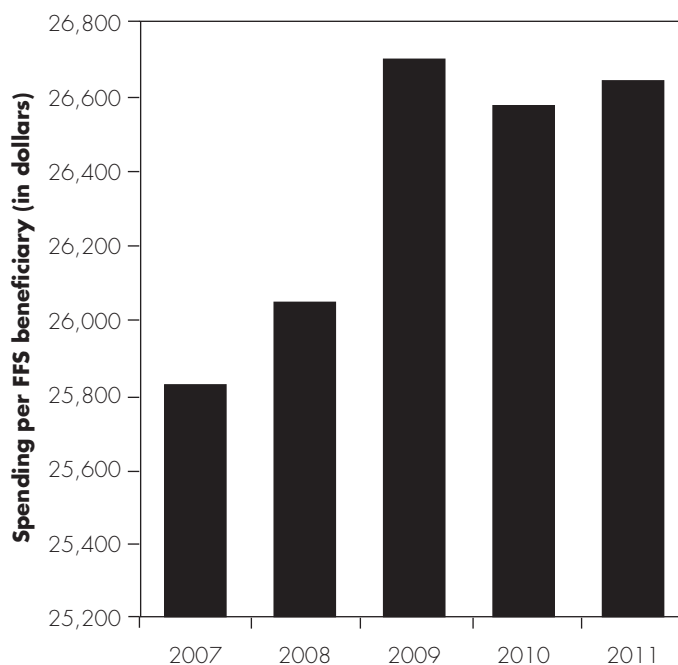
### Summary of last year's analysis of Medicare payments and providers' costs

In our March 2012 report, we found that:

- Between 2005 and 2010, the cost per treatment for services paid under the former composite rate payment system using the composite rate rose by an average of 2.5 percent per year. Variation from this average across freestanding dialysis facilities shows that some facilities were able to hold their cost growth well below that of others. For example, between 2005 and 2010, per treatment costs increased by 0.7 percent per year for facilities in the 25th percentile of cost growth, compared with 4.2 percent for facilities in the 75th percentile.
- For 2010, we estimated the Medicare margin for composite rate services and dialysis drugs at 2.3 percent. The distribution of margins in 2010 showed wide variation in performance among freestanding

**FIGURE 6-4**

### Spending for dialysis services, 2007–2011



Note: FFS (fee-for-service). The payment per beneficiary for 2011 was adjusted by excluding the payment for services furnished by other providers in prior payment years (laboratory services, durable medical equipment, and the oral equivalent of Part B dialysis drugs). This adjustment was estimated based on CMS data reported in the 2010 final rule for the end-stage renal disease prospective payment system (Centers for Medicare & Medicaid Services 2010).

Source: MedPAC analysis of 2007–2011 claims submitted by dialysis facilities to CMS.

facilities. One-quarter of facilities had margins at or below –6.7 percent and one-quarter of facilities had Medicare margins of at least 11.9 percent.

- On the basis of 2010 payment and cost data, we projected a 2012 aggregate margin of 2.7 percent.

### Outpatient dialysis Medicare margins for 2011 and 2013

Our estimate of the Medicare margin is based on the most current cost and payment data available for freestanding dialysis facilities: 2010 cost reports and 2011 Medicare claims data. Because 2011 dialysis facility cost reports are not yet available, we estimate a range for the 2011 Medicare margin of 2 percent to 3 percent, and we project that the 2013 Medicare margin will be in the range of 3 percent to 4 percent. The lower end of the range reflects a more conservative assumption about the efficiencies

anticipated under the modernized payment bundle. The 2013 Medicare margin includes the following policy changes: (1) the increase in the payment rate via the statutory update for 2012 and 2013 (of 2.1 percent and 2.3 percent, respectively), (2) the estimated decrease in total payments due to the quality incentive program in 2012 and 2013 (0.2 percent and 0.3 percent, respectively), and (3) the increase in payments due to the 2013 transitional budget-neutrality factor that CMS finalized for the 2013 payment year (of 0.1 percent).

## How should Medicare payments change in 2014?

Two major provisions under current law affect the 2014 outpatient dialysis payment rate. First, the American Taxpayer Relief Act of 2012 rebases the outpatient dialysis payment rate effective 2014 to reflect more current utilization of dialysis drugs and other services. The law mandates that the Secretary (1) rebase the outpatient dialysis payment rate effective 2014 based on changes between 2007 and 2012 in the utilization of ESAs, other drugs and biologicals, and diagnostic laboratory tests; and (2) delay the inclusion of oral-only ESRD-related drugs into the payment bundle until 2016.

Second, 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 modernized prospective payment bundle. CMS's latest forecast of this index for calendar year 2014 is 2.8 percent. Under current law, the ESRD update is subject to a productivity adjustment, currently estimated at 0.4 percent.

### Update recommendation

Our payment adequacy indicators suggest that payments are adequate. It is also relevant to note that over 90 percent of the industry opted to be paid fully under the new payment system rather than go through a transition. It also appears that facilities have become more efficient under the new payment method as measured by declining use of injectable dialysis drugs between 2010 and 2011.

## RECOMMENDATION 6

**The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2014.**

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 realized efficiencies under the modernized payment method as evidenced by declining use of injectable dialysis drugs. The Medicare margin is estimated at 2 percent to 3 percent in 2011 and projected at 3 percent to 4 percent in 2013.

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

## IMPLICATIONS 6

### Spending

- Under current law, the payment rate would be (1) rebased in 2014 to reflect changes between 2007 and 2012 in the use of dialysis drugs and diagnostic laboratory tests and (2) updated by the ESRD market basket less a productivity adjustment, which is currently estimated at 2.4 percent. This recommendation, which holds the 2014 payment rate at the 2013 level, would increase federal program spending relative to the statutory update law by between \$50 million and \$250 million for one year and by less than \$1 billion over five years.

### Beneficiary and provider

- We do not anticipate any negative effects on beneficiary access to care. This recommendation is not expected to affect providers' willingness or ability to serve beneficiaries.

### Future research agenda

To address the high and unchanging rates of inpatient admission, the Commission intends to explore the effectiveness of payment approaches that have the potential to improve dialysis quality by decreasing the



high inpatient admission rate. Such approaches include expanding the dialysis payment bundle to include outpatient services that have the potential to affect the high rate of inpatient morbidity, such as vascular access services (Medicare Payment Advisory Commission 2008). We also intend to consider an even larger payment bundle that could, for example, include all services needed to treat dialysis beneficiaries during the course of a month. One example of such a larger payment

bundle is the ESRD special needs plans—a subcategory of coordinated care plans in MA. In this report, we recommend that the Congress continue chronic special needs plans only for a small number of conditions, including ESRD (see Chapter 14). ESRD ACOs represent another payment approach of a larger payment bundle that ESRD industry representatives have proposed as a means to improve dialysis quality and control costs (Nissenson et al. 2012). ■

## Endnotes

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- 1 In this chapter, we use the terms “beneficiaries” to refer to individuals covered by Medicare and “patients” for individuals who may or may not be covered by Medicare. As we discuss later in this chapter, most dialysis patients are covered by Medicare as the primary or secondary payer.
- 2 To become eligible for Medicare, individuals with ESRD who are less than 65 years of age do not necessarily have to be receiving Social Security disability insurance benefits. In 2011, about 20 percent of all dialysis beneficiaries were eligible for Medicare benefits due to ESRD alone, about 30 percent were eligible due to disability (with or without ESRD), and the remainder were eligible due to age (being 65 years or older).
- 3 This estimate remained relatively steady between 2006 and 2011 (the most recent five-year period for which data are available).
- 4 According to CMS’s Medicare Managed Care Manual, an individual who receives a kidney transplant and 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.
- 5 For individuals entitled to Medicare due to ESRD only or ESRD and disability, Medicare coverage does not begin until the fourth month after the start of dialysis, unless the individual had a kidney transplant or began training for self-care, including those dialyzing at home.
- 6 For this analysis, new patients with ESRD include those who (1) are Medicare eligible and not Medicare eligible and (2) initiate dialysis or receive a kidney transplant.
- 7 Patients with higher levels of residual kidney function were those who started dialysis 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 2012). Clinicians consider the estimated glomerular filtration rate the best measure of residual kidney function; lower values of this measure suggest reduced residual kidney function.
- 8 In 2011, 85 percent of Medicare’s payments for monthly capitated payment services were billed by nephrologists.
- 9 In 2013, under the former method (i.e., basic case-mix-adjusted composite rate system), the base composite rate is \$165.62 per treatment, including a 14 percent drug add-on payment. Separately billable dialysis drugs are paid according to the Part B average sales price.
- 10 CMS defined a low-volume facility as one that furnishes fewer than 4,000 treatments (including those for non-Medicare patients) in each of the three years before the payment year and that has not opened, closed, or received a new provider number due to a change in ownership during the three-year period. Facilities under common ownership and within 25 road miles of each other are treated as if they were one unit for purposes of applying the low-volume adjustment; facilities certified for Medicare participation before January 1, 2011, are exempt from this provision. Pediatric dialysis treatments are not eligible for the low-volume adjustment.
- 11 For payment years 2011 and 2012, CMS used 2007 utilization data to calculate the outlier payment factors.
- 12 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 (compared with lower hemoglobin levels) and that dosing should be individualized to maintain hemoglobin levels between 10 grams per deciliter of blood (g/dL) and 12 g/dL. Changes to the ESA label in 2011 include recommendations that providers consider starting ESA treatment for patients with chronic kidney disease when the hemoglobin level is less than 10 g/dL and use the lowest dose of ESA sufficient to reduce the need for red blood cell transfusions.
- 13 These three drug classes accounted for nearly all dialysis drug spending (about 97 percent) in 2010, the year before the start of the modernized payment method.
- 14 To assess how facilities meet Medicare’s clinical performance measures, we used data from the Elab Project, in which nearly all dialysis facilities provide the ESRD networks with patient-level laboratory data on clinical indicators, such as dialysis adequacy and anemia status. We used data from CMS’s quality project, Fistula First, to monitor changes in the types of vascular access hemodialysis patients used. To assess trends in hospitalization, mortality, and renal transplantation overall for all patients, we used data from USRDS. We used data from CMS and the Elab Project to assess clinical outcomes under the modernized payment method (since 2010).
- 15 Surgeons create an AV fistula by joining an artery to a vein under the patient’s skin (frequently in the forearm). A few months are usually needed to allow the AV fistula to properly develop before it can be used during dialysis. Surgeons may

implant an AV graft for certain patients (including those with small or weak veins) who are not candidates for an AV fistula. Like AV fistulas, AV grafts are implanted under the skin, usually in the patient's forearm. AV grafts use a soft plastic tube to join an artery and a vein. Compared with AV fistulas, AV grafts can be used sooner after placement, often in two to three weeks. A catheter placed in the patient's neck, chest, or leg is used as a temporary access when a patient needs

dialysis immediately and is waiting for an AV fistula or AV graft to mature. A catheter is also used when an AV fistula or AV graft fails.

- 16 Researchers have found a strong inverse correlation between dialysis patients' albumin levels and mortality. However, inflammation and infection can affect albumin levels.

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CHAPTER

# 7

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

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

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries recovering from an acute hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). As with any service, the Commission's goal is to recommend policies related to payments for PAC providers that ensure beneficiaries receive appropriate, high-quality care in the least costly setting appropriate for their clinical condition.

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### Shortcomings in how Medicare defines and pays for PAC services

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Medicare's definition of and payments for PAC services fail to establish incentives for providers to deliver efficient, high-value care. First, PAC is not well defined and the need for these services is not always clear—some patients can go home from an acute hospital stay without PAC while others need it but receive services in varying amounts. Still other patients may do best by staying a few more days in the acute care hospital and avoiding the transition to a PAC setting.

Further, many PAC providers furnish similar services, yet Medicare pays different rates for them depending on the setting. For example, patients recovering from the lowest severity strokes are treated in IRFs, SNFs, LTCHs, and

with home health care. Conditions of participation and coverage rules do not clearly delineate the types of patients who belong in each setting. In addition, without a common assessment instrument for PAC services, the quality of care and patient outcomes cannot be compared across settings, making it impossible to evaluate the comparative efficacy of services provided in different settings.

Current use patterns do not necessarily reflect how much or where patients would best receive their care because there are no financial incentives for providers to refer patients to the most efficient and effective setting. Instead, placement decisions can reflect a local market's availability of PAC settings, geographic 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 it contracts with). Providers also have no incentive to consider the cost to Medicare of a patient's total episode of care. Providers receiving a fixed prospective payment may discharge patients to another provider or setting to keep their own costs below Medicare's payment, even if that increases Medicare's spending over the course of treatment.

Current use patterns also reflect the financial incentives under fee-for-service to increase volume when services are paid for on a per service basis. For example, Medicare's day-based payments to SNFs encourage more days, while the episode-based home health payment system

encourages more 60-day episodes. Furthermore, the design of Medicare's payment systems for both SNF services and home health care encourages providers to furnish rehabilitation therapy to boost payments above costs. Current practice patterns reflect these financial incentives to provide more and certain types of service, regardless of their clinical value for the patient. Finally, the separate PAC silos of payment—each setting is paid under a separate payment system, each of which has its own set of financial incentives—do not include any incentives to coordinate care across multiple providers or encourage safe transitions to the patient's home. Instead, providers have an incentive to focus on their narrow, near-term gains, which may not best serve the beneficiary.

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## **Broad reforms that would move Medicare beyond PAC silos**

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Recognizing the shortcomings in Medicare payment systems, the Commission has worked on four broad reforms to encourage a more seamless, patient-centered approach to match services and settings to the needs of each patient. Under these reforms, payments would reflect the characteristics of the patient, not the services furnished or the setting, and would encourage the use of the lowest cost mix of services necessary to achieve the best outcomes. These reforms include bundled payments and accountable care organizations (ACOs); a common patient assessment instrument; the development of risk-adjusted, outcomes-based quality measures; and the alignment of readmission policies across settings.

### **Bundled payments and ACOs**

Bundled payments and ACOs would pay an entity for an array of services over a defined period. Under bundled payments, one payment bundle would cover all PAC services following a hospitalization. Under an ACO, participating health care providers assume some financial risk for the cost and quality of care delivered to a defined population and share in savings if they can limit costs while maintaining quality. Under both reforms, providers have an incentive to get patients the right services at the right time, coordinate care, and use resources efficiently. The Commission recommended testing bundled payments for PAC services in 2008 and continues to work on these PAC bundle reforms. In 2011, the CMS Innovation Center launched a bundling initiative with two models that include PAC (one model includes the hospital stay

and PAC; the other includes only PAC during a period after discharge from the hospital). In June 2012, entities interested in participating in the initiative submitted proposals that described the conditions that would be included, the length of the bundle (30, 60, or 90 days after discharge from the hospital), and the target price. After reviewing the applications, CMS announced a preliminary list of 48 conditions candidates can select to test. There are 69 participants in models that include PAC, involving 357 health care organizations. Pending contract finalization and program integrity audits, awardees are expected to be at risk midyear 2013.

The Commission commented on the proposed rules for ACOs and continues to monitor their progress. Shared savings programs for ACOs represent an opportunity to reward providers who control their costs, improve quality of care, better coordinate care, and become more engaged in their care management. Given the wide variation in Medicare spending, both bundled payments and ACOs could yield considerable savings over time by replacing inefficient and unneeded care with a more effective mix of services.

### **A common assessment instrument**

The second broad reform would require all PAC providers to use the same patient assessment tool. In 2005, the Commission called for such a tool so that patients, their service use, and outcomes could be compared across settings. CMS completed a mandated demonstration of a common assessment tool in 2011. It found that such a tool was feasible, and its analysis of resource use indicated the potential for a single-payment system across institutional settings.

### **New quality measures**

The Commission has begun to develop risk-adjusted, outcomes-based measures for some PAC settings so that the efficacy of settings and services can be assessed. Because much PAC aims to get the patient home, we have developed measures for risk-adjusted rates of discharge to the community for SNFs and IRFs. Rehospitalization rates, especially for conditions that are potentially avoidable, are a good gauge of the care furnished by the facility, and we now use this measure in evaluating the quality of SNFs, IRFs, and HHAs. We have developed measures for these same three settings that extend rehospitalization measures to include a period after discharge. This inclusion holds providers accountable for safe care transitions. Aligning measures across sites allows comparisons of providers' quality and could eventually be used to tie payments to outcomes.

## **Expanded readmission policies**

The Commission has examined expanding readmission policies to PAC settings so that hospital and PAC incentives are aligned and focused on unnecessary rehospitalizations. Such policies would hold PAC providers and hospitals jointly responsible for the care they furnish in their own settings and for safe transitions to the next one. Such policies discourage providers from

discharging patients prematurely or without adequate patient and family education. Aligning policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality. We have recommended readmission policies for hospitals (now in place) and SNFs, and we are working on similar policies for home health care and IRFs. ■



CHAPTER

8

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**Skilled nursing facility services**

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## 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. 178.)*

# 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 2011, almost 15,000 SNFs furnished Medicare-covered care to 1.7 million fee-for-service (FFS) beneficiaries during 2.4 million stays. The Office of the Actuary estimates that Medicare spending for 2011 was \$31.3 billion and comprised about 6 percent of Medicare's spending.

## Assessment of payment adequacy

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

**Beneficiaries' access to care**—Access to SNF services remains stable for most beneficiaries.

## In this chapter

- Are Medicare payments adequate in 2013?
- How should Medicare payments change in 2014?
- Medicaid trends

- **Capacity and supply of providers**—The number of SNFs participating in the Medicare program increased slightly between 2010 and 2011. Three-quarters of beneficiaries live in a county with five or more SNFs, and less than 1 percent live in a county without one. Bed days available did not change between 2009 and 2010, the most recent years with available data. The median occupancy rate was 88 percent, indicating some excess capacity for admissions.
- **Volume of services**—Days and admissions on a per FFS beneficiary basis were essentially unchanged between 2010 and 2011.

**Quality of care**—SNF quality of care, as measured by risk-adjusted rates of community discharge and rates of rehospitalization for patients with five avoidable conditions, has changed little over the past decade. This year, the Commission reports a third measure—rehospitalizations within 30 days of discharge from the SNF. The three measures show considerable variation across the industry.

**Providers' access to capital**—Because most SNFs are part of a larger nursing home, we examine nursing homes' access to capital. Lending in 2013 is expected to be similar to that in 2012. Uncertainties surrounding the federal budget continue to make borrowers and lenders wary, but this lending environment reflects the economy in general, not the adequacy of Medicare payments. Medicare remains a preferred payer.

**Medicare payments and providers' costs**—Increases in payments between 2010 and 2011 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In addition, payments in 2011 were unusually high because of overpayments resulting from an adjustment made to implement the new case-mix groups. Because Medicare cost reports were not available in time for this report, we estimated a range for the 2011 margins: from 22 percent to 24 percent. This year is the 11th year in a row with Medicare margins above 10 percent. We project that the 2013 margin will range from 12 percent to 14 percent.

Last year, the Commission made a recommendation to first restructure the SNF payment system and then rebase payments. Specifically, the Commission recommended that the Congress direct the Secretary to revise the SNF prospective payment system (PPS) in 2012; during the year of revision, the 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) need to be removed from the nursing component and made through a separate component established specifically to



adjust for differences in patients' needs for these services. Third, an outlier policy would be added to the PPS. After the PPS is revised, in the following year, CMS would begin a process of rebasing payments, starting with a 4 percent reduction in payments.

This multiyear recommendation to revise the PPS in the first year and rebase payments the next year was based on several factors:

- high and sustained Medicare margins,
- widely varying costs unrelated to case mix and wages,
- cost growth well above the market basket that reflects little fiscal pressure from the Medicare program,
- the ability of many SNFs (more than 900) to have consistently below-average costs and above-average quality of care,
- the continued ability of the industry to maintain high margins despite changing policies, and
- the fact that in some 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 will materially affect the trajectory of these findings going forward. Therefore, the Commission maintains its position with respect to the SNF PPS and urges the Congress as soon as practicable to direct the Secretary to revise the PPS and begin a process of rebasing payments.

## **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 2011 and 2012. In 2011, estimates of non-Medicare margins and total margins indicate that both improved over 2010. Non-Medicare margins ranged from an estimated -1 percent to -3 percent, and total margins ranged from 4 percent to 6 percent for all payers and all lines of business. ■



**TABLE  
8-1**

**A growing share of fee-for-service Medicare stays and payments go to freestanding SNFs and for-profit SNFs**

Type of SNF	Facilities		Medicare-covered stays		Medicare payments	
	2006	2011	2006	2011	2006	2011
Total number	15,178	14,935	2,454,263	2,455,730	\$19.5 billion	\$28.8 billion
Freestanding	92%	95%	89%	93%	94%	97%
Hospital based	8	5	11	7	6	3
Urban	67	71	79	81	81	84
Rural	33	29	21	19	19	16
For profit	68	70	67	72	73	76
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 2011.

**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 2011, almost 1.7 million fee-for-service (FFS) beneficiaries (4.7 percent) used SNF services at least once (there were over 2.4 million stays). The Office of the Actuary estimates program spending on SNF services was \$31.3 billion in 2011. Of all beneficiaries hospitalized in 2011, about 20 percent were discharged to SNFs.<sup>1</sup>

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.<sup>2</sup> 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 2013, the copayment is \$148 per day.

The term “skilled nursing facility” refers to a provider that meets Medicare requirements for Part A coverage.<sup>3</sup> Most SNFs (more than 90 percent) are dually certified as a SNF and as a nursing home (which typically furnishes 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 is the predominant payer in nursing homes, accounting for the majority of days and dollars.

The mix of facilities and the facility type where beneficiaries seek care has shifted toward freestanding and for-profit facilities (Table 8-1). Between 2006 and 2011, freestanding facilities and for-profit facilities accounted for growing shares of Medicare stays and spending. In 2011, 70 percent of SNFs were for profit; they provided about 72 percent of stays and accounted for 76 percent of Medicare payments.

Medicare-covered SNF patients typically comprise a small share of a facility’s total patient population but a larger share of the facility’s payments. In 2010, in freestanding facilities the median Medicare-covered share of total facility days was 12 percent, but it accounted for 23 percent of facility revenue. These shares represent increases from 2000, when Medicare’s share of facility days was 7 percent and its share of revenues was 14 percent.

The most frequent hospital conditions referred to SNFs for post-acute care were joint replacement, septicemia, kidney and urinary tract infections, hip and femur procedures except major joint replacement, 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 dual eligible (see text box, pp. 162–163).

## Description of beneficiaries who use skilled nursing facility services

Compared with other Medicare beneficiaries who have not used a skilled nursing facility (SNF), SNF users are more likely to be female, older, and White (Table 8-2). 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 (such as dressing, bathing, and eating), with 49 percent reporting this level of impairment. Further, only 13 percent of SNF users report being in excellent or very good health compared with 43 percent of other beneficiaries. Compared with other beneficiaries,

**TABLE  
8-2**

**Users of skilled nursing facilities are older, frailer, and more likely to report poor health status compared with other beneficiaries, 2010**

Characteristic	Percent of:	
	Beneficiaries who use SNF services	Other beneficiaries
Sex		
Female	59%	54%
Male	41	46
Race/ethnicity		
White, non-Hispanic	85	79
African American	10	9
Hispanic	2	6
Other	2	5
Age (in years)		
Less than 65	8	18
65-74	20	45
75-84	34	25
85 or older	39	12
Self-reported health status		
Excellent or very good	13	43
Good or fair	68	48
Poor	19	8
Limitations in ADLs		
No ADLs	26	69
1-2 ADLs	25	19
3-6 ADLs	49	12
Education		
No high school diploma	32	23
Completed high school	29	30
Beyond high school	36	46
Living arrangement		
In an institution	33	4
Alone	28	29
With a spouse	23	49
Other	15	18

Note: SNF (skilled nursing facility), ADL (activity of daily living).

Source: MedPAC analysis of Medicare Current Beneficiary Survey 2010 cost and use files.

(continued next page)

## Description of beneficiaries who use skilled nursing facility services (cont.)

SNF users are less educated—more likely to have not completed high school and less likely to have education beyond that level.

SNF users are much more likely to be living in an institution, with 33 percent living in one compared with 4 percent of beneficiaries who have not used a SNF. Almost equal shares of SNF users and other beneficiaries live alone. However, 23 percent of SNF users live with a spouse compared with 49 percent of other beneficiaries who live with a spouse. SNF users are more than twice as likely as other beneficiaries to be disabled.

Comparing SNF users who were dually eligible for Medicare and Medicaid and SNF users who were not, in 2010, dual-eligible beneficiaries accounted for 17 percent of Medicare beneficiaries but 37 percent of SNF users. Compared with other SNF users, dual-

eligible SNF users were younger, more likely to be a minority, less likely to be married, and more dependent in function as indicated by a lower average Barthel activity of daily living score (a score of 34 vs. 41 out of a possible score of 90).<sup>4</sup> They also had a higher rate of most chronic medical conditions (e.g., falls, heart failure, diabetes mellitus), mental illnesses, and cognitive impairments (Table 8-3). Dual-eligible SNF users were more than twice as likely to be discharged to long-term nursing home care rather than to a community setting compared with other SNF users (50 percent vs. 22 percent). This substantially higher rate of long-term nursing home placement was only partially explained by differences in patient characteristics, indicating that dual-eligible SNF users are substantially more likely to be placed in long-term nursing home care than other SNF users, independent of risk (Kramer et al. 2013). ■

**TABLE  
8-3**

**Dual-eligible users of SNFs are younger, more likely to be minority, and more likely to have mental illness or cognitive impairment compared with other SNF users, 2010**

Characteristic	Percent of:	
	Dual-eligible SNF users	Other SNF users
Race/ethnicity		
White, non-Hispanic	72%	92%
African American	18	6
Hispanic	8	1
Other	3	1
Age (in years)		
Less than 65	19	4
85 or older	28	39
Married	20	39
Falls since admission or prior assessment	23	16
Mental illness		
Alzheimer's disease	9	5
Dementia	33	21
Depression	46	33
Psychosis	9	3
Schizophrenia	5	1

Note: SNF (skilled nursing facility).

Source: Analysis of patient assessment data for fiscal year 2011 (Kramer et al. 2013).

## SNF prospective payment system and its shortcomings

Medicare uses a prospective payment system (PPS) to pay for each day of service.<sup>5</sup> 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 to perform activities of daily living (such as eating and toileting). Medicare’s payments for SNF services are described in Medicare *Payment Basics*, available on the Commission’s website ([http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_SNF.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_SNF.pdf)). Though the payment system is referred to as “prospective,” two features undermine its prospectivity: Payments are made for each day of care (rather than establishing a payment for the entire stay) and payments are partly based on the amount of service furnished to a patient. Both features result in providers having some control over their payments.

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. The PPS encourages the provision of therapy because payments are based in part on the amount of service furnished to beneficiaries, rather than being set prospectively, and payments are not proportional to costs. That is, as therapy costs increase, therapy payments rise even faster (Garrett and Wissoker 2008, Medicare Payment Advisory Commission 2008). The problem with payments for NTA services is that they 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 that the PPS be revised to base therapy payments on patient characteristics (not service provision), remove the 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 policy (Medicare Payment Advisory Commission 2008). A revised PPS would raise payments for medically complex care (and the SNFs that provide it) and lower payments for high-intensity therapy (and the SNFs that provide it) (Wissoker and Garrett 2010).

Since 2008, the Commission has updated its PPS design work in three ways. First, the Commission compared an alternative PPS design with current (2012) policy that incorporates changes to the case-mix system and the balance of payments between therapy and nontherapy care. We found that a revised design is still needed to improve the predicted costs per day and redistribute payments from SNFs with high shares of therapy stays to SNFs with high shares of medically complex stays (Carter et al. 2012, Wissoker and Zuckerman 2012). The effects of a revised payment design would vary considerably across SNFs by type and ownership, reflecting differences in patient mixes and therapy practices. 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. Given the mix of patients facilities treat, Medicare margins would increase for nonprofit facilities and hospital-based facilities (facilities with the lowest Medicare margins) and decline slightly for for-profit facilities and freestanding facilities (facilities with the highest Medicare margins).

Second, a 2009 update to this work explored designs for the NTA component that met the criteria CMS laid out for this component (Centers for Medicare & Medicaid Services 2009). These designs retained most of their ability to predict NTA costs and considerably improved the accuracy of payments for NTA services (Wissoker and Garrett 2010).

Third, the Commission examined designs that paid for therapy on a per stay basis as a way to dampen the incentive to extend stays or furnish unnecessary therapy. We found that stay-based designs would be less accurate, though not remarkably so. One stay-based design explained between 18 percent and 21 percent of the variation in therapy costs per stay. The better designs included features of the case-mix system used to pay inpatient rehabilitation facilities or the predictive model developed by CMS’s Post-Acute Care Payment Reform Demonstration to explain the direct patient care costs of therapy. One of the better day-based designs, using CMS’s predictive therapy cost model, explained 26 percent of the variation (Wissoker 2012). Designs that included measures of length of stay had more than double the explanatory power but, like current policy, would most likely result in unnecessary services.

## **CMS's revisions to 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 to base payments for rehabilitation therapy services on patient care needs. In 2010, CMS changed the definitions of the existing case-mix groups and added 13 case-mix groups for medically complex days.<sup>6</sup> At the same time, CMS shifted program dollars away from therapy care and toward medically complex care (Centers for Medicare & Medicaid Services 2010). After these changes, between 2010 and 2011, the share of days classified into medically complex groups increased from 5 percent to 7 percent. In addition, in 2010 and 2011, CMS made important changes to more accurately pay for rehabilitation therapy—including lower payments for therapy furnished to multiple beneficiaries treated at the same time rather than in one-on-one sessions and requiring providers to reassess patients when the provision of therapy changed or stopped (that would, in turn, change the assignments to case-mix groups).<sup>7</sup>

SNFs continue to be adept at modifying their practices in response to changes in policy—varying the amount of therapy provided and deciding whether they furnish therapy individually or in groups—and they will most likely continue to do so. For example, in 2010, when Medicare payments were lowered by 1.1 percent, total spending increased almost 5 percent from 2009. SNFs achieved this increase in part by providing more intensive rehabilitation that resulted in more days being classified into the higher intensity case-mix groups, from 65 percent to 69 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. Individual therapy now makes up over 99 percent of therapy furnished, up from 74 percent in 2006 (Centers for Medicare & Medicaid Services 2012).

Provider adjustments to rate reductions in 2012 have included both cost reduction and revenue enhancement strategies. Cost reductions have focused on nonpatient care areas, such as corporate overhead, administration, and outsourcing of dietary, laundry, and housekeeping services. Some providers have improved the efficiency of therapists with the use of hand-held devices. This technology has reduced the time needed to complete paperwork and allowed therapists to bill more hours per

shift (Kindred Healthcare 2012b). Increasing occupancy is another strategy (Ensign Group 2012). Revenue enhancements have targeted improving payer mix (i.e., lowering Medicaid days by expanding commercial days) and continuing to seek short-term, high-rehabilitation Medicare patients (Ensign Group 2012, Extendicare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012).

With respect to the Commission's recommendations to reform the PPS, CMS continues to evaluate a possible NTA component and in 2012 began a multiyear study to consider alternative PPS designs for therapy services. To establish a separate NTA component, CMS will need to complete its research before deciding whether to pursue this option. CMS is likely to exclude services that are especially discretionary (e.g., oxygen therapy) and is updating its analysis to reflect more recent practice patterns. In fall 2012, CMS engaged a contractor to study possible reforms to therapy payments within the PPS, including (but not limited to) episode-based payments and payments for therapy services based on patient characteristics (as the Commission recommended). 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, and it therefore has not aggressively pursued these options. Congressional action is required to make these changes to the SNF PPS.

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## **Are Medicare payments adequate in 2013?**

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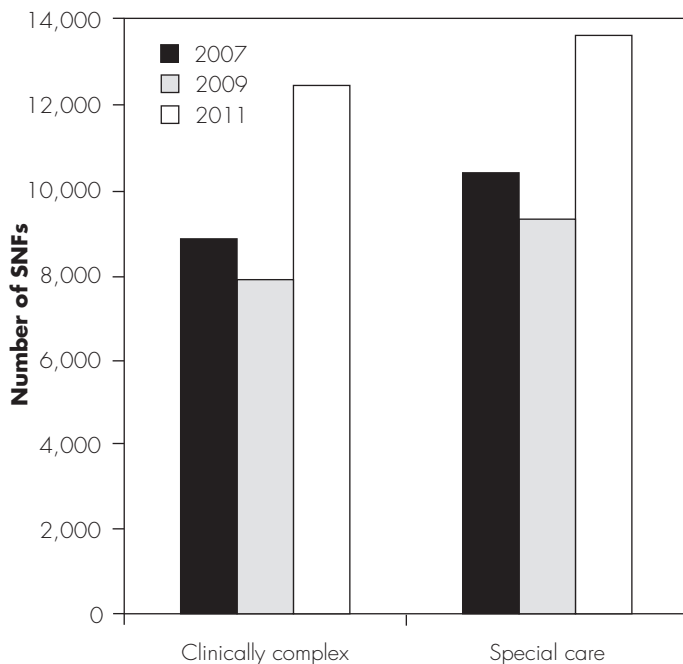
To examine the adequacy of Medicare's payments, we analyzed access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compared the performance of SNFs with relatively high and low Medicare margins and 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 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.

**FIGURE 8-1**

**Number of SNFs with clinically complex and special care cases increased after case-mix groups were expanded in 2010**



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 are comatose; have burns, septicemia, pneumonia, internal bleeding, or dehydration; or receive dialysis or chemotherapy. The special care category includes patients with multiple sclerosis or cerebral palsy, those who receive respiratory services seven days per week, or those who are aphasic or tube-fed.

Source: MedPAC analysis of 2007, 2009, and 2011 Minimum Data Set data from CMS.

**Capacity and supply of providers: Supply remains stable**

Since 2006, the number of SNFs participating in the Medicare program decreased slightly to 14,935 in 2011. However, between 2010 and 2011, 24 more SNFs were treating Medicare beneficiaries. Most new participants are for profit and freestanding.<sup>8</sup> Most SNFs are also freestanding (96 percent) and for-profit facilities make up 70 percent of the industry.

Most beneficiaries live in counties with multiple SNFs. Over three-quarters of beneficiaries live in counties with 5 or more SNFs and the majority of beneficiaries live in counties with 10 or more. Few beneficiaries (less than 1 percent) live in a county without a SNF.

Although more recent data were not available, our prior work found that 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 were unchanged between 2009 and 2010. Between 2001 and 2010, the increase in bed days available averaged 6 percent a year. In 2010, the median occupancy rates were 88 percent in freestanding facilities and 81 percent in hospital-based units, indicating capacity to admit beneficiaries seeking SNF care.

The number of SNFs admitting medically complex patients increased between 2009 and 2011, reversing a steady decline from 2005 (Figure 8-1, early years not shown). Medically complex admissions continued to be more concentrated in fewer SNFs compared with rehabilitation admissions, though less so than in previous years.<sup>9</sup> Nonprofit SNFs and hospital-based units were disproportionately represented in the group of SNFs with the highest shares (defined as the top 10th percentile) of medically complex patients. The concentration of medically complex cases in certain SNFs may have implications for minorities because minority beneficiaries made up a disproportionate share of medically complex admissions to SNFs in 2011.<sup>10</sup>

The expansion of the number of SNFs 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 75 minutes a week) to qualify them for a higher payment therapy group. Although CMS's changes may increase the willingness of SNFs to admit medically complex patients, the PPS continues to disadvantage SNFs that admit high shares of medically complex cases (Wissoker and Zuckerman 2012). Some facilities may be discouraged from admitting these patients if they have a higher likelihood of exhausting their 100-day benefits, which may put financial pressure on the provider.

**Volume of services: Essentially unchanged between 2010 and 2011**

In 2011, just under 5 percent of FFS beneficiaries used SNF services. We examine per person utilization for FFS beneficiaries, as the CMS data on counts of 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 a declining number of FFS beneficiaries rather than reductions in service use.



**TABLE  
8-4**

**Volume essentially unchanged between 2010 and 2011**

Volume measure	2006	2008	2009	2010	2011	Percent change 2010-2011
Covered admissions per 1,000 FFS beneficiaries	72	73	72	71.5	71.2	-0.3%
Covered days (in thousands)	1,892	1,977	1,963	1,938	1,935	-0.2
Covered days per admission	26.3	27.0	27.3	27.1	27.2	0.4

Note: FFS (fee-for-service). Data include 50 states and the District of Columbia.

Source: Calendar year data from CMS, Office of Research, Development, and Information.

SNF volume per FFS beneficiary was essentially unchanged between 2010 and 2011. Admissions per 1,000 FFS beneficiaries were essentially constant (they declined 0.3 percent), while covered days declined slightly less, resulting in a very small increase in covered days per admission (Table 8-4).<sup>11</sup> Although the decline in inpatient cases was larger (about 1.5 percent) than the decline in SNF admissions, the decline in hospital cases that go on to use post-acute care may have been smaller than the overall average. Hospital stays of at least three days (which qualify a beneficiary for Medicare coverage of a SNF stay) declined only 0.6 percent.

**Intensity of rehabilitation services unexplained by health status factors**

Between 2001 and 2011, the share of days classified into rehabilitation case-mix groups increased from 75 percent to 92 percent.<sup>12</sup> In the rehabilitation case-mix groups, intensive therapy days made up three-quarters of the days in 2011.<sup>13</sup> Even after all policy and payment changes CMS made to therapy care, the levels of therapy remained high. Payments are determined by the amount of therapy furnished, and even though costs increase when more therapy is furnished, payments rise even faster. 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 than nonprofit facilities and facilities in rural and frontier areas.

Between 2008 and 2011, changes in the frailty of patients at admission to a SNF do not explain the increases in therapy. During this period, the average modified Barthel score was about the same (it increased one point, indicating slightly more independence). We also looked at the nine individual measures (see endnote 4) and found that the shares of patients requiring the most help

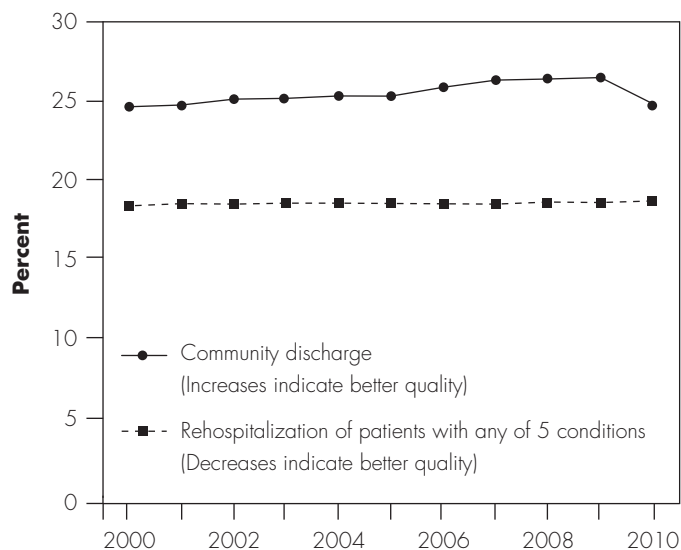
(and possibly less able to tolerate high levels of therapy) decreased an average of 3 percent. Although more patients may be able to tolerate the highest levels of therapy, the increase in the most intensive therapy days (16 percent) far outpaces the changes in patient characteristics. Shorter hospital stays could have shifted some therapy provision from the hospital to the SNF sector. For example, between 2008 and 2011, hospital lengths of stay decreased less than 7 percent on average for the five highest volume diagnosis related groups discharged to SNFs.

The Office of Inspector General has continued to investigate the billing practices of SNFs. Earlier work found that between 2006 and 2008, SNFs increasingly billed for higher payment RUGs, even though the ages and diagnoses of beneficiaries were largely unchanged (Office of Inspector General 2011). Recently, it found that one-quarter of Medicare claims in 2009 were billed in error, with upcoding making up the majority of errors (Office of Inspector General 2012). In about half of these cases, SNFs billed for the highest rehabilitation case-mix groups when they should have billed for lower levels of care. In addition to recommending that CMS expand its review of claims and increase monitoring of industry practices, the Office of Inspector General recommended that CMS change the way it pays for therapy, consistent with the Commission’s recommendation.

In the past, we reported that the intensification of therapy could partly reflect some of the shift in cases from inpatient rehabilitation facilities to SNFs. This trend appears to have stabilized between 2010 and 2011. Of the top 10 diagnosis related groups discharged to inpatient rehabilitation facilities, there was almost no change in the shares of cases going to SNFs. For example, among patients recovering from major joint replacement, 33

**FIGURE 8-2**

**SNF quality shows little improvement over 10 years**



Note: SNF (skilled nursing facility). Increases in rates of discharge to community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, septicemia, and electrolyte imbalance. Increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are calculated for all facilities with 25 or more stays.

Source: Risk-adjusted rates for years 2003 to 2010 calculated by MedPAC based on a risk-adjustment model developed by the Division of Health Care Policy and Research, University of Colorado at Denver and Health Sciences Center (Fish et al. 2011).

percent were discharged to SNFs in 2004; this share increased to 38 percent in 2010 and remained at that share in 2011.

**Quality of care: A decade with little improvement**

The Commission tracks two indicators of SNF quality: risk-adjusted rates of community discharge and rehospitalization of patients with five potentially avoidable conditions during the SNF stay.<sup>14</sup> Between 2000 and 2010, the rates showed little change. This year, the Commission developed a risk-adjustment measure of rehospitalization of beneficiaries within 30 days of discharge from the SNF. This performance measure would encourage facilities to ensure safe and appropriate transitions to the next health care setting (or home). Between 2010 and 2011, performance for all three measures varied considerably across facilities.

**Rehospitalization and community discharge rates are essentially unchanged from 2000**

Between 2000 and 2010, rates of rehospitalization for patients with any of five potentially avoidable conditions and discharge to the community remained almost the same (Figure 8-2). These rates differ slightly in level but not in the trends previously reported by the Commission. The levels differ because the Commission adopted a new base year for the measures (2011) so that the rates are more directly comparable over time to the rates reported for 2011, as discussed below.

The persistent lack of improvement in rehospitalization rates likely reflects the financial incentive to transfer patients back to the hospital when they require expensive ancillary services, poor communication (among staff and between staff and physicians), and a lack of adequate staffing at facilities (especially at night and on weekends). Although all SNFs face the same incentives, there are facilities with consistently low and high rehospitalization rates. Last year, we found over 1,200 SNFs with rehospitalization rates in the lowest (the best) quartile of the distribution of rates for 3 years in a row; of them, over 300 were in the best 10th percentile each of the 3 years. Conversely, over 900 facilities had rates in the top quartile (the worst) 3 years in a row; of them, almost 200 were in the worst 10th percentile each year.

In October 2010, CMS implemented a new patient assessment tool for use by nursing homes and SNFs (Minimum Data Set version 3.0). The change in assessment tools required us to revise the methods we use to risk adjust the quality measures the Commission tracks. The revised Minimum Data Set has improved patient tracking and provides more complete data than the previous assessment data. The risk-adjustment methods continue to include patient comorbidities and measures of functional status but exclude service-use measures, such as the provision of therapy or the patient’s use of a feeding tube or catheter—conditions that providers could influence.<sup>15</sup> Because the comorbidity index includes indicators for several mental illnesses, a separate measure of cognitive status was not statistically significant and was excluded from the final risk-adjustment model.<sup>16</sup> While the risk-adjusted rates for 2011 are close to those for 2010, some discrepancies exist that partly reflect differences in methods. Thus, changes between 2010 and 2011 need to be interpreted with caution. However, going forward, the new and more current methodology will be used and will be comparable to that used for 2011. In that year, the community discharge rate was 27.8 percent and the

**TABLE  
8-5**

**SNF quality measures vary within and across ownership and facility type, 2011**

Quality measure	Mean	Group mean relative to industry mean	25th percentile	Median	75th percentile	Ratio of 75th to 25th percentile
<b>Discharged to the community</b>						
All	27.8%		21.7%	28.8%	34.7%	1.6
Freestanding	27.9	1.00	21.8	28.7	34.6	1.6
For profit	27.9	1.00	21.8	28.7	34.6	1.6
Nonprofit	28.8	1.04	22.8	29.4	35.0	1.5
Government	23.4	0.84	16.8	24.3	30.2	1.8
Hospital based	32.5	1.17	27.9	33.1	38.1	1.4
For profit	32.2	1.16	27.3	32.5	38.6	1.4
Nonprofit	33.0	1.19	28.5	33.3	38.1	1.3
Government	30.2	1.09	25.2	31.8	37.3	1.5
<b>Readmission for patients with any of 5 potentially avoidable conditions</b>						
All	19.2		14.8	19.1	23.4	1.6
Freestanding	19.8	1.03	15.5	19.5	23.7	1.5
For profit	20.3	1.06	16.0	19.9	24.1	1.5
Nonprofit	18.7	0.97	14.3	18.4	22.5	1.6
Government	17.5	0.91	13.0	17.3	22.2	1.7
Hospital based	12.7	0.66	8.4	11.7	16.4	2.0
For profit	12.7	0.66	7.7	11.1	17.1	2.2
Nonprofit	12.9	0.67	8.6	11.9	16.3	1.9
Government	11.9	0.62	7.4	11.6	16.2	2.2

Note: SNF (skilled nursing facility). Increases in rates of discharge to community indicate improved quality. The five conditions include congestive heart failure, respiratory infection, urinary tract infection, septicemia, and electrolyte imbalance. Increases in rehospitalization rates for the five conditions indicate worsening quality. Rates are facility averages and calculated for all facilities with 25 or more stays. Rehospitalizations are for beneficiaries during SNF stay. Facility counts do not sum to the total because ownership or facility type was unknown.

Source: Analysis of fiscal year 2011 Minimum Data Set data by Kramer et al. (2013).

rehospitalization rate was 19.2 percent (Kramer et al. 2013).

There is considerable variation in the performance of quality measures across the industry. One-quarter of facilities had rates 60 percent higher than facilities in the lowest quartile (Table 8-5). Hospital-based facilities had higher risk-adjusted community discharge rates and lower rehospitalization rates than freestanding SNFs, indicating better quality at hospital-based facilities. Compared with nonprofit facilities, freestanding for-profit SNFs had lower rates of discharge to the community and higher rates of rehospitalization. Within groups (ownership and facility type), there was also considerable variation in

rehospitalization rates. For example, among freestanding for-profit facilities, community discharge rates were 60 percent higher and rehospitalization rates were 50 percent higher for facilities in the worst quartile than for those in the best quartile. Between 2000 and 2010, the variation in rates remained about the same.

Demographics (including race, gender, and age categories except those less 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. 2013). Differences in observed rehospitalization rates between dual-eligible

and other SNF users were essentially eliminated with risk adjustment. However, differences in rates of community discharge between dual-eligible and other SNF users remained after risk adjustment, reflecting the more limited options dual-eligible beneficiaries have in being placed in affordable community settings with adequate support services.

These data predate industry initiatives to lower rehospitalizations. In September 2012, the American Health Care Association announced a quality initiative to lower readmission rates 15 percent by 2015. Some providers are hoping to position themselves as preferred post-acute care providers for patients being discharged from hospitals, which are now subject to readmission penalties. Industry efforts include identifying patients at high risk of readmission, carefully monitoring changes in patients' conditions and communicating those changes among staff, and educating hospital discharge planners about facility capabilities.

### **Rates of rehospitalization after discharge from the SNF**

Last year, to align the incentives of hospitals and SNFs to lower unnecessary rehospitalizations, the Commission recommended that the Congress direct the Secretary to reduce payments to SNFs with relatively high risk-adjusted rates of rehospitalization during Medicare-covered stays. The Commission stated that the measure should consider a time period after discharge from the facility once a risk-adjusted measure was developed, similar to the hospital readmission policy that holds hospitals accountable for admissions that occur within 30 days of discharge. Because the processes and actors are likely to differ for the period when a patient is in the SNF versus the period after discharge, separate measures would give the SNF more actionable information. For example, a high rehospitalization rate for patients after discharge from the SNF could point out shortcomings in community-based care, poor patient (and family) education before discharge from the SNF, or a patient's limited ability to manage at home. Financial incentives may also play a role in when patients are discharged. A beneficiary may go home when copayments begin on day 21 of a stay even though she could benefit from additional days of care. If facilities faced rehospitalization penalties, they would be more inclined to ensure that patients were physically ready, to see that their families were adequately educated (e.g., about medication management, advance directives,

and hospice care), and to partner with high-quality community services to avoid readmission to the hospital.

A high rate of rehospitalization of patients still in the SNF would point to the care processes in the facility. To lower rehospitalization rates, facilities could focus efforts on improving staff competencies (such as their ability to detect and manage small changes in a patient's condition); staff mix and level; communication among staff about the current medical status of each patient; medication management; and medical staff backup on weekends and at night. Staff could also be educated about appropriate and inappropriate hospitalizations and best practices for potentially avoidable conditions.

This year, Commission staff worked with a contractor to develop a risk-adjusted measure of rehospitalization during the 30 days after discharge from the SNF. Consistent with the other SNF risk-adjustment methods, the method for the 30-day measure considers a patient's comorbidities, ability to perform activities of daily living, whether the patient had a surgical procedure during a prior hospital stay, and the number of times physicians' orders were changed (reflecting patient instability). SNF discharges, excluding direct hospitalizations and deaths, were to long-term nursing home care 31 percent of the time, home health care 45 percent of the time, and the community with no services or some other type of care (e.g., hospice) 24 percent of the time. Because the characteristics of patients discharged to these three settings are different, the readmission risk models for patients discharged to each type of setting were tailored to each patient setting.<sup>17</sup> As with the other measures, to estimate the rehospitalization rate for each SNF during the 30-day period after SNF discharge, the readmission risk for all SNF beneficiaries was aggregated to calculate the risk-adjusted readmission rate for the facility.

The average risk-adjusted rate of rehospitalization after discharge from the SNF for the five potentially avoidable conditions was 10 percent. Compared with the rates while the beneficiaries were in the SNF, there was more variation across facilities. One-quarter of facilities had rates of 7 percent or lower, while one-quarter had rates of 12.5 percent or higher.

When the separate rehospitalization rates are considered together, they indicate that over 28 percent of beneficiaries were rehospitalized (for any one of the five conditions) either during or after a SNF stay. This finding suggests considerable opportunities for SNFs to improve the

care they provide and the arrangements they make for beneficiaries after discharge. It also represents considerable program spending for those hospitalizations that could have been avoided.

### **Providers' access to capital: Lending in 2012**

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. Most operators make their bottom line using Medicare profits; lenders and owners use Medicare patient mix as one metric of a facility's financial health. Even after Medicare's reduction in payments in fiscal year 2012, the industry continues to seek Medicare patients, particularly those who could receive intensive rehabilitation.

The Department of Housing and Urban Development (HUD) is an important 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.<sup>18</sup> Between 2011 and 2012, the number of HUD-financed projects increased 68 percent (to 706 projects), with insured amounts totaling \$5.5 billion in 2011 (Department of Housing and Urban Development 2012). HUD is expected to maintain the same level of activity for 2013, particularly as providers seek to refinance existing loans with lower interest rates. To evaluate loan applications, HUD's underwriting considers a facility's Medicare share of revenues, quality ratings, and performance on state surveys. In addition to these indicators, other lenders report looking at the diversification of the potential borrower's risk (whether the company spans multiple states or other businesses), the quality of the management team, and the stability of the company's cash flow.

Non-HUD lending began slowly in early 2012, reflecting uncertainty over how the industry would react to lower Medicare rates. As lenders realized that providers were adjusting to lower rates, borrowing picked up and lending for 2012 will be higher than for the previous year. Analysts report companies being adept at mitigating the effects of Medicare's lower payments by carefully examining the cost of their operations, including lowering overhead and corporate expenses, renegotiating the terms of contracts, and increasing the efficiency of their therapists.

Some companies report a decline in Medicare business (days and payments) but an increase in MA business.

Capital market analysts report that expansion of MA at the expense of FFS Medicare will lower facility revenues given MA's shorter stays and lower payment rates. However, because MA plans often contract with specific providers for post-acute care, high-quality SNFs that partner with plans may be able to offset some of the revenue reductions with volume (Stifel Nicolaus 2012). Companies continue to seek to grow their high-acuity rehabilitation days. Publicly traded firms report higher average Medicaid rates for 2012 than for 2011 (Ensign Group 2012, Extendicare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012). Higher Medicaid rates in 2012 reflect many states' improved economies (fewer states lowered or froze their payments to nursing homes compared with 2011) and the expanded use of provider taxes to bolster their Medicaid payments. In 2012, 42 states had provider taxes for nursing homes, up from 39 in 2011 (Smith et al. 2012, Smith et al. 2011).

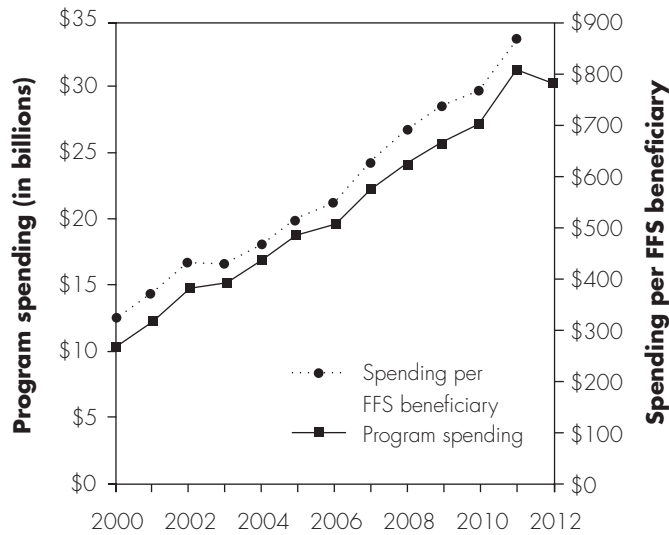
Market analysts and lenders we spoke with thought borrowing in 2013 would continue at about the same pace as in 2012. On the risk side, credit may tighten for some borrowers due to uncertainties over possible rate reductions through sequestration or as part of a broad fiscal package and state budget discussions. Some companies have spread their risk by expanding their other high-margin businesses, including home health care, hospice, and outpatient therapy (Flavelle 2012, Kindred Healthcare 2012a, Sun Healthcare Group 2012). At the same time, lenders see the sector as having long-term viability. High-quality SNFs can position themselves as the lower cost option for post-acute care relative to inpatient rehabilitation facilities and long-term care hospitals.

### **Estimated Medicare payments and providers' costs: Medicare margins continue to increase in 2011**

Between 2010 and 2011, Medicare payments increased faster than Medicare costs, especially given the overpayments that occurred with initial implementation of the new case-mix groups. The estimated aggregate 2011 Medicare margin ranges from 22 percent to 24 percent, depending on the assumptions used to model growth in days and costs.<sup>19</sup> Last year, we reported that high-margin SNFs had considerably lower costs and, to a smaller extent, higher payments (from providing more intensive therapy) than low-margin SNFs. The variations in Medicare margins and costs per day were not attributable to differences in patient mix. We also found that about

**FIGURE 8-3**

**Overpayments in 2011 sparked spike in program spending on SNFs**



Note: SNF (skilled nursing facility), FFS (fee-for-service). Data for 2012 are estimates.

Source: CMS, Office of the Actuary, 2012.

10 percent of freestanding facilities furnished relatively low-cost, high-quality care and had substantial Medicare margins over three consecutive years.<sup>20</sup> Compared with the average, relatively efficient SNFs had costs per day that were 10 percent lower (adjusted for differences in wages and case mix), quality measures that were considerably better (17 percent lower rehospitalization rates and 38 percent higher community discharge rates), and Medicare margins of 22 percent (Medicare Payment Advisory Commission 2012). MA plans' payments, which were considerably lower than Medicare's FFS payments, are unlikely to be explained by differences in patient mix.

**Trends in spending and cost growth**

In 2012, the Office of the Actuary projects program FFS spending for SNF services to be \$30.4 billion (Figure 8-3). In 2011, payments were unusually high because the rates included an adjustment for implementation of the new case-mix classification system. Once 2011 data were available, it became clear the adjustment was too large and the resulting payment rates had been set too high. Thus, CMS revised the adjustment downward in 2012, putting spending back in line with previous trends. After the reductions, 2012 rates were 3.7 percent higher than those in 2010. Even though rates were lowered, total spending

in 2012 was projected to be 12 percent higher than it was in 2010. On a per FFS beneficiary basis, spending in 2011 was \$871.

Between 1999 and 2011, the cumulative increase in cost per day (49 percent) outpaced the market basket updates. Payments rose far faster than either of these (84 percent), reflecting changes in the provision of therapy that resulted in more days classified as higher payment case-mix groups (Figure 8-4).

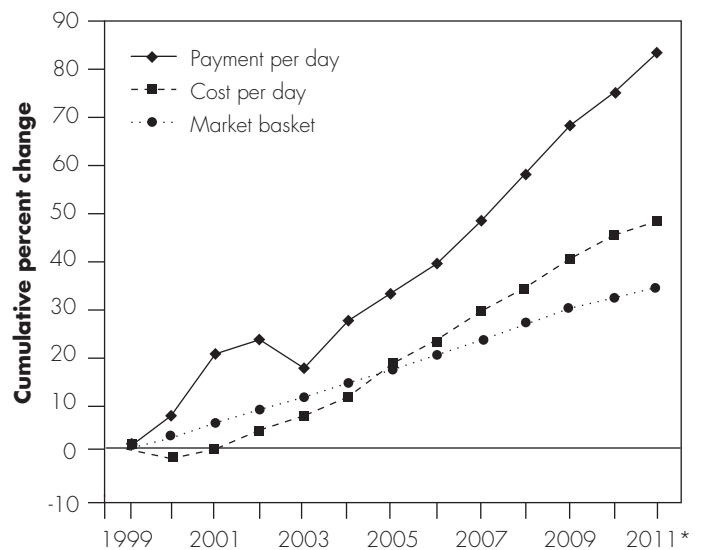
**SNF Medicare margins continue to grow**

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.

Because Medicare cost reports were not available to conduct our margin analysis for 2011, we estimated a range of margins for that year. We modeled revenues for

**FIGURE 8-4**

**Cumulative change in payments per day, costs per day, and market basket update since 1999**

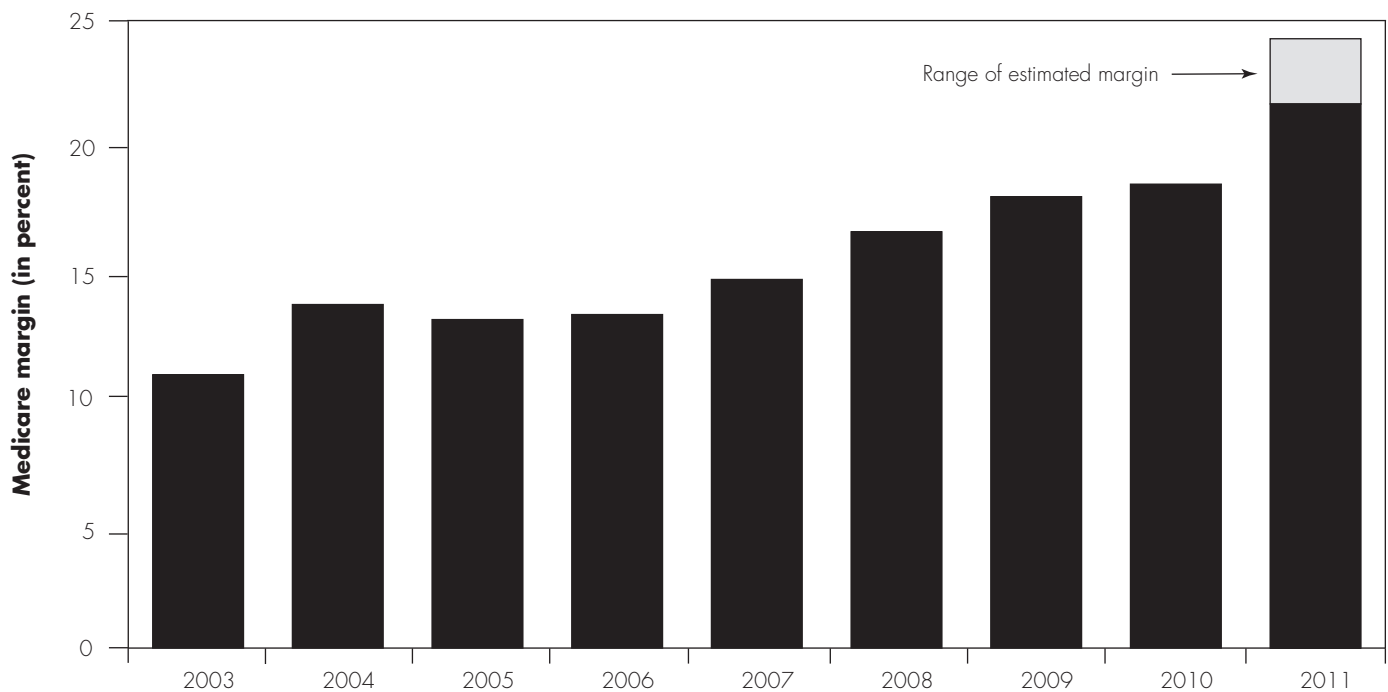


Note: \*Estimated.

Source: MedPAC analysis of freestanding skilled nursing facility Medicare cost reports from 1999 to 2010, estimates of 2011 revenues and costs, and Federal Register final rules for skilled nursing facility services for fiscal years 1999 to 2011.

**FIGURE  
8-5**

**Freestanding SNF Medicare margins continue to increase**



Note: SNF (skilled nursing facility). Range of estimates for 2011 incorporate different assumptions about days, revenues, and costs.

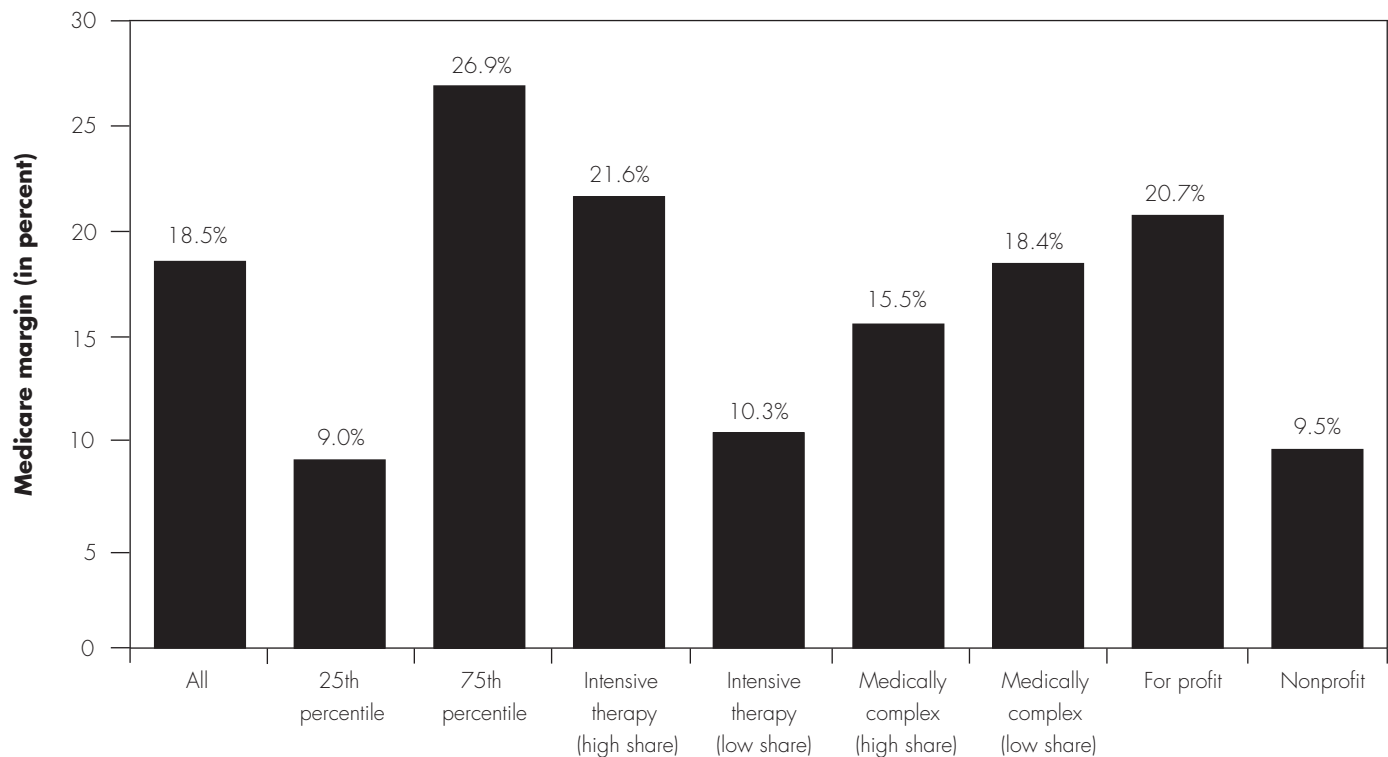
Source: MedPAC analysis of freestanding SNF cost reports from 2003 to 2011.

2011 using 2011 claims matched to freestanding facilities' cost reporting periods and we adjusted the revenues for differences between claims and cost reports. To estimate 2011 costs, we calculated cost per day in 2010 and modeled three cost growth assumptions: the market basket for 2011, the most recent cost increase between 2009 and 2010, and the middle point between the two. We used claims to estimate the days in 2011 but adjusted the count for historical differences between the day counts in the claims and cost reports. We did not estimate margins by ownership or location.

SNF aggregate Medicare margins have steadily increased since 2005 (Figure 8-5). The revised case-mix groups implemented in 2006 led to even higher Medicare margins, reflecting the continued concentration of days in the highest paying case-mix groups. Estimates of the Medicare margin for freestanding SNFs in 2011 range from 22 percent to 24 percent. This year is the 11th consecutive year that the average SNF margin exceeded

10 percent and the 4th year in a row it was above 15 percent. Margins spiked in 2011 because of Medicare's overpayments in implementing the new case-mix groups. This spike aside, Medicare payments per day have increased faster than costs per day since 2006, resulting in growing SNF margins.

In 2011, hospital-based facilities (3 percent of facilities) continued to have negative Medicare margins (-60 percent). However, administrators consider the SNF units in the context of the hospital's overall financial performance. Hospitals with SNFs can lower their inpatient length of stay and make inpatient beds available to treat additional admissions. As a result, SNFs contribute to the bottom line financial performance of the hospitals. Hospitals with SNFs had lower inpatient costs per case and higher inpatient Medicare margins than hospitals without SNFs. Given the mix of patients that hospital-based facilities treat and their therapy practices, the Commission's changes to the SNF PPS would increase

**FIGURE  
8-6****Freestanding SNF Medicare margins are highly variable, 2010**

Note: SNF (skilled nursing facility). High share is defined as facilities in the top 25th percentile of shares; low share is defined as facilities in the bottom 25th percentile.

Source: MedPAC analysis of 2010 freestanding SNF Medicare cost reports.

payments to hospital-based facilities by an estimated 27 percent.

**Level and variation in SNF Medicare margins indicate reforms to the PPS are 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. Last year we found one-quarter of SNFs had Medicare margins of 26.9 percent or higher in 2010, while one-quarter of SNFs had margins of 9 percent or lower (Figure 8-6). Facilities with the highest SNF margins had high shares of intensive rehabilitation therapy and low shares of medically complex days and dual-eligible days. The disparity between for-profit and nonprofit facilities is considerable and reflects differences in patient mix, service provision, and costs.

Comparing freestanding facilities with the highest and lowest Medicare margins (those in the bottom and top

25th percentiles of Medicare margins), we found cost and payment 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 payments (by 10 percent) associated with the high-therapy case-mix groups. Differences in patient characteristics (shares of beneficiaries who are dual eligible, minority, or very old) did not explain the cost differences across facilities. Facilities with high margins had identical case-mix indexes—as measured by the relative weights associated with the nursing component of the case-mix groups.<sup>21</sup> Even after CMS expanded the number of medically complex case-mix groups and shifted payments 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 payments to



**TABLE  
8-6**

**Comparison of Medicare fee-for-service and Medicare Advantage daily payments in 2012 for five companies**

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	MA	
Ensign Group	\$561	\$372	1.51
Extendicare	459	430	1.07
Kindred	490	409	1.20
Skilled Healthcare Group	509	383	1.33
Sun Healthcare	464	380	1.22
Average ratio			1.27

Note: FFS (fee-for-service), MA (Medicare Advantage). The MA payments are listed for Kindred and Sun Healthcare. In the other reports, the rates are reported as “managed care payments,” of which MA would make up the majority.

Source: Third quarter 2012 results available at each company’s website.

SNFs according to their mix of patients, not the amount of therapy furnished (see discussion on p. 164).

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). Costs per day varied by more than 60 percent across all freestanding providers after differences in wages and case mix were taken into account. Within each subgroup (e.g., nonprofit SNFs), standardized costs varied consistently by 20 percent to 30 percent between the 25th and 75th percentiles and by 60 percent to 70 percent between the 10th and 90th percentiles. 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.

For the past three years, we have examined efficient SNFs (those furnishing relatively high-quality care and having low costs per day) and compared them with other SNFs. In 2011, we found that 10 percent of facilities had relatively low costs and provided good quality care while maintaining high margins. Compared with the other SNFs, relatively efficient SNFs had community discharge rates that were 38 percent higher, rehospitalization rates that were 17 percent lower, and costs per day that were 10 percent lower. The efficient SNFs achieved these costs and quality metrics even though their patients were more complex (as measured by their nursing component case-

mix index) and more days were classified in the medically complex case-mix groups.

Another indicator that Medicare’s payments are too high is the comparison of FFS and MA payments. We compared Medicare FFS and MA payments at five large nursing home companies where such information was publicly available. These companies, which report managed care payments, note that MA is the majority of their business. Medicare’s FFS payments averaged 27 percent higher than MA rates (Table 8-6).<sup>22</sup> Last year, we reported even larger differences because of the FFS overpayments associated with implementation of the new case-mix groups. It is unlikely that these large differences in payments are due solely to the comorbidities of the enrollees in FFS and MA. However, until encounter-level data are available, we cannot compare the patient severity of FFS and MA enrollees who use SNFs. That said, the considerably lower MA payments suggest that some facilities accept considerably lower payments to treat beneficiaries.

**Total margins estimated to increase in 2011**

The aggregate total margin for freestanding SNFs in 2011 is estimated to be 5 percent. A total margin reflects services to all patients (public and private) across all lines of business and revenue sources. This estimate represents an improvement in the financial performance over 2010, when the total margin was 3.6 percent. 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). In fiscal year 2011, 19 states reported increasing payments to nursing homes (Government Accountability Office 2012). The five publicly traded nursing home companies report higher average Medicaid payments for 2012 than for 2011 (Ensign Group 2012, Extencare 2012, Kindred Healthcare 2012c, Skilled Healthcare 2012, Sun Healthcare Group 2012).

Using Medicare payments to subsidize Medicaid payments is ill advised for several reasons (see text box). In addition to Medicare's share of payments, 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 2013**

In assessing the payment update for 2014, the Commission considers the estimated relationship between SNF costs and Medicare payments in 2013. Because cost reports for 2011 are not yet available, we used a range of estimated 2011 revenues and costs as a starting point for estimating a range for the Medicare margin for 2013.

To estimate costs for 2012 and 2013, we used the middle point cost estimate for 2011 costs and modeled 2012 and 2013 costs using two growth assumptions: the market basket and a middle point between the market basket for each year and the most recent cost increase between 2009 and 2010.

To estimate 2013 payments, we began with 2011 payments from claims and modeled the impacts of the policy changes that went into effect in 2012 and 2013 (as estimated by CMS). These policy changes included the following:

- 2012 payments were estimated by factoring in the impact of the lowered payments for 2012 and the market basket offset by the productivity adjustment, as required by the Patient Protection and Affordable Care Act of 2010. CMS estimated that 2012 payments would be 11.1 percent lower than payments in 2011, which included the overpayments. Despite the reductions taken in 2011, payment rates in 2012 were 3.7 percent higher than they were in 2010.
- 2013 payments were estimated by increasing estimated 2012 payments by the market basket and offset by the productivity adjustment.

For 2013, the projected Medicare margin ranges from 12 percent to 14 percent. Ignoring the high margin for 2011, which reflects temporary overpayments, the margin is lower than the 2010 margin because costs may increase faster than the market basket in 2011, and each year the payment updates are lowered by the productivity adjustments.

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### **How should Medicare payments change in 2014?**

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Last year, the Commission recommended to the Congress that it direct the Secretary to first revise the PPS and then, in the following year, to rebase Medicare payments in stages, with an initial reduction of 4 percent (see text box, p. 178). 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, payments for nontherapy ancillary services (such as drugs) need to be removed from the nursing component and made through a separate component established specifically to adjust for differences in patients' needs for these services. Third, an outlier policy should be added to the PPS.

The Commission stands by its recommendation, believing that the PPS requires fundamental reforms to correct the known shortcomings and to 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 both parts of the recommendation.

The recommendation began with revising the PPS and with no update in the first year (2013). 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, taking reductions in stages. This

## 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, the strategy of using Medicare rates to supplement low payments from other payers 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. Medicare and Medicaid shares vary widely across facilities (Table 8-7). 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 payments. In 2009, Medicaid payments to nursing homes varied twofold, yet Medicare's high payments subsidize facilities even in states with relatively high Medicaid rates. 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 current overpayments 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  
8-7**

**Distribution of Medicare and Medicaid share of facility days in freestanding facilities, 2010**

Payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicare share	5%	8%	12%	17%	25%
Payer	Percentile of facility days				
	10th	25th	Median	75th	90th
Medicaid share	0	45	63	74	82

Note: Medicare share includes fee-for-service and Medicare Advantage days.

Source: MedPAC analysis of skilled nursing facility Medicare cost reports, 2010.

approach acknowledges the need to proceed cautiously but deliberately to help ensure there are no unintended disruptions caused by rebasing. The recommended changes should not impair beneficiary access to care; in fact, they should improve access to services for beneficiaries who are disadvantaged by the design of the current payment system.

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.

## 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 March 2012, its spending implications were that it would lower program spending relative to current law by between \$250 million and \$750 million for fiscal year 2013 and between \$5 billion and \$10 billion over five years. Savings occur because current law requires a market basket increase (offset by a productivity adjustment, as required by the Patient Protection and Affordable Care Act of

2010). Updated for implementation a year later, the direction of the savings is identical. The one-year savings estimate remains the same, while the five-year estimated savings grew slightly and are 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. Impacts on individual providers will be a function of their mix of patients and current practice patterns. The recommendation will not eliminate all the differences in Medicare margins among providers due to their large cost differences. ■

- Variations in Medicare margins are 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, and beneficiary demographics.
- Relatively efficient SNFs, with relatively low costs and high quality, indicate that payments could be lowered without adversely affecting the quality of care.
- FFS payments to some SNFs were considerably higher than some MA payments, suggesting that some facilities are willing to accept much lower rates than FFS payments to treat beneficiaries.
- The industry has shown it is nimble at responding to the level of Medicare's payments in two ways: Medicare's cost growth has consistently been above the SNF market basket since 2001 and revenues increased even when payment rates were lowered in

2010. In reaction to the lower payments in 2012, SNFs focused on the efficiency of their therapists so they could continue to furnish high levels of therapy.

These factors show 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 with a high Medicaid payer mix, a better targeted and separately financed program could be established to do so.

For 2014, there are no policy changes known at this time aside from the required update and productivity adjustment. 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 2014 is projected to be 2.8 percent and the productivity adjustment is estimated to be 0.4 percent, but CMS will update both before establishing payment rates for 2014.

**TABLE  
8-8**

**Number of nursing homes treating Medicaid enrollees declined slightly in 2012**

	2002	2004	2006	2008	2010	2011	2012	Percent change 2011-2012
Number of facilities	15,992	15,609	15,273	15,162	15,083	15,058	15,007	-0.3%

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2002-2012.

**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.

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**

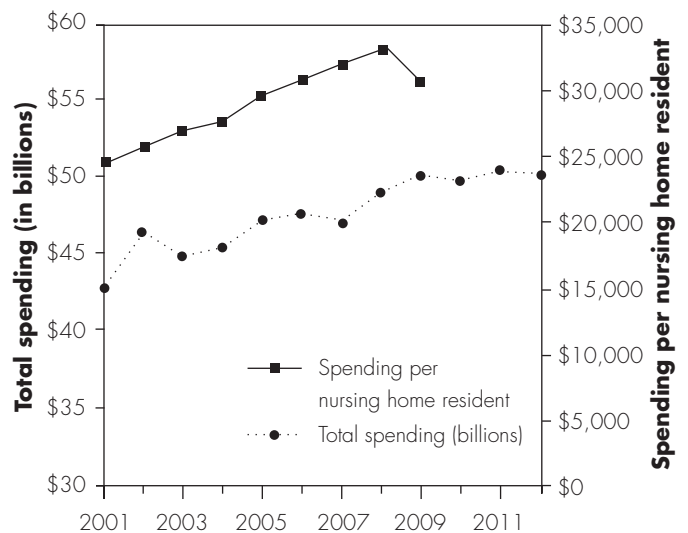
There were over 1.64 million users of Medicaid-financed nursing home services in 2009, the most recent year of data (Centers for Medicare & Medicaid Services 2011). This use represents a small increase over 2008 but a 5 percent decline from 2001. The number of nursing facilities certified as Medicaid providers declined slightly between 2011 and 2012 (Table 8-8). In a recent Government Accountability Office survey, two states reported challenges to ensuring adequate numbers of nursing home providers for Medicaid recipients (Government Accountability Office 2012). The decline in users and facilities reflects the expansion in some states of home- and community-based services that allow some residents to remain in their homes. A vast majority of nursing home facilities are certified as Medicare and Medicaid providers.

**Spending**

In 2012, CMS estimates just over \$50 billion was spent on Medicaid-funded nursing home services (combined state and federal funds) (Figure 8-7). Spending increases averaged 1.5 percent annually between 2001 and 2012, for a total of 17 percent over the period (Office of the Actuary 2012). Year-to-year changes in spending were variable, increasing in some years and decreasing in others. Between 2011 and 2012, CMS estimates that spending will decrease slightly. On a per user basis, spending per nursing home resident averaged \$29,551 in 2009, the most recent year for resident counts. Between 2008 and

**FIGURE  
8-7**

**Total and per user  
Medicaid spending**



Note: Total spending for 2012 is an estimate. Resident counts (and therefore per resident spending) are not available for 2010 through 2012.

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>.

**TABLE  
8-9****Non-Medicare margins were negative but total margins were positive, 2001-2011**

Type of margin	2001	2003	2005	2007	2009	2011*
Non-Medicare margin	-2.6%	-1.7%	-0.8%	-1.2%	-1.2%	-1 to -3%
Total margin	1.0	1.7	2.2	2.5	3.4	4 to 6

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.

\*Margins for 2011 are estimates, and the range is based on varying assumptions about growth in days and costs.

Source: MedPAC analysis of freestanding 2000-2010 skilled nursing facility cost reports. Margins for 2011 are based on 2010 data trended forward.

2009, spending per resident declined 8 percent but still represented a 25 percent increase from 2001 (Centers for Medicare & Medicaid Services 2011).

In fiscal year 2012, Medicaid spending growth slowed to 2 percent, one of the slowest rates of growth in the past 15 years. This slowdown in spending is largely attributable to lower growth in enrollment, as the economy improved relative to 2010, as well as expiration of federal matching funds for the Medicaid program in June 2011. For the state fiscal year 2012, 28 states restricted payments (16 states enacted freezes and 12 states enacted rate reductions) for nursing homes (Alliance for Quality Nursing Home Care 2012). For fiscal year 2013, 20 states restricted rates and, of them, three states lowered nursing home rates (Smith et al. 2012). States expect enrollment to continue to increase but at a slower pace than in 2012.

States continue to use provider taxes to raise federal matching funds. In fiscal year 2013, 44 states had provider taxes on nursing homes, up from 42 states in fiscal year 2012 (Smith et al. 2012). The President's budget includes a proposal to slowly reduce provider taxes from a maximum 6 percent to 3.5 percent in 2017.

The differences between Medicaid's and Medicare's payments are sometimes compared. Although Medicare's payments are much higher than Medicaid's, the acuity of the average Medicare beneficiary is considerably higher, as reflected in the average nursing case-mix index for Medicaid and Medicare patients. In 2011, the average

Medicare nursing case-mix index was 45 percent higher than that for Medicaid residents (after adjusting the nursing indexes of all case-mix groups for overstatement of the parity adjustment) (White 2012). Differences in the therapy case-mix indexes were even larger. The therapy case-mix index for Medicare beneficiaries was almost 13 times that for Medicaid patients. In 2011, Medicare's payments for the average Medicaid resident would be \$235, compared with \$433 for the average Medicare patient. That is, the differences in acuity between the average Medicaid resident and the average Medicare patient translate to payments that would be 84 percent higher for Medicare patients.

### Non-Medicare and total margins in nursing homes

In 2011, we estimate non-Medicare margins (i.e., for Medicaid and private payers) to range from -1 percent to -3 percent. Total margins (reflecting services to all patients across all lines of business and including revenue sources) were positive and increased in 2011, reflecting the increased payments from Medicare (Table 8-9). Total margins have steadily increased since 2000 and are estimated to be between 4 percent and 6 percent in 2011.

In 2012, we reported that non-Medicare margins were slightly more variable than total margins (Medicare Payment Advisory Commission 2012). Given the delay in the availability of cost reports this year, we cannot verify this pattern for 2011. ■

## Endnotes

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- 1 Throughout this chapter, “beneficiary” refers to individuals whose SNF stay (Part A) coverage is paid for by Medicare. 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 Barthel score is a composite measure of nine functional abilities: bowel and urinary incontinence and patients’ ability to transfer, walk in the facility corridor, feed themselves, toilet, bathe, perform personal hygiene, and dress.
- 5 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).
- 6 There are two broad categories of medically complex days: clinically complex and special care case-mix groups. Clinically complex groups are used to classify patients who have burns, septicemia, or pneumonia or who receive chemotherapy, oxygen therapy, intravenous medications, or transfusions while a 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.
- 7 In 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 fiscal year 2012, CMS lowered payments for therapy furnished in groups (multiple patients engaged in the same therapy activities at the same time).
- 8 A facility may begin to participate in the program but may not be “new.” For example, a facility could have a change in ownership (and be assigned a new provider number) or in its certification status from Medicaid only to be dually certified for the Medicaid and Medicare programs.
- 9 In 2011, SNFs with the highest shares of medically complex admissions (the top quartile) treated 41 percent of all these patients. By contrast, SNFs with the highest rehabilitation shares (the top quartile) treated 31 percent of all rehabilitation admissions. In 2009, the comparable shares were 57 percent (for medically complex admissions) and 32 percent (for rehabilitation admissions).
- 10 Minority beneficiaries made up 20 percent of medically complex admissions in 2011, even though they made up only 16 percent of all SNF admissions.
- 11 A recent court case between the Department of Health and Human Services and the Center for Medicare Advocacy (*Jimmo v. Sebelius* 2011) will require the program to clarify the language in its benefit manual regarding the coverage of services needed to maintain or prevent deterioration of a patient’s current condition. Coverage will hinge on existing requirements that the beneficiary needs daily skilled care furnished by skilled personnel and has had a hospital stay of at least three days preceding admission to the SNF. Until CMS revises the benefit manuals, specifies instructions, and trains claims contractors and providers, it is hard to estimate the impact this change will have on utilization. If these changes broaden access to care, then expenditures could increase.
- 12 Medically complex days make up the other 8 percent of days. See endnote 6 for the definition of medically complex.
- 13 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 is for those patients who received over 720 minutes per week; very-high rehabilitation includes patients who received 500–719 minutes per week.
- 14 The five conditions are congestive heart failure, respiratory infection, urinary tract infections, septicemia, and electrolyte imbalance.
- 15 The models include 19 diagnostic and 4 mental illness categories and other elements from the Minimum Data Set

- found to be associated with one or both quality measures: whether the patient uses a walker, shortness of breath when sitting, presence of a fever, whether the patient had a fall since admission or the prior assessment, and average number of times physicians' orders were changed. One factor important in the prior models (whether the patient had do-not-resuscitate orders) is no longer reported in the assessment. The models explain a fair amount of the variation in rates across facilities, with C-statistics of 0.76 and 0.75. A C-statistic measures the probability that the prediction is better than chance, and a model with a value greater than 0.7 is considered reasonable.
- 16 The comorbidity index includes indicators for the following mental illnesses: Alzheimer's disease, dementia, depression, psychotic disorders, and schizophrenia.
  - 17 Separate models were developed for patients discharged to a nursing home, home health care, or the community or other (such as receiving hospice). The models included the same variables, but the importance of each factor (the coefficients) varied.
  - 18 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.
  - 19 SNF cost reports were not available for fiscal year 2011. Providers were given more time to complete the reports because they include new schedules. We estimated margins using 2010 data and various assumptions about growth in costs and days.
  - 20 To measure costs, we look at costs per day that were adjusted for differences in wages and case mix. To measure quality, we examined risk-adjusted rates of community discharge and potentially avoidable rehospitalizations. To be in the group of relatively efficient providers, a SNF had to be in the best third of one measure and not in the bottom third on any measure for three consecutive years (2006–2008).
  - 21 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.
  - 22 The differences for Extencare are smaller than for other companies because almost half of its contracts with managed care companies are based on the FFS system.



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CHAPTER

9

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**Home health care services**

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

*(The Commission reiterates its previous recommendations on improving the home health payment system. See text box, pp. 207–209.)*

# Home health care services

## Chapter summary

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

## 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: Ninety-nine percent of beneficiaries live in a ZIP code where a Medicare home health agency operates and 98 percent live in a ZIP code with two or more agencies.

- **Capacity and supply of providers**—The number of agencies continues to increase, with over 700 new agencies and 12,199 total agencies in 2011. Most new agencies were concentrated in a few states, and for-profit agencies accounted for the majority of new providers.
- **Volume of services**—In 2011, the volume of services was level, and total payments declined by about 5 percent, or \$1 billion. The decline in payments was attributable to a reduction in the Medicare base rate.

## In this chapter

- Are Medicare payments adequate in 2013?  
.....
- How should Medicare payments change in 2014?  
.....

The lower spending comes after several years of increases, as total spending between 2002 and 2011 increased by 92 percent. Between 2002 and 2010, the average number of 60-day episodes per home health user increased from 1.6 to 2.0, indicating that beneficiaries who use home health care stayed 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 other 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. For smaller agencies, the significant number of new agencies in 2011 suggests that they had access to the capital necessary for start-up.

*Medicare payments and providers' costs*—For over a decade, payments have consistently and substantially exceeded costs in the home health prospective payment system. Medicare margins for freestanding agencies equaled 14.8 percent in 2011 and averaged 17.7 percent in 2001 through 2010. Two factors have contributed to payments exceeding costs: Fewer visits are delivered in an episode than is assumed in Medicare's rates, and cost growth has been lower than the annual payment updates for home health care. Medicare margins are estimated to equal 11.8 percent in 2013.

### **The Commission reiterates recommendation from prior years**

In 2011, the Commission made a multiyear recommendation for home health payments, and this report reiterates that recommendation (Medicare Payment Advisory Commission 2011). The Patient Protection and Affordable Care Act of 2010 includes reductions in payment for home health care, but these policies will leave home health agencies with margins well in excess of cost. Overpaying for home health services has negative financial consequences for the federal government and raises the Medicare premiums 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 home health agencies. ■

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## Background

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Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. Medicare requires that a physician certify a patient's eligibility for home health care and that a patient receiving service be under the care of a physician. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Unlike most other services, Medicare does not require copayments or a deductible for home health services. In 2011, about 3.4 million Medicare beneficiaries received home care, and the program spent about \$18.4 billion on home health services. Medicare spending for home health care has doubled since 2001 and currently accounts for about 5 percent of fee-for-service (FFS) spending. The number of home health agencies (HHAs) participating in Medicare reached 12,199 in 2011.

Medicare pays for home health care in 60-day episodes. Episodes delivered to beneficiaries in rural areas receive a 3 percent payment increase for 2010 through 2015. Payments for an episode are adjusted for patient severity based on patients' clinical and functional characteristics and some of the services they use. If they 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. (An overview of the home health prospective payment system (PPS) is available at [http://medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_HHA.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_12_HHA.pdf).) Coverage for additional episodes generally has the same requirements (e.g., beneficiary must be homebound and need skilled care) as the initial episode.

Medicare also pays for services rendered in the home under Part B via the fee schedule for physicians and other health professionals, though the aggregate amount of services provided under Part B is relatively small compared with the volume of services under the home health benefit. For example, in 2011 Part B paid for 2.6 million physician visits in the home, compared with 59 million skilled nursing visits under the home health benefit. Though utilization of the Part B fee schedule for services in the home is less frequent, several features may make it an appropriate substitute for some home health beneficiaries.

Services provided in the home under the Part B fee schedule do not have to meet the homebound requirement, though the provider does need to document why the service must be provided at home instead of in an office or other professional setting. The fee schedule also covers a broader range of service than home health care, such as mental health, imaging, laboratory testing, and physician management services. Beneficiaries can receive most Part B services during a home health episode, with the exception of outpatient physical therapy. Therapy services are covered under the home health PPS, the agency must bill for them through the PPS, and billing for them under the fee schedule is not permitted in most cases.<sup>1</sup>

Medicare payments for home visits under the Part B fee schedule are generally lower than payments for similar visits in the home health benefit, although many services covered under the home health benefit do not have an equivalent or similar service in the fee schedule. Physical therapy is one example because both home health care and the fee schedule cover this service. The Medicare allowed charge for a 45-minute home visit to provide therapeutic exercises under the fee schedule in 2010 was \$89. The beneficiary would pay 20 percent of this amount, with the remainder paid by the program. Under the home health PPS, the average per visit payment would be about \$193.<sup>2</sup>

Part of the discrepancy between the payment systems reflects the differences in services covered and costs included in each payment system. Home health care covers some services, such as some medical supplies, as part of the PPS. These elements are billed separately under the Part B fee schedule. Other differences may arise due to the costs Medicare includes in its rate calculations. For example, HHAs that reimburse mileage to traveling staff could include these costs in their Medicare allowed costs, while travel costs for physicians are not included in the costs considered in development of the Part B fee-schedule rates for home visits. Also, some of the commonly provided home services are evaluation and management visits, which the Commission has suggested are undervalued. Even with these considerations, the magnitude of the differences is substantial. Medicare has typically overpaid for home health care by 15 percent to 23 percent since 2001, and some of the discrepancy likely reflects the disconnect between payments and costs in the home health PPS. If home health PPS payments were lowered to be closer to actual agency costs, the difference between the fee-schedule rates for home services and the home health PPS would decline.

**TABLE  
9-1**

**Changes in supply and utilization of home health care, 1997-2011**

	1997	2000*	2011	Percent change	
				1997-2000	2000-2011
Agencies	10,917	7,528	12,199	-31%	62%
Total spending (in billions)	\$17.7	\$8.5	\$18.4	-52	117
Users (in millions)	3.6	2.5	3.5	-31	40
Number of visits (in millions)	258.2	90.6	118.0	-65	30
Visit type (percent of total)					
Skilled nursing	41%	49%	51%	20	4
Home health aide	48	31	15	-37	-50
Therapy	10	19	33	101	71
Medical social services	1	1	1	1	-2
Number of visits per user	72.6	36.8	36.2	-49	-7
Percent of FFS beneficiaries who used home health services	10.5%	7.4%	9.5%	-30	29

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.

### Use and growth of home health benefit has varied substantially due to changes in coverage and payment policy

The home health benefit has changed substantially since the 1980s. Implementation of the inpatient PPS in 1983 led to increased use of home health services as hospital lengths of stay decreased. Medicare tightened coverage of some services, but the courts overturned these curbs in 1988. After this change, the number of agencies, users, and services expanded rapidly in the early 1990s. Between 1990 and 1995, the number of annual users increased by 75 percent and the number of visits more than tripled to about 250 million a year. From 1990 to 1995, spending increased from \$3.7 billion to \$15.4 billion. As the rates of use and lengths of 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 (OIG) found that about 40 percent of the services in a sample of Medicare claims did not meet Medicare requirements for reimbursement, with most of the errors due to the services not meeting Medicare's standards for a reasonable and

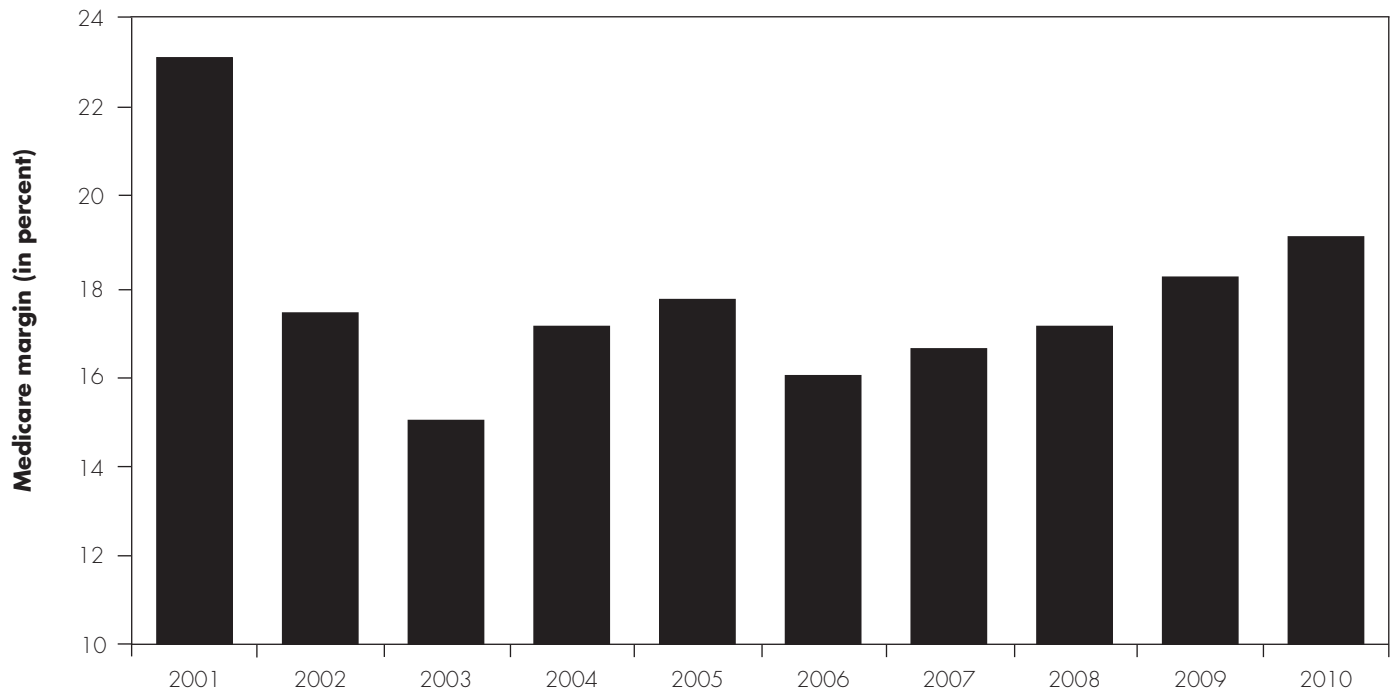
necessary service, the patient not meeting the homebound coverage requirement, or the medical record not documenting that a billed service was provided (Office of Inspector General 1997).

The trends of the early 1990s prompted increased program integrity actions, refinements to eligibility 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). The mix of services changed from predominantly aide services in 1997 to mostly nursing visits in 2000, and therapy visits increased from 10 percent of visits in 1997 to 33 percent in 2011. Total spending for home health services declined by 52 percent between 1997 and 2000. 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. Between 2001 and 2010, the number of home health episodes rose from 3.9 million to 6.8 million. The number of agencies in 2011 was over 12,000, over 1,000 agencies higher than the supply at the earlier peak of spending in 1997. Almost all



**FIGURE  
9-1**

**Medicare margins of freestanding home health agencies since 2001**



Source: Medicare cost reports.

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. 2003, McCall et al. 2004). An analysis of the Balanced Budget Act of 1997 changes related to post-acute care (PAC), including the home health IPS and changes for other PAC services, concluded that the rate of adverse events generally improved or did not worsen when the IPS was in effect. A study by the Commission also concluded that the quality of care had not declined between the IPS and the PPS (Medicare Payment Advisory Commission 2004). The similarity in quality of care under the IPS and the PPS suggests that the payment reductions in the Balanced Budget Act of 1997 led agencies to reduce costs and excess utilization without a measurable difference in the quality of patient care.

Home health margins for freestanding HHAs have been very high since the PPS was implemented, as Medicare margins averaged 17.7 percent between 2001

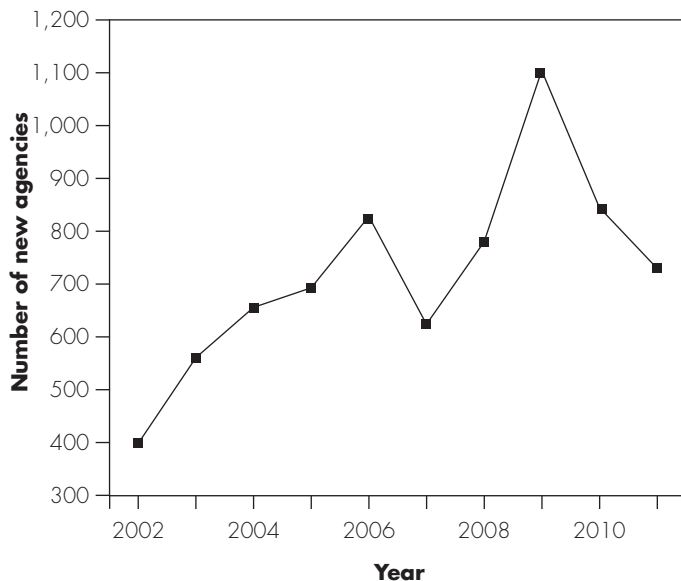
and 2010 (Figure 9-1). The high overpayments have led the Commission to recommend that home health rates be lowered to a level consistent with costs (Medicare Payment Advisory Commission 2011). These high margins likely have encouraged the entry of new HHAs, as the total number of agencies participating in Medicare has increased by an average of about 532 agencies a year since 2002 (Figure 9-2, p. 192).

**Patient Protection and Affordable Care Act of 2010 changes to payment for home health services**

In 2010, the Commission recommended that Medicare lower home health payments to make them more consistent with costs, referred to as payment rebasing. The Patient Protection and Affordable Care Act of 2010 (PPACA) includes several reductions intended to address home health care's high Medicare payments, but these policies may not achieve the Commission's goal of making payments more consistent with actual costs. PPACA calls for base rate reductions to be phased in over four years beginning in 2014. The law sets a maximum reduction of 3.5 percent a year, for a cumulative reduction of 14

**FIGURE  
9-2**

**Annual number of new home health agencies in Medicare, 2002-2011**



Source: CMS Providing Data Quickly database.

percent but offsets this reduction with the payment update for each year. With this offset, the maximum reduction is roughly halved to 7 percent over the four-year period. With margins that typically exceed 15 percent, these lower reductions could leave HHAs with a significant profit margin. The Commission's policy would reduce payments over a two-year period and would not offset reductions with increases from the payment update. The Commission's proposed reductions would likely bring payments more in line with costs than the PPACA rebasing policy.

**Some PPACA initiatives may expand the role of home health services**

PPACA also includes several new models of care that may have a potential role for home health services. Some of these models are designed to improve PAC (Center for Medicare & Medicaid Innovation 2012). For example, the Bundled Payment for Care Improvement demonstration tests models that include PAC as a part of an acute care bundle or as a stand-alone bundle. Another initiative, the Community-Based Care Transitions Initiative, uses community-based organizations, such as area agencies on aging, to provide and manage care for beneficiaries after

discharge. Community-based organizations must agree to have formal partnerships with area hospitals and consumer groups. In both of these demonstrations, HHAs may serve as providers for participating beneficiaries when they return home.

Models that focus on chronic care needs and care coordination may also have a role for home health services. For example, the Independence at Home demonstration will test the effectiveness of delivering comprehensive primary care services at home (Center for Medicare & Medicaid Innovation 2012). The demonstration makes payments to home care physicians for delivering services at home for frail elderly populations with multiple chronic conditions. Practices that achieve quality and cost-saving goals can receive bonus payments under the demonstration. Home care physicians frequently serve community-dwelling homebound Medicare beneficiaries and use Medicare HHAs as a supplement to physician home visits.

Other delivery system reforms may seek to use home health services as a substitute for hospitalizations. For example, some providers have tested a "hospital at home" approach in which patients are diverted from the emergency department and sent home with intensive home health services to address their urgent care needs (Cryer et al. 2012). This approach can be appropriate for patients who need intensive assistance to stabilize a condition but do not require the full scope of emergency department or inpatient care.

**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 when 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 are 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.

A recent review by the Department of Health and Human Services OIG suggests that a significant number of HHAs had questionable patterns of payment (Office of Inspector General 2012). The review found that about 25 percent of HHAs in Medicare had unusual utilization or payment trends in 2010. For example, over 400 agencies had an unusually high rate of beneficiaries who received five or more episodes in a consecutive set of home health episodes. OIG cited 257 agencies for providing an unusually high number of therapy visits, which increases the episode payment under the home health PPS. About 80 percent of the agencies considered to have questionable billing practices were in four states: California, Florida, Michigan, and Texas. Some of these states have experienced rapid growth in the number of HHAs participating in Medicare.

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. Medicare has implemented increased screening requirements for new agencies but has not implemented all the tools available under current law. For example, many areas with fraud concerns have a supply of agencies that many believe far exceeds the legitimate need for services. PPACA permits Medicare to implement temporary moratoriums on the

enrollment of new agencies in areas believed to have a high incidence of fraud, but it has yet to use this authority. A moratorium on the enrollment of new providers in these areas would prevent new agencies from entering markets that may already be saturated. Medicare also has the authority to require HHAs to hold surety bonds, but it has not exercised this authority and made surety bonds a requirement.<sup>3</sup>

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 deterioration of a patient's current condition. Coverage will hinge on existing requirements: that the beneficiary needs skilled care and meets the homebound requirement. Until CMS revises the benefit manuals, specifies instructions, and trains claims contractors and providers, it is hard to estimate the impact this change will have on utilization. However, given the rapid growth the benefit has experienced in the past, it remains possible that utilization could increase.

The home health benefit provides a valuable service to beneficiaries and the Medicare program, particularly when it substitutes for a higher level of PAC or helps community-dwelling beneficiaries avoid hospitalization. However, the broad program standards and fragmented nature of the FFS program do not encourage effective targeting of the benefit to meet these goals and provide opportunities for fraud, waste, and abuse that have proven difficult to eliminate. Many of these issues might be more easily addressed if the payment and delivery of home health care were more closely integrated with the other sources of care typically provided during an episode. For example, accountable care organizations at risk for the cost of a beneficiary's Medicare spending would have an incentive to use home health care when it could reduce overall costs but to avoid the excessive utilization observed in many parts of the country.

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## **Are Medicare payments adequate in 2013?**

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The Commission reviews several indicators to determine the level at which payments will be adequate to cover the costs of an efficient provider in 2013. We assess beneficiary access to care by examining the supply of home health providers and annual changes in the volume

**TABLE  
9-2**

**Number of home health agencies continues to rise**

	2002	2004	2006	2008	2010	2011	Average annual percent change	
							2002-2010	2010-2011
Number of agencies	7,057	7,804	8,955	10,040	11,654	12,199	6.5%	4.6%
Agencies that opened	399	656	828	780	831	730	9.8	-14.0
Agencies that closed	277	183	176	167	181	218	-4.6	15.0
Number of agencies per 10,000 beneficiaries	2.0	2.1	2.5	2.8	3.3	3.4	6.1	3.7

Note: Agencies' census includes all agencies operating during a year, including agencies that closed or opened.

Source: CMS's Providing Data Quickly database and 2012 annual report of the Boards of Trustees of the Medicare trust funds.

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 2011, almost all beneficiaries (99.5 percent) lived in a ZIP code served by at least one HHA, 98 percent lived in a ZIP code served by two or more HHAs, and over 80 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our review of access from prior years.<sup>4</sup>

**Capacity and supply of providers: Agency supply surpasses previous peak**

In 2011, there were 12,199 HHAs participating in Medicare, a net increase of about 512 agencies compared with the previous year. Most new agencies in 2011 were for-profit agencies. The number of agencies exceeded the previous record of the 1990s when supply exceeded 10,900 agencies. The high rate of growth is a particular concern, as the new agencies appear to be concentrated in areas with fraud issues, including California, Florida, and Texas. These states, like most, do not have state certificate-of-need laws for home health care, which can limit the entry of new providers.<sup>5</sup>

Since 2004, when 99 percent of beneficiaries lived in a ZIP code served by an HHA, the number of agencies per 10,000 FFS beneficiaries has risen 60 percent, from 2.0 to

3.4 (Table 9-2). Some of this growth is due to a decrease in the number of FFS enrollees as more beneficiaries enroll in Medicare Advantage, but even when managed care beneficiaries are included with FFS, the number of agencies per beneficiary has increased by about 35 percent since 2004. Supply can vary significantly among states. In 2010, Texas averaged 9.6 agencies per 10,000 beneficiaries, whereas New Jersey averaged 0.4 agency per 10,000 beneficiaries. Some of this variation in supply is likely due to certificate-of-need laws, as New Jersey has certificate-of-need laws and Texas does not. The extreme variation demonstrates that the number of providers is a limited measure of capacity, as agencies can vary in size and capability. 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 2011, total spending for home health care dropped by about 5 percent, and most of this reduction was due to a decline in the home health episode base rate.<sup>6</sup> The average payment per episode declined by about 5 percent, while the number of episodes and beneficiaries using home health care held steady between 2010 and 2011 (Table 9-3). This steady level of utilization is in sharp contrast to the utilization trends in prior years. Between 2002 and 2010, the number of episodes increased by 66 percent, from 4.1 million to 6.8 million episodes. Between 2002 and 2010, the share of beneficiaries using home health

**TABLE  
9-3**

**Share of beneficiaries using home health services continues to rise**

	2002	2006	2008	2010	2011	Average annual percent change	
						2002-2010	2010-2011
FFS beneficiaries (in millions)	35.0	36.1	35.5	36.0	36.3	0.4%	0.9%
Home health users (in millions)	2.5	3.0	3.2	3.4	3.4	3.9	0.7
Share of beneficiaries using home health care	7.2%	8.4%	8.9%	9.5%	9.5%	3.5	-0.1
Episodes (in millions):	4.1	5.5	6.1	6.8	6.9	6.6	0.1
Per home health user	1.6	1.8	1.9	2.0	2.0	2.6	-0.7
Per FFS beneficiary	0.12	0.14	0.16	0.19	0.19	6.2	-0.8
Payments (in millions)	\$9.6	14.0	16.9	19.4	18.4	9.2	5.2
Per home health user	\$3,803	\$4,606	\$5,359	\$5,679	\$5,367	5.1	-5.9
Per FFS beneficiary	\$274	\$387	\$479	\$543	\$507	8.9	-6.0

Note: FFS (fee-for-service).

Source: MedPAC analysis of home health standard analytical file.

care increased from 7.2 percent to 9.5 percent but was steady in 2011 relative to the prior year.

The cause of the lack of growth may be, at least in part, related to the new requirement, effective 2011, that a certifying physician or an allowed nonphysician practitioner had a face-to-face encounter with the patient when authorizing home 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 for 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.

**Home health care stays have grown longer and less focused on post-acute care since 2002**

The average number of episodes per user has increased by 22 percent since 2002, rising from 1.6 to 2.0 episodes per user by 2010. Though the trend is flat for 2011, the increase in episodes per user in 2002 through 2010 indicates that beneficiaries are receiving home health care for longer periods of time and suggests that home health care is serving 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 these episodes coincides with Medicare’s PPS incentives that encourage additional volume: The per episode unit of payment and the payment system has an adjustment that raises payments for the third and later episodes in a consecutive spell of home health episodes.<sup>7</sup>

The rise in the average number of episodes per beneficiary also coincides with a shift away from using home health care as a PAC service. Over the 2001 to 2010 period, the number of episodes that were not preceded by a hospitalization or PAC stay increased by 117 percent (Table 9-4, p. 196). In 2001, about 52 percent of all episodes were not preceded by a hospitalization or PAC stay, but by 2010 the share had increased to 66 percent of all episodes. A corresponding decrease occurred between 2001 and 2010 in episodes preceded by a hospitalization or PAC stay, decreasing from 48 percent to 34 percent. These episodes increased at a lower pace of 26 percent in 2001 through 2010.

A review of utilization, demographic, and clinical characteristics suggests that beneficiaries who use home health care primarily for PAC differ on several metrics compared with community-admitted users.<sup>8</sup>

**TABLE  
9-4**

**Increase in home health episodes more rapid when episode not preceded by hospitalization or PAC stay**

	Number of episodes (in millions)		Cumulative growth	Percent of episodes	
	2001	2010		2001	2010
Episodes preceded by a hospitalization or PAC stay:					
First	1.6	1.9	15%	40%	27%
Subsequent	0.3	0.5	67	8	7
Subtotal	1.9	2.4	26	48	34
Episodes not preceded by a hospitalization or PAC stay (community-admitted episodes):					
First	0.8	1.3	68	20	19
Subsequent	1.3	3.2	148	32	46
Subtotal	2.1	4.5	117	52	66
Total	3.9	6.8	74	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 hospitals), 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 due to rounding.

Source: CMS Datalink file, 2010.

Community-admitted home health care users accounted for about 50 percent of all home health users, but they accounted for 4.5 million episodes in 2010 (64 percent of all episodes). PAC users averaged 1.4 episodes in 2010, while community-admitted users averaged 2.6 episodes for the year. About 94 percent of the episodes provided to community-admitted patients were not preceded by a hospitalization or prior PAC use. 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 had fewer hospitalizations and physician visits compared with PAC users, but this result was likely due, at least in part, to a hospitalization being a criterion for being categorized as a PAC user.

About 74 percent of community-admitted users were White, compared with 86 percent of PAC users.

Community-admitted users also tended to be older, with relatively more users in the 85 or older age group and relatively fewer in the 65–74 age group. Community-admitted users had 3.8 chronic conditions on average, compared with 4.2 for PAC users. The mix of conditions also varied, with 29 percent of community-admitted users having Alzheimer’s disease and dementia compared with 21 percent for PAC users. The rate of chronic conditions was lower for community-admitted users for most other conditions, such as heart disease, chronic obstructive pulmonary disease, and heart failure.

The differences between the two populations suggest that Medicare is serving different populations within the home health benefit. PAC users appear to be a more clinically severe population, as measured by the number of chronic conditions; the smaller number of episodes per user for this population indicates they remain in home health care for relatively shorter periods of time.

By contrast, community-admitted users had some characteristics that were more suggestive of long-term care needs. Community-admitted users consume almost twice as many episodes per user as PAC users, indicating

that they remain in home health care for a longer period of time. The higher rates of home health aide services for community-admitted users suggest that they need more assistance with activities of daily living. The high share of community-admitted users who were also Medicaid eligible suggests that some of this utilization may be due to state Medicaid programs leveraging the Medicare home health benefit to provide long-term care. Such an approach can permit states to 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

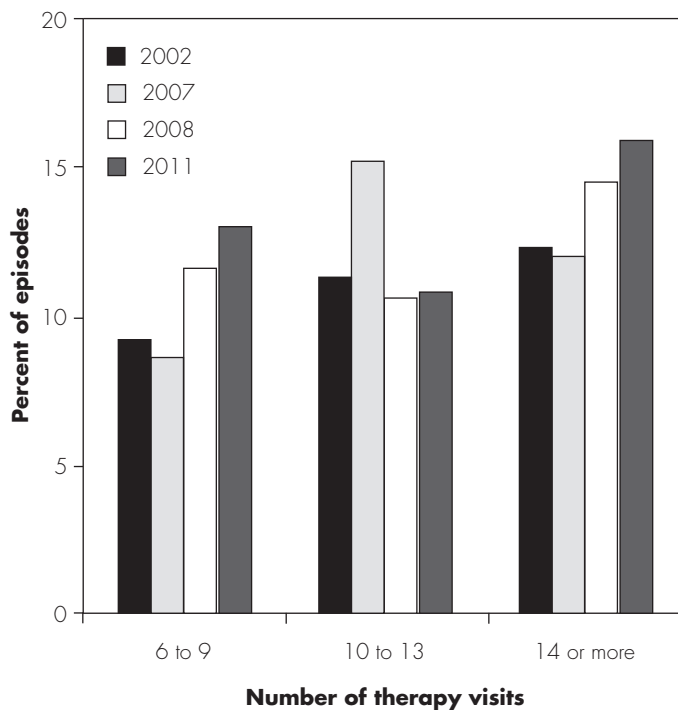
The number of therapy visits a beneficiary receives during a home health care episode is one of the factors that determines Medicare’s payment for a home health episode. Generally, providing more therapy visits raises the episode payment. The Commission has long had a concern that allowing actual utilization to drive payment creates an incentive for agencies to provide more services to increase payment, and changes in episode volume have generally reflected the incentives for therapy payment in the payment system. The Commission recommended that Medicare redesign the payment system to rely solely on patient characteristics, and 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 significantly 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 payments for episodes in the 6 to 9 and 14 or more therapy visit ranges. The subsequent changes in therapy utilization reflected the new incentives: Episodes with 10 to 13 therapy visits decreased 27 percent, while those with 6 to 9 therapy visits and 14 or more visits increased by 43 and 27 percent, respectively (Figure 9-3). This was the largest one-year shift in therapy volume since the PPS was implemented. Since 2008, the growth in episodes has followed this pattern, with episodes with 14 or more visits growing significantly.

**FIGURE 9-3**

**Annual episode volume for episodes with select numbers of home health visits**



Note: From 2002 to 2007, CMS had a single payment adjustment that increased payment for episodes with 10 or more therapy visits. In 2008, CMS added payment adjustments that lowered payments for episodes with 10 to 13 visits and raised them for episodes with 6 to 9 visits and 14 or more visits. These revised thresholds remain in effect.

Source: MedPAC analysis of 2011 home health standard analytical file.

### Volume in 2011 decreased for therapy episodes affected by new review requirement

In 2011, CMS implemented a requirement for agencies to review the need for additional therapy care at two points in a home health episode: before the 14th therapy visit and again before the 20th therapy visit. That year, CMS also implemented a new requirement for tighter supervision of therapy services provided under the home health care benefit. In these assessments, the therapist must review the patient’s progress and determine whether the patient will benefit from additional therapy visits. Medicare targeted these visit intervals because under the current PPS, the payments increase substantially for episodes at the 14th and 20th therapy visits. The additional review is intended to serve as a safeguard against manipulation of therapy visits to garner increased payment.

**TABLE  
9-5**

**Utilization by type of county, 2011**

**Number of home health episodes per 100 FFS beneficiaries**

Type of county	All states	Top 5 states	All other states
Urban	17.7	33.5	14.3
Rural, by subcategory			
Micropolitan	16.0	37.7	11.7
Rural, adjacent to urban	18.1	40.2	12.7
Rural, nonadjacent to urban	16.3	43.6	11.9
All rural	16.5	39.2	11.9
National (all counties)	17.5	34.7	13.7

Note: FFS (fee-for-service). "Top 5 states" category includes the states with the highest rates of episodes per beneficiary in 2011: Florida, Louisiana, Mississippi, Oklahoma, and Texas. An urban county includes a city that has a population of more than 50,000. A micropolitan county has a population of 10,000 to 50,000.

Source: MedPAC analysis of home health standard analytic file and 2011 beneficiary annual summary file.

Claims data for 2011 suggest that these requirements had some impact, as the number of episodes with visits at and beyond these thresholds decreased relative to 2010 (data not shown in Figure 9-3). For example, the number of episodes with 14–17 therapy visits decreased by 9.5 percent and the number of episodes with more than 20 therapy visits decreased by 9.2 percent. The decline in 2011 is a reversal of the trend in 2008 through 2010, when episodes with 14 or more therapy visits were growing rapidly.

Episodes with more than 6 and fewer than 14 therapy visits, accounting for 45 percent of episodes that include any therapy visits, have no requirement for additional review.<sup>9</sup> The volume of these episodes continued to rise in 2011. This lack of scrutiny is problematic because agencies can significantly raise their Medicare payment by increasing visits within this range. For example, the payment for low-severity episodes increases by 20 percent when the number of therapy visits increases from five visits to six visits. While administrative actions such as additional review may reduce these incentives, these efforts require more resources by agencies and Medicare. Eliminating the use of therapy visits as a payment factor, as the Commission recommended, would eliminate the need for administrative resources to scrutinize therapy use and would ensure that financial incentives did not trump patient needs when determining the amount of therapy to provide in a home health care episode.

In 2012, CMS also raised the payment-relative weights 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.

**Adjacent urban and rural areas have comparable total utilization**

Home health care utilization tends to vary more in different regions of the nation than between urban and rural areas within regions or states. In 2011, the national average for home health care episodes per 100 Medicare FFS beneficiaries was about 17.5 (Table 9-5). The average utilization for rural-nonadjacent counties—counties not adjacent to an urban area—was slightly higher than this average and slightly lower for micropolitan counties and rural counties adjacent to an urban area. While rural areas generally had utilization similar to that in urban areas, frontier counties—those that average six or fewer individuals per square mile—had significantly lower utilization. In 2008, the most recent year for which the Commission has data, utilization in frontier counties averaged 8 episodes per 100 beneficiaries, about half the average rate of utilization in other rural areas (data not shown in Table 9-5).



Regions or states with utilization that is high relative to the national average typically have above-average utilization in both rural and urban counties, and states or regions with utilization below the national average generally have below-average utilization in urban and rural areas. For example, utilization in both urban and rural areas of Wisconsin is well below the national average. In 2011, rural Wisconsin areas averaged 5.6 episodes per 100 beneficiaries, compared with 7.6 episodes per 100 beneficiaries in urban Wisconsin areas. In contrast, utilization in both urban and rural areas of Texas is above average. Rural areas of Texas average 43.5 episodes per 100 beneficiaries, and urban areas average 41 episodes per 100 beneficiaries.

### **Home health care utilization is concentrated in select states**

The highest utilization of home health services is concentrated in a few areas of the country. The top five states (Florida, Louisiana, Mississippi, Oklahoma, and Texas) account for about 35 percent of all home health care episodes despite accounting for only 17 percent of beneficiaries. The utilization in these five states is 34.7 episodes per 100 FFS beneficiaries, compared with 13.7 episodes per 100 FFS beneficiaries for all other states (Table 9-5). Large differences in utilization occur in both rural and urban areas. Urban areas in the top five states have a rate of utilization more than double that in the other states, and rural areas in the top five states have rates of utilization double or triple the rates in rural areas in the other states.

The concentration of high utilization in a few areas of the country has raised concerns that some of this utilization may be due to fraud and abuse. It is hard to distinguish between fraudulent and legitimate home health care services in Medicare claims data. However, a comparison of areas with remarkably high spending compared with national benchmarks provides some indication of the potential impacts if utilization in these areas could be curbed. As an example, the 25 counties with the highest utilization (Table 9-6, p. 200) had an average utilization of 88 episodes per 100 beneficiaries. If policies to reduce fraud could lower utilization to 18.5 episodes per 100 beneficiaries (the 75th percentile), the total number of episodes in these counties would have declined by about 290,000 episodes, or about 80 percent of these counties' total utilization in 2011. Medicare spending would have been lower by about 4.3 percent or \$783 million in 2011.

### **Rural areas with high utilization benefit most from Medicare's rural add-on payment**

The high level of utilization in many rural areas results in a maldistribution of the add-on payments Medicare makes for rural home health services. 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 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, 70 percent of the episodes that received the add-on payments in 2011 were in rural counties with utilization significantly higher than 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 clearly below the national average, accounted for 13 percent of the episodes eligible for the add-on payment.

The Commission noted in our June 2012 report that Medicare should target payment adjustments for rural areas 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 suggestive of fraud and abuse are rural—for example, 22 of the 25 top spending counties in 2011 are rural areas (Table 9-6, p. 200). Agencies in these 25 counties received approximately \$28 million from the rural add-on that was in effect in 2011. Higher payments in areas without access problems may encourage the entry or expanded operations of agencies that seek to exploit the financial incentives of the Medicare program. More targeted approaches that eliminate rural add-on payments to areas without access problems could be pursued.

### **Quality of care: Quality measures generally held steady**

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, p. 201). In general, the share of beneficiaries showing improvement in these measures has increased since 2004, and a similar trend is observed for most measures in 2011 and 2012. However, these data

**TABLE  
9-6**

**Counties with the highest rates of home health care use in 2011**

State	County	Share of FFS beneficiaries using home health services	Episodes per user	Episodes per 100 FFS beneficiaries
TX	Duval	34.4%	4.5	154.8
TX	Brooks	33.6	4.2	142.6
TX	Jim Hogg	32.3	4.0	128.3
TX	Starr	31.7	4.1	129.5
TX	Willacy	29.6	3.5	103.8
FL	Miami-Dade	28.9	2.8	79.8
TX	Jim Wells	28.6	4.1	117.3
MS	Claiborne	27.1	3.1	83.2
TX	Zapata	26.9	3.9	104.5
LA	Madison	26.2	4.4	114.3
TX	Hidalgo	26.2	3.7	97.7
OK	Choctaw	25.7	4.2	107.2
OK	McCurtain	24.3	4.5	108.5
TX	Webb	24.1	3.8	92.8
LA	East Carroll	23.6	4.5	106.9
TX	Cameron	22.9	3.3	75.5
LA	Avoyelles	22.6	4.1	91.4
TX	Red River	22.2	4.0	90.0
TN	Hancock	22.2	3.1	68.6
OK	Pushmataha	22.0	4.1	89.3
OK	Latimer	21.8	4.5	98.1
LA	Washington	21.6	3.7	81.1
TX	Falls	21.6	3.3	71.1
TX	Kleberg	21.3	3.8	79.9
MS	Sharkey	21.0	3.7	76.9
National average		9.5	2.0	17.5

Note: FFS (fee-for-service). Counties with fewer than 100 home health users have been excluded.

Source: MedPAC analysis of the 2011 home health standard analytical file and the 2010 Medicare denominator file.

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 public debt, like 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 businesses 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 than in other sectors the Commission reviews.

Analysis of for-profit companies indicates that they have adequate access to capital in 2011, though on terms less favorable than in previous years. The PPACA changes

**TABLE  
9-7**

**Average agency performance on select quality measures**

	2004	2005	2006	2007	2008	2009	2011	2012
Share of an agency's beneficiaries with improvement in:								
Transferring	47%	49%	50%	50%	51%	51%	51%	52%
Bathing	56	58	60	61	62	63	62	63
Walking							53	55
Medication management							43	45
Pain management							65	65

Note: The measures for walking, medication management, and pain management changed in 2011 and are not comparable to data from prior years. Data are risk adjusted for differences between home health agencies in the mix of patients they serve.

Source: MedPAC analysis of CMS Home Health Compare data.

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 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. For smaller or nonpublic entities, the entry of new providers indicates that access to capital for privately held agencies is adequate. In 2011, over 700 new HHAs entered Medicare; most of these agencies were for profit.

The low capital requirements for home health care services allow the industry to react rapidly when the supply of agencies changes or contracts. For example, during the interim payment system (1997–2000), when payments dropped by about 50 percent in two years, many agencies exited the program. However, new agencies entered the program (about 200 agencies a year) and existing agencies expanded their service areas to enter markets left by exiting agencies. Because of these adjustments, reviews of access found that access to care remained adequate during this period despite a substantial decline in the number of agencies (Liu et al. 2003).

**Medicare payments and providers' costs: Payments decreased in 2011 but costs remained steady**

In 2011, average payments per episode declined by about 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. The average cost per episode in 2011 was unchanged from 2010. Low cost growth 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 the high margins under the Medicare PPS.

**Medicare margins remained high in 2011**

In 2011, HHA Medicare margins in aggregate were 14.8 percent for freestanding agencies (Table 9-8, p. 202). Financial performance varied from –0.3 percent for the agency at the 25th percentile of the margin distribution to 22.8 percent for the agency at the 75th percentile.

Margins for hospital-based agencies in 2011 were –10.9 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. Potential lower inpatient costs due to shorter hospital stays may more than compensate for any losses from operating an HHA. The Commission includes hospital-based HHAs in the analysis of inpatient hospital margins because these agencies operate in the financial context of hospital operations. Operating an HHA may permit a hospital to discharge its patients earlier, thereby lowering hospital costs for inpatient services.

The negative margins for hospital-based agencies may be an issue for counties that have only these types of agencies. A number of hospital-based agencies experienced small but consistent declines in recent years and may cause access challenges for counties with no other source of home health care.

**TABLE  
9-8****Medicare margins for freestanding home health agencies, 2010 and 2011**

	2010	2011	Percent of agencies, 2011	Percent of episodes, 2011
All	19.1%	14.8%	100%	100%
Geography				
Majority urban	19.1	14.8	84	82
Majority rural	19.4	15.3	16	18
Top 5 states in utilization	14.4	11.4	35	37
All other states	19.8	15.3	65	63
Type of control				
For profit	20.3	15.7	89	80
Nonprofit	15.1	12.2	11	20
Government*	N/A	N/A	N/A	N/A
Volume quintile				
First (smallest)	10.2	6.6	20	3
Second	11.2	8.3	20	7
Third	13.5	10.1	20	11
Fourth	17.7	13.4	20	20
Fifth (largest)	22.0	17.4	20	61

Note: N/A (not applicable). "Top 5 states in utilization" category includes the states with the highest rates of episodes per beneficiary in 2011: Florida, Louisiana, Mississippi, Oklahoma, and Texas.

\*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.

As mentioned earlier, there are several parts of the country with unusual patterns of home health care utilization. A review of Medicare margins for agencies operating in the five states with the highest rates of utilization indicates that they have lower margins than agencies in other areas—11.4 percent compared with 15.3 percent (Table 9-8). The higher margins of agencies in states with more typical patterns of utilization also indicate that, on average, agencies in these states have margins higher than the 2011 national average of 14.8 percent. Conversely, margins for agencies in the five states with high utilization are below the national average. While the margins of agencies in these five states exceed the margins of many other categories of Medicare providers, their below-average performance actually reduces the national average Medicare margin for HHAs.

Since an individual HHA can serve a mix of urban and rural patients, we determine an agency's rural or urban designation based on where most of its episodes are provided. In 2011, rural providers had higher margins

than urban providers, but this finding is not surprising, as PPACA included a 3 percent add-on for episodes delivered in rural counties beginning in March 2010. Margins did not vary significantly among subcategories of rural agencies (Table 9-9).

There did not appear to be a relationship between the share of episodes preceded by a hospitalization or PAC use and Medicare margins for most agencies, but agencies with the lowest share of posthospital or PAC episodes had lower margins than other quintile groups (Table 9-10). Agencies that admitted the fewest posthospital episodes (or, conversely, had the greatest share of community-admitted episodes) had an average margin of 14 percent. Margins for agencies that admitted higher shares of posthospital or PAC patients—those in the second through fifth quintiles—averaged margins of 19 percent to 21 percent. Agencies in Texas, a state with an aberrant pattern of utilization relative to national benchmarks, accounted for a disproportionate share of agencies in the first quintile of this measure.

The share of episodes qualifying for therapy payments (episodes with six or more therapy visits) is consistent with the Commission’s past conclusion that these episodes were overvalued under the case-mix system in effect in 2010 (Table 9-10). Agencies with the lowest share of these episodes had margins of 13 percent, while those with the highest share of these episodes averaged margins of 25 percent. Medicare made changes to the case-mix system that lowered payments for therapy episodes in 2012. Under the revised system, the margins for agencies in the lower quintiles would likely be higher and the margins for agencies in the upper quintiles would be lower.

There was also a limited relationship between the share of an agency’s episodes provided to beneficiaries dually eligible for Medicare and Medicaid and Medicare margins. Agencies with the highest share of dual eligibles (fifth quintile) had margins of 13 percent, while the margins averaged 20 percent to 21 percent for agencies in the first through fourth quintiles. Similar to results for the share of agencies preceded by a hospitalization or PAC use, agencies in Texas accounted for about one-third of the providers in the highest quintile.

Historically, Medicare margins have varied widely among HHAs. To better understand the factors driving this variation, in a prior analysis the Commission examined the characteristics of high-margin and low-margin agencies in 2007. The analysis concluded that the greatest difference between high-margin and low-margin agencies was the average cost per visit and that the quality of care and patient severity did not differ significantly among these two groups. Agencies with lower costs had better profit margins, suggesting that cost efficiency was an important determinant of agency profits (Medicare Payment Advisory Commission 2010).

**TABLE  
9-10**

**Medicare margins of freestanding home health agencies based on select characteristics, 2010**

	Average Medicare margin
All agencies	19%
Agencies ranked by share of episodes preceded by a hospitalization or PAC service (quintile)	
First (low share)	14
Second	20
Third	21
Fourth	20
Fifth (high share)	19
Agencies ranked by share of episodes qualifying for therapy payments (quintile)	
First (low share)	13
Second	16
Third	19
Fourth	21
Fifth (high share)	25
Agencies ranked by share of episodes provided to dual-eligible beneficiaries (quintile)	
First (low share)	20
Second	21
Third	21
Fourth	21
Fifth (high share)	13

Note: PAC (post-acute care). Table displays average Medicare margins for groups of agencies in each quintile. Each agency was assigned to a quintile by computing the share of its episodes with a given characteristic as a percentage of all of the agency’s episodes. Weighted Medicare margins were calculated for each agency group.

Source: MedPAC analysis of cost reports and CMS Datalink file.

**TABLE  
9-9**

**Medicare margins for subcategories of rural agencies, 2011**

Subcategory	Margin
Micropolitan	15.0%
Rural, adjacent to urban or micropolitan	15.2
Rural, not adjacent to urban or micropolitan	14.7

Note: A micropolitan county has a population of 10,000 to 50,000. Table excludes some rural agencies that lacked sufficient data for determining rural subcategory.

Source: MedPAC analysis of home health cost report files from CMS.

**Efficient HHAs serve patients similar to patients served by all other HHAs**

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 9-11, p. 204). The measure of cost is a risk-adjusted cost per episode, and the measure of quality is a risk-adjusted measure of hospitalization. Our approach categorizes an HHA as efficient if the agency is in the best third on at

**TABLE  
9-11**
**Performance of relatively efficient home health agencies, 2007-2009**

<b>Provider characteristics</b>	<b>All</b>	<b>Relatively efficient provider</b>	<b>All other providers</b>
Number of agencies	2,223	320	1,903
Share of for-profit agencies	66%	63%	67%
<b>Medicare margin</b>			
2010	19.4%	23.8%	18.5%
2009	18.7%	24.8%	17.6%
<b>Quality</b>			
Hospitalization rate (2009)	28%	23%	29%
<b>Costs and payments</b>			
Average payment per episode (2009)	\$2,815	\$2,803	\$2,817
Cost per visit, standardized for wages and CMI (2009)	132	115	135
<b>Visits per episode</b>			
Total visits per episode (2009)	17.5	16.8	17.6
<b>Share of visits by type</b>			
Skilled nursing visits	49%	52%	48%
Aide visits	15%	12%	16%
MSS visits	1%	1%	1%
Therapy visits	35%	35%	35%
<b>Size, 2009</b> (number of 60-day payment episodes)			
Mean	1,003	1,111	985
Median	575	714	552
<b>Share of episodes, 2009</b>			
Low-use episode	11%	12%	11%
Outlier episode	2%	2%	2%
Community-admitted episodes	58%	51%	60%
Therapy episodes	38%	38%	38%
<b>Share of agencies by region</b>			
New England	8%	10%	7%
Middle Atlantic	9%	11%	9%
South Atlantic	22%	17%	23%
East North Central	19%	13%	20%
East South Central	5%	2%	6%
West North Central	9%	9%	9%
West South Central	8%	1%	9%
Mountain	9%	9%	9%
Pacific	10%	27%	8%
<b>Beneficiary demographics, 2009</b>			
Share of episodes provided to dual eligible Medicare/Medicaid beneficiaries	31%	30%	31%
Average age	77.4	77.6	77.3
Share of episodes provided to rural beneficiaries	21%	13%	22%

Note: CMI (case-mix index), MSS (medical social services). A home health agency is classified as relatively efficient if it is in the best third of performance of quality or cost and is not in the bottom third of either measure for three consecutive years (2007-2009). 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 4 or fewer visits in a 60-day episode. Outlier episodes are those that received a very high number of visits and qualified for outlier payments. Community-admitted episodes are those episodes that were not preceded by a hospitalization or prior post-acute care stay. Therapy episodes are those with six or more therapy visits.

Source: Medicare cost reports and home health standard analytic file.

least one measure (either low cost per episode or a low hospitalization rate) and is not in the bottom third of the other measures for three consecutive years (2007–2009). About 14 percent of agencies met these criteria in this period.

The analysis indicates that relatively efficient HHAs can provide above-average quality while incurring below-average costs. Relatively efficient agencies had margins that were 6 percentage points to 7 percentage points higher with a hospitalization rate that was 20 percent lower compared with other HHAs, and the average cost per visit was 15 percent lower compared with other HHAs.<sup>10</sup> The median relatively efficient agency was larger than the median in the all-other-agency cohort. Relatively efficient HHAs provided about 0.8 fewer visit per episode but provided a similar mix of nursing, aide, therapist, and social work visits. Relatively efficient providers were also typically larger in size than other agencies.

The agencies had about the same share of high-cost outlier episodes and low-use episodes, suggesting they serve about the same share of beneficiaries at the extremes of utilization. Relatively efficient agencies had more episodes that were not preceded by a hospitalization but about the same share of episodes that qualified for additional therapy payments.

The Commission's criteria for identifying efficient providers exclude all providers operating in areas that have unusually high rates of utilization. Therefore, it is not surprising that relatively efficient agencies were found more frequently in areas with lower utilization, such as New England and the Pacific region. Areas of the country with questionable patterns of utilization—such as the South Atlantic, East South Central, and West South Central—accounted for a smaller share of agencies.

Relatively efficient agencies appear to serve beneficiaries with characteristics similar to those other agencies serve. The share of episodes provided to dual-eligible beneficiaries was similar. The mean beneficiary age was also similar for the two cohorts of agencies. A smaller share of the episodes provided by relatively efficient providers was for beneficiaries in rural areas.

The high margins of relatively efficient agencies reinforce that Medicare overpays for home health care. Relatively efficient agencies in 2009 had a Medicare margin about 40 percent higher than the margin for all other agencies. They were typically larger and had lower costs per visit, indicating some economies of scale. The relatively

efficient agencies achieved these profits even though they served mostly similar patients, provided a similar mix of services, and had about the same average payment per episode as other agencies. Average providers can achieve high margins in Medicare, but relatively efficient providers reap even higher profits.

### **Projecting margins for 2013**

In modeling 2013 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2011, and the year for which we are making margin predictions, 2013. The major changes are:

- payment updates in 2012 and 2013, equal to market basket minus 1 percent (per PPACA) for each year;
- reductions to account for coding improvements in 2011 (–3.79 percent) and 2012 (–1.32 percent);
- 3 percent add-on in effect for rural areas in 2012; and
- assumed episode growth of 0.5 percent a year for 2012 and 2013, higher than the trend for 2011.

On the basis of these policies and assumptions, the Commission projects a margin of 11.8 percent in 2013.

### **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 2001, the first year of PPS, 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 9-12, p. 206). By providing fewer visits than anticipated, HHAs were able to garner extremely high average payments relative to the services provided.

Margins have stayed high since 2001 because annual increases in payment have exceeded growth in costs. The Commission's review of the annual change in cost per episode suggests that cost growth has been minimal, typically less than 1 percent. In some years, a decline has been observed. Average payments per episode have generally increased from year to year, driven by market basket increases and increases in the average case-mix index.

**TABLE  
9-12****Medicare visits per full episode before and after implementation of PPS**

Type of visit	Visits per episode			Change in:	
	1998	2001	2011	1998-2001	2001-2011
Skilled nursing	14.1	10.5	9.5	-25%	-10%
Therapy (physical, occupational, and speech-language)	3.8	5.2	6.1	39	18
Home health aide	13.4	5.5	2.9	-59	-48
Medical social services	0.3	0.2	0.1	-36	-31
Total	31.6	21.4	18.6	-32	-13

Note: PPS (prospective payment system). The PPS was implemented in October 2000.

Source: Home health standard analytic file.

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 mandated some 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 government and the beneficiary; implementing the Commission's prior recommendation for rebasing would better align Medicare's payments with the actual costs of HHAs.

The need to reset the base rate in Medicare is particularly acute because high margins exist across the range of agency types. Urban, rural, for-profit, and nonprofit agencies have margins in excess of 12 percent. While some agencies have margins significantly lower than average, the Commission's review of agencies in 2007 found that these differences are primarily due to their

higher costs. These higher costs do not appear to be related to patient severity, as low-margin agencies, for most measures, did not serve more severely ill patients.

### How should Medicare payments change in 2014?

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 as well as address the high Medicare margins. These recommendations call for expanded efforts to fight fraud, improving beneficiary and provider incentives, and rebasing home health payments (see text box for a summary of recommendations from 2011 and 2012). ■



## 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 last year the Commission recommended that the Secretary exercise this new authority to curb fraud in home health care. So far, it does not appear that the Secretary has used this authority in any broad capacity. For many years, the Commission has published a list of counties with questionable utilization patterns (Table 9-6, p. 200). As the Commission recommended in our March 2011 report, these counties would be appropriate areas for the Secretary to exercise new PPACA authorities for investigating and interdicting home health fraud.

### **Implications 8-1**

#### **Spending**

- The Congressional Budget Office has already scored savings from the PPACA provision, so its baseline already assumes savings for the new authorities. 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 may encourage providers to deliver services even when they are unnecessary or of low value. Payments should be rebased as soon as 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 our 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 need to rebase is particularly acute because Medicare's coverage guidance for the home health care benefit is under revision. 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 deterioration of a patient's current condition. Until CMS revises the benefit manuals, specifies instructions, and trains claims contractors and providers, it is hard to estimate how this change will affect utilization. If these changes broaden access to care, then expenditures could increase.

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 in other Medicare services. It does not require extensive capital expenditures like facility-based providers, and many states do not require certificate-of-need analysis to establish a new home health agency.

*(continued next page)*

## Strengthening incentives for effective and efficient use of the home health benefit

### Implications 8-2

#### Spending

- This recommendation would reduce Medicare spending by \$750 million to \$2 billion in 2014 and by \$5 billion to \$10 billion over five years.

#### Beneficiary and provider

- Some reduction in provider supply is likely, particularly in areas that have experienced rapid growth in the number of providers. Access to appropriate care is likely to remain adequate, even if the supply of agencies declines.

### Recommendation 8-3, March 2011 report

**The Secretary should revise the home health case-mix system to rely on patient characteristics to set payment for therapy and nontherapy services and should no longer use the number of therapy visits as a payment factor.**

The Commission is concerned that Medicare's home health PPS encourages providers to base therapy regimens on financial incentives and not patient characteristics. The PPS uses the number of therapy visits provided in an episode as a payment factor: The more visits a provider delivers, the higher the payment. The higher payments obtained by meeting the visit thresholds have led providers to favor patients

who need therapy over patients who do not and have encouraged providers to deliver services that are of marginal value to a beneficiary. Our 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 approaches 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

*(continued next page)*

## Strengthening incentives for effective and efficient use of the home health benefit

is limited or nonexistent, and some evidence suggests that the additional services do not always contribute to better health. The lack of cost sharing is a particular concern for home health care, because PPS pays for care on a per episode basis that rewards additional volume. The lack of a cost-sharing requirement stands in contrast to most other Medicare services, which generally require the beneficiary to bear some of the costs of Medicare services.

One concern with cost sharing is that it can lead beneficiaries to reduce their use of effective as well as ineffective care. Although some studies have found evidence of adverse effects of reduced care due to cost sharing (Chandra et al. 2010, Rice and Matsuoka 2004), the RAND Health Insurance Experiment, concluded that, on average, nonelderly patients who consumed less health care because of cost sharing suffered no net adverse effects (Newhouse 1993). The Commission's review of the impact of medigap insurance generally found that beneficiaries with this insurance had higher total Medicare spending (Medicare Payment Advisory Commission 2009). The results of the RAND Health Insurance Experiment and the Commission's study suggest that a home health care copay would decrease utilization for home health care and result in lower overall Medicare spending.

To encourage appropriate utilization, the Commission recommended that Medicare add an

episode copayment for services not preceded by a hospitalization or other post-acute use.<sup>11</sup> The high rate of volume growth for these types of episodes, which have more than doubled since 2001, suggests there is significant potential for overuse. The addition of a copayment would allow for 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 by \$250 million to \$750 million in 2014 and by \$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

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- 1 The exceptions pertain to therapy services that require equipment that is not available in the home, such as whirlpool therapy and other treatments requiring specialized equipment.
- 2 Medicare pays for most services under the home health PPS through a bundled 60-day payment that does not have payment amounts for individual services. The per visit payment amounts for home health services indicated here have been estimated using a pro-rata share of the average full episode payment in 2010, \$2,877. This amount was divided among the different visit types (nursing, aide, therapy, and social work) based on each discipline's share of standardized costs in the average home health episode. Costs were standardized with the per visit payment amounts Medicare uses to reimburse episodes with fewer than five visits, referred to as the low utilization payment adjustment (LUPA). The LUPA rate is useful because it allows the weights for allocating the payment to each discipline to reflect the relative costliness of each discipline (i.e., that nursing is more costly than aide services). However, the payment levels included in the 60-day episode payment are set separately from the LUPA rates, so LUPA rates cannot be used as a proxy for the per visit amount assumed in the full 60-day payment.
- 3 Surety bond firms review the organizational and financial integrity of an HHA and agree to cover the Medicare obligations, up to a set amount, for those agencies that the surety bond firm believes are low risk.
- 4 Our measure of access is based on data collected and maintained as part of CMS's home health compare database as of November 2012. The service areas listed are 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 that did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.
- 5 Certificate-of-need laws vary from state to state, and not all states have them. In general, the laws require that an area have a demonstrated need for additional health care services before a new provider is permitted to enter the market.
- 6 In 2011, Medicare implemented a –3.79 adjustment to account for changes in agency coding practice that appeared unrelated to severity. PPACA also reduced the payment update by 1 percent and had a base rate reduction of 2.5 percent. The combined impact of all these adjustments lowered the 60-day episode payment rate by 5.2 percent.
- 7 The Commission's review of margins has generally found that larger agencies have higher margins, suggesting some economies of scale for HHAs. These economies, combined with Medicare's per unit payment system, suggest that agencies with higher episode volume can achieve higher profits.
- 8 Home health care users were categorized into PAC users and community-admitted users based on the share of their episodes in 2010 that were preceded by a hospitalization or other PAC use. Users with more than 50 percent of their episodes preceded by a hospitalization or PAC use were categorized as primarily PAC users; those with less than 50 percent of their episodes preceded by these events were categorized as primarily community-admitted users.
- 9 The home health care PPS includes additional payments for therapy at the 6th, 14th, and 20th therapy visits (with incremental increases in the intervals between these numbers). In 2011, CMS implemented a requirement that agencies conduct additional reviews shortly before the 14th and 20th therapy visits but made no similar requirement for the 6th therapy visit.
- 10 This risk-adjusted measure of hospitalization includes those that occur at the end of a home health stay or within 30 days of the end of a stay.
- 11 The recommendation applied only to full episodes—those that include five or more visits.

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CHAPTER

# 10

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**Inpatient rehabilitation  
facility services**

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## 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 2014.

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



## Inpatient rehabilitation facility services

### Chapter summary

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an injury, illness, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic devices, and speech–language pathology. In 2011, 1,165 IRFs treated over 371,000 Medicare fee-for-service (FFS) beneficiaries. Between 2010 and 2011, Medicare FFS payments for IRFs increased from \$6.14 billion to \$6.46 billion. In 2011, the number of beneficiaries 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 2011, with the number of cases and number of unique patients per 10,000 beneficiaries increasing.

- **Capacity and supply of providers**—The aggregate supply of IRFs declined slightly in 2011. While the total number of freestanding facilities increased slightly, the number of hospital-based facilities decreased by

### In this chapter

- Are Medicare payments adequate in 2013?
- How should Medicare payments change in 2014?

1.6 percent, for a total of 1,165 facilities in 2011. The number of rehabilitation beds declined moderately for both hospital-based and freestanding facilities (0.8 percent decline to about 35,250 beds), and the occupancy rate increased for both facility types (1.4 percent rise overall to 63.3 percent). While IRFs may offer the most intense program of rehabilitation services, they are not the sole providers of rehabilitation services in communities, with skilled nursing facilities (SNFs) and home health agencies as potential alternatives to beneficiaries with rehabilitation care needs. Despite the overall supply of IRF beds decreasing slightly, other measures such as low occupancy rates, growth in volume, and availability of other rehabilitation alternatives suggest that capacity remains adequate to meet demand.

- **Volume of services**—The volume of Medicare FFS beneficiaries treated in IRFs—as a measure of resources or services used—grew by about 3 percent in 2011.

**Quality of care**—Data suggest that quality of care across the IRF industry remained fairly stable between 2009 and 2010. Outcomes on a functional improvement measure increased from 26.7 points in 2009 to 27.4 points in 2010. Performance on two hospital readmission measures was roughly unchanged between 2009 and 2010; in 2010, the median rate of discharge to an acute care hospital was about 10 percent and the rate of hospital readmission within 30 days after discharge to the community was 12 percent. While performance decreased slightly on admission to a SNF within 30 days after discharge to the community (4.0 percent in 2010 compared with 3.6 percent in 2009), rates of discharge to the community improved moderately (71.1 percent in 2010 compared with 70.6 percent in 2009).

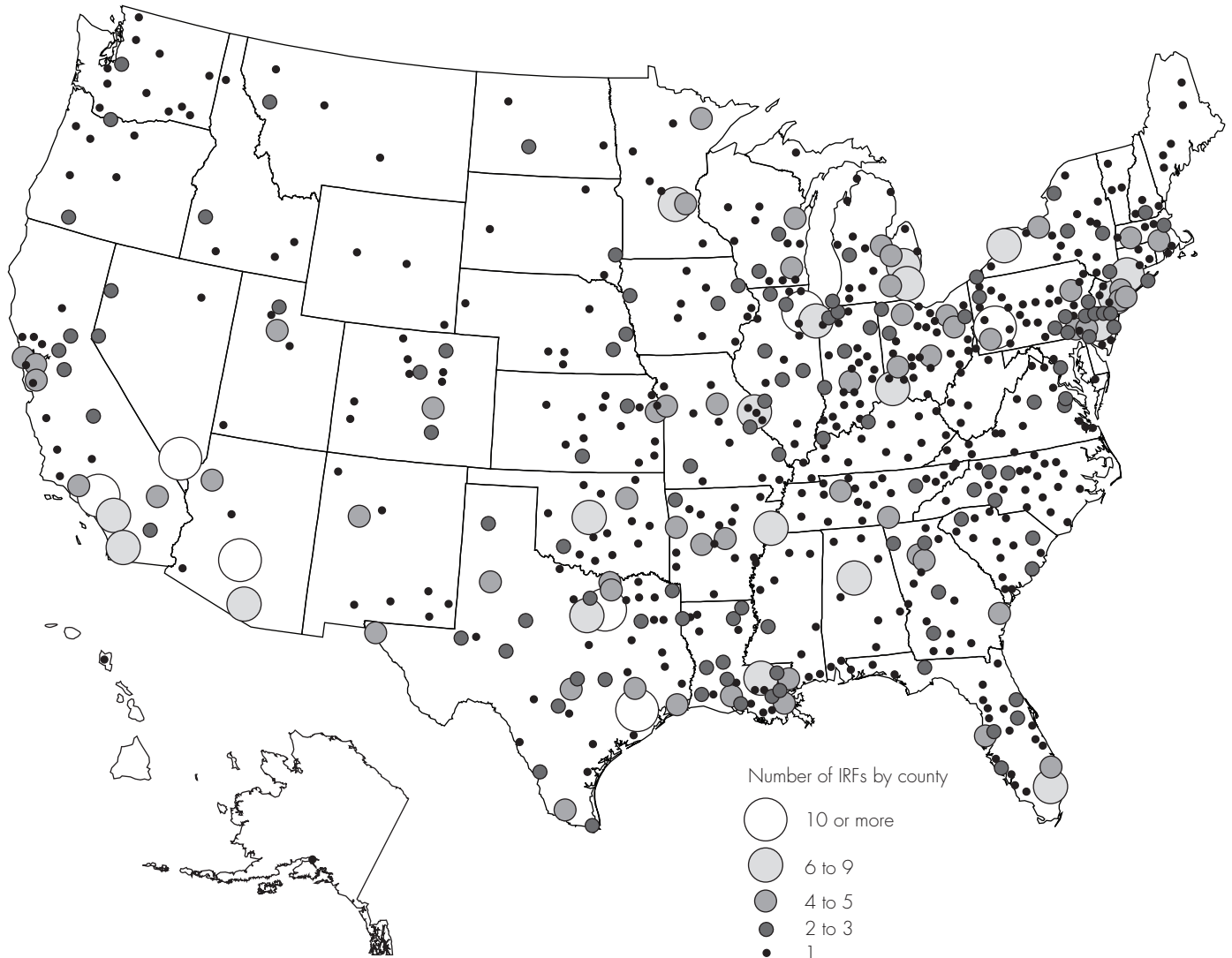
**Providers' access to capital**—Hospital-based IRF units access capital through their parent institutions, which have adequate access to capital. One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF Medicare revenues and 23 percent of revenues for the entire IRF industry has good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital.

**Medicare payments and providers' costs**—In 2011, Medicare payments per case to IRFs grew faster than costs per case; between 2010 and 2011, payments grew 2.5 percent compared with 1.6 percent for costs. The aggregate Medicare margin for IRFs in 2011 was 9.6 percent. We project a 2013 Medicare IRF margin of 8.5 percent.

On the basis of these indicators, the Commission 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 2014. ■

**FIGURE  
10-1**

**Geographic distribution of IRFs, 2011**



Note: IRF (inpatient rehabilitation facility).

Source: MedPAC analysis of 2011 Provider of Services 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 coordinated, multidisciplinary manner. For these services to qualify for Medicare coverage, the care for IRF patients must be supervised by a rehabilitation physician, use an interdisciplinary approach to care, and

address a documented clinical need for therapy in at least two disciplines. IRFs may be specialized units within an acute care hospital or specialized freestanding hospital, which tend to be larger. Approximately 80 percent of facilities are hospital-based units and 20 percent are freestanding. However, hospital-based units accounted for only 55 percent of Medicare discharges to IRFs in 2011.

In 2011, there were 1,165 IRFs in the United States, representing about 35,250 beds, with at least one in every state and the District of Columbia (Figure 10-1). In

**TABLE  
10-1**

**Medicare FFS spending, volume, and utilization for IRFs, 2002–2011**

	2002	2004	2006	2008	2009	2010	2011	Average annual change			Annual change
								2002–2004	2004–2008	2008–2010	2010–2011
Total Medicare spending (in billions)	\$4.97	\$6.58	\$6.22	\$5.93	\$6.03	\$6.14	\$6.46	15.1%	-2.6%	1.7%	5.2%
Number of cases	446,000	495,000	404,633	356,000	364,000	359,000	371,288	5.3	-7.9	0.4	3.3
Unique patients per 10,000 FFS beneficiaries	115.7	123.0	102.2	91.5	93.0	91.1	92.7	3.1	-7.1	-0.2	1.8
Payment per case	\$11,127	\$13,290	\$15,380	\$16,646	\$16,552	\$17,085	\$17,398	9.3	5.8	1.3	1.8
ALOS (in days)	13.2	12.7	13.0	13.3	13.1	13.1	13.0	-2.3	1.3	-0.8	-0.8

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 the person had multiple IRF admissions in that year. Previous analyses used data on total Medicare spending from the Office of the Actuary, rather than payment data from Medicare Provider Analysis and Review (MedPAR) files. Medicare hospital cost report data from CMS shows a 2.5 percent increase in average payment per case; source differences include accounting for settlements in the cost report data, slight time period differences, and completeness of data.

Source: MedPAC analysis of MedPAR data from CMS.

general, IRFs are concentrated in highly populated states that have large Medicare populations. Overall, 69 percent of beneficiaries live in a county that has at least one IRF: 31 percent of Medicare beneficiaries live in a county that does not have an IRF, while 25 percent of beneficiaries live in a county that has only one IRF, and 44 percent live in a county with two or more IRFs. However, IRFs are not the sole provider of rehabilitation services in communities; skilled nursing facilities (SNFs), home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers also furnish rehabilitation services. Given the number and distribution of these other rehabilitation therapy providers relative to IRFs, it is unlikely that many areas exist where IRFs are the only provider of rehabilitation therapy services available to Medicare beneficiaries.

In this chapter, our analysis includes only Medicare beneficiaries in the fee-for-service (FFS) program. 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, over 371,000 Medicare FFS beneficiaries received care in IRFs in 2011 (Table 10-1) with almost \$6.5 billion dollars in Medicare payments. Medicare is the principal payer for IRF services, accounting for 62 percent of total IRF discharges in 2011. Almost all IRF Medicare patients (95 percent) were admitted to an IRF directly from an acute care hospital in 2011. A small percentage of patients (2.4 percent) were admitted from a community setting, and the rest (2.6 percent) were admitted from other health care facilities, such as SNFs. Beneficiaries admitted to an IRF directly from the community must pay Medicare’s Part A inpatient hospital deductible, which is \$1,184 in 2013. With respect to patient demographics, most Medicare IRF patients in 2011 were White (81 percent) and female (58 percent), 10 percent were African American, and 4 percent were Hispanic. The demographic distribution of Medicare IRF patients is similar to the distribution in the general Medicare population (Medicare Payment Advisory Commission 2012a), although the proportion of Hispanic patients treated at IRFs is lower than in the general Medicare population (4 percent vs. 8 percent). Patients’ median age in 2011 was 77 years.

## Medicare IRF classification requirements and coverage criteria

To qualify as an IRF for Medicare payment, both freestanding and hospital-based facilities must meet the Medicare conditions of participation for acute care hospitals. They must also meet other classification criteria, which include:

- 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 inpatient rehabilitation who provides services 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.<sup>1</sup>

The compliance threshold mandates that a certain proportion of patients in each IRF must have specific diagnoses identified by CMS as typically requiring intensive inpatient rehabilitation. The intent of the compliance threshold, as well as the other classification criteria, is to distinguish IRFs from acute care hospitals for payment purposes. If an IRF does not meet the compliance threshold, Medicare will pay for all its cases on the basis of the inpatient prospective payment system (PPS) rather than at IRF discharge rates. From 1984 through 2004, the compliance threshold required that 75 percent of an IRF’s cases have 1 of 10 diagnoses. In 2002, CMS suspended enforcement of the rule because of inconsistent enforcement patterns among Medicare’s fiscal

intermediaries. In 2004, CMS revised the compliance threshold policy and enforcement in several ways: first, by increasing the number of conditions that count toward the threshold to 13 (by redefining the arthritis conditions that counted);<sup>2</sup> second, by clarifying that only a subset of patients with major joint replacement—a condition that was commonly treated in IRFs—counted toward the compliance threshold; and third, by enforcing IRFs’ compliance with the threshold consistently. The combination of not allowing most major joint replacement patients to count toward the threshold and renewed enforcement of the threshold resulted in a substantial decline in the volume of Medicare patients treated in IRFs after 2004. As volume declined, occupancy rates and the number of rehabilitation beds fell as well. Case-mix severity increased, however, as the IRF patient population shifted from less severe hip and knee patients to patients with more severe disorders who counted toward the threshold. Growth in cost per case increased as well—a function of greater patient severity (i.e., higher case-mix weight) and of the facilities’ fixed costs 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 in response to the compliance threshold. 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 types of cases to this intensive, costly setting.

Determining compliance can be complex. A case is first evaluated for compliance based on the impairment group code, a category that describes the primary reason for admission that is later used to assign a case to a case-mix group (CMG) for payment. If compliance cannot be determined based on the impairment group code, the case is evaluated for compliance based on the patient’s International Classification of Diseases, Ninth Revision, Clinical Modification (ICD–9–CM) codes (a billing system that classifies diseases and injuries). Guidelines list approximately 1,300 codes that could qualify a case as being associated with a compliant condition, and compliance is presumed if the ICD–9–CM code applies to either the “primary” impairment for which a patient is receiving rehabilitation or to a patient comorbidity.

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary. Revised coverage criteria, which became effective in January 2010, clarified which patients are appropriate to be treated in an IRF, when therapy must begin, and how and when beneficiaries are evaluated. Specifically:

- 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.
- An IRF admission for the purpose of assessing whether a patient is appropriate for IRF care is no longer covered and therapy must begin within 36 hours from midnight of the day of admission.
- The patient is sufficiently medically stable at the time of the IRF admission to be able to actively participate in intensive therapy.
- 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.

Revised process and documentation requirements were also effective January 2010 that addressed the timing and requirements for rehabilitation physician involvement in preadmission screening, postadmission evaluation, development of individualized care plans, and interdisciplinary team meetings.

### **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 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 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 (e.g., a stroke or burns) and their age and levels of functional and cognitive impairments. In each

CMG, patients are further categorized into one of four payment tiers based on certain comorbidities they may have that 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 has an adjustment that reflects the costliness of that tier's patients 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 receive lower payments for patients who are discharged 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 CMG 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://medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_IRF.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_12_IRF.pdf).

### **FFS Medicare spending trends for IRFs**

In 2011, FFS spending on IRFs increased by over 5 percent to \$6.46 billion, the highest level since 2006. Aggregate expenditures for IRF services in the Medicare FFS program grew after implementation of the PPS in 2002, when these expenditures totaled nearly \$5 billion; between 2002 and 2004, they grew at an average annual rate of 15.1 percent to about \$6.6 billion (Table 10-1, p. 218). Between 2005 and 2008, however, aggregate FFS expenditures for IRFs fell, as more beneficiaries enrolled in Medicare Advantage (MA) plans and as facilities adjusted to meet the compliance threshold that CMS reinstated in 2004. FFS expenditures also fell when CMS reduced IRF payments in 2006 and 2007 by 1.9 percent and 2.6 percent, respectively, to adjust for changes in IRF coding practices that CMS analyses determined did not reflect real changes in IRF patients' severity of illness. Aggregate FFS expenditures for IRF services increased in 2009 and 2010.

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### **Are Medicare payments adequate in 2013?**

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To assess whether payments for fiscal year 2013 are adequate to cover the costs that efficient providers incur and how much payments should change in fiscal year 2014, 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,

**TABLE  
10-2**

**Supply of hospital-based and nonprofit IRFs continued to decline in 2011, with total supply declining modestly**

Type of IRF	2004	2005	2006	2008	2009	2010	2011	Average annual change		Annual change
								2004–2008	2008–2010	2010–2011
All IRFs	1,221	1,235	1,225	1,202	1,196	1,179	1,165	-0.4%	-1.0%	-1.2%
Urban	1,024	1,027	1,018	1,001	992	981	972	-0.6	-1.0	-0.9
Rural	197	208	207	201	204	198	193	0.5	-0.7	-2.5
Freestanding	217	217	217	221	225	233	234	0.5	2.7	0.4
Hospital based	1,004	1,018	1,008	981	971	946	931	-0.6	-1.8	-1.6
Nonprofit	768	768	758	738	732	729	711	-1.0	-0.6	-2.5
For profit	292	305	299	291	295	294	294	-0.1	0.5	0.0
Government	161	162	168	173	169	156	158	1.8	-5.0	1.3

Note: IRF (inpatient rehabilitation facility). For all years, the rural/urban breakdown is by Core-Based Statistical Area (CBSA) definition. For 2011, two facilities are missing ownership data in the source file.

Source: MedPAC analysis of 2011 fourth quarter Provider of Services files from CMS.

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 are not able to determine the necessity of providing rehabilitation services in the more therapy-intensive IRF setting rather than another post-acute care setting for particular beneficiaries. However, our analysis of IRF supply and volume suggests that capacity remains adequate to meet demand.

**Capacity and supply: Number of IRFs, occupancy rates, and number of rehabilitation beds suggest adequate capacity**

The supply of IRFs has been declining since 2005, and the industry shrank by a net of 14 facilities between 2010 and 2011 (Table 10-2). Although 80 percent of IRFs are still hospital based, 2011 continued a trend of hospital-based facilities leaving the market and the number of freestanding facilities slowly increasing. Between 2006

and 2010, the number of freestanding IRFs increased by an average of 1.8 percent each year, and in 2011, there was a net increase of one facility. The number of nonprofit IRFs declined by 18 between 2010 and 2011 (a 2.5 percent decrease), the net result of a loss of two freestanding nonprofit IRFs and 16 hospital-based nonprofit IRFs. The number of for-profit IRFs remained the same between 2010 and 2011—the net result of a loss of one hospital-based for-profit IRF and a gain of one freestanding for-profit IRF. The supply of IRFs increased slightly after implementation of the IRF PPS in 2002 and peaked at 1,235 facilities in 2005.

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. 222). Occupancy rates increased from 62.4 percent in 2010 to 63.3 percent in 2011. In 2011, occupancy rates were higher for freestanding IRFs (68.3 percent) than for hospital-based IRFs (59.8 percent) and higher for IRFs in urban areas than in rural areas (64.5 percent and 49.6 percent, respectively). From 2002 through 2007, occupancy rates fell, with the decline accelerating in 2004 due to renewed enforcement of the compliance threshold. In 2008, occupancy rates began to rise again and increased overall since then by 1.2 percentage points as of 2011.

**TABLE  
10-3**

**IRF occupancy rates rose slightly in 2011**

Occupancy rates	2004	2006	2008	2009	2010	2011	Average annual change		Annual change
							2004-2008	2008-2010	2010-2011
All IRFs	67.8%	61.9%	62.1%	62.9%	62.4%	63.3%	-2.2%	0.2%	1.4%
Urban	69.0	63.0	63.4	64.0	63.6	64.5	-2.1	0.2	1.4
Rural	56.1	50.7	49.4	50.9	49.7	49.6	-3.1	0.3	-0.2
Hospital based	65.7	60.4	59.8	60.2	59.4	59.8	-2.3	-0.3	0.7
Freestanding	71.9	64.7	66.1	67.3	67.2	68.3	-2.1	0.8	1.6
Nonprofit	68.2	63.4	63.2	63.6	62.6	63.4	-1.9	-0.5	1.3
For profit	68.2	60.2	60.9	62.2	62.9	63.7	-2.8	1.6	1.3
Government	65.0	60.1	60.9	61.5	60.1	60.7	-1.6	-0.7	1.0
Number of beds									
1 to 10	55.2	49.5	51.6	49.6	49.9	51.6	-1.7	-1.7	3.4
11 to 21	63.2	58.7	57.5	57.5	56.3	56.5	-2.3	-1.0	0.4
22 to 59	68.1	61.5	61.2	62.7	62.8	63.2	-2.6	1.3	0.6
60 or more	71.1	65.4	66.8	67.3	66.6	67.6	-1.5	-0.1	1.5

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.

The total number of rehabilitation beds nationwide is another measure of IRF capacity. After increasing between 2002 and 2003, the number of IRF beds declined after 2004, as the industry adjusted to a decrease in the volume of cases due to renewed enforcement of the compliance threshold. Between 2004 and 2011, the number of beds declined by an average of 0.8 percent each year (Table 10-4). The decline in IRF beds from 2010 to 2011 was the result of a 1.1 percent decrease in hospital-based IRF beds and a 0.2 percent decrease in freestanding IRF beds.

**Volume of services: Volume of FFS patients in IRFs increased in 2011**

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 changes in MA enrollment and allows us to examine the prevalence of IRF use among Medicare FFS enrollees. This measure counts each user only once per year, regardless of whether the patient had multiple IRF admissions. Between 2002 and 2004, the number of cases and the number of patients per 10,000 FFS beneficiaries

grew, with the number of cases increasing by an annual average of 5.3 percent (Table 10-1, p. 218). However, volume declined substantially after 2004, as providers adjusted to renewed enforcement of the compliance threshold. From 2004 through 2008, the number of cases declined by an average of 7.9 percent each year; during the same period, the number of unique patients per 10,000 FFS beneficiaries declined by an annual average of 7.1 percent.

In 2008, the volume decline began to level off, coinciding with actions taken by the Congress in late 2007 to permanently cap the compliance threshold at 60 percent. Volume increased in 2009 but declined slightly in 2010. This decline may have been due, in part, to revised coverage criteria that went into effect in January 2010. The revised coverage criteria did not change but more clearly delineated which Medicare beneficiaries are appropriate for IRFs, potentially leading to different admission decisions for patients who would otherwise have been admitted before 2010. However, this decline did not continue in 2011: The number of cases grew by 3.3



**TABLE  
10-4**

**Number of IRF beds decreased slightly in 2011**

Type of bed	2004	2006	2008	2009	2010	2011	Average annual change		Annual change
							2004-2008	2008-2010	2010-2011
All IRFs	37,393	36,617	35,758	35,817	35,521	35,249	-1.1%	-0.3%	-0.8%
Hospital based	23,742	23,757	22,666	22,317	21,948	21,698	-1.2	-1.6	-1.1
Freestanding	13,650	12,861	13,092	13,500	13,573	13,551	-1.0	1.8	-0.2

Note: IRF (inpatient rehabilitation facility). Counts exclude data from Maryland, non-U.S. hospitals, and outliers. Number of beds is calculated by taking the total number of available bed days for all patients (not specific to Medicare) divided by the total number of days in the cost reporting period.

Source: MedPAC analysis of hospital cost report data and 2011 fourth quarter Provider of Services files from CMS.

percent and the number of unique patients per 10,000 FFS beneficiaries grew by 1.8 percent, both slightly higher than the growth in 2009.

**Changes in admission patterns and case mix**

If patients who need intensive rehabilitation services are able to obtain appropriate care in other settings, limitations to IRF availability due to the compliance threshold may not constitute an access problem. We analyzed changes in posthospital discharge destinations for patients likely

to need rehabilitation from 2004 through 2011. We found that among stroke cases, the share of hospital patients discharged to IRFs and other settings remained largely unchanged (Table 10-5). In contrast, for hip and knee replacement cases, a condition 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 between 2004 and 2011. Over the same period, the share of patients with hip and knee replacements discharged to SNFs and home

**TABLE  
10-5**

**Share of hospital discharges to IRFs has 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	2006	2008	2010	2011	2004-2011
Major joint replacement/hip and knee replacement	IRF	28%	20%	14%	12%	12%	-16
	SNF/swing bed	33	35	36	38	38	5
	Home health	21	27	30	32	31	10
	All other settings	18	18	19	19	19	1
Stroke	IRF	18	19	19	19	19	1
	SNF/swing bed	27	26	25	26	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.

**TABLE  
10-6****Compliance rate of Medicare IRF cases continued to meet 60 percent threshold in 2012**

	2004	2005	2006	2010	2011	2012
Estimated compliance rate of Medicare IRF cases	45.1%	55.6%	60.5%	61.6%	61.2%	60.3%

Note: IRF (inpatient rehabilitation facility). The data for 2012 are limited to discharges that occurred between January and June 2012. The compliance rate is the aggregate percent of IRF cases that fall into 1 of 13 CMS-specified conditions. As of July 2007, 60 percent of a facility's cases must fall into one of these conditions for Medicare to pay the facility as an IRF.

Source: MedPAC analysis of 2004 to 2012 data from eRehabData®.

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 Medicare 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 10-6).<sup>3</sup> In the first three years of renewed enforcement of the revised compliance threshold (2004–2006), the aggregate percentage of Medicare cases meeting the threshold increased rapidly from 45.1 percent to 60.5 percent. However, when MMSEA capped the compliance threshold permanently at 60 percent in 2007, the increase

in the compliance rate began to level off. The rate of compliance with the 60 percent threshold has been decreasing slightly since 2009 (62 percent); in 2011 and the first six months of 2012, the compliance rates were about 61 percent and 60 percent, respectively.

After 2004, the average case mix of IRF patients increased in severity most years, both for patients who counted toward the compliance threshold and for those who did not. On average, the cases that did not count toward the compliance threshold (noncompliant cases) were less complex than those that did (compliant cases), according to our analysis of proprietary data from eRehabData®. In 2004, the average relative payment weight for compliant cases was about 1.28, compared with about 0.90 for noncompliant cases. In 2012, the average relative payment

**TABLE  
10-7****IRF patient mix has changed, 2004–2012**

Type of case	Percent of IRF Medicare FFS cases						Percentage point change		
	2004	2006	2008	2010	2011	2012*	2004–2008	2008–2011	2011–2012
Stroke	16.6%	20.4%	20.4%	20.1%	19.6%	19.5%	3.9	–0.8	–0.1
Fracture of the lower extremity	13.1	16.1	16.0	14.3	13.8	13.2	3.0	–2.2	–0.6
Major joint replacement of the lower extremity	24.0	17.8	13.1	11.5	10.7	10.1	–10.9	–2.5	–0.6
Debility	6.1	6.2	9.1	10.0	10.3	9.9	3.0	1.2	–0.5
Neurological disorders	5.2	7.0	8.0	9.8	10.3	11.3	2.8	2.3	1.0
Brain injury	3.9	6.0	7.0	7.3	7.6	7.7	3.0	0.6	0.1
Other orthopedic conditions	5.1	5.2	6.1	6.7	7.1	7.5	0.9	1.1	0.4
Cardiac conditions	5.3	4.0	4.7	4.9	5.1	5.4	–0.6	0.5	0.3
Spinal cord injury	4.2	4.6	4.3	4.3	4.5	4.5	0.1	0.1	0.1
Other	16.4	12.8	11.3	11.1	11.0	10.9	–5.1	–0.4	–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 2012.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instruments from CMS for 2004–2011, and January 1 through June 30, 2012.

weight for compliant cases was 1.39, compared with 1.10 for noncompliant cases.

As IRFs have adjusted their patient admission patterns to meet the revised compliance threshold, the average residual case-mix severity of the Medicare FFS IRF population has increased; the largest increases in case mix occurred during the first three years of renewed enforcement of the revised compliance threshold. The average annual increase in case mix was 4.5 percent from 2005 to 2007.<sup>4</sup> After the compliance threshold was capped at 60 percent in 2007, the increase in patient severity slowed and case mix increased in 2008 and 2009 by about 2 percent in each year. The increase in patient severity slowed further between 2010 and 2011, with an increase of 0.3 percent (case mix of 1.29 in 2011) and an increase of 1.1 percent between 2011 and the first six months of 2012 (a case mix of 1.30 in 2012). In addition, the average length of stay for Medicare FFS IRF patients in 2011 was 13 days, which has changed little since 2009 (Table 10-1, p. 218). The stability in the average length of stay may reflect IRFs' increasing experience with managing their current patient mix.

The change in case mix over time is reflected in the shifting pattern of diagnoses admitted to IRFs among Medicare cases since 2004 (Table 10-7). The share of major joint replacements of the lower extremity fell by 13.9 percentage points between 2004 and the first half of 2012, 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 increased, such as stroke, brain injury, and neurological disorders. Since 2004, the shares of debility cases and other orthopedic conditions also increased by 3.8 percentage points and 2.4 percentage points, respectively. The growth in debility cases and other orthopedic conditions is more surprising, because neither is among the 13 conditions included in the compliance threshold.

Between 2011 and the first half of 2012, the distribution of case type remained relatively stable. The share of neurological disorders increased by 1.0 percentage point. Other case types changed by less than 1.0 percentage point. Debility decreased slightly. The shares of fracture and major joint replacement of the lower extremity both decreased slightly, although other orthopedic conditions increased slightly.

**TABLE  
10-8**

**Top 10 types of cases  
in hospital-based and  
freestanding IRFs, 2011**

Type of case	Type of IRF	
	Hospital based	Freestanding
Stroke	21%	16%
Fracture of the lower extremity	14	12
Major joint replacement of the lower extremity	11	10
Neurological disorders	7	13
Brain injury	8	7
Other orthopedic conditions	5	9
Cardiac conditions	5	5
Spinal cord injury	5	4
Miscellaneous	12	13
Short-stay patients*	4	4

Note: IRF (inpatient rehabilitation facility).  
\*The short-stay category includes patients who expired while in the IRF.

Source: MedPAC analysis of 2011 Medicare claims data.

Hospital-based and freestanding IRFs have relatively similar Medicare patient populations (Table 10-8). In 2011, the top 10 types of cases were the same for both facility types, and they accounted for 92 percent and 93 percent of cases in hospital-based IRFs and freestanding IRFs, respectively. Some of these conditions do not count toward the compliance threshold (miscellaneous, major joint replacement of the lower extremity, other orthopedic conditions, and cardiac conditions). Although the 10 most common conditions were the same for hospital-based IRFs and freestanding IRFs, the distribution of those cases differed somewhat. Stroke patients constituted a smaller share of freestanding IRF cases than of hospital-based IRF cases (16 percent and 21 percent, respectively), while patients with neurological disorders constituted a larger share of freestanding IRF cases than of hospital-based IRF cases (13 percent and 7 percent, respectively). Other orthopedic conditions, which do not count toward the compliance threshold, also accounted for a larger share of total cases in freestanding IRFs than in hospital-based IRFs (9 percent and 5 percent, respectively).

In addition to case type, the tier level within each CMG reflects another measure of patient severity. Tier 1 reflects

**TABLE  
10-9**

**Distribution of IRF cases by case-mix group tier, 2011**

Tier	Type of IRF	
	Hospital based	Freestanding
1	4%	4%
2	7	9
3	26	28
4 (no comorbidities)	62	59

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. Numbers may not sum to 100 percent due to rounding.

Source: MedPAC analysis of 2011 Medicare claims data.

the costliest patients (i.e., it has the highest relative weight); the tiers descend in costliness through tier 4, which reflects the least costly patients—those who do not have any of the comorbidities identified to increase the cost of care. The distribution of Medicare IRF cases by tier is fairly consistent for hospital-based IRFs and freestanding IRFs, although freestanding IRFs have slightly higher proportions of patients in the more costly tiers (Table 10-9). Approximately 60 percent of cases in both hospital-based IRFs and freestanding IRFs are in tier 4 and do not have a specific comorbidity identified as increasing the cost of care, although hospital-based IRFs have a slightly larger share of tier 4 cases (62 percent compared with 59 percent for freestanding IRFs).

**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 because of the compliance threshold. Overall, research studies do not conclusively identify one post-acute care setting as having better outcomes for rehabilitation patients. A 2010 CMS report to the Congress (Gage et al. 2010) analyzed peer-reviewed research on the effectiveness of IRFs compared with other post-acute care settings and concluded that the studies comparing outcomes in IRFs with outcomes in other post-acute care settings were limited because they did not adequately control for selection bias. 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 appropriate for many patients across sites of care, such as readmission to the hospital and improvements in two functional measures, mobility and self-care function. The 2011 report summarizing the findings (Centers for Medicare & Medicaid Services 2012, Gage et al. 2011) compared outcomes among home health agencies, IRFs, long-term care hospitals (LTCHs), and SNFs. Results indicated that unadjusted readmission rates did not vary greatly among settings, although IRFs had the lowest rate and LTCHs had the highest rate among the settings. Risk-adjusted rates that controlled for differences in patient severity of illness did not differ among IRFs, SNFs, and home health agencies (patients served by LTCHs had a lower risk-adjusted rate of readmission than SNF patients). On functional outcomes, IRF patients had the greatest average improvement in mobility and self-care function, unadjusted for patient severity at admission. The risk-adjusted analysis found no significant difference in the average degree of improvement in mobility but a slightly 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 study examined improvement in self-care for the subgroups of patients with musculoskeletal or nervous system conditions, two conditions that typically receive significant amounts of therapy. For nervous system conditions, the average risk-adjusted gain in self-care improvement was higher in IRFs than in SNFs. In contrast, for musculoskeletal conditions, there was no significant difference in the risk-adjusted degree of improvement among LTCH, IRF, and SNF patients (the average improvement was greater for home health patients than for SNF patients).

When 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 appear to have better improvement in self-care outcomes, but

unobserved factors regarding patient characteristics can also influence 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 that are not included in the model, such as informal caregiver support, can influence both the likelihood of referral to home health care and the outcomes.

### Quality of care: Risk-adjusted measures show relative stability

We measured IRF quality through the following metrics: Functional Independence Measure™ (FIM™) gain, rates of discharge to the community, rates of discharge from an IRF to an acute care hospital, admission to a SNF within 30 days of discharge to the community, and admission to an acute care hospital for any reason within 30 days of discharge to the community. The latter two measures are restricted to beneficiaries who were initially discharged home and then admitted to a SNF or readmitted to an acute care hospital. Acute hospital readmission measures include all-cause readmissions and do not account for planned readmissions. FIM gain is the total difference between admission scores and discharge scores for a range of items addressing functional improvement on the IRF–Patient Assessment Instrument.<sup>5</sup>

Our analysis suggests that quality of care across the IRF industry remained fairly stable between 2009 and 2010. FIM gain increased from 26.7 points in 2009 to 27.4 points in 2010 (Table 10-10). Performance on both of the hospital readmission measures remained fairly unchanged between 2009 and 2010. For 2010, the median rate of discharge to an acute care hospital was 10.3 percent and the rate of hospital readmission within 30 days after discharge to the community was 12.0 percent. Performance decreased slightly on admission to a SNF within 30 days after discharge to the community (from 3.6 percent in 2009 to 4.0 percent in 2010), while rates of discharge to the community improved moderately (from 70.6 percent in 2009 to 71.1 percent in 2010). These outcomes do not control for population changes between 2009 and 2010, although the increase in case-mix severity was slight.

Our March 2012 report presented an analysis of IRF industry performance on risk-adjusted quality measures, evaluating improvement between 2004 and 2009 (Medicare Payment Advisory Commission 2012b). To control for large changes in patient mix over the time

**TABLE 10-10** IRF quality of care is relatively stable

	2009	2010
FIM™ gain	26.7	27.4
Discharge to community	70.6%	71.1%
Discharge to acute care hospital	10.4%	10.3%
Hospital readmission within 30 days after discharge to community	12.0%	12.0%
SNF admission within 30 days after discharge to community	3.6%	4.0%

Note: IRF (inpatient rehabilitation facility), FIM™ (Functional Independence Measure™), SNF (skilled nursing facility). FIM gain is the difference between the FIM on the IRF–Patient Assessment Instrument (IRF–PAI) between admission and discharge. The risk-adjustment models controlled for patient demographics; patients’ Impairment Group Code at admission (indicates a patient’s medical condition); prior admission to an IRF; admission to the IRF from the community; certain comorbidities that have been shown in the literature to be predictive of hospital charges, length of stay, and patient health outcomes; and certain complications present at admission to an acute care hospital. Models are preliminary and may be further refined in the future.

Source: RAND analysis of the IRF–PAI, Medicare Provider Analysis and Review file, denominator file, and Provider of Services file.

period, the analysis adjusted performance outcomes using a risk-adjustment model that held the 2004 Medicare IRF patient cohort constant through 2009. The analysis found that adjusted quality improved for all measures over this time period. In the present analysis, the risk-adjustment model does not hold constant the Medicare patient cohort. Due to the relative stability in case-mix index in recent years, quality outcomes can be meaningfully compared between 2009 and 2010 without the controls needed for a longer historic analysis. The models are preliminary and may be further refined in the future.

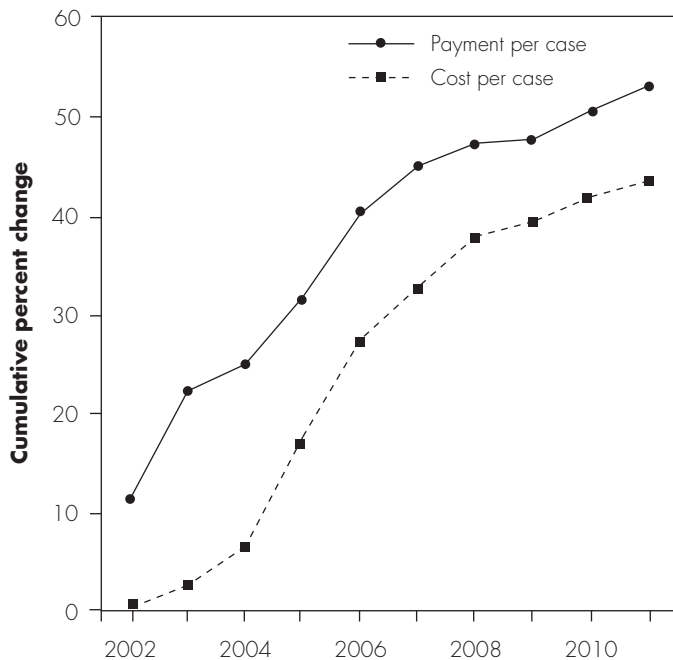
### Providers’ access to capital: IRFs appear to have adequate access to capital

Eighty percent of IRFs are hospital-based units that access capital through their parent institution. As detailed in Chapter 3 of this report, hospitals have overall maintained reasonable levels of access to capital in 2011, in part due to historically low interest rates. Spending on hospital construction projects moderated somewhat in 2011 but remained high, and industry consolidation increased.

As for freestanding IRFs, market analysts we spoke with thought that access to capital for one major national chain

**FIGURE  
10-2**

**Under the PPS, IRFs' payments per case have increased cumulatively more than costs, 2002-2011**



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.

remains good. Its ability to borrow has increased, largely due to improving credit markets and the chain's strong operating performance. Besides this chain, most other freestanding facilities are independent or local chains with only a few providers (for profit or nonprofit). The extent to which these providers have access to capital is not clear.

**Medicare payments and providers' costs: Since 2002 PPS implementation, payments to IRFs have grown faster than costs**

Since implementation of the PPS in 2002, Medicare's payments per case to IRFs have cumulatively increased more than IRFs' costs per case, although in most years from 2004 to 2010, costs per case grew faster than payments (Figure 10-2). According to Medicare cost reports, between 2010 and 2011, payments per case increased more than costs per case did (2.5 percent payment growth compared with 1.6 percent cost growth). Payments also increased more than costs in 2010, the first year since 2003 that average payments grew more than average costs.

Costs per case grew rapidly between 2004 and 2006, as revisions to the compliance threshold resulted in IRFs' fixed costs being spread over fewer cases, and patient severity increased. Cost growth slowed after 2006, as patient volume steadied. The average Medicare payment per case grew 56 percent between 2002 and 2011 (Table 10-1, p. 218). While payments per case grew by an annual average of 9.3 percent between the first two years of the PPS (2002-2004), the average payment per case fell between 2008 and 2009 because of a zero payment update in 2009, as required by MMSEA, and CMS's adjustment of the 2009 outlier threshold.

**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. In 2011, the mean adjusted cost per discharge for all IRFs was \$15,822 (Table 10-11). On average, after adjustment, costs per discharge in

**TABLE  
10-11**

**Mean adjusted costs per discharge are lower for freestanding IRFs and larger facilities, 2011**

Type of IRF	Mean adjusted cost per discharge
All IRFs	\$15,822
Hospital based	16,725
Freestanding	12,388
Nonprofit	15,979
For profit	14,767
Government	17,837
Urban	15,300
Rural	18,567
Number of beds	
1 to 10	17,854
11 to 21	17,303
22 to 59	15,097
60 or more	12,538

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 2011 standard analytical file and Medicare cost report data from CMS.

freestanding IRFs were about \$4,340 lower (26 percent) than in hospital-based IRFs, and costs per discharge in urban IRFs were approximately \$3,270 (18 percent) lower than in rural IRFs. Larger facilities have lower costs per discharge, which likely results from economies of scale. In 2011, costs per discharge were \$5,320 (29 percent) lower in facilities with more than 60 beds compared with 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 10-12) for 2011. Nearly all facilities (about 96 percent) in the highest cost quartile were hospital based, whereas facilities in the lowest cost quartile were disproportionately freestanding (about 56 percent were freestanding even though they make up only 20 percent of industry facilities). 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 beds compared with the highest cost quartile's median of 17 beds. The median occupancy rate for IRFs in the lowest cost quartile was 71 percent, while the rate in the highest cost quartile was 51 percent. Case mix varied only slightly across quartiles, suggesting that number of beds and occupancy rates rather than case mix accounted for lower costs per discharge. The median Medicare margins reflect the differences in adjusted costs: The median margin for IRFs in the lowest cost quartile of costs was about 25 percent compared with -26 percent for IRFs in the highest cost quartile.

### IRF Medicare margins increased in 2011

Between 2010 and 2011, aggregate IRF Medicare margins increased from 8.7 percent to 9.6 percent (Table 10-13, p. 230). 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 from 2004 through 2009, although they remained healthy. Margins rose moderately in 2010 and 2011.

As in other Medicare sectors, margins varied substantially across providers. Medicare margins in freestanding IRFs far exceed those of hospital-based facilities. In 2011, margins for freestanding IRFs (45 percent of discharges) increased to 22.9 percent, while hospital-based IRFs (55 percent of discharges) had margins of -0.8 percent. It was the second year of negative margins for hospital-based facilities. Aggregate margins in for-profit facilities were 21.3 percent in 2011, while nonprofit IRFs had margins

**TABLE  
10-12**

### Higher number of beds and occupancy rates are characteristics of IRFs in the low-cost quartile of standardized costs, 2011

Characteristic	Quartile	
	Low cost	High cost
Number of IRFs	247	247
Percent:		
Hospital based	43.7%	95.6%
Freestanding	56.3	4.5
Nonprofit	39.7	62.4
For profit	57.5	18.6
Government	2.8	19.0
Urban	93.5	67.6
Rural	6.5	32.4
Median:		
Medicare margin	24.5%	-26.4%
Number of beds	42	17
Occupancy rate	71%	51%
Case-mix index	1.25	1.20

Note: IRF (inpatient rehabilitation facility). Costs per discharge are 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 2011 standard analytical file and Medicare cost report data from CMS.

of 2.0 percent. However, margins by ownership status varied by facility type. Among freestanding facilities, for-profit IRFs had margins of 25.3 percent, while nonprofit facilities had margins of 14.8 percent. Among hospital-based IRFs, nonprofits had margins of -0.9 percent, while hospital-based for-profit IRFs had margins of 3.9 percent. Between 2010 and 2011, total (all-payer) margins for freestanding facilities increased from 10.2 percent to 11.9 percent.<sup>6</sup>

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 (57 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.

**TABLE  
10-13****IRFs' Medicare margins rose in 2011, but vary by type of facility**

Type of IRF	Share of Medicare discharges	Margins					
		2004	2006	2008	2009	2010	2011
All IRFs	100%	16.7%	12.4%	9.5%	8.4%	8.7%	9.6%
Urban	91.4	17.0	12.6	9.7	8.6	9.1	10.3
Rural	8.6	13.9	10.6	7.6	6.3	5.4	5.7
Freestanding	44.6	24.7	17.5	18.2	20.3	21.4	22.9
Hospital based	55.4	12.2	9.6	4.1	0.3	-0.3	-0.8
Nonprofit	53.7	12.8	10.7	5.6	2.3	2.0	2.0
For profit	36.6	24.4	16.3	16.7	19.0	19.7	21.3
Government	9.5	N/A	N/A	N/A	N/A	N/A	N/A
Number of beds							
1 to 10	2.6	3.4	-3.8	-4.9	-11.6	-10.3	-7.1
11 to 21	18.3	9.6	7.0	0.7	-2.6	-3.2	-3.8
22 to 59	41.3	16.1	12.4	8.5	6.5	6.9	7.8
60 or more	37.7	22.6	17.5	17.1	18.3	18.5	19.4

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.

Analysis of changes in component costs shows that freestanding facilities have contained cost growth more than hospital-based facilities have, particularly growth in routine costs, which include room and board and nursing (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, drugs, and other supplies, and for 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.

Although in 2010 hospital-based IRFs averaged a -0.3 percent margin, in aggregate, the Medicare payments for hospital-based IRFs were 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 an IRF unit than in hospitals without one. In 2011, Medicare margins for inpatient hospitals with an IRF unit averaged -3.6 percent compared with -5.2 percent for hospitals without an IRF unit, which suggests that IRF units were able to make positive financial contributions to their parent hospitals.

### Medicare margins for 2013

To project the aggregate Medicare margin for 2013, we model the policy changes that went into effect in 2012 and 2013. These policies include:

- an average payment rate increase of 2.2 percent in fiscal year 2012, the net result of a 2.9 percent market basket increase, an estimated 0.4 percent payment



increase for changes in the outlier threshold, a -0.1 percentage point budget adjustment per the Patient Protection and Affordable Care Act of 2010 (PPACA), and a -1.0 percentage point reduction for productivity per PPACA; and

- an average payment rate increase of 2.1 percent in fiscal year 2013, the net result of a 2.7 percent market basket increase, an estimated 0.2 percent payment increase for changes in the outlier threshold, a -0.1 percentage point budget adjustment per PPACA, and a -0.7 percentage point reduction for productivity per PPACA.

We project that the aggregate Medicare margin between 2011 and 2013 will decline from 9.6 percent to 8.5 percent. The margin projection for 2013 assumes that costs will increase by the market basket and 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 2014?

### RECOMMENDATION 10

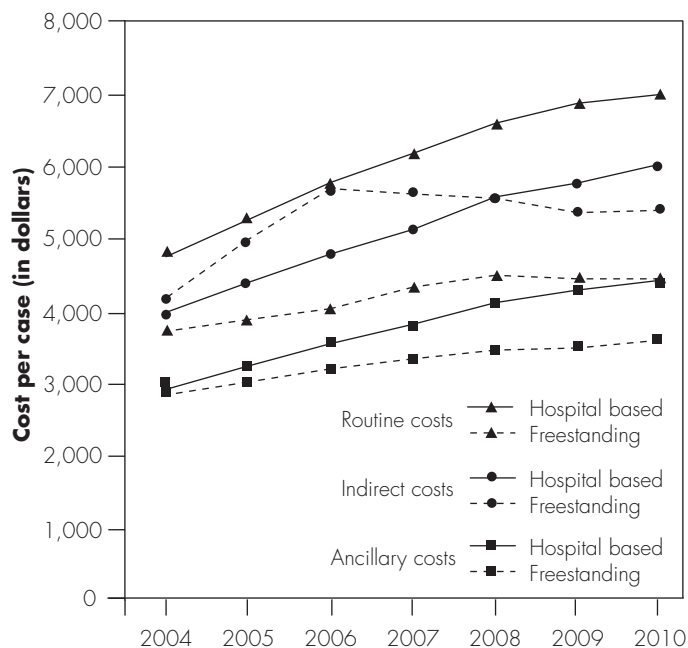
**The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2014.**

### RATIONALE 10

Our indicators of Medicare payment adequacy for IRFs are positive. Despite the overall supply of IRF beds decreasing slightly, other measures such as low occupancy rates, growth in volume, and availability of other rehabilitation alternatives suggest that capacity remains adequate to meet demand. In 2011, spending increased by 5.2 percent, and margins averaged 23 percent for freestanding facilities, which tend to have lower costs. Risk-adjusted quality of care remained stable, and access to credit appears adequate for both hospital-based and freestanding IRFs. Finally, we calculate a margin of 9.6 percent in 2011 and project a margin of 8.5 percent for 2013. On the basis of our assessment of the indicators of payment adequacy, we conclude that IRFs should be able to accommodate cost changes in fiscal year 2014 with payments held at 2013 levels. 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.

**FIGURE 10-3**

### Growth in component costs by IRF type, 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.

### IMPLICATIONS 10

#### Spending

- The payment update for IRFs under current law in fiscal year 2014 consists of a forecasted 2.7 percent market basket increase for rehabilitation, psychiatric, and long-term care hospitals; a forecasted -0.5 percent productivity adjustment; and a -0.3 percent budget adjustment per PPACA.<sup>7</sup> This recommendation would decrease federal program spending relative to current law by between \$50 million and \$250 million in 2014 and by less than \$1 billion over five years.

#### Beneficiary and provider

- We do not expect this recommendation to have adverse effects on Medicare beneficiaries with respect to access to care or out-of-pocket spending. This recommendation may increase the financial pressure on some providers, but, overall, a minimal effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries is expected. ■

## Endnotes

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- 1 This rule does not take the place of Medicare’s general medical necessity requirements.
- 2 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; and hip or knee replacement when bilateral, body mass index  $\geq 50$ , or age 85 or older. These conditions may count toward an IRF meeting the compliance threshold if they are being actively treated in conjunction with the condition that is the primary cause for admission.
- 3 The proprietary data come from eRehabdata<sup>®</sup>, which has data on a subset of IRFs that subscribe to their inpatient rehabilitation outcomes system. eRehabdata has developed a protocol to assess whether a case satisfies the compliance threshold.
- 4 Source: MedPAC analysis of the Inpatient Rehabilitation Facility–Patient Assessment Instrument. Annual percent changes in average case mix are for the first half of one year to the first half of the following year.
- 5 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.
- 6 All-payer margins for hospital-based facilities reflect the total margins for the entire hospital rather than for the IRF unit alone. Therefore, we present all-payer margins only for freestanding facilities.
- 7 The market basket forecast and productivity adjustment were made in the third quarter of 2012. 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

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**Long-term care  
hospital services**

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**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 2014.

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

## Long-term care hospital services

### Chapter summary

Long-term care hospitals (LTCHs) furnish care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals, and its Medicare patients must have an average length of stay greater than 25 days. In 2011, Medicare spent \$5.4 billion on care furnished in 424 LTCHs nationwide. About 123,000 beneficiaries had almost 140,000 LTCH stays. On average, Medicare accounts for about two-thirds of LTCHs' discharges.

### 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.

- **Capacity and supply of providers**—In spite of the moratorium imposed by the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) and subsequent amendments, the number of LTCHs filing Medicare cost reports increased 9.3 percent between 2008 and 2011.
- **Volume of services**—Controlling for growth in the number of fee-for-service beneficiaries, we found that the number of LTCH cases rose 2.8 percent between 2010 and 2011, suggesting that access to care increased during this period.

### In this chapter

- Are Medicare payments adequate in 2013?
- How should Medicare payments change in 2014?

***Quality of care***—LTCHs only recently began submitting quality data to CMS. Those data are not yet available for analysis. Using claims data, we found stable or declining rates of readmission, death in the LTCH, and death within 30 days of discharge for almost all of the top 25 diagnoses in 2011.

***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, a moratorium imposed by the MMSEA and subsequent amendments 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, it is unclear whether LTCH companies will act quickly to open new facilities or proceed cautiously, given the continued scrutiny of Medicare spending on LTCH care. Companies may opt to focus on relatively low-risk capital investment, such as bed expansions.

***Medicare payments and providers' costs***—Between 2008 and 2009, growth in payments per case accelerated to 5.5 percent, more than twice as much as the growth in costs. This surge was due in part to congressional actions that halted or rolled back the implementation of CMS regulations designed to address overpayments to LTCHs. Between 2009 and 2011, growth in payments slowed to an average of 1.6 percent per year, while growth in costs increased less than 1 percent per year. In 2011, the aggregate LTCH margin rose to 6.9 percent. With the expiration of legislative provisions offering temporary relief from some of CMS's payment regulations, payment growth is likely to slow. We expect that LTCHs will continue to constrain their costs and project that cost growth will be modest—roughly similar to the latest forecast of the market basket for 2013 of 2.6 percent. We estimate that LTCHs' aggregate Medicare margin will be 5.9 percent in 2013. ■



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## Background

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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 relatively 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). These facilities can be freestanding or co-located 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.<sup>1</sup> Because of the relatively long stays and the level of care provided, care in LTCHs is expensive. In 2011, Medicare’s average payment per case was almost \$39,000. In total, Medicare spent \$5.4 billion on care provided in an estimated 424 LTCHs nationwide. About 123,000 beneficiaries had almost 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.<sup>2</sup> 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 based primarily on 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.<sup>3</sup> 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. 242–243).

As medical technologies have advanced, researchers and clinicians have noted the growing prevalence of CCI patients (Carson et al. 2008, Macintyre 2012, Nelson et

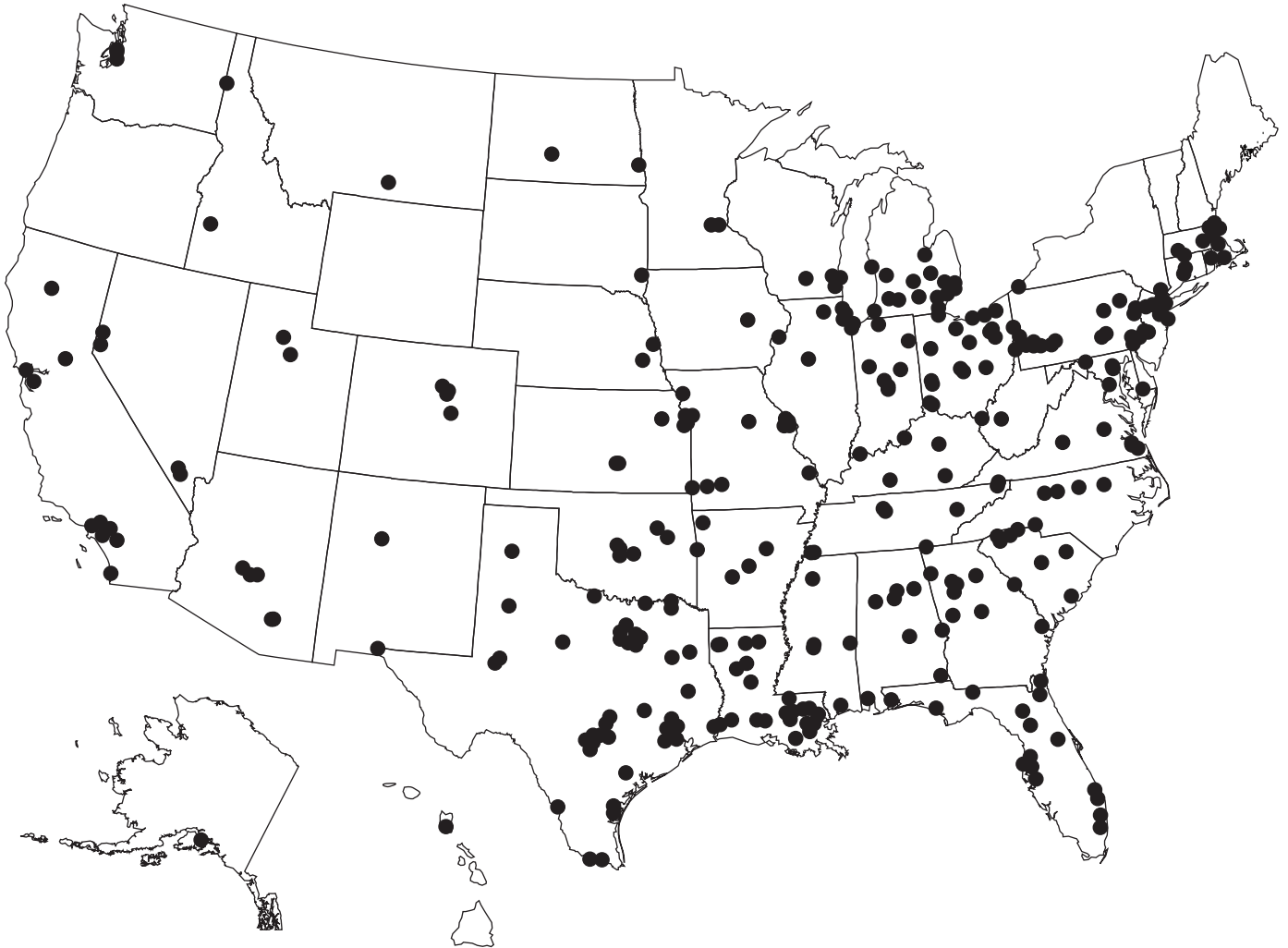
al. 2010, Zilberberg et al. 2012, Zilberberg et al. 2008) (see text box, pp. 245–246). CCI patients often require prolonged mechanical ventilation (PMV); as a result, many studies of the CCI population have used the need for PMV as a defining characteristic. The Commission’s analysis of claims data found that 19 percent of LTCH patients used at least one ventilator-related service in 2011. Another way researchers define this patient population is by the extended use of intensive care services. Our analysis of ACH claims from 2010 found that 5.7 percent of cases spent eight or more days in an intensive care unit (ICU) or cardiac care unit (CCU), and almost half of these cases went on to use an institutional provider of post-acute care, such as a skilled nursing facility (SNF), an inpatient rehabilitation facility (IRF), or an LTCH.<sup>4</sup> Nationwide, 12 percent of the CCI cases discharged to institutional post-acute care providers used an LTCH, but use is higher in states with high concentrations of LTCH beds.<sup>5</sup> In Louisiana and Massachusetts, about a third of CCI cases discharged to post-acute care had an LTCH stay. In Texas and Nevada, one-quarter of CCI cases discharged to post-acute care used an LTCH.

Most CCI patients remain in the ACH for long periods until they can be transferred to a lower level of care. Nevertheless, 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, though the overall number of Medicare admissions to ACH ICUs fell 14 percent between 1997 and 2006, the number of Medicare ICU patients discharged to LTCHs almost tripled (Kahn et al. 2010).<sup>6</sup>

The number of LTCHs has grown in concert. Indeed, between 1990 and 2005, LTCHs were one of the fastest growing providers in the Medicare program. 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 existed instead of in markets with few or no direct competitors. As a result, LTCHs are not distributed evenly across the country (Figure 11-1, p. 240). Some areas have no LTCHs, underscoring the fact that medically complex patients can be treated appropriately in other settings.<sup>7</sup> At the same time, some areas have many LTCHs. This concentration has financial implications for the Medicare program because an oversupply of LTCH beds may result in admissions to LTCHs of less complex cases that could appropriately be treated in less costly settings. Commission analysis of LTCH claims from 2010 found that, in markets where LTCHs are used most frequently,

**FIGURE  
11-1**

**Long-term care hospitals are not distributed evenly across the nation, 2011**



Source: MedPAC analysis of cost report data from CMS.

the average LTCH case mix was lower than in markets where LTCHs are used less often.<sup>8</sup> Further, our analysis of ACH discharges that went on to use LTCHs in 2010 found that 47 percent spent three or fewer days in the ACH ICU or CCU before discharge. While severity of illness cannot be measured solely by a patient's use of ICU or CCU services, this finding raises concerns about the extent to which LTCH care is provided unnecessarily.

The fact that Medicare pays more for LTCH services than for similar services provided elsewhere has likely encouraged growth in the number of LTCHs and use of these facilities. But in many cases it is not clear what Medicare is purchasing with its higher LTCH payments.

Research on outcomes for beneficiaries who receive care in LTCHs is mixed, with some studies suggesting that LTCH care may have value for very sick patients but not for those who are less severely ill. A 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 SNFs and IRFs and found that, after controlling for differences in case mix, LTCH patients had a lower risk of readmission within 30 days of discharge from the ACH (Gage et al. 2011). That LTCH patients

would have lower readmission rates is not unexpected since LTCHs must meet the conditions of participation for ACHs and thus can provide a higher level of care than can 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 the 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 2010). This study (which used 2004 claims data from the three states to construct episodes of care for beneficiaries assigned to ventilator-related diagnoses 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 requiring mechanical ventilation who spent at least 14 days in an ACH 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).

Studies by the Commission and others have also examined whether spending for LTCH care reduces 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 for the episode of care were the same or lower for those who used an LTCH than for those who did not; 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 2010).

However, a more recent study by RTI for CMS looked at 2007 claims nationwide and identified 74 ACH diagnosis groups in which LTCH referral is most common (Kandilov and Dalton 2011). The researchers created episodes of care for beneficiaries admitted to the ACH with these diagnoses and compared Medicare payments for episodes that included LTCH care with those that did not. This analysis found that 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.<sup>9</sup> By contrast, Kahn and colleagues found that, for beneficiaries who spent at least 14 days in an ACH ICU, transfer to an LTCH was associated with lower total provider costs but higher total Medicare payments (Kahn et al. 2013). These studies, though conflicting, suggest that LTCH care may have value for very sick patients but not for those who are less severely ill.

Medicare must ensure that its payments to providers are properly aligned with the resource needs of beneficiaries. Inaccurate payments can influence providers' decisions about admission, service delivery, transfer, and discharge, and thus can result in inappropriate care, unnecessary use of services, and program overpayments. Attractive payment rates for LTCH care may have resulted in an oversupply of facilities in some areas and unwarranted use of LTCH services by less severely ill patients. At the same time, in areas of the country without LTCHs, ACHs may incur costs in caring for CCI beneficiaries that are not accrued by their counterparts in areas with LTCHs. The Commission has long held that payment for the same set of services should be the same 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 (Medicare Payment Advisory Commission 2009). The Commission has therefore begun investigating ways to rationalize Medicare's payments for CCI beneficiaries.

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## **Are Medicare payments adequate in 2013?**

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To address whether payments for 2013 are adequate to cover the costs providers incur and how much providers' costs should change in the coming year (2014), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to care by examining the capacity and supply of LTCH providers and

## Short-stay outlier cases in long-term care hospitals

In the long-term care hospital (LTCH) payment system, a short-stay outlier (SSO) is a case with a length of stay that is less than or equal to five-sixths of the geometric average length of stay for the case type.<sup>10</sup> 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 to those under the ACH inpatient prospective payment system (IPPS). About 28 percent of LTCH discharges receive SSO payment adjustments, but this share varies across types of cases. For example, about 32 percent of cases with pulmonary edema and respiratory failure were SSOs in fiscal year 2011, compared with about 25 percent of cases with skin ulcers and major comorbidities/complications.

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 Medicare severity long-term care diagnosis related group (MS–LTC–DRG) specific per diem amount multiplied by the patient's length of stay,
- the full MS–LTC–DRG payment, or
- a blend of the IPPS amount for the Medicare severity–diagnosis related group (MS–DRG) and 120 percent of the MS–LTC–DRG per diem amount.<sup>11</sup>

Generally, for the same MS–DRG, the IPPS payment is substantially less than the payment under the LTCH

PPS. As an example, for a case assigned to MS–LTC–DRG 189 (pulmonary edema and respiratory failure), the IPPS payment in 2013 might be \$6,665 while the LTCH payment would be \$37,639. LTCHs therefore have a strong financial incentive to keep patients until their lengths of stay exceed the SSO threshold for the relevant case type. As shown in Figure 11-2, LTCHs appear to respond to that incentive. Analysis of lengths of stay for the two most common case types in 2011 shows that the number of discharges rises sharply immediately after the SSO threshold. The data strongly suggest that LTCHs' discharge decisions may be influenced at least as much by financial incentives as by clinical indicators.

Beginning on December 29, 2012, Medicare applies a different standard for very short-stay outlier cases (VSSOs).<sup>12</sup> VSSO cases are those in which the length of stay is less than or equal to the IPPS average length of stay for the same case type plus one standard deviation. For these cases, LTCHs are paid the lowest of:

- 100 percent of the cost of the case,
- 120 percent of the MS–LTC–DRG-specific per diem amount multiplied by the patient's length of stay,
- the full MS–LTC–DRG payment,
- the IPPS per diem amount multiplied by the length of stay for the case, or
- the full IPPS payment for the MS–DRG.

*(continued next page)*

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 increased access for most beneficiaries**

We have no direct measures of beneficiaries' access to LTCH services. The absence of LTCHs in many areas of the country makes it particularly difficult to assess the

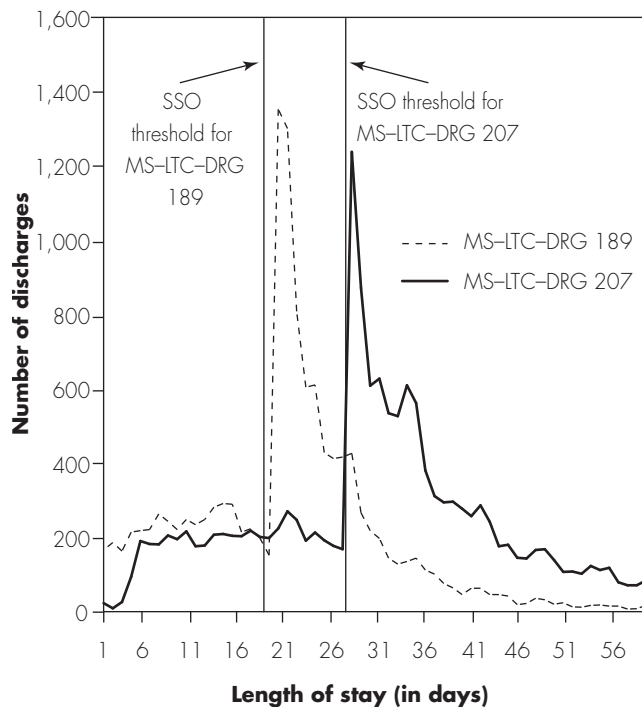
need for LTCH care and therefore the adequacy of supply. Instead, we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish.

### **Capacity and supply of providers: Supply has grown between 2008 and 2011**

The Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments imposed a limited moratorium on new LTCHs and new beds in existing LTCHs from December 29, 2007, to December 28,

## Short-stay outlier cases in long-term care hospitals (cont.)

**FIGURE 11-2** Many LTCH cases in FY 2011 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. LTCHs usually receive reduced payments for cases with lengths of stay that are below the SSO threshold for the MS-LTC-DRG.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

If the VSSO policy had been in place in 2011, the Commission estimates that 14 percent of all cases would have been classified as VSSOs.

We compared cases that would have been 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 (54 percent vs. 45 percent for longer stays). About 19 percent of VSSO cases were MS-LTC-DRG 207 (respiratory system diagnosis with prolonged mechanical ventilation), compared with 11 percent of cases that were not SSOs. Many VSSO cases had such short lengths of stay 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. Thus, as a group, VSSO cases appeared to be much more severely ill than non-SSO cases, even though the per discharge cost of caring for them tended to be lower.

This analysis highlights the importance of identifying medically complex patients who are appropriate for admission to an LTCH. Some of the most severely ill medically complex patients may not be appropriate for LTCH admission because they are too sick to benefit from specialized LTCH care or because their prognosis for improvement is so poor. ■

2012. We examined Medicare cost report data to assess the number of LTCHs and found that, in spite of the moratorium, the number of LTCHs filing Medicare cost reports increased 9.3 percent between 2008 and 2011 (Table 11-1, p. 244). New LTCHs were able to enter the Medicare program because they met specific exceptions to the moratorium. Most of the new LTCHs filing cost reports were for-profit facilities.

It is difficult to determine a precise number of LTCHs for 2011 because of discrepancies in Medicare's data

sources on these facilities. However, our analysis of these sources indicates that the number of LTCHs increased between 2010 and 2011. Cost report data indicate that eight more LTCHs filed valid cost reports in 2011 than in 2010. However, analysis of Medicare's Provider of Services (POS) data suggests that the supply of LTCHs remained unchanged over the period, as we would expect in these later years of the moratorium. As we have found in previous years, Medicare's POS file includes a larger number of facilities than are found in the cost report file. The two data sources differ for a number of reasons.

**TABLE  
11-1****Growth in the number of LTCHs has slowed under the moratorium**

Type of LTCH	2003	2004	2005	2006	2007	2008	2009	2010	2011	Average annual change		
										2003-2005	2005-2010	2010-2011
All	277	315	366	373	382	388	411	416	424	14.9%	2.6%	1.9%
Urban	264	299	342	348	358	362	388	389	397	13.8	2.6	2.1
Rural	13	16	24	25	24	26	23	27	27	35.9	2.4	0.0
Nonprofit	57	67	78	76	76	77	79	82	82	17.0	1.0	0.0
For profit	202	229	265	274	283	291	313	314	323	14.5	3.5	2.9
Government	18	19	23	23	23	20	19	20	19	13.0	-2.8	-5.0

Note: LTCH (long-term care hospital).

Source: MedPAC analysis of Medicare cost report data from CMS.

Some Medicare-certified LTCHs may not yet have filed a cost report for 2011 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

**TABLE  
11-2****Medicare LTCH spending per FFS beneficiary continues to rise**

	2004	2005	2006	2007	2008	2009	2010	2011	Average annual change		
									2004-2005	2005-2010	2010-2011
Cases	121,955	134,003	130,164	129,202	130,869	131,446	134,683	139,715	9.9%	0.1%	3.7%
Cases per 10,000 FFS beneficiaries	33.4	36.4	36.0	36.2	36.9	37.0	37.4	38.5	9.0	0.6	2.8
Users	108,814	119,282	115,598	114,299	115,328	115,834	118,322	122,838	9.6	-0.2	3.8
Spending (in billions)	\$3.7	\$4.5	\$4.5	\$4.5	\$4.6	\$4.9	\$5.2	\$5.4	21.6	2.9	4.0
Spending per FFS beneficiary	\$101.3	\$122.2	\$124.5	\$126.1	\$129.8	\$138.0	\$144.4	\$148.8	20.7	3.4	3.1
Payment per case	\$30,059	\$33,658	\$34,859	\$34,769	\$35,200	\$37,465	\$38,582	\$38,664	12.0	2.8	0.2
Average length of stay (in days)	28.5	28.2	27.9	26.9	26.7	26.4	26.6	26.3	-1.1	-1.2	-1.0

Note: LTCH (long-term care hospital), FFS (fee-for-service).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

## Chronically critically ill beneficiaries

Researchers and clinicians have noted the growing prevalence of chronically critically ill (CCI) patients, those who have survived acute critical illness in the hospital but face organ system failure requiring prolonged institutional care (Carson et al. 2008, Macintyre 2012, Nelson et al. 2010, Zilberberg et al. 2012, Zilberberg et al. 2008). Patients typically have long acute care hospital (ACH) stays with heavy use of intensive care services followed by stays in long-term care hospitals (LTCHs), skilled nursing facilities (SNFs), and inpatient rehabilitation facilities and may transition several times between these different venues of care (Macintyre 2012, Unroe et al. 2010).<sup>13</sup>

The CCI patient exhibits metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure, abnormalities that have slowed or precluded recovery from a wide range of acute forms of medical, surgical, and neurologic critical illness (Nierman and Nelson 2002). Many require prolonged mechanical ventilation (PMV); as a result, many studies of the CCI population have used the need for PMV as a defining characteristic. Another way to define this patient population is by the extended use of intensive care services.

Mortality rates in this population are very high, especially for patients needing PMV. A cohort study of 300 intensive care unit patients (mean age = 56 years) requiring mechanical ventilation after acute illness

for at least 21 days found that almost half had died within three months (Carson et al. 2008). A multicenter study in 2002 of 1,419 patients admitted to 23 LTCHs offering weaning from PMV found that 52 percent died within 12 months of the LTCH admission (Scheinhorn et al. 2007). Kahn and colleagues reported that in 2006, 69 percent of Medicare beneficiaries transferred to LTCHs needing mechanical ventilation after treatment for critical illness in the ACH died within a year (Kahn et al. 2010). Dematte D'Amico and colleagues observed that LTCH patients with more than two organ system failures (one of which may be respiratory failure) had very poor prognoses, with survival rates of less than 10 percent (Dematte D'Amico et al. 2003). Relatively few CCI survivors return to their previous level of health and function, and most end up with significant physical and cognitive limitations (Carson et al. 1999, Cox et al. 2007, Nelson et al. 2004, Scheinhorn et al. 2007, Unroe et al. 2010).

Some researchers and clinicians believe that gross misunderstanding of prognosis accounts for some of the growth in the number of CCI patients, especially those receiving PMV (Cox et al. 2009). Studies suggest that providers may fail to furnish families with key information needed to make decisions about prolonged life support (Cox et al. 2009, Nelson et al. 2010, Nelson et al. 2007). Participants in the Commission's October 2010 expert panel on LTCH quality reported that ACHs routinely discharge CCI patients to LTCHs without having had end-of-life and advanced care planning discussions with patients or their surrogates.

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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 (Table 11-1).

### **Volume of services: LTCH stays and cases rose in 2011**

Beneficiaries' use of services suggests that access is adequate. From 2010 to 2011, the number of beneficiaries who had LTCH stays increased by 3.8 percent. Controlling for the number of FFS beneficiaries, we found that the

number of LTCH cases rose 2.8 percent between 2010 and 2011, suggesting that access to care increased during this period (Table 11-2).

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 a greater incidence of critical illness in this population (Mayr et al. 2010). At the same time, African American beneficiaries may be more likely

## Chronically critically ill beneficiaries (cont.)

Others have raised concerns that beneficiaries (or their surrogates) may not understand the differences between LTCHs and ACHs or SNFs and thus may not fully appreciate why transfer to an LTCH is recommended or what it signifies (de Lissovoy et al. 2013). CCI patients who are admitted to LTCHs (and their families) thus may have unrealistic expectations of LTCH care. Regardless of the health care setting, CCI is distressing and burdensome for patients and families. Experts therefore assert that treatment decisions for CCI patients must be driven by patients' values and preferences and bolstered by a thorough understanding of possible outcomes (Nelson and Hope 2012, Nelson et al. 2007, White 2012). Given the challenges of physician-patient communication about advanced illnesses, use of shared decision-making tools could improve the timeliness and clarity of information that patients receive about their condition and treatment options and empower patients to make choices based on their preferences.

CCI patients require specialized care from an interdisciplinary team including physicians, nurses, social workers, respiratory therapists, physical therapists, and nutritionists. Providers should have the capability to provide prolonged complex respiratory services, including the use of protocols for weaning from mechanical ventilation, and appropriate metabolic and nutritional support. They must be able to provide functional and cognitive support to patients with neurocognitive impairments and to minimize infections

in a high-risk population (Macintyre 2012, Nelson et al. 2010). A growing number of researchers and clinicians insist that palliative care—including pain management and symptom relief; communication with patients and families about values, preferences, and care goals; transitional planning; and emotional support—is also an essential component of treatment for CCI patients, even when these patients are not at the end of life (Carson 2012, Macintyre 2012, Nelson et al. 2010, Nelson and Hope 2012, White 2012).

The Commission has posited that providers may need to reach a certain volume of medically complex patients to maintain treatment expertise and achieve high-quality care (Medicare Payment Advisory Commission 2008a, Medicare Payment Advisory Commission 2008b, Medicare Payment Advisory Commission 2010). Research has shown that higher patient volume is associated with better outcomes for certain procedures, such as surgery for cancers of the pancreas and esophagus (Birkmeyer et al. 2002, Institute of Medicine 2000). Studies have also found a positive relationship between volume and outcomes for patients admitted to intensive care units in ACHs, notably those receiving mechanical ventilation (Durairaj et al. 2005, Kahn et al. 2006, Kahn et al. 2009). Such a relationship may hold true in LTCHs as well. The Commission's analyses of LTCHs with high and low Medicare margins suggest that some volume of patients might also be needed to achieve economies of scale necessary to be profitable. ■

to opt for LTCH care since they are less likely to choose withdrawal from mechanical ventilation in the ICU, have do-not-resuscitate orders, or elect hospice care (Barnato et al. 2009, Borum et al. 2000, Diringer et al. 2001). The concentration of LTCHs in urban areas and in areas of the country with larger African American populations may also be a contributing factor (Kahn et al. 2010). Further, as noted, a disproportionate number of Medicare beneficiaries who use LTCHs are disabled, a group that is itself more likely to be African American.

LTCH discharges are concentrated in a relatively small number of diagnosis groups. In fiscal year 2011, the top

25 LTCH diagnoses made up 62 percent of all LTCH discharges (Table 11-3). 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 patients, were respiratory conditions.

Between 2008 and 2011, the number of LTCH cases with a principal diagnosis of skin ulcers with complications or comorbidities (CCs) and with major complications or comorbidities (MCCs) fell 38 percent and 15 percent, respectively, while the number of cases with the three most common aftercare diagnoses fell 20 percent, 7 percent, and



**TABLE  
11-3**

**The top 25 MS-LTC-DRGs made up three-fifths of LTCH discharges in 2011**

MS-LTC-DRG	Description	Discharges	Percentage	Change 2008-2011
207	Respiratory system diagnosis with ventilator support 96+ hours	16,101	11.5%	7.4%
189	Pulmonary edema and respiratory failure	13,042	9.3	49.1
871	Septicemia or severe sepsis without ventilator support 96+ hours with MCC	8,453	6.0	30.4
177	Respiratory infections and inflammations with MCC	4,997	3.6	15.1
592	Skin ulcers with MCC	3,425	2.5	-14.5
208	Respiratory system diagnosis with ventilator support <96 hours	3,029	2.2	21.8
949	Aftercare with CC/MCC	3,004	2.1	-19.9
190	Chronic obstructive pulmonary disease with MCC	2,769	2.0	8.2
193	Simple pneumonia and pleurisy with MCC	2,573	1.8	-4.6
539	Osteomyelitis with MCC	2,541	1.8	33.5
573	Skin graft and/or debridement for skin ulcer or cellulitis with MCC	2,101	1.5	9.9
314	Other circulatory system diagnosis with MCC	2,039	1.5	37.2
919	Complications of treatment with MCC	2,033	1.5	22.5
862	Postoperative and post-traumatic infections with MCC	2,008	1.4	20.1
166	Other respiratory system OR procedures with MCC	1,988	1.4	17.4
682	Renal failure with MCC	1,987	1.4	14.3
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major OR	1,887	1.4	33.5
559	Aftercare, musculoskeletal system and connective tissue with MCC	1,808	1.3	-7.0
870	Septicemia or severe sepsis with ventilator support 96+ hours	1,774	1.3	64.6
291	Heart failure and shock with MCC	1,713	1.2	1.5
593	Skin ulcers with CC	1,615	1.2	-37.6
178	Respiratory infections and inflammations with CC	1,591	1.1	-19.0
603	Cellulitis without MCC	1,539	1.1	9.9
602	Cellulitis with MCC	1,451	1.0	27.5
560	Aftercare, musculoskeletal system and connective tissue with CC	1,369	1.0	-17.3
	Top 25 MS-LTC-DRGs	86,837	62.0	12.8
	Total	139,741	100.0	6.8

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.

17 percent, respectively (Table 11-3).<sup>14</sup> At the same time, cases with serious infections have grown significantly. The number of Medicare cases diagnosed with complicated septicemia without ventilator support grew 30 percent, while the number with septicemia and prolonged ventilator support climbed 65 percent. The number of cases with osteomyelitis with MCCs grew 34 percent over the period. In addition, the number of cases with postoperative or post-traumatic infections with MCCs increased 20 percent, while the number with cellulitis with and without MCCs increased 28 percent and 10 percent, respectively.

It is not clear whether the increase in cases with serious infections is due to changes in coding practices or to real growth in the number of beneficiaries admitted with infections. LTCH patients already face a high risk of hospital-acquired infection because they typically require invasive medical devices such as mechanical ventilators and catheters; they often suffer from conditions such as hyperglycemia and malnutrition; and they may have nonintact skin due to surgical wounds or pressure ulcers (Deutscher et al. 2011, Marchaim et al. 2012, Nelson et

## 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.<sup>15</sup> On October 1, 2013, CMS intends to begin pay for reporting for three measures—urinary catheter-associated urinary tract infections, central line catheter-associated bloodstream infections, and new or worsened pressure ulcers—and has begun collecting the necessary data from LTCHs. Data on urinary tract and central line infections are being collected through the National Healthcare Safety Network, an Internet-based surveillance system maintained by the Centers for Disease Control and Prevention. Because the data elements necessary to calculate the pressure ulcer measure are identical to those collected through the Minimum Data Set (MDS), the reporting instrument used in nursing homes, LTCHs are reporting these data

elements using a subset of the MDS. On January 1, 2013, CMS will begin collecting data to support the development of two additional measures: the share of patients assessed for and appropriately given influenza vaccine and influenza vaccination coverage among health care personnel. Pay for reporting for these two measures will begin on October 1, 2015. The measures that CMS has chosen to date are already in use in acute care hospitals and post-acute care. Additional measures are needed that align with the conditions commonly treated in LTCHs. CMS has stated that future measures could include rates of other health care–acquired infections, such as ventilator-associated pneumonia and surgical-site infections; avoidable adverse events, such as rehospitalizations, injuries secondary to polypharmacy, and air embolisms; and nursing care measures, such as rate of restraint use, rate of falls with injury, and skill mix. ■

al. 2010). Therefore, growth in admissions to LTCHs of patients already infected with drug-resistant pathogens could pose a major challenge to infection control, not just within the LTCH but—because chronically critically ill patients often transition several times between different care venues—also for providers across the health care continuum (Gould et al. 2006, Macintyre 2012, Marchaim et al. 2012, Munoz-Price and Stemer 2010, Unroe et al. 2010).

### **Quality of care: Meaningful measures not available, but trends for gross indicators are stable**

Unlike most other health care facilities, LTCHs only recently began submitting quality data to CMS (see text box); 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. Medicare does not collect assessment data for LTCH patients. 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 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–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 2011, 10 percent of LTCH cases were readmitted to an ACH. Thirteen percent of LTCH cases died in the facility, and another 12 percent died within 30 days of discharge from the LTCH. Mortality rates varied markedly by diagnosis group. Thirty-nine percent of patients with a principal diagnosis of septicemia with prolonged ventilator support died in the LTCH, and an additional 14 percent died within 30 days of discharge. By comparison, 5 percent of patients with a principal diagnosis of aftercare with major complications or comorbidities died in the LTCH, with an additional 8 percent dying within 30 days of discharge.

We considered readmission and mortality trends for the top 25 LTCH diagnoses over the period from 2008 to 2011. Although rates of readmission and death can vary

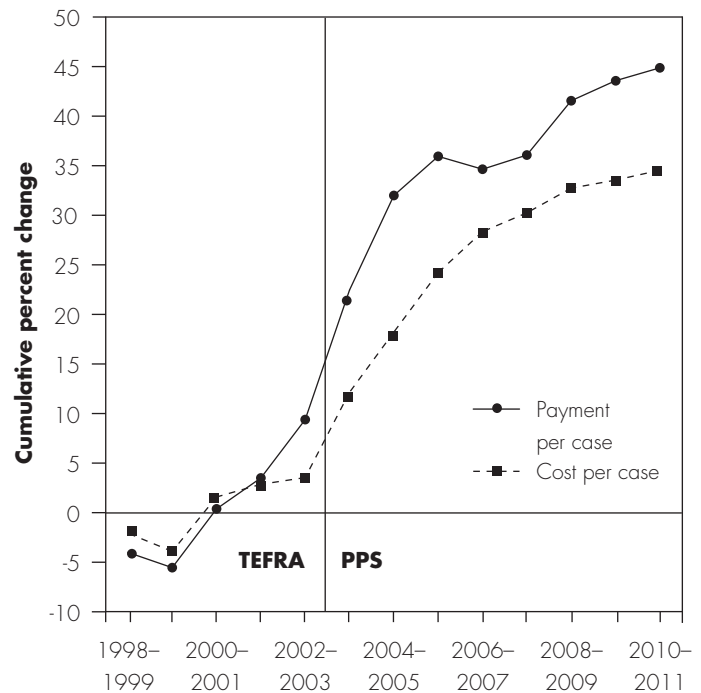
from year to year, over time we found stable or declining rates of death in LTCHs and death within 30 days of discharge for almost all of these diagnoses. The exception was cellulitis without MCCs, for which the share of cases that died in LTCHs increased an average of 1.4 percent annually between 2008 and 2011. Readmissions for the top 25 diagnoses also were generally stable or declining, except for cases with heart failure and shock with MCCs, some types of aftercare with CCs/MCCs, and other respiratory operating room procedures with MCCs.<sup>16</sup> In 2011, patients with a diagnosis of complications of treatment with MCC (MS-LTC-DRG 919) had the highest readmission rate (19.3 percent).<sup>17</sup>

### Providers' access to capital: Moratorium has reduced need for new capital

Access to capital allows LTCHs to maintain and modernize 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 July 2007 until December 2012 appear to have altered industry behavior. Although the number of LTCHs continued to rise during the moratorium, the rate of increase modified, while mergers and acquisitions of existing LTCHs—which were not prevented by the moratorium—dropped off considerably, with no such activity observed in the past year. With the expiration of the moratorium at the end of 2012, it is unclear whether LTCH companies will act quickly to open new facilities or proceed cautiously, given the continued scrutiny of Medicare spending on LTCH care. Companies may opt to focus on relatively low-risk capital investment, such as bed expansions. Kindred Healthcare, which owned 117 LTCHs as of September 2012, has continued to pursue its “cluster market” strategy, whereby the company operates SNFs, home health agencies, and LTCHs within a single market in order to position itself as an integrated provider of post-acute care. This strategy is intended to improve the chain’s ability to control costs and limit the impact of payment policy changes in any one industry. In August 2012, the company acquired IntegraCare, which provides home health and hospice care in 47 locations in Texas.

**FIGURE 11-3**

**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.

### Medicare's payments and providers' costs: Growth in payments continues to outpace growth in costs

Between 2010 and 2011, Medicare payments increased faster than costs, resulting in an aggregate 2011 Medicare margin of 6.9 percent. Medicare margins increased for almost every type of LTCH.

### Reduction in the LTCH base rate slowed spending growth between 2010 and 2011

In the first three years of the LTCH PPS, Medicare spending for LTCH services grew rapidly, climbing an average of 29 percent per year. Subsequent changes in payment policies and growth in the number of beneficiaries enrolling in Medicare Advantage plans slowed growth in FFS spending between 2005 and 2008 to less than 1 percent per year (Figure 11-3). Between 2008 and 2010, however, spending jumped about 6 percent per year. A reduction in Medicare's payment rate for LTCH services helped to slow growth in spending between 2010 and 2011.<sup>18</sup>

**TABLE  
11-4**

**Aggregate average LTCH Medicare margin rose in 2011**

Type of LTCH	Share of discharges	2004	2005	2006	2007	2008	2009	2010	2011
All	100%	9.1%	11.9%	9.7%	4.6%	3.5%	5.6%	6.6%	6.9%
Urban	95	9.3	12.0	9.9	4.9	3.8	5.9	6.9	7.1
Rural	4	2.6	10.2	4.7	-0.4	-3.3	-3.0	-0.3	1.1
Nonprofit	14	6.9	9.1	6.5	1.4	-2.5	-0.9	-0.2	-0.1
For profit	84	10.0	13.1	10.9	5.6	5.1	7.3	8.2	8.5
Government	1	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.

**Per case payments continued to exceed costs in 2012**

In the first years of the PPS, LTCHs appeared to be responsive to changes in payment, adjusting their costs per case when payments per case changed. Payment per case increased rapidly after the PPS was implemented, climbing an average 16.6 percent per year between 2003 and 2005. Cost per case also increased rapidly during this period, albeit at a somewhat slower pace (Figure 11-3, p. 249). Between 2005 and 2008, however, growth in cost per case outpaced that for payments as regulatory changes to Medicare’s payment policies for LTCHs slowed growth in payment per case to an average of 1.5 percent per year.

Between 2008 and 2009, growth in payments per case accelerated to 5.5 percent, more than twice as much as the growth in costs. This surge was due in part to congressional actions that halted or rolled back the implementation of CMS regulations designed to address issues of overpayments to LTCHs. 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.<sup>19</sup> Between 2009 and 2011, growth in payments slowed to an average of 1.6 percent per year, while growth in costs increased less than 1 percent per year.

**High margins reflect economies of scale**

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, consistent with the growth in payments described above. In 2011, the aggregate LTCH margin was 6.9 percent.

Although financial performance in 2011 varied across LTCHs, margins increased for all types of facilities. At 8.5 percent, margins were highest for for-profit LTCHs, which account for three-quarters of all LTCHs. The aggregate margin for rural LTCHs—which constitute about 6 percent of all LTCHs—was 1.1 percent, compared with 7.1 percent for their urban counterparts. Rural LTCHs tend to be much smaller than urban LTCHs, caring for a smaller

volume of patients on average and benefiting less from economies of scale.

We looked closely at the characteristics of established LTCHs with the highest and lowest margins.<sup>20</sup> As with SNFs and home health agencies, lower unit costs—rather than higher payments—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). Low-margin LTCHs had standardized costs per discharge that were 36 percent higher than high-margin LTCHs (\$36,849 vs. \$27,160). The average Medicare length of stay was one day longer in low-margin than in high-margin facilities. After controlling for the number of short-stay outliers, high-margin LTCHs had a higher average CMI, indicating a sicker patient population.

High-cost outlier payments per discharge for low-margin LTCHs were almost four times those of high-margin LTCHs (\$4,434 vs. \$1,134) (Table 11-5).<sup>21</sup> At the same time, short-stay outliers made up a larger share of low-margin LTCHs' cases (32 percent vs. 27 percent). Low-margin LTCHs thus cared for disproportionate shares both of patients who were high-cost outliers and patients who had shorter stays.

Compared with their low-margin counterparts, high-margin LTCHs were much more likely to be for profit, and they had more cases overall (an average of 553 compared with 428 for low-margin LTCHs). Low-margin LTCHs therefore benefited less from economies of scale.

## How should Medicare payments change in 2014?

To estimate 2013 payments, costs, and margins with 2011 data, the Commission considered policy changes effective in 2012 and 2013. Those that affect our estimate of the 2013 Medicare margin include:

- a market basket increase of 2.9 percent for 2012, offset by a 1.1 percent reduction required by the Patient Protection and Affordable Care Act of 2010 (PPACA), for a net update of 1.8 percent;
- a market basket increase of 2.6 percent for 2013, offset by required PPACA reductions totaling 0.8 percent, for a net update of 1.8 percent;

**TABLE 11-5**

**LTCHs in the top quartile of Medicare margins in 2011 had lower costs**

Characteristics	High-margin quartile	Low-margin quartile
Mean margin	20.6%	-9.2%
Mean total discharges (all payers)	553	428
Medicare patient share	61%	63%
Average length of stay (in days)	26	27
Mean adjusted CMI	1.0057	0.9454
Mean per discharge:		
Standardized costs	\$27,160	\$36,849
Standard Medicare payment*	38,960	35,027
High-cost outlier payments	1,134	4,434
Share of:		
Cases that are SSOs	27%	32%
Medicare cases from primary-referring ACH	39	44
LTCHs that are for profit	92	62

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 2008 and 2009. 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. CMIs 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 Medicare cost reports and Medicare Provider Analysis and Review data from CMS.

- a budget-neutrality adjustment in 2013 to account for CMS's underestimate of LTCH spending in the first year of the PPS. This adjustment, 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 estimate that LTCHs' aggregate Medicare margin will be 5.9 percent in 2013. The Secretary has the discretion to update payments for LTCHs; there is no congressionally mandated update. In anticipation of the expiration of

temporary legislative relief from some of CMS's payment regulations, LTCHs are likely to continue to constrain their cost growth. We expect growth in costs to be modest, albeit somewhat greater than the current pace—roughly similar to the latest forecast of the market basket for 2013 of 2.6 percent.

### Update recommendation

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.

#### RECOMMENDATION 11

**The Secretary should eliminate the update to the payment rates for long-term care hospitals for fiscal year 2014.**

#### RATIONALE 11

The supply of facilities and beds grew between 2008 and 2011 and the number of LTCH cases rose, suggesting that access to care has increased. The limited quality trends we

measure appear stable. The moratorium limited the need for capital. Medicare margins for 2011 were positive, and we expect they will remain so. These trends suggest that LTCHs are able to operate within current payment rates.

#### IMPLICATIONS 11

##### Spending

- Because CMS typically uses the market basket as a starting point for establishing updates to LTCH payments, this recommendation would decrease federal program spending by between \$50 million and \$250 million in one year and by less than \$1 billion over five years.

##### Beneficiary and provider

- This recommendation is not expected to affect Medicare beneficiaries' access to care or providers' ability to provide care. ■

## Endnotes

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- 1 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.
- 2 More information on the prospective payment system for LTCHs is available at [http://medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_LTCH.pdf](http://medpac.gov/documents/MedPAC_Payment_Basics_12_LTCH.pdf).
- 3 About 13 percent of LTCH cases received high-cost outlier payments in fiscal year 2011. Some case types were far more likely to be high-cost outliers than others. For example, 23 percent of cases assigned to MS–LTC–DRG 4 (tracheostomy with prolonged mechanical ventilation) were high-cost outliers, compared with 9 percent of cases assigned to MS–LTC–DRG 193 (simple pneumonia and pleurisy with major comorbidities/complications). High-cost outlier cases also differed by LTCH ownership. About 12 percent of cases in for-profit LTCHs were high-cost outliers, compared with 18 percent of cases in nonprofit LTCHs and 25 percent of cases in government-owned LTCHs.
- 4 Some beneficiaries who were not discharged to institutional post-acute care providers may have been discharged to their homes with home health care.
- 5 Nationwide, CCI patients requiring PMV in the ACH were by far the most likely to be discharged to LTCHs.
- 6 Kahn and colleagues found that the share of Medicare critical acute care hospitalizations ending in transfer to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs) has also increased, while the percentage of critical acute care hospitalizations ending in discharge to the home has decreased. Among critical acute care patients receiving intensive ventilator support, discharges to SNFs and IRFs have remained relatively constant, while discharges to LTCHs have increased (Kahn et al. 2010).
- 7 Kahn and colleagues found that 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 IRFs (Kahn et al. 2010).
- 8 This analysis looked at non-short-stay outlier cases by core-based statistical areas (CBSAs). CBSAs with no LTCH claims were eliminated from the analysis.
- 9 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, then 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 within the episode.
- 10 A geometric mean 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 skewed. SSO cases that are very costly may qualify for high-cost outlier payments.
- 11 For the blended alternative, the LTCH per diem payment amount makes up more of the total payment amount as the patient’s length of stay approaches the geometric mean length of stay for the MS–LTC–DRG.
- 12 CMS initially implemented the VSSO policy in July 2007. However, the Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent amendments halted the application of the standard and prohibited the Secretary from applying it for five years.
- 13 A cohort study of 103 survivors of mechanical ventilation in the ACH ICU found that the patients experienced 457 separate transitions in postdischarge care settings. Sixty-seven percent were readmitted at least once (Unroe et al. 2010).
- 14 A principal diagnosis of aftercare with complications or comorbidities (MS–LTC–DRG 949) is assigned to patients who need hospital-level services (but not prolonged ventilator support) following a stroke or traumatic brain injury. A principal diagnosis of aftercare, musculoskeletal system and connective tissue (MS–LTC–DRGs 559 and 560) is assigned to patients who need hospital-level services for conditions such as a fracture with delayed healing.
- 15 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.

- 16 We observed growth over time in the readmission rate for both MS–LTC–DRG 949 (aftercare with CC/MCC) and MS–LTC–DRG 560 (aftercare, musculoskeletal system and connective tissue, with CC).
- 17 We observed a higher readmission rate (23.4 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 principal diagnosis of “respiratory diagnosis with 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 14.3 percent of these cases were readmitted in 2011.
- 18 The Patient Protection and Affordable Care Act of 2010 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.
- 19 CMS reduced the update to the LTCH base payment rate in fiscal year 2010 and fiscal year 2011 to partly offset payment increases due to documentation and coding improvements between 2007 and 2009.
- 20 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 2010 and 2011. We excluded government-owned LTCHs.
- 21 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 (\$15,408 in 2013). Medicare pays 80 percent of the LTCH’s costs above the threshold.



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CHAPTER 12

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**Hospice services**

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**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 2014.

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

## 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 2011, more than 1.2 million Medicare beneficiaries received hospice services from over 3,500 providers, and Medicare expenditures totaled about \$13.8 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 2011, hospice use increased across all demographic and beneficiary groups examined. However, hospice use rates remained lower for racial and ethnic minorities than Whites.

- **Capacity and supply of providers**—The supply of hospices has increased substantially since 2000 and continued to grow in 2011, almost entirely due to growth in the number of for-profit providers.
- **Volume of services**—The proportion of beneficiaries using hospice services at the end of life continues to grow, while average length of stay

### In this chapter

- Are Medicare payments adequate in 2013?  
.....
- How should Medicare payments change in 2014?  
.....

was steady overall in 2011 after substantial growth since 2000. In 2011, 45.2 percent of Medicare beneficiaries who died that year used hospice, up from 44.0 percent in 2010 and 22.9 percent in 2000. Average length of stay among decedents, which grew between 2000 and 2010 from 54 days to 86 days, held steady at 86 days in 2011. The median length of stay during the same years remained stable at approximately 17 or 18 days.

***Quality of care***—At this time, we do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries since information on quality of care is very limited. The Patient Protection and Affordable Care Act of 2010 mandated that a hospice quality reporting program begin by fiscal year 2014. In 2013, hospices must report data for two quality measures or face a 2 percentage point reduction in their annual update for fiscal year 2014. The first is a pain management measure endorsed by the National Quality Forum. CMS created the second measure, in which hospices report whether they are tracking at least three quality indicators related to patient care and what those measures focus on (to help CMS identify options for future quality measures). Given the penalty for nonreporting and the limited scope of the initial measures, it is likely that the vast majority of providers will report in 2013.

***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 5 percent increase in 2011) suggests that access to capital is adequate for these providers. Less is known about access to capital for nonprofit freestanding providers, 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 costs, was 7.5 percent in 2010, up from 7.4 percent in 2009. The projected 2013 margin is 6.3 percent. These 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). They 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 1.9 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 payment rates in 2014. ■



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## Background

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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 biologicals 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. In 2011, more than 1.2 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about \$13.8 billion.

Beneficiaries must “elect” the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of the terminal illness. 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. Under current policy, 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.<sup>1</sup> If the patient's terminal illness continues to engender the likelihood of death within six months, the patient can be recertified for another 90 days. After the second 90-day period, the patient can be recertified for an unlimited number of 60-day periods, as long as he or she remains eligible.<sup>2</sup> For recertification, only the hospice physician has to certify that the beneficiary's life expectancy is six months or less. Beneficiaries can transfer from one hospice to another

once during a hospice benefit period and can disenroll from hospice at any time.

In recent years, Medicare spending for hospice care increased dramatically. Spending reached about \$13.8 billion in 2011, more than quadrupling since 2000. This spending increase was driven by greater numbers of beneficiaries electing hospice and by longer stays among hospice patients with the longest stays.

### Medicare payment for hospice services

The Medicare program pays a daily rate to hospice providers for each day a beneficiary is enrolled in hospice. The hospice 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 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 beneficiary's 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. 264). A hospice is paid the routine home care rate (about \$153 per day in 2013) for each day the patient is enrolled in hospice, unless the hospice provides care under one of the other categories (continuous home care, inpatient respite care, or general inpatient care). 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 in fiscal year 2013, the annual update 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 is required in fiscal year 2013 and possibly in fiscal years 2014 through 2019 if certain targets for health insurance coverage among the working-age population are met. 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 geographically to account for differences in wage rates

**TABLE  
12-1**

**Medicare hospice payment categories and rates**

Category	Description	Base payment rate, 2013	Percent of hospice days, 2010
Routine home care	Home care provided on a typical day	\$153.45 per day	97.3%
Continuous home care	Home care provided during periods of patient crisis	\$37.32 per hour	0.5
Inpatient respite care	Inpatient care for a short period to provide respite for primary caregiver	\$158.72 per day	0.2
General inpatient care	Inpatient care to treat symptoms that cannot be managed in another setting	\$682.59 per day	2.0

Note: Payment for continuous home care (CHC) is an hourly rate for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. A nurse must deliver more than half of the hours of this care to qualify for CHC-level payment. The minimum daily payment rate at the CHC level is about \$299 per day (8 hours at \$37.32 per hour); maximum daily payment at the CHC level is about \$896 per day (24 hours at \$37.32 per hour).

Source: CMS Manual System Pub 100-04 Medicare Claims Processing, Transmittal 2497, "Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index and the Hospice Pricer for FY 2013," July 20, 2012.

among local markets. Each category of care's base rate has a labor share, which is adjusted by the hospice wage index for the location where care is furnished, and the result is added to the nonlabor portion. From 1983 to 1997, Medicare adjusted hospice payments with a 1983 wage index based on 1981 Bureau of Labor Statistics data. In fiscal year 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. In fiscal year 2010, CMS began phasing out the budget-neutrality adjustment over seven years. It was reduced by 0.4 percentage point in 2010 and by an additional 0.6 percentage point in each year from 2011 through 2013. The budget-neutrality adjustment will be reduced by an additional 0.6 percentage point each subsequent year until it is eliminated entirely in 2016.

Beneficiary cost sharing for hospice services is minimal. There is no cost sharing for hospice care other than for prescription drugs and inpatient respite care. For prescriptions, hospices may charge 5 percent coinsurance (not to exceed \$5) for each prescription furnished outside the inpatient setting. For inpatient respite care, beneficiaries may be charged 5 percent of Medicare's respite care payment per day. In practice, hospices do not generally charge or collect these copays from Medicare beneficiaries. Because hospice is one of the few areas in the Medicare program with minimal or no cost sharing

and hospice length of stay has increased substantially for patients with the longest stays, in the future the Commission may explore the potential for modest cost sharing for the hospice benefit. (For a more complete description of the hospice payment system, see [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_hospice.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_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. 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. We also found that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice and that CMS lacks data vital for effective management of the benefit. In March 2009, the Commission made recommendations to reform the hospice payment system, ensure greater accountability in use of the hospice benefit, and improve data collection and accuracy (see text box). Since that time, additional data have become available allowing us to analyze hospice visit patterns across

## March 2009 Commission recommendations on hospice

The Commission's June 2008 and March 2009 reports raised concerns that the structure of the hospice payment system creates financial incentives for very long stays and that CMS does not have adequate administrative controls to check these incentives or ensure providers' compliance with the benefit's eligibility criteria. These reports found:

- a substantial increase in the number of hospices, driven almost entirely by growth in for-profit providers;
- a substantial increase in average length of stay due to increased lengths of stay among patients with the longest stays;
- higher profit margins among hospice providers with longer stays;
- longer stays among for-profit hospices than nonprofit hospices across all diagnoses;
- anecdotal reports, obtained from a Commission-convened panel of hospice industry experts, that some hospices admit patients who do not meet the Medicare hospice eligibility criteria (a life expectancy of six months or less if the disease runs its normal course) and that some hospice physicians are not engaged in the hospice certification process; and
- focused efforts by some hospices to enroll nursing home residents, a population that tends to have conditions associated with long hospice stays,

as well as anecdotal reports of questionable relationships between some nursing facilities and hospices.

The Commission's several analyses of the hospice payment system show that long stays in hospice are more profitable for providers than short stays. They find that 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. As a result, long hospice stays, which generally have a lower average visit intensity over the course of an episode, are more profitable than short stays. The incentives in the current hospice payment system for long stays may have spurred some providers to pursue business models that maximize profit by enrolling patients more likely to have long stays. The mismatch between Medicare payments and hospice service intensity throughout an episode distorts the distribution of payments across providers, making those hospices with longer stays more profitable than those with shorter stays. To address these problems, the Commission made recommendations in March 2009 to reform the hospice payment system, to ensure greater accountability in use of the hospice benefit (which included two parts: increased accountability standards for providers and a request for the Office of Inspector General (OIG) to investigate selected hospice arrangements), and to improve data collection and accuracy. The Congress and CMS have adopted policies consistent with several of these recommendations.

*(continued next page)*

episodes of care. In the online appendixes to the March 2010 and March 2011 reports, available at <http://www.medpac.gov>, we analyzed patient-level data on hospice visits from a group of 17 nonprofit hospices and initial Medicare claims data on hospice visits through 2009 for the full Medicare provider population. Analyses of these data confirmed our earlier findings—that the number of hospice visits per week is higher early in a hospice episode and at the end of an episode near the time of a patient's death—and supported the need for a payment system

that is better aligned with the U-shaped pattern of service intensity during a hospice care episode.

PPACA includes a number of provisions related to Medicare hospice services, including several policies consistent with some of the Commission's recommendations, particularly in the areas of greater accountability and data collection. PPACA also gives CMS the authority to revise in a budget-neutral manner the methodology for determining hospice payment rates

## March 2009 Commission recommendations on hospice (cont.)

Several policies to increase provider accountability have been adopted. Effective October 2009, CMS adopted a requirement that all certifications and recertifications include a brief physician narrative explaining the clinical basis for the patient's prognosis. Effective January 2011, the Patient Protection and Affordable Care Act of 2010 (PPACA) requires a hospice physician or nurse practitioner to have a face-to-face visit with a patient before the 180th-day recertification and prior to each subsequent recertification.<sup>3</sup>

The Commission also recommended that the OIG study several issues related to hospice care in nursing facilities. The OIG has completed or has work under way in several of these areas. The OIG completed a study on hospices that rely heavily on nursing home patients (Office of Inspector General 2011). It found that these hospices are more likely to be for profit and to treat patients with conditions that typically have longer stays and require less complex care. The OIG recommended that CMS (1) monitor hospices that rely heavily on nursing home patients and (2) reduce payment rates for hospice services provided in nursing homes. The OIG's 2013 work plan includes additional studies examining hospices' marketing practices and financial relationships with nursing facilities.<sup>4</sup>

In the area of data collection, CMS expanded its data-reporting requirements for hospice claims in January 2010 consistent with the Commission's

recommendation to include the length of visits in 15-minute increments, as well as additional types of visits such as physical, speech, and occupational therapist visits. PPACA mandated that CMS begin collecting additional data to inform hospice payment system reform as the Secretary of Health and Human Services determines appropriate not later than January 1, 2011.

Additional steps have been taken by the Congress and CMS on payment reform, but the pace and shape of those efforts are unclear at present. 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 is no longer feasible since 2013 is already under way, the indicators that led us to make this recommendation have not changed, and thus the need for payment reform still exists and the recommendation still stands. In addition, PPACA includes a provision requiring that, beginning January 2011, Medicare perform medical reviews of hospice claims exceeding 180 days for hospices with many long-stay patients, consistent with a Commission recommendation. CMS has not yet implemented this PPACA provision, so we are also reprinting our standing recommendation on that issue below.

### **Recommendation 6-1, March 2009 report**

**The Congress should direct the Secretary to change the Medicare payment system for hospice to:**

*(continued next page)*

for routine home care and other services as the Secretary of Health and Human Services determines appropriate, beginning no earlier than fiscal year 2014. PPACA includes additional hospice provisions, such as a hospice quality data pay-for-reporting program beginning in fiscal year 2014, a pilot project to test a hospice pay-for-performance program to start by January 2016, and a demonstration project to test concurrent hospice and conventional care.

### **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

## March 2009 Commission recommendations on hospice (cont.)

- **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.**

Compared with the current hospice payment system, the Commission-recommended payment model would result in a much stronger relationship between Medicare payments and hospices' service intensity throughout an episode, and it has the potential to promote stays of a length consistent with hospice as an end-of-life benefit. It would also change the distribution of payments across providers. Providers with shorter stay patients, which tend to have lower margins, would see an increase in their Medicare payments, whereas providers with longer stay patients, which tend to have higher margins, would see a decrease.

Under PPACA, the Congress gave CMS the authority to revise in a budget-neutral manner the hospice payment system for routine home care and other services as the Secretary determines appropriate, not earlier than fiscal year 2014. The statute indicates that such revisions may

include adjustments to the per diem payments to reflect changes in the resource intensity of services throughout a hospice episode, but it does not mandate such an approach. CMS is required to consult with hospices and the Commission on revisions to the payment system.

Measures consistent with the Commission's recommendation for increased hospice accountability have been implemented, with the exception of focused medical review (third point below). 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.

### **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. ■**

that beneficiaries who elect hospice incur less Medicare spending in the last two months of life than comparable beneficiaries who do not but also that Medicare spending for beneficiaries is higher for hospice enrollees in the earlier months before death than it is for nonenrollees. In essence, hospice's net reduction in Medicare spending decreases the longer the patient is enrolled, and beneficiaries with very long hospice stays may incur higher Medicare spending than those who do not elect hospice. (For a fuller discussion of the cost of hospice

care relative to conventional care at the end of life, see the Commission's June 2008 report.)

To make cost savings more likely, the Congress included in the hospice benefit two limitations, or "caps," on payments to hospices. The first cap limits the number of days of inpatient care a hospice may provide to 20 percent of its total Medicare patient care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are reimbursed at the routine home care payment rate.

**TABLE  
12-2**

**Use of hospice continues to increase**

**Percent of Medicare decedents who used hospice**

	<b>2000</b>	<b>2008</b>	<b>2009</b>	<b>2010</b>	<b>2011</b>	<b>Average annual percentage point change 2000-2010</b>	<b>Percentage point change 2010-2011</b>
All beneficiaries	22.9%	40.1%	42.0%	44.0%	45.2%	2.1	1.2
FFS beneficiaries	21.5	39.2	41.0	43.0	44.2	2.2	1.2
MA beneficiaries	30.9	44.0	46.1	47.8	48.9	1.7	1.1
Dual eligibles	17.5	35.9	37.5	39.2	40.3	2.2	1.1
Nondual eligibles	24.5	41.5	43.4	45.5	46.8	2.1	1.3
Age (in years)							
<65	17.0	25.1	26.1	27.2	27.8	1.0	0.6
65-74	25.4	36.2	37.3	38.6	39.3	1.3	0.7
75-84	24.2	41.2	43.1	45.1	46.3	2.1	1.2
85+	21.4	45.4	48.0	50.4	52.0	2.9	1.6
Race/ethnicity							
White	23.8	41.8	43.7	45.8	47.0	2.2	1.2
African American	17.0	30.8	32.6	34.1	35.4	1.7	1.3
Hispanic	21.1	32.9	34.8	37.0	38.3	1.6	1.3
Asian American	15.2	24.5	26.0	28.1	30.0	1.3	1.9
Native North American	13.0	29.8	29.7	30.6	32.4	1.8	1.8
Sex							
Male	22.4	36.8	38.6	40.4	41.3	1.8	0.9
Female	23.3	43.0	45.1	47.2	48.6	2.4	1.4
Beneficiary location							
Urban	24.3	41.7	43.5	45.5	46.6	2.1	1.1
Micropolitan	18.5	35.8	37.5	39.8	41.4	2.1	1.6
Rural, adjacent to urban	17.6	34.7	36.9	38.7	40.2	2.1	1.5
Rural, nonadjacent to urban	15.8	30.5	32.8	34.5	35.9	1.9	1.4
Frontier	13.2	25.7	27.1	30.1	30.7	1.7	0.6

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. "Urban" areas contain a core area with a population of 50,000 or more; "micropolitan" areas contain at least one cluster of between 10,000 and 50,000 people; "rural, adjacent to urban" are counties that are adjacent to urban areas and do not have a city of 10,000 people in the county; and "rural, not adjacent to urban" are rural counties that are not adjacent to urban areas and do not have a city of 10,000 people. "Frontier" counties have six or fewer people per square mile.

Source: MedPAC analysis of data from the denominator file and the Medicare Beneficiary Database from CMS.

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 (\$25,377.01 in 2012), it must repay the excess

to the program.<sup>5,6</sup> This cap is not applied individually to the payments received for each beneficiary but rather to the total payments across all Medicare patients treated 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).

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## **Are Medicare payments adequate in 2013?**

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To address whether payments for 2013 are adequate to cover the costs efficient providers incur, 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 2011, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life. In 2011, 45.2 percent of Medicare beneficiaries who died that year used hospice, up from 44.0 percent in 2010 and 22.9 percent in 2000 (Table 12-2). While hospice use continued to grow in 2011, the rate of increase was not as large as prior years. Hospice use varies by beneficiary characteristics (i.e., enrollment in traditional fee-for-service (FFS) Medicare or Medicare Advantage (MA); beneficiaries dually eligible for Medicare and Medicaid and Medicare-only beneficiaries; urban and rural residence; and age, gender, and race), but it increased across all beneficiary groups in 2011.

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 (Table 12-2). (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 the Medicare FFS program but may remain enrolled in the MA plan to receive any plan supplemental benefits as well as Medicare Part D coverage

for drugs not related to the terminal condition.<sup>7</sup>) In 2000, in rounded figures, 22 percent of Medicare FFS decedents used hospice compared with 31 percent of decedents enrolled in MA. By 2011, these use rates rose to 44 percent of Medicare FFS decedents and 49 percent of MA decedents.

Hospice use varies by other beneficiary characteristics. In 2011, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (about 40 percent and 47 percent, respectively) (Table 12-2). Hospice use has increased in all age groups but is more prevalent and has grown more rapidly among older beneficiaries. In 2011, more than half (52 percent) of Medicare decedents age 85 or older used hospice. Female beneficiaries were also more likely than male beneficiaries to use hospice, which partly reflects the longer average life span among women than men and greater hospice use among older beneficiaries.

Hospice use also varies by racial and ethnic groups (Table 12-2). As of 2011, hospice use was highest among White Medicare decedents followed by Hispanic, African American, Native North American, and Asian American decedents. Hospice use grew substantially among all these groups between 2000 and 2011. Nevertheless, differences in hospice use across racial and ethnic groups persist but are not fully understood. Researchers examining this issue have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care, socioeconomic factors, disparities in access to care or information about hospice, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000).

Hospice use is more prevalent among urban beneficiaries than rural, although use has grown in all types of areas (Table 12-2). In 2011, the share of decedents residing in urban counties who used hospice was 47 percent; in micropolitan counties, 41 percent; in rural counties adjacent to urban counties, 40 percent; in rural nonadjacent counties, 36 percent; and in frontier counties, 31 percent. Use rates for beneficiaries residing in these areas increased between 0.6 percentage point and 1.6 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, as there has been increased recognition that hospice can appropriately care for such patients.

**TABLE  
12-3**

**Increase in total number of hospices driven by growth in for-profit providers**

Category	2000	2007	2008	2009	2010	2011	Average annual percent change		
							2000-2007	2007-2010	2010-2011
All hospices	2,255	3,250	3,329	3,385	3,498	3,585	5.4%	2.5%	2.5%
For profit	672	1,676	1,755	1,834	1,954	2,052	13.9	5.2	5.0
Nonprofit	1,323	1,334	1,334	1,324	1,319	1,308	0.1	-0.4	-0.8
Government/other	258	240	240	227	225	225	-1.0	-2.1	0.0
Freestanding	1,069	2,103	2,203	2,282	2,397	2,485	10.2	4.5	3.7
Hospital based	785	685	663	634	612	597	-1.9	-3.7	-2.5
Home health based	379	441	440	447	466	480	2.2	1.9	3.0
SNF based	21	21	23	22	23	23	0.0	3.1	0.0
Urban	1,424	2,190	2,268	2,323	2,430	2,534	6.3	3.5	4.3
Rural	788	1,012	1,008	1,005	1,002	985	3.6	-0.3	-1.7

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.

We estimate that the share of hospice decedents with noncancer diagnoses has grown from 48 percent in 2000 to 68 percent in 2011.<sup>8</sup> The biggest increase in hospice enrollment among patients with noncancer diagnoses occurred among those with neurological conditions, debility, and nonspecific signs and symptoms. For example, between 2000 and 2011, the share of hospice decedents with neurological conditions (e.g., Alzheimer’s or non-Alzheimer’s dementia) grew from 10 percent to 16 percent. During this same period, the share of hospice decedents with debility grew from 4 percent to 10 percent, and those with nonspecific signs and symptoms increased from 2 percent to 6 percent.

**Capacity and supply of providers: Supply of hospices continues to grow, driven by growth in for-profit providers**

The number of hospice providers has grown substantially since 2000. From 2000 to 2011, the total number of hospices increased 59 percent, from about 2,255 to 3,585 (Table 12-3). The number of providers grew most rapidly in the years prior to 2007, with an average annual growth rate of 5.4 percent between 2000 and 2007. The number of hospices grew at an average rate of about 2.5 percent per year from 2007 to 2010 and grew another 2.5

percent in 2011. The somewhat slower growth in the past few years may in part be influenced by guidance CMS issued in 2007 to state survey and certification agencies. This guidance placed surveys of hospices applying to be new Medicare providers (and surveys of certain other providers) in the lowest tier of their workload priorities.<sup>9</sup>

For-profit hospices have accounted for most of the growth in the number of hospices. Between 2000 and 2011, the number of for-profit hospices more than tripled, increasing from 672 to 2,052 (Table 12-3). During this time period, the number of nonprofits declined 1 percent and the number of government hospices declined 13 percent. As of 2011, about 57 percent of hospices were for profit, 36 percent were nonprofit, and 6 percent were government. The number of providers by ownership type in this report is based on different data sources, which we believe more accurately capture ownership type and changes in ownership, than those used for prior reports.<sup>10</sup> The use of the different data sources does not alter our longstanding finding of rapid growth in the number of for-profit providers.

Growth in the number of hospices occurred mostly among freestanding providers, increasing from 1,069 in 2000 to 2,485 in 2011 (Table 12-3). Over this period, the number



**TABLE  
12-4**

**Hospice use has increased substantially**

Category	2000	2010	2011	Average annual change, 2000-2010	Change, 2010-2011
Number of hospice users (in millions)	0.534	1.159	1.219	8.1%	5.2%
Total spending (in billions)	\$2.9	\$13.0	\$13.8	16.2%	6.8%
Average length of stay among decedents (in days)	54	86	86	4.8%	0.0%
Median length of stay among decedents (in days)	17	18	17	+1 day	-1 day

Note: Average length of stay is calculated for decedents who used hospice at the time of death or prior to death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his/her lifetime. The percent change in number of hospice users and total spending displayed in the chart may not equal the percent change calculated using the yearly data displayed in the chart due to rounding.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and the 100 percent hospice claims standard analytic file from CMS.

of hospital-based hospices declined nearly 25 percent, and the number of home-health-based hospices increased by just over 25 percent. The number of SNF-based hospices is small and changed little. As of 2011, about 69 percent of hospices were freestanding, 17 percent were hospital based, 13 percent were home health based, and less than 1 percent were SNF based. This report uses a data source to identify type of hospice (freestanding, hospital based, home health based, or SNF based) that is different from prior reports. In this report, we identify the type of hospice based on the type of cost report filed for the hospice (i.e., the hospice filed a freestanding hospice cost report or was included in the cost report of a hospital, home health agency, or SNF).<sup>11,12</sup>

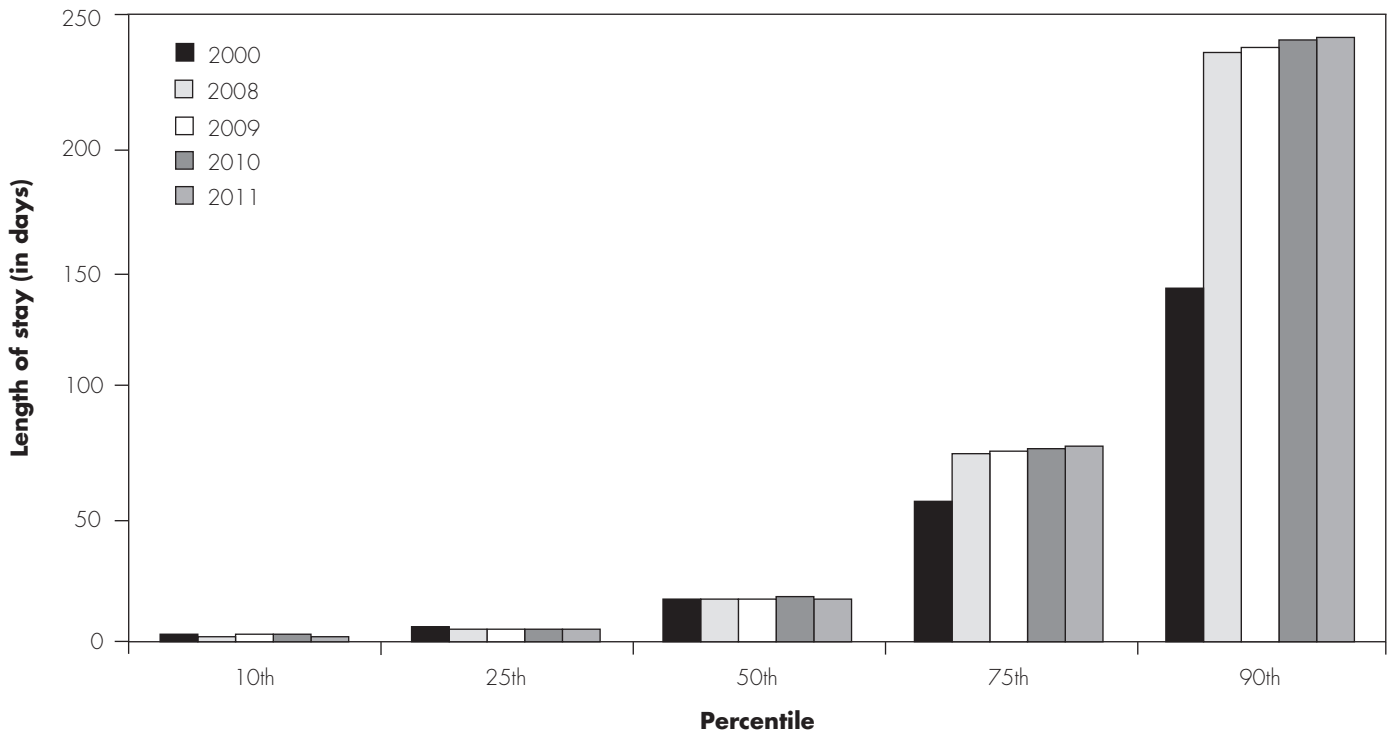
Overall, the supply of hospices has increased substantially since 2000 in both urban and rural areas, although the number of hospices located in rural areas has declined modestly since 2007 (Table 12-3). Roughly consistent with the share of Medicare beneficiaries residing in each area, 72 percent of hospices were located in urban areas and 28 percent were located in rural areas as of 2011. 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. In addition, 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: Number of hospice users continues to grow, while average length of stay was steady overall in 2011**

The number of Medicare beneficiaries receiving hospice services increased rapidly in the last decade, more than doubling since 2000. In 2011, more than 1.2 million beneficiaries used hospice services, up from just over 0.5 million in 2000 (Table 12-4). Between 2000 and 2010, the number of hospice users increased at an average rate of 8.1 percent per year. The number of hospice users continued to grow in 2011 by 5.2 percent.

Average length of stay, which has increased substantially since 2000, grew more slowly in the last few years and changed little in 2011. Between 2000 and 2011, average length of stay among Medicare decedents increased from 54 days to 86 days. In the past few years, growth in average length of stay has slowed, increasing in 2008, 2009, and 2010 from 83 days to 84 days to 86 days, respectively, and holding steady at 86 days in 2011.

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. 272). Between 2000 and 2011, hospice length of stay at the 90th percentile grew substantially, increasing from 141 days to 241 days. Growth in very long stays has slowed in recent years. The 90th percentile of length of stay grew 5 days between 2008 and 2010 and grew 1 additional day in 2011. Median length of stay, which held steady at 17 days for most of the decade, edged upward to 18 days in 2010 and returned to 17 days in 2011. In 2011,

**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 denominator file and the Medicare Beneficiary Database from CMS.

25 percent of stays were 5 days or less, unchanged from the prior year.

The Commission has previously expressed concern about very short and very long hospice stays. With very short hospice stays, the concern is that patients enter hospice too late to fully benefit from all that hospice has to offer. As discussed in our March 2009 report, a Commission-convened panel of hospice industry representatives indicated that very short stays in hospice stem largely from factors unrelated to the Medicare hospice payment system, such as some physicians' reluctance to have conversations about hospice or a tendency to delay such discussions until death is imminent; difficulty some patients and families may have in accepting a terminal prognosis; and financial incentives in the FFS system for increased volume of services (Medicare Payment Advisory Commission 2009). The issue of the FFS system rewarding volume over quality is a broader issue that affects not only Medicare's hospice services but 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. With respect to the challenges of physician-patient communication about advanced illnesses, there may be potential for shared decision-making tools to improve the timeliness and clarity of information patients receive about their condition and treatment options and empower patients to make choices based on their preferences.

Some point to the requirement that beneficiaries forgo intensive conventional care to enroll in hospice as a factor that contributes to deferring hospice care and thus short hospice stays. PPACA 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, so its future is unclear. A few private

**TABLE  
12-5**

**Hospice average length of stay among decedents by beneficiary and hospice characteristics, selected years**

Average length of stay among decedents (in days)

Characteristic	2000	2009	2010	2011
<b>Beneficiary</b>				
Diagnosis				
Cancer	50	53	53	52
Neurological conditions	63	132	134	137
Heart/circulatory	46	76	76	74
Debility	49	98	97	97
COPD	69	107	110	107
Other	48	85	88	86
Main location of care				
Home	N/A	87	87	88
Nursing facility	N/A	107	111	111
Assisted living facility	N/A	143	148	149
Hospice facility or hospital	N/A	14	14	15
<b>Hospice</b>				
Hospice ownership				
For profit	59	100	101	102
Nonprofit	49	69	70	69
Type of hospice				
Freestanding	55	87	89	89
Home health based	46	70	69	68
Hospital based	49	62	62	61

Note: COPD (chronic obstructive pulmonary disease), N/A (not available). Average length of stay is calculated for Medicare beneficiaries who died in a given year 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 is defined as the location where the beneficiary spent the largest share of his/her hospice days in a given year.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file data, Medicare Beneficiary Database, Medicare hospice cost reports, Provider of Services file data from CMS.

insurers are experimenting with this approach 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, with the absence of health plan utilization management and an elderly population with a greater prevalence of noncancer diagnoses, which tend to result in longer hospice stays.

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 2011 with neurological conditions and chronic obstructive pulmonary disease had substantially higher average lengths of stay (137 days and 107 days, respectively) than those with cancer (52 days) and heart or circulatory conditions (74 days). While length of stay changed little for most diagnosis groups in the last three years, length of stay for decedents with neurological conditions increased five days between 2009 and 2011—from 132 days to 137 days.

Differences in length of stay by diagnosis are reflected in the percentile distribution of length of stay (Table 12-6, p. 274). Length of stay is similar for patients with the

**TABLE  
12-6**

**Distribution of hospice length of stay among decedents by beneficiary and hospice characteristics, 2011**

Characteristic	Percentile of length of stay				
	10th	25th	50th	75th	90th
<b>Beneficiary</b>					
Diagnosis					
Cancer	3	6	17	51	126
Neurological	3	7	25	140	423
Heart/circulatory	2	4	11	54	210
Debility	3	7	23	100	280
COPD	2	5	20	105	316
Other	2	4	13	79	251
Main location of care					
Home	4	9	26	86	231
Nursing facility	3	6	21	105	332
Assisted living facility	5	12	50	180	423
Hospice facility or hospital	2	2	4	9	19
<b>Hospice</b>					
Hospice ownership					
For profit	3	6	21	92	295
Nonprofit	2	5	14	58	184
Type of hospice					
Freestanding	2	5	17	78	251
Home health based	2	5	15	61	183
Hospital based	2	5	14	53	160

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2011 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 is defined as the location where the beneficiary spent the largest share of his/her hospice days in 2011.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file data, Medicare Beneficiary Database, Medicare hospice cost reports, Provider of Services file data from CMS.

shortest stays, irrespective of diagnosis. For example, when stratified by diagnosis, 10 percent of patients have a length of stay of two to three days regardless of their condition, and 25 percent of patients have stays of a week or less. Length-of-stay differences become more pronounced among patients with the longer stays (e.g., 75th percentile and 90th percentile). 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 roughly 300 days longer at the 90th percentile.

Length of stay also varies by site of service. In 2011, average length of stay was higher among Medicare decedents whose main location of care was an assisted living facility (149 days) or a nursing facility (111 days) rather than home (88 days). Further, length of stay has increased since 2009 by four to six days in these facility settings, but by one day in the home (Table 12-5, p. 273). 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 (86 days at home, 105 days at a nursing facility, and 180 days at an assisted living facility) and the 90th percentile varied by just under 200 days (231 days, 332 days, and 423 days across the

three settings, respectively) (Table 12-6). 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 differences in length of stay, but the markedly longer stays among assisted living facility residents are not understood and bear further monitoring and examination.

The differences in length of stay by patient characteristics are reflected in differences in length of stay by provider type. In 2011, average length of stay was substantially higher at for-profit hospices than at nonprofit hospices (102 days compared with 69 days); between 2009 and 2011, stays increased 2 days among for profits and stayed essentially the same for nonprofits. The higher length of stay among for profits has two components: (1) for profits have more patients with diagnoses that tend to have longer stays, and (2) for profits 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.

The markedly longer stays of some providers raise program integrity questions. An expert panel of hospice medical directors and executives that the Commission sponsored in fall 2008 indicated that some hospices were enrolling patients who did not meet the eligibility criteria. In March 2009, the Commission recommended several steps to improve accountability, including requiring a physician narrative on certifications and recertifications, physician or nurse practitioner face-to-face visits prior to recertification at 180 days and beyond, and focused medical review of hospice providers where stays beyond 180 days made up an unusually high share of their caseload compared with other providers. CMS implemented a physician narrative requirement in October 2009, and PPACA required face-to-face recertification visits as of January 2011 (implementation was delayed to April 2011).

The 2011 hospice claims data offer a first look at utilization patterns after implementing the face-to-face visit requirement. In 2011, average length of stay was steady, and length of stay at the 90th percentile increased by one day. With the available data it is difficult to discern what influence the face-to-face visit requirement may have had on length of stay versus other factors such as a general increase in regulatory scrutiny. Another aspect of hospice care that the face-to-face visit might affect is live discharge rates if physicians or nurse practitioners find

**TABLE  
12-7**

**Percent of hospice benefit periods that ended with a live discharge, by benefit period number and year**

Hospice benefit period number	Percent of hospice benefit periods ending with a live discharge	
	2010	2011
1	9.2%	8.8%
2	13.9	13.6
3	10.6	10.7
4	10.3	10.0
5 or higher	9.0	8.3

Note: Data include benefit periods that ended between April and December of 2010 and 2011.

Source: MedPAC analysis of the denominator file, the Medicare Beneficiary Database, and 100 percent hospice claims standard analytic file from CMS.

patients ineligible for hospice after conducting the visit. Face-to-face visits are required prior to recertifying any hospice patient for a third or subsequent benefit period. If the face-to-face visit requirement led to more live discharges, we would expect to see more live discharges at the end of the second benefit period (i.e., before the patient is recertified for the third benefit period) and subsequent benefit periods. The share of benefit periods ending with a live discharge changed little in 2011 compared with the prior year; if anything, they declined slightly (Table 12-7). For example, 13.6 percent of second benefit periods ended with a live discharge in 2011, down slightly from 13.9 percent in 2010.<sup>13</sup> It is difficult to know what is driving the slight decline in live discharges, but it could suggest more appropriate patients being admitted to hospice.

One example of hospices with unusual utilization patterns are the roughly 10 percent of hospices that exceed the aggregate payment cap. As shown in our March 2011 and 2012 reports and online Appendix 12-A to this report, which is available at <http://www.medpac.gov>, above-cap hospices have substantially higher lengths of stay and rates of discharging patients alive than other hospices (Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011).<sup>14</sup> As noted in our March 2012 report, these data may suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the OIG and CMS.

**TABLE  
12-8****Hospices that exceeded Medicare's annual payment cap, selected years**

	2002	2006	2008*	2009*	2010*
Percent of hospices exceeding the cap	2.6%	9.4%	10.2%	12.5%	10.1%
Average payments over the cap per hospice exceeding the cap (in thousands)	\$470	\$731	\$571	\$485	\$426
Payments over the cap as percent of overall Medicare hospice spending	0.6%	2.4%	1.7%	1.7%	1.2%
Total Medicare hospice spending (in billions)	\$4.4	\$8.8	\$11.4	\$12.0	\$12.9

Note: The cap year is defined as the period beginning November 1 and ending October 31 of the following year.

\*Due to a change in data availability and refinements in the estimation methodology, the estimates in 2008, 2009, and 2010 are not entirely comparable to the estimates for 2002 and 2006.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file data, Medicare hospice cost reports, Provider of Services file data from CMS. Data on total spending for each fiscal year from the CMS Office of the Actuary.

In 2010, 10.1 percent of hospices exceeded the cap, down from an estimated 12.5 percent in 2009 (Table 12-8).<sup>15</sup> This decline is a reversal of the trend we observed in the last decade of a growing share of hospices exceeding the cap.<sup>16</sup> Among hospices that exceeded the cap, the average amount over the cap was smaller in 2010 than in 2009, 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 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 for hospices that close. At the extreme, one hospice provider in 2012 reportedly closed and opened as a new hospice to avoid repaying cap overpayments (Waldman 2012).

Given the concerns about very short and very long hospice stays, it may be worthwhile to consider providing physicians who refer patients to hospice with summary feedback on the length of stay of patients they refer. If referring physicians have information about the outcome of their referrals, it might help them gauge the timing of their conversations with patients about hospice and might lower the prevalence of very short stays and very long stays. Of course, there will always be some very short and very long stays in hospice because of uncertainty in predicting life expectancy and unforeseen events. But to the extent that some of these stays occur because physicians lack information about what occurs after a hospice referral, this type of feedback has the potential to

influence referrals to hospice and help promote lengths of stay that are sufficient to benefit patients and are consistent with an end-of-life benefit.

### 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.

CMS has adopted two quality measures for the first year of the pay-for-reporting program. Hospices must report these measures in 2013 (based on data from the last three months of calendar year 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, focuses on pain management (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—commonly referred to as the National Hospice and Palliative Care Organization's comfortable dying measure). The second measure is process related and is designed to help develop future quality measures. Hospices will report whether they are tracking at least three measures focused on patient care and what those measures are, which CMS indicated will help identify feasible quality measures in the future. Given the penalty for nonreporting and the limited scope of the initial

measures, it is likely that the vast majority of providers will report in 2013.

For future reporting years, CMS has expressed interest in developing a more comprehensive set of hospice quality measures for payment years after 2015. CMS has indicated that a standardized patient assessment instrument might be needed to support the collection of a broader set of quality measures. CMS has indicated that it is in the early stages of developing and testing a patient-level data set and may consider implementation as early as calendar year 2014. The patient assessment instrument that CMS is testing includes items that would support several new quality measures recently endorsed by the National Quality Forum, including process measures related to pain screening and assessment, dyspnea assessment and treatment, and provision of a bowel regimen for patients receiving opioids. CMS has also expressed interest in developing a bereaved family member survey.

As discussed in our March 2012 report, in November 2011 we convened a technical panel of hospice clinicians, researchers, quality experts, and other stakeholders to provide input on hospice quality measurement (Medicare Payment Advisory Commission 2012). Several panelists indicated that Medicare claims data might be a source of quality care indicators. For example, claims data showing hospices that provided few visits in the last days of life, provided no higher acuity hospice care (general inpatient care or continuous home care) to any patients, or had unusually high live-discharge rates could signal potentially poor quality and indicate the need for further CMS scrutiny.

### **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.

Some freestanding hospices are part of large publicly traded chain providers. Recent financial reports for these hospices have been favorable, with strong margins and cash flow. In 2011 and 2012, publicly traded hospice companies made investments to expand operations, either through acquisition of other hospice providers or through investments in new inpatient units, suggesting adequate access to capital among these providers. Also, a few

publicly traded nursing home companies have reported expanding into the hospice sector through acquisitions, citing favorable margin opportunities.

Less information is available on access to capital for privately held providers. Among private equity groups, the number of merger and acquisition transactions for hospice providers, which increased in 2009, 2010, and 2011, declined in the first half of 2012. Some analysts have characterized this decline as a natural lull after a period of high acquisition activities rather than a reflection of reduced interest in the sector (Braff Group 2012a, Braff Group 2012b). The continued growth in the number of for-profit providers suggests adequate access to capital for these providers. Less is known about access to capital for nonprofit freestanding providers, which may be more limited. Hospital-based and home-health-based hospices have access to capital through their parent providers, which also 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 providers' costs. We examined margins through the 2010 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 12-9, p. 278), which is one reason for differences in hospice margins across provider types. In 2010, hospice costs per day were \$143 on average across all hospice providers, a very slight increase from \$142 per day in 2009.<sup>17</sup> 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 lengths of stay have lower costs per day.

**TABLE  
12-9**

**Hospice costs per day vary  
by type of provider, 2010**

	Average	Percentile		
		25th	50th	75th
All hospices	\$143	\$110	\$134	\$167
Freestanding	138	108	130	157
Home health based	151	114	139	184
Hospital based	181	117	161	210
For profit	130	104	125	154
Nonprofit	157	121	147	184
Above cap	119	93	114	136
Below cap	145	112	137	170
Urban	146	113	137	170
Rural	126	102	126	160

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 not adjusted for differences in the case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services data from CMS.

Freestanding hospices have longer stays than provider-based hospices, which accounts for some but not all of the difference in costs per day. Another substantial factor is the higher level of indirect costs among provider-based hospices. A few examples of indirect costs are management and administrative costs, accounting and billing, and capital costs. In 2010, indirect costs made up 34 percent of total costs for freestanding hospices, compared with 40 percent of total costs for home-health-based hospices and 43 percent of total costs for hospital-based hospices. The higher indirect costs among provider-based hospices suggest that their costs may be inflated because of the allocation of overhead costs from the parent provider.<sup>18</sup>

**Hospice margins**

From 2004 to 2010, the aggregate hospice Medicare margin oscillated from as low as 4.6 percent to as high as 7.5 percent (Table 12-10).<sup>19</sup> As of 2010, the aggregate hospice Medicare margin was 7.5 percent, up from 7.4 percent in 2009. Margins varied widely across individual hospice providers. In 2010, the Medicare margin was -11.5 percent at the 25th percentile, 6.9 percent at the 50th

percentile, and 19.9 percent at the 75th percentile. Our estimates of Medicare margins from 2004 to 2010 exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.<sup>20</sup>

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, but it prohibits Medicare payment for these services (section 1814(i)(1)(A) of the Social Security Act). Hospices report their costs associated with providing 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 2010 aggregate Medicare margin by at most 1.4 percentage points.<sup>21</sup> This estimate of 1.4 percentage points 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 (10.7 percent) than home-health-based and hospital-based hospices (3.2 percent and -16.0 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, capital costs), which are likely inflated because of the allocation of overhead costs from the parent provider. 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 up to 8 percentage points higher for home-health-based hospices and 13



**TABLE  
12-10**

**Hospice Medicare margins by selected characteristics, 2004-2010**

Category	Percent of hospices 2010	Medicare margin						
		2004	2005	2006	2007	2008	2009	2010
All	100%	5.0%	4.6%	6.4%	5.8%	5.5%	7.4%	7.5%
Freestanding	69	8.3	7.2	9.7	8.7	8.3	10.2	10.7
Home health based	13	3.1	3.1	3.8	2.3	3.4	5.9	3.2
Hospital based	17	-11.6	-9.1	-12.7	-10.9	-11.3	-12.2	-16.0
For profit (all)	56	11.8	9.9	12.0	10.4	10.3	11.7	12.4
Freestanding	51	12.3	10.3	12.7	11.3	11.5	12.9	13.4
Nonprofit (all)	38	0.3	1.0	1.5	1.6	0.7	3.8	3.2
Freestanding	17	3.7	3.8	5.8	5.6	3.7	6.6	7.6
Government (all)	14	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Urban	71	5.9	5.1	7.1	6.3	5.9	7.9	7.8
Rural	29	-2.3	0.2	0.8	1.4	2.1	3.7	5.3
Patient volume (quintile)								
Lowest	20	-6.1	-6.6	-5.1	-7.9	-8.4	-6.5	-5.2
Second	20	-1.2	-1.6	0.3	1.0	0.1	2.0	4.0
Third	20	1.1	1.9	2.4	3.0	4.4	4.5	7.2
Fourth	20	2.8	4.4	5.8	5.8	7.2	6.8	7.1
Highest	20	7.2	5.9	8.1	7.0	6.1	9.0	8.4
Below cap	89.9	5.6	5.1	7.0	6.1	5.9	7.9	7.8
Above cap (excluding cap overpayments)	10.1	-3.4	-0.8	0.3	2.5	1.2	1.4	3.2
Above cap (including cap overpayments)	10.1	18.9	20.7	20.7	20.5	19.0	18.3	17.3

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. 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 hospice cost reports, 100 percent hospice claims standard analytical file, and Medicare Provider of Services data from CMS.

percentage points higher for hospital-based hospices, and the industry-wide aggregate Medicare margin would be up to 1.9 percentage points higher.<sup>22</sup> We intend to continue to examine the differences in the levels of indirect costs across providers and consider whether issues with the allocation of overhead from the parent provider warrant the exclusion of provider-based hospices from our margin calculations.

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 (12.4 percent) than for nonprofit hospices (3.2 percent). However, freestanding nonprofit hospices, which are not affected by overhead allocation issues, had a higher margin (7.6 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 (7.8 percent) than those in rural areas (5.3 percent).

Hospice financial performance also varies by length of stay (Table 12-11, p. 280). In 2010, 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).<sup>23</sup> As noted previously, the higher profitability of long stays reflects a mismatch between the Medicare payment system and hospices' level of effort throughout an episode. 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

**TABLE  
12-11****Hospice Medicare margins  
by length of stay and  
patient residence, 2010**

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	-8.9%
Second quintile	0.8
Third quintile	10.1
Fourth quintile	14.1
Highest quintile	11.6
Percent of stays > 180 days	
Lowest quintile	-8.3
Second quintile	1.5
Third quintile	10.6
Fourth quintile	14.7
Highest quintile	11.3
Percent of patients in nursing facilities	
Lowest quartile	1.5
Second quartile	6.8
Third quartile	6.8
Highest quartile	13.5
Percent of patients in assisted living facilities	
Lowest quartile	2.1
Second quartile	1.9
Third quartile	8.8
Highest quartile	11.4

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports, Medicare Beneficiary Database, 100 percent hospice claims standard analytical file, and Medicare Provider of Services data from CMS.

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 2010, hospices in the top quartile of the percent of their patients residing in nursing facilities had a 13.5 percent margin compared with a margin of 6.8 percent in the middle quartiles and a 1.5 percent margin in the bottom quartile (Table 12-11).

Margins also vary by the share of a provider's patients in assisted living facilities, with a margin ranging from roughly 2 percent in the lowest two quartiles to about 11 percent in the highest quartile. Some of the difference in margins among hospices with different percentages 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, there may also be efficiencies in the nursing facility setting, possibly from treatment of patients in a centralized location (e.g., lower mileage costs and staff time required for travel when a hospice treats more patients in a single location), and from overlap in aide services, supplies, and equipment provided by the hospice and nursing facility.

The OIG recently completed a report on hospices that have a large share of their patients in nursing facilities. These providers are more likely to be for profit, have longer lengths of stay, and treat patients with diagnoses that require less complex care (Office of Inspector General 2011). They also noted an overlap in payments provided to hospices and nursing facilities for aide services. The OIG recommended that CMS monitor hospices that focus on nursing facilities and reduce payments for hospice care in nursing facilities. In the Commission's letter to the Congress on repeal of the sustainable growth rate and possible offsets, the Commission included a placeholder policy to implement the OIG's recommendation for a reduction in hospice rates in nursing homes (see Appendix B, pp. 371–392).

### Projecting margins for 2013

To project the aggregate Medicare margin for 2013, we model the policy changes that went into effect between 2010 (the year of our most recent margin estimates) and 2013. The policies include:

- a market basket update of 2.6 percent for fiscal year 2011, 3.0 percent for fiscal year 2012, and 2.6 for fiscal year 2013;
- a 1.0 percentage point reduction to the market update in 2013 (reflecting a productivity adjustment of -0.7 percentage point and an additional adjustment of -0.3 percentage point);
- years two through four 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 2011 through 2013;

- additional wage index changes, which reduced payments in fiscal years 2011 and 2013 and increased payments in fiscal year 2012;<sup>24</sup> and
- additional net costs associated with the face-to-face visit requirement for recertification of patients in the third and subsequent benefit periods beginning in 2011 and the quality reporting program beginning in 2013.

Taking these policy changes into account and assuming that hospice costs in 2012 and 2013 grow at a rate similar to forecasted input price growth, we project an aggregate Medicare margin for hospices of 6.3 percent in fiscal year 2013. In recent years, hospice costs have grown more slowly than market basket, and if that trend continues, the 2013 margin would be higher than we have projected. This margin projection excludes the nonreimbursable costs associated with bereavement services and volunteers (which would lower the aggregate margin at most by 1.4 percentage points and 0.3 percentage point, respectively). It also does not include any adjustment for the higher indirect costs observed among hospital-based and home-health-based hospices (which would increase the industry-wide aggregate Medicare margin by up to 1.9 percentage points).

In considering the 2013 margin projection as an indicator of the adequacy of current payment rates for 2014, one policy of note is the continued phase-out of the wage index budget-neutrality adjustment. Our 2013 margin projection reflects the first four years (through 2013) of the seven-year phase-out of the wage index budget-neutrality adjustment. In 2014, the fifth 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 2014?

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On the basis of our review of payment adequacy for hospice services, the Commission recommends that the Congress eliminate the update to the hospice payment rates for fiscal year 2014.

## Update recommendation

### RECOMMENDATION 12

**The Congress should eliminate the update to the hospice payment rates for fiscal year 2014.**

### 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 also continues to increase, while growth in average length of stay has leveled off. Access to capital appears adequate. The projected 2013 aggregate Medicare margin is 6.3 percent.

### IMPLICATIONS 12

#### Spending

- Under current law, hospices would receive an update in fiscal year 2014 equal to the hospital market basket index (currently estimated at 2.6 percent), less an adjustment for productivity (currently estimated at 0.5 percent). Hospices may also face an additional 0.3 percentage point reduction in the fiscal year 2014 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 1.8 percent or 2.1 percent (based on current estimates). Our recommendation to eliminate the payment update in fiscal year 2014 would decrease federal program spending relative to the statutory update by between \$50 million and \$250 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

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- 1 If a beneficiary does not have an attending physician, then 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 CMS interpreted the 180th-day recertification and each subsequent recertification to mean the recertification prior to the third benefit period and each subsequent benefit period. The first two benefit periods are 90 days (unless the patient is discharged in the middle of the benefit period), so the third benefit period typically begins after 180 days.
- 4 The OIG has also released or planned studies on other hospice issues. The OIG recently released a study examining use of certain Medicare Part D drugs by patients in hospices and concluded that some drugs that should be covered by hospice may be currently billed to Part D (Office of Inspector General 2012). The OIG's 2013 work plan also includes an examination of the appropriateness of general inpatient hospice care and an assessment of Medicare payments when patients are transferred from acute care hospitals to hospice general inpatient care.
- 5 The average annual payment cap is calculated for the period November 1 through October 31 each year. There are two methodologies for calculating the beneficiary count used in the cap calculation: a streamlined methodology and proportional methodology. For years prior to cap year 2012, the streamlined methodology is used unless the hospice has filed a lawsuit or appeal regarding the methodology, in which case the proportional methodology is used for the challenged year going forward. Beginning in cap year 2012, the proportional methodology will be used for all hospices unless they elect to remain with the streamlined methodology. In the streamlined methodology, beneficiaries are counted in a given year if they have filed an election to receive care from the hospice during the period beginning on September 28 before the beginning of the cap period and ending on September 27 before the end of the cap period. If a beneficiary receives care from more than one hospice, that beneficiary is included in the beneficiary count for a hospice and a cap year as a fraction that represents the beneficiary's total hospice days provided by that hospice in that cap year as a percent of the beneficiary's total hospice days across all hospices and all cap years. The proportional approach uses the streamlined formula for counting beneficiaries who switched hospices and applies it to all of the hospice's patients, including those who do not switch hospices.
- 6 This 2012 cap threshold is equivalent to an average length of stay of 168 days of routine home care for a hospice with a wage index of 1.
- 7 The beneficiary may stay enrolled in the MA plan after enrollment in hospice. The rate Medicare pays to the MA plan would be reduced to include only the Part D premium (assuming an MA–Prescription Drug plan) and rebate dollars. The MA plan would be responsible for providing the beneficiary with any plan supplemental benefits and any Part D drugs unrelated to the terminal condition. If the beneficiary needs Part A or Part B services for a condition not related to the terminal illness, the MA plan can provide those services or the beneficiary can seek those services from a Medicare FFS provider. If such services were provided by the MA plan, the plan would be paid the Medicare FFS rate for those services by the Medicare program, but the services would be subject to the level of cost sharing of the MA benefit package (not the FFS cost-sharing levels).
- 8 In 2009, cancer was the cause of death for about 22 percent of decedents age 65 or older (Centers for Disease Control and Prevention 2012). As hospice use among beneficiaries with noncancer diagnoses has grown, the share of hospice decedents with cancer has declined from 52 percent in 2000 to 32 percent in 2011. Thus, the share of hospice decedents with cancer has become increasingly similar over time to the share of deaths attributed to cancer.
- 9 In late 2007, CMS issued guidance to state survey and certification agencies indicating that surveys of new hospices applying to be Medicare providers (as well as other types of providers that have the option of obtaining Medicare status through accreditation rather than state surveys) should be in the lowest tier of their workload priorities. While accreditation continues to be an option for obtaining Medicare status, the financial costs associated with pursuing accreditation may have slowed entry among some providers.
- 10 In this report, we count hospice providers by type of ownership by matching hospice claims data to the cost report data on provider ownership type, or in cases where cost report data were not available, matched to the Provider of Services file. In previous reports, we used data on type of ownership from CMS's Providing Data Quickly (PDQ) system. We believe the cost reports more accurately distinguish hospice ownership type than the PDQ in situations where a hospice changes ownership due to an acquisition or merger or in situations where the PDQ records the hospice's ownership as "other" but the cost report indicates a specific ownership type (i.e., for profit, nonprofit, government).
- 11 In this report, provider type (freestanding, hospital based, home health based, and SNF based) is based on the type of cost report submitted for the hospice. In prior reports, we used the hospice's self-reported type (freestanding, hospital based, home health based, and SNF based) from the CMS PDQ system. We

- believe the cost report data provide a more accurate reflection of the type of hospice than the PDQ data because some hospices in the PDQ data report being home health based even though they are included in a hospital's cost report.
- 12 The type of cost report filed—freestanding, home health, hospital, or SNF—does not necessarily reflect the location of individual patients served by the hospice. For example, all four types of hospices may serve some patients in nursing facilities.
  - 13 These figures focus on beneficiaries entering the second benefit period and reflect the percentage of those beneficiaries whose second benefit period ended with a live discharge. Another way to look at live discharge rates is to focus on all hospice discharges in a year and calculate the share accounted for by live discharges. In 2011, just over 17 percent of hospice discharges involved patients who were discharged alive.
  - 14 Above-cap hospices are more likely to be for-profit, freestanding providers and to have smaller patient loads than below-cap hospices.
  - 15 The estimates of hospices over the cap are based on the Commission's analysis and are not identical to those of the CMS claims processing contractors. While the estimates are intended to approximate those of the 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 alternative 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 (or recalculated) from the challenged year going forward using the alternative methodology. At the time of writing of this report, the 2010 hospice cap calculations have not been finalized by the contractors and appeals are still possible, so uncertainty exists about which cap formula will be used to calculate cap overpayments for 2010 for individual providers. In light of this uncertainty, for estimation purposes we have assumed that the original cap methodology is used for the 2010 cap calculation for all hospices. This approach is conservative and likely results in our overstating the amount of cap overpayments and understating our margin estimates slightly.
  - 16 Because of refinements to our methodology for calculating cap overpayments in 2008 through 2010 (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 12-8 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 percent of hospices exceeding the cap increased through 2009 and declined in 2010, while the percent of total hospice payments over the cap and the average amount of the overpayment per above-cap hospice has declined since 2006.
  - 17 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 Medicare 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.
  - 18 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 when comparing providers with similar patient volumes.
  - 19 The aggregate Medicare margin is calculated by the following formula:  $((\text{sum of total payments to all providers}) - (\text{sum of total costs to all providers})) / (\text{sum of total payments to all providers})$ . Data on total costs come from the Medicare cost reports. Data on total Medicare payments and total cap overpayments come from Medicare claims data. We present margins for 2010 because of time lags in the claims data. We have complete claims data for all hospices only through the 2010 cost-reporting year (which for some hospices includes part of calendar year 2011).
  - 20 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.
  - 21 Bereavement costs are generally similar across most types of hospices; however, nonprofits report higher costs than for profits (1.9 percent and 1.0 percent of total costs in 2010, respectively).
  - 22 These estimates are adjusted to account for differences in patient volume across freestanding and provider-based hospices.
  - 23 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).
  - 24 Hospices' payments increase or decrease slightly from one year to the next because of the annual recalibration of the hospital wage index. The annual wage index recalibration was expected to reduce Medicare hospice payments by 0.2 percent in 2011 and 0.1 percent in 2013 and increase payments by 0.1 percent in 2012, according to estimates in the CMS final rules or notices establishing the hospice payment rates for those years.

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CHAPTER

# 13

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**The Medicare Advantage  
program: Status report**

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## The Medicare Advantage program: Status report

### Chapter summary

Each year the Commission provides a status report on the Medicare Advantage (MA) program. In 2012, the MA program included more than 3,600 plan options, enrolled more than 13 million beneficiaries, and paid MA plans about \$136 billion. 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 from the traditional FFS Medicare program. The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans, because they are paid a capitated rate rather than on an FFS basis, have greater incentives to innovate and use care management techniques.

The Commission has stressed the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. For MA, the Commission recommended that payments be brought 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

### In this chapter

- Trends in enrollment, plan availability, and payment
- Quality in MA plans
- Conclusion

has reduced the inequity between MA and FFS. As a result, we see evidence of improved efficiency in MA: As plan bids have come down in relation to FFS, enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

The Commission has also 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 (PPACA), enacted in March 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, with better medical record validation and other documentation efforts as a contributing factor in improved performance for many plans. More plans have reached the level of quality ratings that would permit bonuses under the statutory provisions.

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

**Enrollment**—Between 2011 and 2012, MA enrollment increased by 10 percent to 13.3 million beneficiaries (27 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased 10 percent to nearly 9 million enrollees. Local preferred provider organizations (PPOs) showed rapid growth, with enrollment growing about 30 percent, to 3 million enrollees. However, regional PPO enrollment decreased about 16 percent, to 1 million enrollees. Enrollment in private FFS plans also declined from about 0.6 million to about 0.5 million enrollees, continuing the expected decline resulting from legislative changes. The MA plan bids submitted to CMS project an increase in overall enrollment for 2013 of 8 percent to 10 percent, primarily in HMOs.

**Plan availability**—In 2013, 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-six percent of beneficiaries have access to an MA plan that includes Part D drug coverage and

charges no premium (beyond the Medicare Part B premium). Beneficiaries are able to choose from an average of 12 MA plan options, including 9 CCPs in 2013.

**Plan payments**—For 2013, under PPACA, the base county benchmarks used to set plans' payment rates are, on average, roughly the same as the benchmarks for 2012. However, 93 percent of 2013 plan enrollment (similar to the percentage in 2012) is projected to be in plans that will receive add-ons to their benchmarks through a CMS MA quality bonus demonstration program. These quality bonus add-ons range from 3 percent to 10 percent in 2013.

We estimate that 2013 MA benchmarks, bids, and payments (including the quality bonuses) will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively. Last year, we estimated that, for 2012, these figures would be 112 percent, 98 percent, and 107 percent, respectively. The PPACA benchmark reductions, underestimates of FFS spending levels for 2013, and projected enrollment shifts into HMOs, combined with offsetting quality bonuses, resulted in some movement of projected MA payments toward FFS spending levels.

**Quality measures**—In the past year's quality results, MA plans improved in a number of process and intermediate outcome measures that they report to CMS, but there was little change in patient experience measures and measures used to determine whether there was overall improvement in the health status of plan enrollees. With respect to intermediate outcome measures, which are based on documentation from medical records, HMO results remained stable over the past year on most of those measures, while local PPOs have narrowed previously wide differences between the performance of PPO plans and HMOs. As a result of local PPOs' improved medical record validation and other documentation efforts in reporting the intermediate outcome measures, between 2012 and 2013 such plans were able to raise their CMS star ratings, which are the composite plan quality ratings that determine plan bonuses and the level of rebate dollars that plans can use to finance extra benefits. ■



The Medicare Advantage (MA) program allows Medicare beneficiaries to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2012, the MA program included almost 3,600 plan options, enrolled more than 13 million beneficiaries, and paid MA plans about \$136 billion to cover Part A and Part B services. The Commission supports private plans in the Medicare program, as they enable beneficiaries to choose between the FFS Medicare program and the 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 while offering beneficiaries an unconstrained choice of health care providers. Although traditional Medicare also has the potential to modify its payment methods over time to better reward value, more often than not, such alterations require changes in law; to date, application of care management in FFS Medicare has been limited. 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 the excess payments to plans that would have been lower under FFS Medicare for similar beneficiaries. This higher spending results in extra benefits being provided through increased government expenditures and also through 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 in 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.

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## Trends in enrollment, plan availability, and payment

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In contrast to traditional FFS Medicare, MA enrolls beneficiaries in several types of private health plans. In contrast to FFS Medicare, which pays providers a predetermined fixed rate per service, plans are paid a fixed capitated rate per enrollee.

### 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 (Landon et al. 2012). 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

**TABLE  
13-1**

**Medicare Advantage enrollment grew in 2012**

	MA enrollment (in millions)		Percent change in enrollment	2012 MA enrollment as a share of total Medicare
	November 2011	November 2012		
Total	12.1	13.3	10%	27%
Plan type				
CCP	11.5	12.8	11	26
HMO	8.0	8.8	10	17
Local PPO	2.3	3.0	30	6
Regional PPO	1.2	1.0	-16	2
PFFS	0.6	0.5	-12	1
Restricted availability plans included in totals above				
SNPs*	1.4	1.6	10	3
Employer group*	2.2	2.4	10	5
Urban/rural				<b>MA enrollment as share of population</b>
Urban	10.6	11.6	9	29
Rural	1.5	1.7	13	16

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.

\* 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.

did not have provider networks, making them less able than other plan types to coordinate care. They usually used Medicare FFS payment rates and had fewer quality reporting requirements. Given that PFFS plans generally lacked care coordination, had lower quality measures than CCPs on those measures they did report, 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 to become PPOs or HMOs or 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. In Chapter 14 of this report, we make several recommendations related to SNPs. 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, as these plans are not available to all beneficiaries.

**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 58 percent and 72 percent in 2013, 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 still pay premiums to the plan for additional benefits). 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 2012, Part A and Part B payments to MA plans totaled approximately \$136 billion. A more detailed description of the MA program payment system can be found at [http://www.medpac.gov/documents/MedPAC\\_Payment\\_Basics\\_12\\_MA.pdf](http://www.medpac.gov/documents/MedPAC_Payment_Basics_12_MA.pdf).

### Enrollment trends: Plan enrollment grew in 2012

Between November 2011 and November 2012, enrollment in MA plans grew by about 10 percent—or 1.2 million enrollees—to 13.3 million enrollees (compared with growth of about 4 percent in the same time period for the total Medicare population). About 27 percent of all Medicare beneficiaries were enrolled in MA plans in 2012 (Table 13-1).

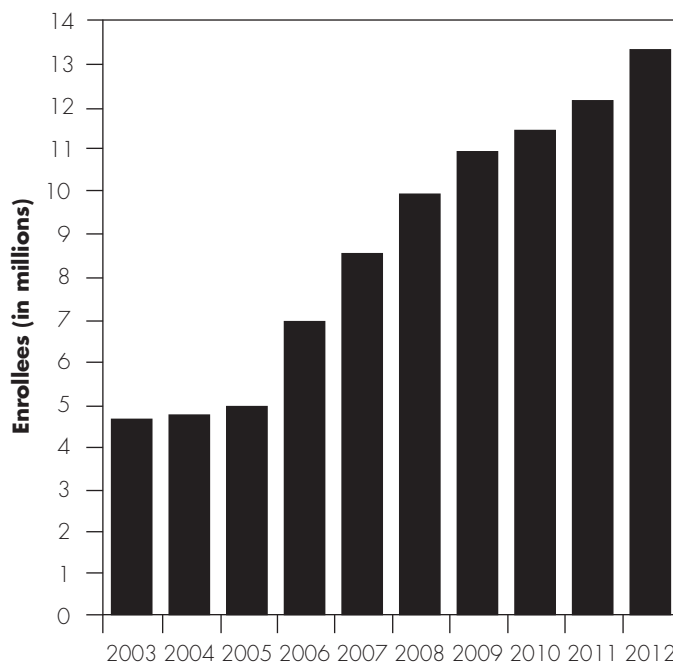
Enrollment patterns differ in urban and rural areas. A larger share of urban beneficiaries are enrolled in MA (about 29 percent) compared with beneficiaries residing in rural counties (about 16 percent). About a third of rural MA enrollees were in HMO plans (not shown in Table 13-1) compared with about 71 percent of urban enrollees. At the same time, 15 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 2012 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).

Among plan types, HMOs continued to enroll the most beneficiaries (8.8 million), with 17 percent of all Medicare beneficiaries in HMOs in 2012. Between 2011 and

**FIGURE 13-1**

**Medicare Advantage enrollment, 2003–2012**



Source: MedPAC analysis of CMS enrollment files.

2012, local PPOs exhibited rapid growth in enrollment, which increased by about 30 percent. However, regional PPO enrollment decreased by about 16 percent. PFFS enrollment shrank from about 0.6 million to about 0.5 million enrollees. In 2012, SNP enrollment and employer group enrollment both grew by about 10 percent.

Growth in MA enrollment in 2012 continued a trend begun in 2003 (Figure 13-1). Since 2003, enrollment has almost tripled. From 2011 to 2012, enrollment growth rates increased from 6 percent to 10 percent. We did not have final 2013 enrollment information as of this report's publication, but plans projected overall enrollment growth of 8 percent to 10 percent for 2013. Most of the growth was projected to be in HMOs, with lower growth in PPO plans, while PFFS plans were projected to contract.

### Plan availability for 2013

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 2013, with most Medicare beneficiaries having access to a large number of plans. While almost

**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
All plan types	84%	100%	100%	100%	100%
Local CCP	67	91	92	93	95
Regional PPO	N/A	86	86	76	71
PFFS	45	100	63	60	59
Zero-premium plans with drugs	N/A	85	90	88	86
Average number of choices	5	21	12	12	12

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), N/A (not applicable), PFFS (private fee-for-service). 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.

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, up from 93 percent in 2012 and 67 percent in 2005. Regional PPOs are available to 71 percent of beneficiaries, down from 76 percent in 2012 due to withdrawal of the regional PPOs in Nevada and the seven-state region of the Great Plains for 2013. Access to PFFS plans decreased between 2012 and 2013, from 60 percent to 59 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 2013, 86 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 88 percent in 2012.

The availability of SNPs has changed slightly and varies by the type of special needs population served (not shown in Table 13-2). In 2013, 82 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 78 percent in 2012), 46 percent live in areas where SNPs serve institutionalized beneficiaries (up from 41 percent in 2012), and 55 percent live in areas where SNPs serve beneficiaries with chronic conditions (up from 45 percent in 2012). Overall, 85 percent of beneficiaries reside in counties served by at least one type of SNP.

In most counties, a large number of MA plans are available to beneficiaries. For example, beneficiaries in Miami, New York City, and some areas of Pennsylvania and Florida can choose from more than 40 plans in 2013. 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).<sup>1</sup> On average, 12 plans, including 9 CCPs, are offered in each county in 2013, the same total as in the previous 2 years, but up by 1 CCP over that time. The decrease in plan choices from 2010 to 2011 was due to the reduction in PFFS plan choices.

### 2013 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 their bids in June and incorporate the recently released benchmarks. Benchmarks reflect current law FFS spending estimates for 2013 made by CMS at the time the benchmarks were published in April 2012. For 2013, the April 2012 current law estimates of FFS spending assumed that the sustainable growth rate (SGR) formula would cut



**TABLE  
13-3**

**Projected payments exceed FFS spending for all plan types in 2013**

**Percent of FFS spending in 2013**

<b>Plan type</b>	<b>Benchmarks</b>	<b>Bids</b>	<b>Payments</b>
All MA plans	110%	96%	104%
HMO	110	92	103
Local PPO	111	107	108
Regional PPO	106	97	102
PFFS	110	105	107
Restricted availability plans included in totals above			
SNP*	111	96	105
Employer groups*	111	106	108

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. We estimate FFS spending by county using the 2013 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals.

\* 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 FFS expenditures.

physician fee schedule rates by about 30 percent. (CMS will not adjust the benchmarks for 2013 to correct for the change but will adjust the projections used for the 2014 benchmarks to account for the 2013 SGR change.) However, we project 2013 FFS spending based on a freeze in physician payment rates rather than a reduction from the SGR. This projection results in total FFS spending about 4 percent above what was expected when the benchmarks were set. This process does not reflect a change in our methods, as we make these adjustments each year, but the magnitude of the adjustment has been larger in the past two years because the current law scheduled SGR reduction (as of the April projection) was larger than it has been in the past.

We estimate that 2013 MA benchmarks, bids, and payments will average 110 percent, 96 percent, and 104 percent of FFS spending, respectively (Table 13-3). (Benchmarks, bids, and payments are weighted by plans' projected 2013 enrollment by county to estimate overall averages and averages by plan type.)

Last year, we estimated that, for 2012, these figures would be 112 percent, 98 percent, and 107 percent, respectively. The PPACA benchmark reductions, underestimates of FFS spending levels for 2013, and projected enrollment shifts into HMOs, combined with offsetting quality bonuses, resulted in some movement of projected MA payments

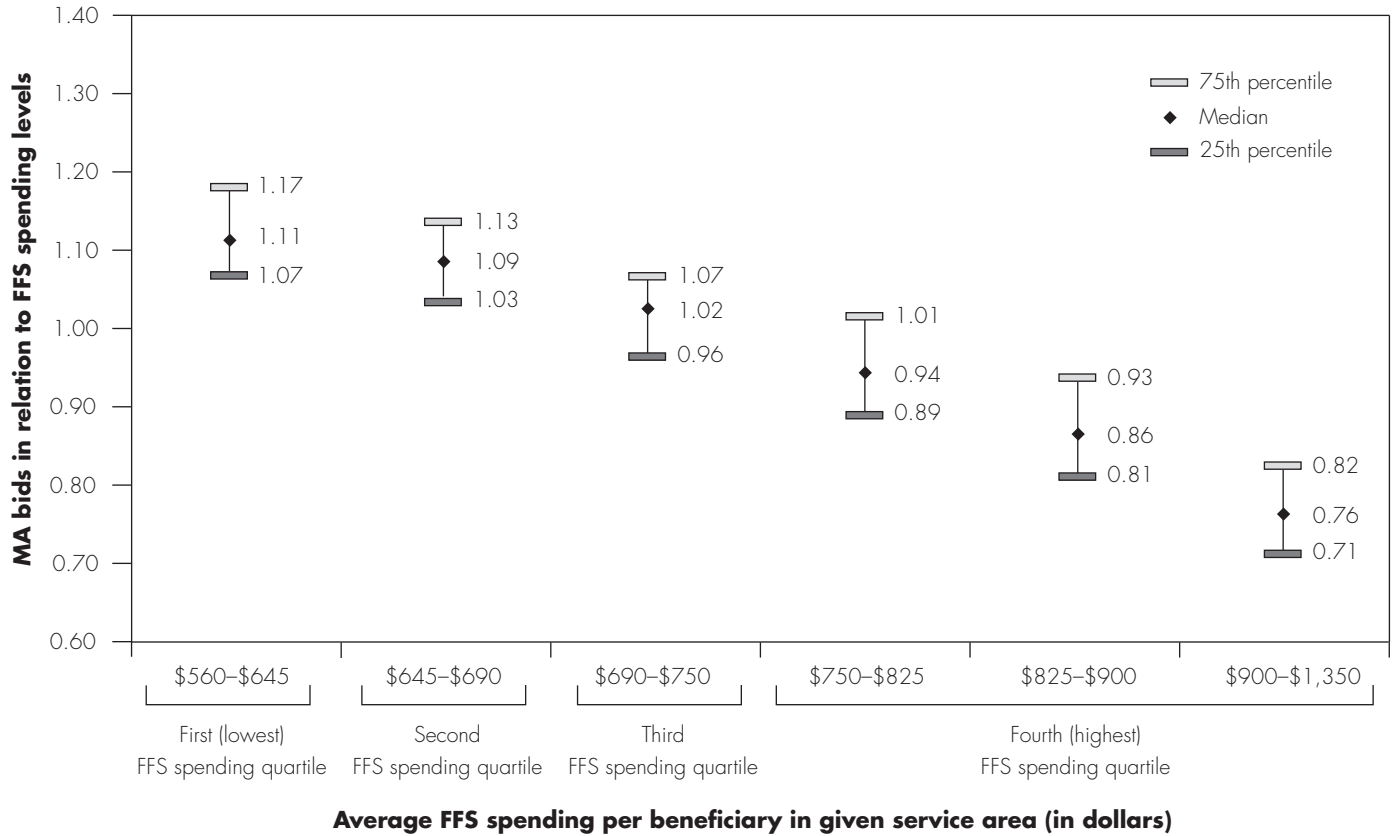
toward FFS spending levels. Payments for all plan types are projected to be closer to FFS spending levels in 2013 than they were in 2012. Most notably, HMOs submitted bids that averaged 92 percent of FFS spending, although there is much variation in the relationships between individual plan bids and expected FFS spending.

**MA benchmarks**

Under PPACA, county benchmarks in 2013 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 our March 2011 report for more details on PPACA benchmark changes.) In 2013, more than half of all counties will have base benchmarks that have fully transitioned to the final PPACA levels. However, only 29 percent of all Medicare beneficiaries and only 21 percent of MA enrollees live in these fully transitioned counties. If all the benchmarks had transitioned completely, average plan benchmarks would have been 3 percent lower.

**FIGURE  
13-2**

**Medicare Advantage bids in relation to FFS spending levels, 2013**



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

Source: MedPAC analysis of MA bid and FFS expenditure data from CMS.

For 2013, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately the same as the benchmarks for 2012. However, for 2013, 93 percent of MA enrollees are 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 2013.

### MA bids and payments for different plan types

The lack of growth in the benchmarks may have exerted fiscal pressure on the plans and encouraged them to better control costs and lower their bids for 2013. The average bid for 2013 is 96 percent of the projected FFS spending for similar beneficiaries, down from 98 percent in 2012. About 56 percent of nonemployer plans (up from 46

percent in 2012) 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 60 percent of nonemployer MA enrollees in 2013. About 0.8 million beneficiaries, excluding those enrolled in employer group MA plans, are projected to enroll in plans that bid lower than 75 percent of FFS spending. On the other hand, a similar number of beneficiaries are projected to enroll in plans that bid at least 115 percent of FFS spending.

Figure 13-2, illustrating over 2,000 plan bids (employer plans, SNPs, and plans in the territories were excluded), shows how plans bid relative to FFS for service areas with different ranges of FFS spending. The first three FFS spending ranges roughly correspond to the FFS ranges in the first three rate quartiles in the PPACA payment rules.

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 140 plans and a half-million projected enrollees, with about 75 percent of the plans and projected enrollment falling in the three groups between \$690 and \$900 of FFS spending per month.

Figure 13-2 shows that plans bid low (relative to FFS) in areas with relatively high FFS spending. When plans bid for service areas that average less than \$700 in monthly FFS spending, they are likely to bid more than FFS. However, when plan service areas average more than \$750 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 percent of beneficiaries live in a county served by at least one plan that bid below the average FFS spending of its service area. Although the bidding and payment patterns reported in Table 13-3 (p. 295) are averages, Figure 13-2 shows there is much variation behind these averages.

Despite the fact that the plan bids average less than FFS spending, payments for enrollees in these plans usually exceed FFS spending because the benchmarks are high relative to FFS spending. For example, HMOs as a group bid an average of 92 percent of FFS spending, yet 2013 payments for HMO enrollees are estimated to average 103 percent of FFS spending because the benchmarks (including the quality bonuses) average 110 percent of FFS spending.

Other plan types (aside from the regional PPOs) have average bids above FFS spending. As a result, payments for PFFS and local PPO enrollees are estimated to be 107 percent and 108 percent, respectively, of FFS spending (Table 13-3, p. 295).

We analyzed bids and payments to SNPs and employer group plans separately, because the plans are available only to subpopulations of Medicare beneficiaries, and bidding behavior differs from that of other plan types. Payments to SNPs and their bids tend to mirror general MA patterns relative to FFS spending. Employer group plans consistently bid higher than plans that are open to all Medicare beneficiaries. These plans bid an average of 106 percent of FFS spending and are paid about 108 percent of FFS, while nonemployer plans bid an average of 94 percent of FFS and are paid about 103 percent of FFS (not shown in Table 13-3). The dynamic of the bidding process for employer group plans is more complicated

than for other MA plans because 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). On the other hand, 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.

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 2013, overall payments to plans average an estimated 104 percent of FFS spending, meaning that the Medicare program will pay approximately \$6 billion more for MA enrollees than it would have paid to cover the same enrollees in FFS Medicare. (This figure includes about \$4 billion attributable to quality bonus payments, about two-thirds of which are due to the demonstration program that will end in 2014.)

### **MA risk adjustment and coding intensity adjustment**

Medicare payment to plans is calculated separately for each beneficiary as the plan's payment rate multiplied by the beneficiary's risk score. The risk scores are based on provider diagnoses 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. For 2013, plan bids project an average risk score of about 1.04 compared with 1.03 projected for 2012 and 1.02 for 2011. 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

**TABLE  
13-4**

**Distribution of enrollment by plan ratings and plan type,  
November 2012 enrollment, 2012 star ratings**

Number of stars	Percentage distribution of enrollment				
	All plan types	HMO	Local PPO	Regional PPO	PFFS
4.0, 4.5, 5.0 <sup>a</sup>	27%	35%	13%	0%	<0.5%
3.0, 3.5 <sup>b</sup>	61	53	77	93	34
Below 3.0 stars <sup>c</sup>	9	10	5	4	12
Not rated	4	1	6	2	55

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data exclude cost-reimbursed HMO plans, which do have star ratings but are not eligible for bonuses. Figures may not sum due to rounding.

a. Eligible for bonus under statutory provisions.

b. Eligible for bonus only under demonstration.

c. Not eligible for bonus payments.

Source: MedPAC analysis of CMS star ratings and enrollment data.

multiple years of coding differences, CMS reduced risk scores by 3.41 percent from 2010 through 2012. Under PPACA, CMS can continue to adjust for the differences it finds without any restrictions for 2013 (it has chosen to maintain the 3.41 percent adjustment), but for 2014 and all future years, PPACA specifies minimum reductions, although CMS has discretion to make larger reductions. The Government Accountability Office (GAO) had found that CMS should make larger reductions to fully account for the coding differences (Government Accountability Office 2012). The American Taxpayer Relief Act of 2012 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 our March 2012 report, the Commission 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 2012a).

The 104 percent of FFS payment figure projected for 2013 assumes that the risk-adjustment system and the CMS coding adjustment properly correct for all the health risk differences between the FFS and MA populations. However, several studies (McWilliams et al. 2012, Medicare Payment Advisory Commission 2012a, 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, 104 percent might understate the additional payments made for plan enrollees relative to Medicare FFS beneficiaries. On the other hand, the payments include quality bonuses worth about 3 percent of payments. If there were no quality bonuses or favorable selection, plan enrollees in 2013 would receive about 101 percent of the funding that Medicare spends on similar FFS Medicare beneficiaries.

### Quality in MA plans

As of 2012, the MA program makes bonus payments to high-performing plans. CMS uses a 5-star rating system to develop composite plan quality ratings that determine bonus levels. The bonus takes the form of a higher benchmark for higher quality plans. Higher rated plans also are entitled to a higher level of rebates (the payments plans use to finance extra benefits if bids are below benchmarks). The highest rated plans, those with a 5-star overall rating, are permitted to enroll beneficiaries year-round rather than having to limit enrollment to the October to December open enrollment season.

In 2012, CMS used 37 Part C (MA) measures or factors to determine each plan's star rating, though additional measures are also collected and reported but not included in the star ratings. For organizations with drug plans (MA-Prescription Drug, or MA-PD plans), an additional 14

**TABLE  
13-5**

**Distribution of enrollment by plan ratings and plan type,  
November 2012 enrollment, 2013 star ratings**

Number of stars	Percentage distribution of enrollment				
	All plan types	HMO	Local PPO	Regional PPO	PFFS
4.0, 4.5, 5.0 <sup>a</sup>	36%	41%	35%	2%	<0.5%
3.0, 3.5 <sup>b</sup>	56	52	57	95	70
Below 3.0 stars <sup>c</sup>	5	6	3	0	23
Not rated	2	1	5	3	7

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Data exclude cost-reimbursed HMO plans, which do have star ratings but are not eligible for bonuses. Figures may not sum due to rounding.  
 a. Eligible for bonus under statutory provisions.  
 b. Eligible for bonus only under demonstration.  
 c. Not eligible for bonus payments.

Source: MedPAC analysis of CMS star ratings and enrollment data.

Part D measures or factors were components of the overall star rating.<sup>2</sup> Each of the 51 measures for an MA–PD plan is given a star rating on the 1–5 scale, with each of the 51 measures also given a relative weight (of 1, 1.5, or 3). The overall rating that determines the bonus level is the average of the weighted value of the individual stars given for each of the 51 measures.<sup>3</sup>

The Medicare statute requires that plans achieve at least a 4-star overall rating to receive bonus payments, with benchmarks increasing by 3 percent for plans at 4 stars or higher. However, under a CMS demonstration that began in 2012 and will continue through 2014, plans with an overall average rating of 3 stars or above receive bonus payments. Under the demonstration, bonus levels vary by star ratings and are at levels higher than under the statutory provisions. Plans at 5 stars have a 5 percent bonus; those at 4 and 4.5 stars have a 4 percent bonus; those at 3.5 stars have a bonus of 3.5 percent, and those at 3 stars have a 3 percent bonus. Because of the demonstration, nearly all plans received bonus payments in 2012. As of November 2012, only 13 percent of enrollees were in plans that had star ratings below bonus levels (9 percent below 3 stars) or that were not rated (4 percent) (Table 13-4). Under the more restrictive statutory provisions, only 27 percent of plan enrollment would have been in bonus-level plans (those with ratings of 4 stars or above). Because of this large difference in the criteria for plans to be eligible for quality bonus payments and the resulting misallocation of Medicare funds, the Commission has expressed serious concerns about the demonstration project, viewing it

as overly broad use of CMS’s demonstration authority (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2011a). GAO also expressed its concerns about the demonstration and noted that CMS actuaries projected that the demonstration would result in added program costs in excess of \$8 billion. GAO recommended that the demonstration be terminated immediately (Government Accountability Office 2012).

Each year, plans receive new star ratings that reflect plan performance based on measures collected in the most recent time period. New star ratings were posted for the open enrollment period of October to December 2012 for enrollments effective in 2013, giving beneficiaries more up-to-date information on plan quality (the star ratings we refer to as the 2013 ratings). The newer star ratings will be the basis of bonus payments in 2014, the last year of the demonstration. If the enrollment distribution in 2014 mirrors the distribution in November 2012, only 7 percent of enrollment will be in plans not eligible for quality bonus payments under the demonstration (Table 13-5). Under the statutory provisions, 63 percent of enrollment would be in plans with star ratings below bonus levels (3.5 or fewer stars).

Analysis of the differences in the star ratings between the two time periods gives a rough snapshot of the extent to which plan quality may have improved between 2012 and 2013 in the MA program.<sup>4</sup> The universe of plans is held constant, as is the enrollment, but the star ratings for each

plan are updated using the new 2013 ratings for the second table (Table 13-5). Although there were some changes in the measures that constitute the star rating system and the weights assigned to the measures, star criteria for the two years are quite comparable.<sup>5</sup> Thus, the change in the percentage of enrollees in plans rated 4 stars or higher indicates that plans improved their performance on the measures that determine the star ratings. In particular, while HMO plan results improved (with 4-star or higher enrollment rising from 35 percent to 41 percent), the most striking shift is in the local PPO category, in which a number of plans raised their star ratings. The proportion of local PPO enrollees in plans with 4 or more stars nearly tripled, rising from 13 percent using the 2012 star ratings to 35 percent with the 2013 ratings. Whereas the 2012 ratings indicated that HMOs had a clear advantage over local PPOs in their overall performance, the 2013 ratings show a narrowing of the differences between HMOs and local PPOs—reflecting improved results for local PPOs in what are classified as intermediate outcome measures.

In what follows, we examine in more detail the differences in plan performance between 2012 and 2013 by looking at individual components of the star rating system. We see that the Part C measures that account for the improvement among local PPOs are measures that health plans report to CMS, based on documentation from medical records, and more heavily weighted in the star rating system.

### **Components of the star rating system**

The 50 measures in the star rating system capture information about plan performance on clinical process and outcome measures, patient experience measures as determined from surveys of beneficiaries, and plan performance in contract administration measures tracked by CMS.

In Part C, there are two sources of clinical process and outcome measures. Health plans report process and intermediate outcome measures to CMS using the Healthcare Effectiveness Data and Information Set<sup>®</sup> (HEDIS<sup>®</sup>).<sup>6</sup> Additional process measures are obtained through a member survey, the Health Outcomes Survey (HOS), which also collects self-reported health information that is used to develop an overall outcome measure to gauge whether a health plan's enrollees have had any improvement or decline in their physical and mental health status over a two-year period.

The Consumer Assessment of Healthcare Providers and Systems for MA (CAHPS<sup>®</sup>-MA)<sup>7</sup> is the source of patient

experience measures whereby beneficiaries report on their access to care in plans and their rating of plan quality and the quality of care rendered by plan providers.<sup>8</sup>

An important consideration with respect to many of the HEDIS measures is that plans report results based on documentation extracted from medical records rather than administrative data such as claims, encounter data, and pharmacy data. For reporting these measures based on medical record review—referred to as the “hybrid” measures—plans use a random sample of medical records (for up to 411 patients) to determine the rate to report in HEDIS. For example, whether plan members diagnosed with hypertension are controlling their blood pressure is a hybrid measure that is based on a review of patient medical records. For some measures, plans can use administrative data or medical record sampling.

As noted above, the measures in the star ratings are not equally valued but are weighted by the type of measure. Individual star measures that are outcome measures or HEDIS intermediate outcome measures have a weight of 3, patient experience measures have a weight of 1.5, and process measures have a weight of 1. Contract administration measures that CMS classifies as “measures affecting access” have a weight of 1.5 and otherwise have a weight of 1. Examples of types of measures, their classification, and their weighting are included in Table 13-6.<sup>9</sup>

The star rating system gives greater weight to outcome and intermediate outcome measures, both by the higher weight given to each star for the individual measures and by the proportion of such weighted measures that go into the overall star rating for a plan. In 2012, 62 percent of the weighting for the 50 star measures was for clinical measures, including clinical process measures as well as outcome measures. For the 2013 ratings, 66 percent of the weighting is for clinical measures—of which two-thirds of the weight is for outcomes (such as improvement in physical health based on HOS results) or intermediate outcomes (such as control of blood sugar among diabetics). In the 2013 ratings, 16 percent of the weighting is for patient experience measures (about the same as in 2012), and 18 percent is for contract performance measures (down from 23 percent in 2012).

### **Cannot determine whether plan quality has improved over the past year**

We cannot definitively say whether quality overall has improved in MA between 2011 and 2012 because various

**TABLE  
13-6**

**Examples of measures included in the CMS star ratings and their sources and weighting**

Measure type (CMS classification) and name	Source of measure	Weight given to the star for this individual measure
<b>Outcome measures</b>		
Plan all-cause readmissions	Plans report via HEDIS®	3
Improving or maintaining physical health	Based on HOS member survey	3
Improving or maintaining mental health	Based on HOS member survey	3
<b>Intermediate outcome measures</b>		
Diabetes care – blood sugar controlled	Plans report via HEDIS	3
Diabetes care – cholesterol controlled	Plans report via HEDIS	3
Controlling blood pressure	Plans report via HEDIS	3
<b>Patients’ experience and complaints measures</b>		
Overall rating of plan	CAHPS member survey	1.5
Members choosing to leave the plan ( disenrollment rates)	CMS tracking	1.5
<b>Measures capturing access</b>		
Plan makes timely decisions about appeals	CMS tracking	1.5
Call center – foreign language interpreter and TTY/TDD availability	Plans report to CMS	1.5
<b>Process measures</b>		
Breast cancer screening	Plans report via HEDIS	1
Cardiovascular care – cholesterol screening	Plans report via HEDIS	1
Monitoring physical activity	Question in HOS member survey	1
Reducing the risk of falling	Question in HOS member survey	1
Enrollment timeliness	CMS tracking	1

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®), HOS (Health Outcomes Survey), CAHPS® (Consumer Assessment of Healthcare Providers and Systems®), TTY/TDD (telecommunications device for the deaf/teletypewriter).

Source: Centers for Medicare & Medicaid Services 2012a.

factors need to be taken into account in evaluating 2012 results. Currently, we cannot distinguish whether the observed differences in plans’ performance on the quality measures reflects distinct actions they are taking to improve quality or improved documentation and reporting practices. As we discuss below, we do see improvement in HEDIS process and intermediate outcome measures—that is, measures that may be more directly under the control of plans in terms of their ability to improve provider performance as well as to improve provider reporting and record keeping. However, we do not see a similar level of improvement in quality measures drawn from beneficiary surveys—the patient experience measures and measures of changes in health status over time.

Traditionally, to judge whether the quality of care in MA has improved from one year to the next, we examine HEDIS rates for plans that report a particular measure for each of the two years—using a “same store” concept to determine whether results show improvement, decline, or no statistically significant changes.<sup>10</sup> We compare measures for which the definitions, or specifications, have not changed materially between the two years. This approach helps to ensure that we are making a valid “apples-to-apples” comparison when attempting to determine whether the trend across MA is in the direction of improvement.

Certain factors affect the results of an analysis of changes in MA quality. For example, for newly introduced

measures, it is often the case that initial rates for the new element are low and subsequent rates show dramatic improvement. When the National Committee for Quality Assurance (NCQA) introduces a new HEDIS measure, the results for the first year the measure is used are not publicly reported; when CMS has included new outcome measures in the star rating system, the new measure is given a weight of 1 in the first year and 3 for subsequent years. This approach allows plans time to become familiar with the measure and make any reporting or other administrative changes to be able to accurately report the measure. Thus, if the measure results show improvement over time initially, it can be due to better record keeping and data collection, as well as better performance now that the process or outcome measure is being measured.<sup>11</sup>

Another factor to consider in evaluating recent HEDIS results is a change in reporting methodology that has occurred. In our yearly analysis of MA quality results, we have traditionally analyzed HMOs and PPOs separately because of a major difference between the two plan types in the specifications for hybrid measures. It was not until 2010 that PPOs were permitted to report hybrid measures using medical record review. Previously, PPO reporting of such measures was based exclusively on administrative records, while HMOs had the option of using medical record review (which generally resulted in higher rates). Because the new specifications for PPOs began in 2010, we did not view the extremely low 2010 results for PPOs as entirely credible for purposes of comparison with HMO hybrid measure results (see, for example, the June 2011 MedPAC data book, Table 4-7 (Medicare Payment Advisory Commission 2011b)). The improvement in PPO results on HEDIS hybrid measures over the past three years—including between 2011 and 2012—suggests that the improvement can be attributed in large part to better record keeping and data collection. PPOs changed from reporting based solely on administrative data for all HEDIS measures to instituting processes for medical record review and data extraction from a sample of medical records as a basis of reporting HEDIS hybrid measures.<sup>12</sup>

Finally, we expect the introduction of the star rating system to motivate plans to improve outcomes and their documentation, record keeping, and reporting systems for a pay-for-performance program tied to results on quality measures. NCQA staff recently published a commentary on whether the star rating system has improved quality in MA. Citing the improvement in HEDIS measures among Medicare plans between 2011 and 2012—a level

of improvement not mirrored in the performance of commercial plans—the authors noted that “anecdotally, we are seeing that several plans that before paid minimal attention to their star scores are now aggressively working to improve” (Cotton et al. 2012). Plans will pay attention to both aspects of quality measurement—better documentation as well as efforts to improve the quality of medical care.

### **Comparing 2011 and 2012 results in quality indicators**

Between 2011 and 2012, a number of HEDIS measures that MA plans report to CMS improved, but little change occurred in measures collected through member surveys—the patient experience measures of CAHPS, the HOS care measures, and the HOS-based determination of improvement or decline in enrollees’ health status. For other star measures, on average, comparing all plans rated in both years, scores for three contract administration measures and disenrollment rates improved between 2011 and 2012. Measures reported exclusively by SNPs also improved.<sup>13</sup>

By plan type, local PPOs, as well as regional PPOs and PFFS plans, improved their scores on the HEDIS hybrid measures (those based on documentation from medical records).<sup>14</sup> For local PPOs reporting on the 45 HEDIS measures in both 2011 and 2012, 13 of the 45 measures had an improved average rate that was statistically significant, while 1 measure declined and the rest were unchanged. Of the 13 improved measures, 10 were hybrid measures (Table 13-7). For HMOs, the results for most of the hybrid measures remained unchanged over the past year. Thus, local PPOs are catching up with HMOs on these measures and have narrowed wide differences between the performance of PPO plans and HMOs (one hybrid measure—cholesterol control among patients with cardiovascular conditions—has a higher average rate for local PPOs, though the difference between HMOs and local PPOs is not statistically significant).

The shift in the star ratings for local PPOs between 2012 and 2013 that we have discussed (Table 13-4, p. 298, and Table 13-5, p. 299)—with more plans moving to the 4-star or higher level—is primarily due to the gains local PPOs have made in the hybrid measures, given their (appropriately) greater weight in the CMS star rating system. As shown in Table 13-7, local PPO rates improved for all three HEDIS intermediate outcome measures that are components of the star system, as did regional PPO rates for these measures (not shown in Table 13-7). The



**TABLE  
13-7**

**Between 2011 and 2012, local PPO plans improved on a number of HEDIS® hybrid measures, and PPO rates are now closer to HMO rates**

Measure name	Weight for star rating (if element of star ratings)	PPO			HMO		
		Mean (2011)	Mean (2012)	Percent change	Mean (2011)	Mean (2012)	Percent change
<b>Measures showing improvement among PPOs reporting in both years</b>							
Hybrid measures							
Adult BMI assessment	1	36.5	63.6	74%	49.7	68.2*	37%
Colorectal cancer screening	1	41.3	55.4	34	57.0	60*	5
Poor blood glucose control among diabetics†	3	34.3	28.4	17	26.3	25.7	2
Control of cholesterol among patients with cardiovascular conditions		50.6	57.4	13	56.4	56.8	1
Control of cholesterol among diabetics	3	46.0	51.6	12	51.6	52.8	2
Controlling high blood pressure in members with hypertension	3	55.8	62.0	11	61.4	63.6*	4
Blood pressure control among diabetics		55.7	61.5	10	61.8	63	2
Blood glucose control among diabetics (<8.0%)		58.2	63.5	9	65.3	65.9	1
Cholesterol screening for patients with cardiovascular conditions	1	87.0	88.4	2	88.5	89.1	1
Monitoring diabetic nephropathy	1	87.2	88.3	1	89.2	90*	1
Administrative-only measures							
Use of high-risk medications in the elderly—one prescription†		22.0	19.1	13%	22.3	18.6*	17%
Use of high-risk medications in the elderly—at least two prescriptions†		5.1	3.7	27	5.2	3.6*	31
Persistence of beta blocker use after a heart attack		83.4	87.2	5	83.0	87.8*	6
<b>Measure that declined among PPOs reporting in both years</b>							
Initiation of alcohol and other drug dependence treatment (administrative measure)		59.7	48.7	-18%	44.5	40.6*	-9%

Note: PPO (preferred provider organization), HEDIS® (Healthcare Effectiveness Data and Information Set®), BMI (body mass index). All listed PPO measures had statistically significant differences in average rates between 2011 and 2012 ( $p < 0.05$ ).

\*Indicates a statistically significant change for HMO results between the two years for plans reporting in both years.

†Lower rate is better.

Source: MedPAC analysis of CMS HEDIS public use files.

three measures (cholesterol and blood sugar control among diabetics and control of blood pressure among members with hypertension) make up about 20 percent of the overall weighting of the 36 Part C components of the stars. For the 10 other measures for which local PPOs improved between 2011 and 2012, 7 are hybrid measures. Four of

the seven measures are included in the star rating system (but weighted at 1). The remaining 31 HEDIS measures for local PPOs were stable between 2011 and 2012.

Of the 13 measures that had statistically significant improvement for local PPOs reporting in both 2011 and 2012, 7 also had statistically significant improvement

**TABLE  
13-8**

**Plan performance on the hospital readmission measure was stable between 2011 and 2012 for HMOs and local PPOs**

Plan type	Year	Number of admissions, age 65 or over (in thousands)	Observed rate of readmission	Expected rate of readmission	Observed-to-expected ratio
HMOs	2011	988	14.2%	15.7%	0.91
	2012	1,032	14.3	15.7	0.91
Local PPOs	2011	107	13.1	14.5	0.90
	2012	184	13.2	14.8	0.90
Regional PPOs	2011	50	15.2	14.9	1.02
	2012	122	14.9	15.3	0.97
PFFS	2011	120	13.3	14.7	0.91
	2012	27	14.2	15.0	0.94

Note: PPO (preferred provider organization), PFFS (private fee-for-service). Observed rates and expected rates are rounded; observed-to-expected ratio is computed on an unrounded basis, but the result reported in the table is rounded. Puerto Rico data are excluded.

Source: MedPAC analysis of CMS Healthcare Effectiveness Data and Information Set<sup>®</sup> public use files.

among HMOs reporting in both years (indicated with an asterisk in Table 13-7). HMOs also improved on the following measures (not shown in table), for a total of 14 out of 45 measures for which there was improvement for HMOs:

- two measures included in the star ratings, weighted at 1—osteoporosis management in women who had a fracture and glaucoma screening in older adults,
- three measures of avoidance of specific drug interactions,
- percent of older women tested for osteoporosis (a measure collected in HOS), and
- testing of blood glucose levels of diabetics.

Both local PPOs and HMOs showed statistically significant declines in a measure of treatment for alcohol and drug abuse, a measure not included in the star ratings. HMOs also had a statistically significant decline in the measure for management of urinary incontinence in older adults (a measure collected in HOS and also not in the star ratings). For HMOs, the remaining 30 HEDIS measures were stable between 2011 and 2012, including the 6 remaining intermediate outcome measures of control of blood pressure and cholesterol for diabetics and for

beneficiaries with cardiovascular conditions and control of blood sugar levels for diabetics.

**Regional PPOs and PFFS plans**

As for plan types other than HMOs and local PPOs, the 2012 HEDIS data include 14 regional PPOs and 22 PFFS plan reporting, compared with 326 HMOs and 130 local PPOs reporting most measures. As in past years, PFFS plans and regional PPOs have lower average HEDIS scores than HMOs and local PPOs. This fact is reflected in the relatively poor performance of these plans in the star ratings (Table 13-5, p. 299). However, in terms of changes between 2011 and 2012, the trend for these plans is similar to the trend for local PPOs. That is, we see large gains in measures based on the extraction of information from medical records (assessment of body mass index and control of blood pressure and cholesterol among patients with diabetes or a cardiovascular condition) as well as in measures indicating reduced use of high-risk medications among the elderly.

**Hospital readmission rates**

Plan performance on hospital readmission rates, an important measure that has been reported in HEDIS for the past two years, remained stable between 2011 and 2012 for HMOs and local PPOs (Table 13-8). The

**TABLE  
13-9****Various factors associated with plan star ratings, including plan age and the extent of special needs plan enrollment**

	Enrollment-weighted average star rating		Number of contracts	Enrollment, November 2012 (in thousands)
	2012	2013		
All plans rated in both years	3.54	3.69	412	12,604
By plan age				
Plans starting 2003 or earlier	3.79	3.90	129	6,810
Plans starting 2004 or later	3.25	3.45	283	5,794
By plan composition of enrollment				
Plans with 90 percent or higher SNP enrollment	3.09	3.12	52	448
Plans with 10 percent or less SNP enrollment	3.52	3.71	247	8,380

Note: SNP (special needs plan).

Source: MedPAC analysis of CMS star ratings and enrollment data.

admission-weighted ratio of observed-to-expected rates of readmission was unchanged for HMOs and for local PPOs. Although there were differences between 2011 and 2012 for regional PPOs and PFFS plans—with regional PPOs improving and PFFS results declining—the large shifts in enrollment in these two plan types (reflected in the number of admissions) may explain the year-to-year differences. Unlike HMOs and local PPOs, most PFFS and regional PPO plans cover very wide geographic areas. Particularly with PFFS plans, which have minimal care management, the difference in rates between the two years may reflect geographic differences across wide service areas.

### **Beneficiary survey results: CAHPS and HOS health status change results**

Using the CAHPS results from the CMS star ratings report, we found little change between 2011 and 2012 in the measures from the beneficiary survey that asks about access to care in plans and rating of overall plan quality and the quality of care rendered by plan providers. The outcomes component of another survey, HOS, which measures two-year changes in self-reported health status, also showed little change in plan results between results posted in 2011 (for the 2008 to 2010 time period) and 2012 (for the 2009 to 2011 time period). As in previous years, about 90 percent of plans had HOS results within expected rates and not different from the national average rates of two-year changes in mental and physical health status across all plans.

### **MA plan performance on quality indicators varies by several plan characteristics**

CMS has posted an analysis of the 2012 and 2013 stars and a map of the distribution of the 2013 star ratings (Centers for Medicare & Medicaid Services 2012a). The map shows that the highest rated plans are in the Northeast, the upper Midwest, and the Pacific Coast.<sup>15</sup> In general, beneficiaries in the South do not have access to plans rated 4 stars or higher, with the exceptions of Florida (a change from 2012) and North Carolina. Consistent with the Commission's past and current findings, CMS has noted that newer plans do not perform as well as more established plans in the star ratings (Table 13-9). CMS also noted that not-for-profit plans perform better than for-profit plans. We have found that SNPs, or plans with a high proportion of SNP enrollment, do not perform as well as other plans, a point we discuss in Chapter 14 of this report.

### **Comparison with FFS Medicare**

We have little information on which to base a comparison of the MA quality indicators we discuss in this chapter with the quality of care in FFS Medicare. However, we can compare CAHPS results in MA with FFS results because beneficiaries in each of these sectors are surveyed. We found little difference between MA and the FFS program in the surveys' results for vaccination rates. MA rates of influenza vaccination were similar to the FFS rate.

**TABLE  
13-10****Plans report a single rate for HEDIS® measures that vary across the states with plan enrollment**

Location of state	Rate for glaucoma screening measure	Star rating for individual measure based on state rate
Upper Midwest	60%	2 stars
Pacific Coast	64	3 stars
Mid-Atlantic	70	4 stars

Note: HEDIS® (Healthcare Effectiveness Data and Information Set®). The denominators for these measures include over 2,000 enrollees in each of the three state locations shown.

Source: MedPAC analysis of CMS HEDIS® person-level data.

There are studies showing differences in utilization 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. One study showed that diabetics enrolled in a chronic care SNP had lower rates of emergency department utilization, 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 over the period 2003 to 2009 and differences in the frequency of certain procedures (e.g., MA HMOs had a greater frequency of coronary artery bypass graft surgeries but fewer hip and knee replacements than FFS beneficiaries) (Landon et al. 2012). Another study comparing hospital readmissions in FFS versus MA examined 2006 data for five states. The authors found that, after risk adjustment and controlling for self-selection in MA, enrollees in MA had a substantially higher likelihood of readmission (Friedman et al. 2012).

### Concerns with the star ratings

CMS has addressed many of the Commission's concerns about the methodology for determining star ratings. Greater weight is being given to clinical process measures and patient experience measures than contract performance measures. Our March 2012 report discusses our concerns about the reporting unit to which the star ratings apply (Medicare Payment Advisory Commission 2012b). We noted that the geographic area to which a single star rating applies may be extensive and may

encompass many kinds of health care markets and provider networks. The amalgamation of diverse areas affects both purposes of the star rating system—to provide beneficiaries with information about the quality of a health plan they are considering joining and to determine which plans are eligible for bonuses because they provide high-quality health care.

In addition to the number of plans operating in large, diverse states, there are at least 17 contracts serving noncontiguous states under one contract with substantial enrollment in the different states (including one regional contract covering more than one region). An example from one plan illustrates how different a star rating might be for each area if star ratings were determined at the appropriate geographic level. We compare person-level HEDIS data in the case of a contract that includes various states (13 of which have substantial plan enrollment at over 1,000 members in the state). The plan received a rating of 3 stars for the HEDIS glaucoma screening measure across its entire contract, but individual states would have received different ratings had the reporting unit been at the state level, as we illustrate with an example of three state locations (Table 13-10).

In last year's report, we suggested that CMS more closely examine the configuration of some contracts to determine whether the reporting units should be modified, given that even within a state there can be large geographic differences that affect the quality of care. We noted that in many cases—though not in the example provided—there could be a problem of small numbers of enrollees and therefore small sample sizes, a methodological problem that can be overcome in different ways, such as by pooling data for multiple years. Given the potential differences in quality measures, and given the known differences in MA benchmarks based on star ratings, including differences by area where certain counties are double-bonus counties, the cost burden associated with additional reporting or data manipulation is likely outweighed by the benefit to beneficiaries and, potentially, to program costs, by ensuring that reporting is done at the appropriate geographic level.

### 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 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 taken the program closer to this point of equity between MA and FFS. As a result, we are seeing evidence of improved efficiency in MA as plan bids have come down in relation to FFS while enrollment in MA continues to grow. The improved efficiency of MA plans enables them to continue to increase MA enrollment by offering packages that beneficiaries find attractive.

The Commission has also 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 such a quality bonus program for MA. The initial results of the program indicate that more plans are achieving ratings that would

qualify them for bonuses as called for in the statute. Plans are paying closer attention to the quality measures, with improved documentation and medical record validation as contributing factors in improved performance for many plans.

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

## Endnotes

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- 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 As stated in CMS documentation of the star rating system, there are 49 unique measures for MA–PD plans. Two additional factors computed from those measures are new factors, one for Part C and one for Part D, that assign a star rating for whether a plan has improved or not. The improvement factor(s) may or may not be used for a particular plan in that a high-performing plan (4 stars or better) would not be penalized if including the improvement measure reduces the plan’s overall star rating (on the assumption that the highest performing plans do not have as much room for improvement as lower performing plans). Part D has 18 total measures or factors, but only 14 are used for MA–PD ratings because 4 measures overlap with Part C. Three measures in Part C apply only to special needs plans (Centers for Medicare & Medicaid Services 2012a).
- 3 Plans can receive a higher star rating after the averaging process, with an increase of 0.2 to 0.4 in the overall star rating, for high scores on the measures if they are consistently high across the range of measures.
- 4 When we refer to ratings as pertaining to a particular year, it is the enrollment year for which the ratings are posted. For the 2013 ratings, beneficiaries are enrolling at the end of 2012 for a 2013 effective date. Plans reported measures such as Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) in 2012 for the 2013 star ratings, but those measures reflect plan performance in 2011 on the HEDIS measures. Thus, there is a lag in reporting in that the star ratings for 2013, announced at the end of 2012, reflect performance in the preceding year (2011).
- 5 Measures are dropped and added from year to year. For example, a new measure for 2013 is a care coordination measure collected through the Consumer Assessment of Healthcare Providers and Systems<sup>®</sup> (CAHPS<sup>®</sup>) beneficiary survey, which is a measure of the extent to which a beneficiary receives information from physicians about his or her care and help in managing care. A measure that was dropped from the star ratings (but that continues to be collected and reported) is the pneumonia vaccination measure, also collected through CAHPS, because of issues with beneficiary recall of whether they had ever received the vaccination (Centers for Medicare & Medicaid Services 2012b).
- 6 HEDIS<sup>®</sup> is a registered trademark of the National Committee for Quality Assurance.
- 7 CAHPS<sup>®</sup> is a registered trademark of the Agency for Healthcare Research and Quality.
- 8 HEDIS, CAHPS, and HOS are described more fully in an online appendix to our March 2010 report ([http://www.medpac.gov/chapters/Mar10\\_Ch06\\_APPENDIX.pdf](http://www.medpac.gov/chapters/Mar10_Ch06_APPENDIX.pdf)).
- 9 How much of a difference there is in the star ratings between plans varies with each measure. For example, for the HEDIS breast screening measure, a 5-star rating is a rate of 83 percent or higher. A 4-star rating is between 74 percent and 83 percent, and a 3-star rating is between 64 percent and 73 percent. For the measure of cholesterol screening among diabetics, for which most plans achieve relatively high rates, the 5-star level is 90 percent or higher, and the differences at each of the star levels below 5 stars are narrower (in absolute percentage point differences) than the breast cancer screening measure. For the cholesterol measure, a 4-star rating is 85 percent to 89 percent and a 3-star rating is 81 percent to 84 percent (Centers for Medicare & Medicaid Services 2012b).
- 10 Technically, we are comparing average results across the universe of reporting plans and not a sample of plans. Therefore, use of the term “statistical significance” to characterize differences is not precisely correct. However, we use statistical significance as a guide to highlight larger differences. We also note that the underlying numbers each plan reports—that is, the reported HEDIS rate for each measure—are based on samples. We also note that some of the changes shown as statistically significant reflect a 1 percent or 2 percent change in the measure, which is a very small change over one year and may not be as meaningful as larger changes in other measures.
- 11 This effect can be seen in the results for the measure of assessment of body mass index (BMI)—whether a person’s BMI was recorded in the medical record. The BMI measure is a relatively new measure first publicly reported in 2010. Among HMOs reporting over three years, the rate rose from 40.8 in 2010 to 54.0 in 2011 and 73.0 in 2012. As shown in Table 13-7, the measure had the greatest rate of increase of any improved measure between 2011 and 2012 among HMOs and local PPOs.
- 12 The following NCQA statement describes the basis of the original prohibition on PPO reporting based on the hybrid methodology: “Currently, HMO and POS plans report HEDIS using data from claims (administrative) and medical records, known as hybrid data collection. Because many PPOs have multi-state service areas, they may face some barriers to accessing medical records. Therefore, for 2008 and 2009 (the first years of PPO reporting), NCQA requires PPOs to

report HEDIS measures based on administrative data only. To assure that all PPOs are compared on equal grounds based on data collection methodologies, NCQA will not accept results based on hybrid data from PPOs.” (National Committee for Quality Assurance. *PPO HEDIS Requirements for Health Plan Accreditation 2010 Products Update – Draft Changes, Appendix 4*. Washington, DC: 2009. (NCQA public comment document, obsolete after 4/1/09.))

13 Several HEDIS measures are reported only by SNPs, all of which are based on medical record documentation. All these measures showed statistically significant improvement in average rates between 2011 and 2012: medication review, functional status assessments, pain screening (the three measures included in the star rating system), advance care planning, and medication reconciliation postdischarge. The three SNP-only measures in the star rating system are a factor in determining the star rating of contracts that are exclusively

SNP contracts; they are also factors for determining the star ratings of organizations that have both SNP and non-SNP members under one contract.

14 As we have noted, plans have the option of reporting hybrid measures using only administrative data, and an organization with good electronic medical records, for example, may choose to report a measure solely on the basis of administrative records. To cite an example, for the measure for colorectal cancer screening, which has a nine-year look-back period to determine whether a beneficiary had a colonoscopy, about 5 percent of plans appear to be reporting based on administrative data, according to an analysis of the confidence intervals for the reported results.

15 There is similar regional variation in health plan performance in the commercial sector (National Committee for Quality Assurance 2011).

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CHAPTER

# 14

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**Medicare Advantage  
special needs plans**

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

**14-1** The Congress should permanently reauthorize institutional special needs plans.

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

.....  
**14-2** The Congress should:

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

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

.....  
**14-3** The Congress should permanently reauthorize dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D-SNPs to expire.

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

.....  
**14-4** For dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should:

- grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;
- direct the Secretary to allow these D-SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;
- direct the Secretary to allow these D-SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and
- direct the Secretary to develop a model D-SNP contract.

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

# Medicare Advantage special needs plans

## Chapter summary

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

SNP authority expires at the end of 2014. SNPs were recently extended from 2013 to 2014 by the American Taxpayer Relief Act of 2012. In the absence of congressional action, on January 1, 2015, SNPs will not be terminated, but they will have to operate as other MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs.

We evaluate each type of SNP on how well they perform on quality-of-care measures, whether they encourage a more integrated delivery system than is currently available in traditional fee-for-service (FFS) Medicare, and how SNP reauthorization would affect Medicare program spending. We found the following:

## In this chapter

- Findings on SNPs

- Reauthorizing all SNPs would result in increased program spending. The current law Medicare baseline assumes that SNP authority will expire. If this termination occurs, some beneficiaries enrolled in SNPs will likely return to traditional FFS. If SNPs are reauthorized and beneficiaries remain enrolled in them, program spending will increase relative to baseline because spending on beneficiaries enrolled in MA is generally higher than Medicare FFS spending for similar beneficiaries.
- Institutional SNPs (I-SNPs) are plans for beneficiaries residing in nursing homes or in the community who are nursing home certifiable. They perform well on a number of quality measures. In particular, I-SNPs have much lower than expected hospital readmission rates, which suggests that I-SNPs are able to reduce hospital readmissions for beneficiaries who reside in nursing homes. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS.
- Chronic condition SNPs (C-SNPs) are plans for beneficiaries with certain chronic conditions. In general, C-SNPs tend to perform no better, and often worse, than other SNPs and MA plans on most quality measures. The Commission recommended in 2008 that the list of conditions to qualify for a C-SNP be narrowed, and although the list of C-SNP conditions was reduced, we continue to believe that it is too broad. It is our judgment that regular MA plans should be able to manage most clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care for these conditions should be imported into MA plans. As a result, MA plans will move toward providing services that are more targeted to particular populations, and integration of the delivery system in regular MA plans for chronically ill enrollees will improve. There has been recent movement in the MA plan industry in the direction of importing the C-SNP model of care into regular MA plans. There may be a rationale, however, for maintaining C-SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions. These conditions dominate an individual's health and may warrant maintaining separate plans for these conditions while innovations in care delivery for these populations are still being made. However, the ability of MA plans to adequately care for beneficiaries with these three conditions should be revisited.
- SNPs for beneficiaries dually eligible for Medicare and Medicaid (dual-eligible SNPs (D-SNPs)) generally have average to below-average performance on quality measures compared with other SNPs and regular MA plans, with some exceptions. D-SNPs are required to have contracts with states. However, the contracts generally have not resulted in D-SNPs clinically or financially

integrating Medicaid benefits. We found exceptions under two D–SNP models in which an incentive exists to clinically and financially integrate with Medicaid benefits. Under one model, a single plan—the D–SNP—covers some or all Medicaid long-term care services and supports (LTSS), behavioral health services, or both through its contract with the state. Under another model, a managed care organization administers the D–SNP and the Medicaid plan that furnishes some or all of the LTSS or behavioral health services. There is overlap in the dual-eligible beneficiaries who are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans. A number of administrative misalignments act as barriers to integrating Medicare and Medicaid benefits. Most of these barriers—the inability to jointly market the Medicare and Medicaid benefits that D–SNPs furnish, multiple enrollment cards, and lack of a model contract for states to use as a reference—can be alleviated by the Secretary of Health and Human Services. Aligning the Medicare and Medicaid appeals and grievances processes, however, would require a change in statute. ■



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## Introduction

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Special needs plans (SNPs) are a type of coordinated care plan in the Medicare Advantage (MA) program. However, unlike regular MA plans, SNPs can limit their enrollment to one of the three categories of special needs individuals recognized in statute and tailor their benefit packages to their special needs enrollees:<sup>1</sup>

- **Institutional SNPs (I-SNPs)** enroll beneficiaries residing in a nursing home or in the community who are nursing home certifiable.
- **Chronic condition SNPs (C-SNPs)** enroll beneficiaries with certain severe or disabling chronic conditions.<sup>2</sup>
- **Dual-eligible SNPs (D-SNPs)** enroll beneficiaries eligible for both Medicare and Medicaid (dual-eligible beneficiaries).

SNP statutory authority expires at the end of 2014. SNPs were recently extended from 2013 to 2014 by the American Taxpayer Relief Act of 2012. As of January 1, 2015, SNPs will lose their ability to limit enrollment to special needs individuals. Their contracts will not be terminated, but they will have to operate as regular MA plans in which all beneficiaries are eligible to enroll, not just beneficiaries with special needs.

## Background on special needs plans

SNPs were introduced in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which authorized them through 2008. Subsequent legislation extended the expiration date of SNP authority on four separate occasions, and the Congress imposed a number of additional requirements on SNPs, including requiring D-SNPs to have contracts with states, narrowing the types of chronic conditions for C-SNPs, requiring all SNPs to meet model-of-care requirements, and having their models of care reviewed by the National Committee for Quality Assurance (NCQA).<sup>3</sup> SNPs benefit from their special enrollment rules, making them an attractive option for some managed care organizations. The general rule in MA is that beneficiaries may enroll in, or disenroll from, an MA plan only during the October to December coordinated open enrollment period. However, dual-eligible beneficiaries and other low-income individuals can enroll and disenroll from MA plans monthly. This provision applies to all MA plans, not just SNPs (and

will survive the expiration of SNP authority). Similarly, beneficiaries who reside in an institution have the month-to-month enrollment option, an alternative that for I-SNPs is extended to beneficiaries at risk of institutionalization. C-SNPs can enroll an individual with CMS-specified chronic or disabling conditions when the presence of the condition is certified by a physician.

As of December 2012, there were almost 1.6 million enrollees in SNPs, or about 11 percent of all MA enrollment (Table 14-1, p. 318). The largest share of SNP enrollment is in D-SNPs, followed by C-SNPs and I-SNPs. Most D-SNPs, C-SNPs, and I-SNPs are HMO plans.

D-SNPs and I-SNPs are widely available; in contrast, C-SNPs have limited availability, with enrollment concentrated in the South (see online Appendix 14-A, available at <http://www.medpac.gov>, for more information on SNPs). Although D-SNPs and I-SNPs are available to a large share of Medicare beneficiaries, residents of rural areas have relatively less access to these specialized plans compared with residents of urban areas.

Overall, the MA program has a smaller share of dual-eligible beneficiaries than fee-for-service (FFS) Medicare, including a smaller share of disabled beneficiaries under the age of 65. Within the MA program, SNP enrollees differ from other MA enrollees in their demographic characteristics (Table 14-2, p. 318). Beneficiaries under the age of 65 and African American beneficiaries are more likely to be SNP enrollees. Dual-eligible beneficiaries also make up a large proportion of C-SNP and I-SNP enrollees.

MA plans (including SNPs) and the providers they contract with are not permitted to charge dual-eligible beneficiaries deductibles or coinsurance for Medicare services. However, MA plans are permitted to charge premiums to dual-eligible beneficiaries. States have the option to pay the MA premiums on behalf of dual-eligible beneficiaries, but they are not required to do so. As of 2013, 86 percent of Medicare beneficiaries have access to at least one MA plan that charges no premium for a benefit package that includes Medicare Part A, Part B, and Part D (see Chapter 13 for information on MA plans).

African Americans enrolled in C-SNPs and I-SNPs are disproportionately dual eligible. Half of African Americans in C-SNPs are dual eligible, and 75 percent of those in I-SNPs are dual eligible. In comparison, 17 percent of African Americans in regular MA plans are dual

**TABLE  
14-1**

**Distribution of SNP enrollment, December 2012**

**Distribution of enrollment by CCP types**

Plan type	Number of contracts	Number of plans	Enrollment (in thousands)	Distribution of enrollment by CCP types		
				HMOs	Local PPOs	Regional PPOs
SNPs						
Dual eligible	214	322	1,303	95%	3%	3%
Chronic or disabling condition	44	115	233	57	5	38
Institutional	45	70	50	60	40	0
Total SNPs	303	507	1,586			
All MA plans	523	2,184	10,471	74	16	9

Note: SNP (special needs plan), CCP (coordinated care plan), PPO (preferred provider organization), MA (Medicare Advantage). CCP includes HMO, local PPO, and regional PPO categories.

Source: MedPAC analysis of CMS enrollment and landscape files.

eligible, and 36 percent of African Americans in FFS are dual eligible (data not shown in Table 14-2).

**Findings on SNPs**

In evaluating whether SNPs should be reauthorized, we considered how SNP reauthorization would affect Medicare program spending, how SNPs perform on quality-of-care measures, and whether SNPs encourage a more integrated delivery system than is currently available in FFS. Our methodology consisted of quantitative assessments of Medicare payments to SNPs, SNP quality-of-care measures (Healthcare Effectiveness Data and Information Set<sup>®</sup> (HEDIS<sup>®</sup>) measures, risk-adjusted

readmissions, and star ratings), and interviews with managed care plans that offer a variety of SNPs, other MA plans, and Medicaid managed care plans.

With respect to quality-of-care measures, we analyzed the subset of HEDIS measures that SNP plans report at the SNP benefit package level (a subset of the HEDIS measures reported at the MA contract level, discussed in Chapter 13), risk-adjusted readmission rates, and MA plan star ratings. As noted in Chapter 13 on MA plans, several HEDIS measures are reported only by SNPs, all of which are based on medical record documentation. In aggregate across all SNPs, these measures showed statistically significant improvement in average rates between 2011 and 2012: medication review, functional status assessments, pain screening (the three measures included

**TABLE  
14-2**

**Demographic characteristics of SNP enrollees, December 2011**

Characteristic	FFS Medicare	All MA plans	D-SNPs	C-SNPs	I-SNPs	Regular MA plans
Dual eligibles*	19%	16%	95%	32%	49%	8%
Under age 65	22	12	37	23	6	10
African Americans	11	11	25	32	12	9

Note: SNP (special needs plan), FFS (fee-for-service), MA (Medicare Advantage), D-SNP (dual-eligible special needs plan), C-SNP (chronic or disabling condition special needs plan), I-SNP (institutional special needs plan).

\*Medicaid status can change monthly. Beneficiaries may lose their Medicaid status and therefore their status as dual-eligible beneficiaries but remain enrolled in an MA plan.

Source: MedPAC analysis of CMS enrollment data.



## Previous Commission recommendations on special needs plans

In Chapter 3 of our March 2008 report, the Commission made a number of recommendations on special needs plans (SNPs) (Medicare Payment Advisory Commission 2008). Many, but not all, of the recommendations have been incorporated into statute or regulatory or subregulatory requirements. However, the actions taken on quality measures and dual-eligible–SNPs’ requirement to have contracts with states fall short of the Commission’s intention (Table 14-3). Recommendation 3-6—that dual-eligible and institutional beneficiaries should not be able to enroll in regular Medicare Advantage (MA) plans outside the MA

open enrollment period—has not been implemented. The recommendation left intact dual-eligible and institutional beneficiaries’ option to disenroll from MA and return to fee-for-service Medicare at any point during the year.

On net, since the Commission’s 2008 recommendations were issued, the Congress has enacted reforms to the SNP program, but more work remains to be done in developing quality measures for special needs individuals and ensuring that plans for dual-eligible beneficiaries coordinate care across the Medicare and Medicaid programs. ■

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (*continued next page*)

Recommendation	Status
<p><b>3-1.</b> The Congress should require the Secretary to establish additional, tailored performance measures for special needs plans and evaluate their performance on those measures within three years.</p>	<p>CMS has added a number of quality measures applicable to SNPs. SNPs are evaluated on their models of care and their performance on structure and process standards. In addition, new SNP-specific process measures are a component of the CMS star system (which determines plan bonuses); these measures include organizations that have both SNP and other MA plan offerings under one contract.</p> <p>Currently, SNPs separately report on results for their specific populations using 23 of the 45 measures in the set of MA quality measures and report on several SNP-specific measures. If an organization has a contract that includes both SNP and non-SNP enrollees in the reporting unit, the organization must report performance on each of 45 measures for the overall population (which includes SNP members) as well as report separate results for the smaller set of SNP-specific measures. SNPs report on two of the eight MA outcome measures (control of blood pressure among enrollees with hypertension and hospital readmission rates). Work is under way to develop a set of measures that are appropriate for populations with special needs.</p>

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

*(continued next page)*

in the star rating system), advance care planning, and medication reconciliation postdischarge. Below, we report quality results separately for I–SNPs, C–SNPs, and D–SNPs and present results on the subset of HEDIS measures reported at the SNP level, risk-adjusted readmission rates at the SNP level, and star ratings (available only at the MA contract level).

### Effect of SNP reauthorization on Medicare spending

A reauthorization of any type of SNP will result in increased Medicare spending. Medicare generally spends more on beneficiaries who enroll in MA plans than the program would have spent had the beneficiaries remained in FFS. Consistent with higher MA spending in

## Previous Commission recommendations on special needs plans (cont.)

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (continued)

Recommendation	Status
<p><b>3-2.</b> The Secretary should furnish beneficiaries and their counselors with information on special needs plans that compares their benefits, other features, and performance with other Medicare Advantage plans and traditional Medicare.</p>	<p>It remains difficult to compare SNPs to regular MA plans. The SNP-specific measures that are currently collected are reported to the public at the medicare.gov website, with star ratings attached to each measure. However, SNP data include results for measures that are not part of the SNP-specific reporting. For those measures, the result shown for the SNP is the contract-wide result for the organization, which includes both SNP and non-SNP enrollees.</p> <p>The medicare.gov site also contains information on the benefits and other features of each plan at the SNP level.</p> <p>Currently, medicare.gov compares MA and FFS on vaccination rates for influenza and pneumonia and on patient experience measures from member surveys (measuring timeliness of access to care and members' rating of the health plan and its providers). There are no comparisons of outcomes.</p>
<p><b>3-3.</b> The Congress should direct the Secretary to require chronic condition special needs plans to serve only beneficiaries with complex chronic conditions that influence many other aspects of health, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems.</p>	<p>This provision was incorporated nearly verbatim in MIPPA. CMS has tightened the rules for the kinds of conditions that can qualify for special needs status.</p>
<p><b>3-4.</b> The Congress should require dual-eligible special needs plans within three years to contract, either directly or indirectly, with states in their service areas to coordinate Medicaid benefits.</p>	<p>This provision was included in MIPPA. As of 2013, all dual-eligible SNPs must have state contracts. However, a contract alone does not ensure that SNPs have greater coordination of Medicare and Medicaid services. The minimum contract standards in the regulations require only that the contract state the financial obligations of the SNP in cost sharing and Medicaid benefits, the Medicaid benefits covered, the categories of beneficiaries covered, information sharing regarding Medicaid provider participation and verification of eligibility, and the SNP service area (42 CFR §422.107).</p>

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

*(continued next page)*

general, we found that, in aggregate, Medicare spending on beneficiaries enrolled in SNPs exceeds spending on comparable beneficiaries in FFS. On the basis of 2013 data, we estimate Medicare payments to SNPs to average 5 percent higher than FFS payments.

The effect on Medicare spending from the expiration of SNPs is already reflected in the Medicare spending baseline. Under current law, SNP authority will end on December 31, 2014. After this date, former SNP plans can convert to regular MA plans or they may exit the market. The SNPs' enrollees can remain in the converted MA

## Previous Commission recommendations on special needs plans (cont.)

**TABLE  
14-3**

### Commission recommendations on special needs plans, March 2008, and current status (continued)

Recommendation	Status
<b>3-5.</b> The Congress should require special needs plans to enroll at least 95 percent of their members from their target population.	The Congress required SNPs to enroll members only from their target population.
<b>3-6.</b> The Congress should eliminate dual-eligible and institutionalized beneficiaries' ability to enroll in Medicare Advantage plans, except special needs plans with state contracts, outside of open enrollment. They should also continue to be able to disenroll and return to fee-for-service at any time during the year.	There has been no change to the current month-to-month enrollment option for dual-eligible and institutional beneficiaries in regular MA plans (a regulatory provision).
<b>3-7.</b> The Congress should extend the authority for special needs plans that meet the conditions specified in Recommendations 3-1 through 3-6 for three years.	SNPs have been extended by statute on four occasions (through 2009 in 2007 legislation, through 2010 in 2008 legislation, through 2013 in 2010 legislation, and through 2014 in 2012 legislation). The 2007 legislation imposed a moratorium on new SNPs in 2008 and 2009, and the 2008 legislation contained the additional requirements imposed on each category of SNPs as of January 1, 2010.

Note: SNP (special needs plan), MA (Medicare Advantage), FFS (fee-for-service), MIPPA (Medicare Improvements for Patients and Providers Act of 2008).

plan, choose another MA plan, or return to FFS Medicare. Although some beneficiaries are expected to return to FFS, most are expected to remain enrolled in an MA plan, since initially, as SNP enrollees, they opted for MA over FFS.

Medicare spending on the beneficiaries who remain in MA will be similar to the spending on these beneficiaries when they were enrolled in SNPs. If beneficiaries cost a certain amount to the program when they were enrolled in a SNP, they will cost the same amount when they enroll in another MA plan because SNPs are generally paid the same as regular MA plans. Spending on the beneficiaries who return to FFS will decline because FFS spending is generally lower than MA spending. After 2014, spending on MA enrollees is expected to approximate or be slightly higher than FFS spending. The Patient Protection and Affordable Care Act of 2010 made changes to the MA benchmarks that over the next several years are designed to better align with, or in some instances be below, FFS spending. Two exceptions to this premise could continue

the trend of MA spending outpacing FFS spending. First, MA plans will receive bonuses for highly rated performance on quality measures, which will increase MA spending relative to FFS spending. Second, MA plans have an incentive that FFS providers do not to assign the most financially favorable diagnostic codes to their enrollees. For example, in 2010, payments to MA plans were \$3.9 billion to \$5.8 billion higher than they would have been if those beneficiaries were in FFS because of coding differences that were not adjusted (Government Accountability Office 2012). The American Taxpayer Relief Act of 2012 increased the coding intensity adjustment to MA plan payments. However, it is likely that coding differences will continue to result in higher payments to MA plans.

#### **I-SNPs**

Overall, I-SNPs perform better than other SNPs and other MA plans on the majority of available quality measures

**TABLE  
14-4**

**Readmission rates by type of SNP**

Plan type	Total admissions	Observed rates of readmission	Risk-adjusted expected rates of readmission	Ratio of observed to expected rates
HMOs*	1,032,428	14.3%	15.7%	0.91
Local PPOs*	186,490	13.2	14.8	0.90
Regional PPOs*	126,151	14.8	15.3	0.97
<b>SNP-specific results</b>				
I-SNPs				
HMOs	5,749	15.0	20.9	0.72
Local PPOs	1,623	9.9	19.2	0.52
D-SNPs				
HMOs	103,353	16.6	17.2	0.97
Local PPOs	3,141	14.5	16.9	0.86
Regional PPOs	3,803	19.3	16.6	1.17
C-SNPs				
HMOs	10,253	16.3	19.8	0.83
Regional PPOs	14,950	20.7	16.6	1.25
All SNPs				
Regional PPOs	18,758	20.4	16.6	1.23

Note: SNP (special needs plan), PPO (preferred provider organization), I-SNP (institutional special needs plan), D-SNP (dual-eligible special needs plan), C-SNP (chronic or disabling condition special needs plan).

\*Overall categories include SNP results for contracts that include both SNP and non-SNP enrollees because data cannot be disaggregated. Results exclude Puerto Rico.

Source: MedPAC analysis of CMS Healthcare Effectiveness Data and Information Set<sup>®</sup> public use files.

for SNPs. The average rates of advance care planning, medication review, functional status assessment, and pain screening are higher than the rates for all SNPs for the same measures. The I-SNP rate for medication reconciliation within 30 days of a hospital discharge (not an element of the star ratings) is about the same as the overall SNP average (31 percent).

Compared with other MA plans, I-SNPs also perform well on a number of process measures. Specifically, they have comparatively higher rates for monitoring of a group of persistently used medications and glaucoma screening in older adults. Although I-SNPs also have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions, their higher rates of monitoring of persistently used drugs suggest that drugs with potential interactions or adverse effects are also being closely monitored.

I-SNPs also perform well on risk-adjusted rates of hospital readmissions relative to other SNPs and other MA plans (Table 14-4). HMO I-SNPs have observed-to-expected readmission ratios of 0.72 and preferred provider organization (PPO) I-SNPs have observed-to-expected readmission ratios of 0.52. These ratios show that I-SNPs have fewer hospital readmissions than would be expected given the clinical severity of their enrollees.

I-SNPs' performance in hospital readmission rates is an important measure of whether they provide a more integrated delivery system. I-SNPs attempt to reduce hospital and emergency department utilization through care management and by emphasizing the provision of primary care. For example, some I-SNPs employ nurse practitioners to work with nursing home staff to provide primary care, care planning, and coordination of medical services. Achieving readmission rates that are lower than expected demonstrates that I-SNPs are meeting their goal

to reduce hospital utilization for beneficiaries who are institutionalized. Further, almost half of I-SNP enrollees are dual eligible (Table 14-2, p. 318). Reducing hospital readmission rates for these dual-eligible beneficiaries residing in nursing homes also helps prevent the churning between Medicare and Medicaid.

## RECOMMENDATION 14-1

**The Congress should permanently reauthorize institutional special needs plans.**

## RATIONALE 14-1

This recommendation makes I-SNPs a permanent plan offering under the MA program. I-SNPs serve a distinct population—beneficiaries who are institutionalized or who live in the community and require a nursing home level of care. I-SNPs on average perform better than SNPs and other MA plans on certain quality measures, including risk-adjusted hospital readmission rates. Reducing hospital readmissions suggests that I-SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in FFS Medicare.

## IMPLICATIONS 14-1

### Spending

- This recommendation will not change Medicare spending in 2014 because I-SNPs are reauthorized through the end of that year. This recommendation will increase spending relative to current law by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. Under current law, the Medicare baseline assumes that I-SNP authority will expire at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in I-SNPs will likely return to FFS. If I-SNPs are reauthorized and beneficiaries remain enrolled in them, Medicare spending will increase relative to baseline because spending on beneficiaries enrolled in MA plans (including I-SNPs) is generally higher than FFS spending.

### Beneficiary and plan

- Beneficiaries currently enrolled in I-SNPs can remain in those plans and new beneficiaries can join I-SNPs.
- Managed care organizations that offer I-SNPs will be permitted to continue to offer these plans. New managed care organizations may enter the I-SNP market once the plans are made permanent.

## C-SNPs

In general, C-SNPs tend to perform no better, and often worse, than other SNPs and other MA plans on most quality measures. Among C-SNPs, regional PPOs (almost 40 percent of the C-SNP population) tend to perform worse than HMOs. For example, for medication reconciliation after discharge, regional PPO C-SNPs scored 18 percent and HMO C-SNPs scored 25 percent, compared with the 31 percent average across all SNPs. The C-SNP rate for glaucoma screening in older adults is about the same as the rate for other MA plans, but C-SNPs perform worse on this measure compared with I-SNPs. However, C-SNPs and I-SNPs have similar performance on measures of monitoring of a specific group of persistently used medications.

There are a few measures for which regional PPO C-SNPs perform worse than HMO C-SNPs. On risk-adjusted hospital readmissions, regional PPO C-SNPs have higher than expected rates (ratio of 1.25, see Table 14-4), which means that enrollees in regional PPOs have more hospital readmissions than would be expected given their clinical severity. Most other SNPs, including HMO C-SNPs, have lower than expected hospital readmission rates. Regional PPO C-SNPs also perform poorly on the advance care planning measure (10 percent) compared with HMO C-SNPs (43 percent) and the average across all SNPs (39 percent). The measures on which regional PPO C-SNPs perform relatively well are the SNP-only measures of medication review, functional status assessment, and pain screening.

The Commission recommended in 2008 that the list of health conditions that qualify for a C-SNP be narrowed (Table 14-3, pp. 319–321). Although the list was later narrowed, we believe the current list continues to be too broad. It is our judgment that regular MA plans should be able to manage most clinical conditions that currently serve as the basis for a plan to be established as a C-SNP and that the C-SNP model of care—that is, their ability to tailor benefits to chronically ill beneficiaries—should be imported into MA plans for these conditions. This change will enable Medicare beneficiaries with chronic conditions such as diabetes, congestive heart failure, and cardiovascular disorders to receive a care management approach and services that are more tailored to their needs through an MA plan. It will also move MA plans in the direction of providing services that are more targeted to particular populations and providing a more integrated delivery system.

There has been recent movement in the MA plan industry in the direction of importing the C–SNP model of care into regular MA plans. Some managed care organizations that primarily operate regular MA plans have recently purchased C–SNPs, consistent with the intention to import the C–SNP model of care into regular MA plans.

MA plans will need flexibility to offer a separate benefit package for chronically ill beneficiaries in order for the C–SNP model of care to be imported into MA plans. Currently, MA plans must offer the same benefit package to all their enrollees. However, under this flexibility, MA plans would be permitted to offer multiple benefit packages. The benefit packages for chronically ill beneficiaries would be permitted to vary from the benefit package for other beneficiaries. For example, under this new flexibility, MA plans could vary the supplemental benefits, cost sharing for services and drugs, and provider networks for chronically ill enrollees. The separate benefit packages for chronically ill beneficiaries would need to differ by type of chronic condition and be designed for the needs of the targeted population.

Importing the C–SNP model of care into MA plans could reduce the potential for MA plans to select relatively healthier beneficiaries (i.e., “favorable selection”). As noted in the MA chapter of this report, the degree of favorable selection in MA is not as great as it has been in the past (Newhouse et al. 2012). Researchers attribute this fact to several factors, one of which is the policy change in the MA plan enrollment period. Previously, all beneficiaries could enroll in or disenroll from MA plans monthly, which created a greater opportunity for favorable selection. Now, most beneficiaries may enroll or disenroll yearly only during the open enrollment period. In contrast, C–SNPs can elect to enroll beneficiaries with only certain chronic conditions and can enroll those beneficiaries throughout the year, which provides greater opportunity for favorable selection. Importing the C–SNP model of care into MA plans would reduce this opportunity, as formerly eligible C–SNP beneficiaries would be subject to the rules of the yearly open enrollment period, which has already shown success in reducing favorable selection.

We recognize that some of the conditions that currently qualify for a C–SNP may warrant maintaining separate plans for these conditions while innovations in the care delivery for these populations are still being made. These conditions include end-stage renal disease (ESRD), HIV/AIDS, and chronic and disabling mental health conditions (currently defined for C–SNP eligibility as bipolar

disorder, major depressive disorders, paranoid disorder, schizophrenia, and schizoaffective disorder).

Few C–SNPs currently operate to serve beneficiaries with ESRD, HIV/AIDS, or chronic and disabling mental health conditions, but some offer models of care that are tailored to beneficiaries with these conditions. For example, one chronic and disabling mental health C–SNP serves beneficiaries with high medical, behavioral, and social needs. Some enrollees are homeless and, although they may be on a medication regimen, they may appear or act mentally unstable. This C–SNP recruits primary care physicians, specialists, and psychiatrists who are willing to treat their enrollees. Beneficiaries are assigned to a primary care physician, a psychiatrist, and a behavioral health case manager upon enrollment, and there is no copay to see the primary care physician. This model of care focuses on coordination between enrollees’ behavioral health and medical care, particularly because many enrollees take behavioral health medications that have medical side effects. The model of care also emphasizes teaching enrollees how to accomplish daily routine tasks and become more independent and social under the premise that such activities may make individuals less vulnerable to their underlying mental health condition. The behavioral health case managers are responsible for knowing enrollees’ whereabouts, helping enrollees comply with their treatment regimen, and helping homeless enrollees find permanent housing. The C–SNP also employs a mobile nurse team that visits enrollees who are homebound or homeless.

## RECOMMENDATION 14-2

### The Congress should:

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

This recommendation is consistent with the Commission's 2008 recommendation to limit the number of conditions that qualify for a C-SNP. It also moves MA plans in the direction of providing more tailored services and offering a more integrated delivery system to chronically ill beneficiaries by importing the C-SNP model of care into MA plans. Under this recommendation, C-SNP authority would expire for most conditions that are currently eligible for a C-SNP. The C-SNP model of care for these conditions would be imported into MA plans, which would be given the flexibility to offer specialized benefit packages within the MA plan to beneficiaries with these conditions. The Secretary would have three years to develop the regulations that permit benefit design flexibility. Our intention is for benefit design flexibility to be fully implemented and for the transition period to end no later than December 31, 2016. During the transition period, current C-SNPs would continue operating, but no new C-SNPs would be permitted to operate for the conditions with expiring authority. For the separate benefit packages for the chronically ill, we anticipate that MA plans would be held to some or all of the existing C-SNP model-of-care requirements, such as having a specialized provider network, developing an individualized care plan for each enrollee, and providing care management. We are not recommending, however, that MA plans' compliance with the model-of-care requirements be measured through the existing SNP model-of-care reporting process. Beneficiaries with conditions for whom the C-SNP model of care is imported into MA plans would follow MA's yearly open enrollment process.

This recommendation gives C-SNP authority to continue for a small number of conditions, including ESRD, HIV/AIDS, and chronic and disabling mental health conditions, making the recommendation consistent with our 2008 recommendation to narrow the conditions eligible for a C-SNP. It also reflects our understanding that there may be a rationale for maintaining a separate plan option for these conditions to permit innovations in the care delivery for these populations to continue. However, we encourage the Secretary to assess how MA plans respond to the increased flexibility to offer separate benefit packages and to revisit whether MA plans can adequately care for beneficiaries with these three conditions under new benefit flexibility authority.

### Spending

- This recommendation decreases Medicare spending by less than \$50 million in 2014. C-SNPs are reauthorized through the end of that year under current law, and this recommendation places a moratorium on new C-SNPs in 2014. This recommendation increases spending by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. Under current law, the Medicare baseline assumes that C-SNP authority expires at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in those C-SNPs will likely return to FFS Medicare, thus lowering spending compared with what spending would have been for them in MA. However, under this recommendation, current C-SNPs could continue to operate during the transitional period. Medicare spending would increase relative to the baseline if beneficiaries who otherwise would have returned to FFS remain enrolled in C-SNPs during the transitional period.

### Beneficiary and plan

- This recommendation is not expected to have adverse impacts on Medicare beneficiaries because chronically ill beneficiaries would be able to receive a specialized benefit package that is tailored to their needs through new benefit flexibility. Benefit flexibility could result in more MA plans offering specialized benefit packages than are currently available through C-SNPs. Beneficiaries with ESRD, HIV/AIDS, and chronic and disabling mental health conditions would still have access to any C-SNPs offered in their service area.
- MA plans can continue to serve beneficiaries with chronic conditions through flexible benefit designs and as appropriate through the C-SNP model. The recommendation also gives plans a three-year period to transition their benefit structures from the C-SNP. C-SNPs for beneficiaries with ESRD, HIV/AIDS, or chronic disabling mental health conditions would be able to continue.

### D-SNPs

Overall, D-SNPs tend to have average to below-average performance on quality measures compared with other SNPs and regular MA plans, but some of the D-SNPs that are the most highly integrated with Medicaid perform well on the star ratings. D-SNPs have the lowest rates of performance by 5 percent to 12 percent on all but one

of the quality measures that only SNPs report. Similar to other SNPs, D–SNPs have higher rates than regular MA plans for the use of potentially harmful drugs among the elderly and the use of drug combinations with potentially harmful interactions. D–SNPs perform similarly to regular MA plans on the rates of monitoring of persistently used drugs, but they perform better than regular MA plans on monitoring anticonvulsants. D–SNPs also have high rates of glaucoma screening, persistence of beta blocker use after a heart attack, and bronchodilator use in managing chronic obstructive pulmonary disease. For most other measures that can be compared with regular MA plans, D–SNPs generally have below average rates. Exceptions to this level of performance include eight D–SNPs that have a star rating of 4 or 4.5. In addition, among the fewer than 25 D–SNPs that furnish some or all Medicaid benefits, 8 have star ratings of 4 or 4.5 (10 of these 25 plans do not have sufficient enrollment or have not been in operation long enough for a star rating to be calculated for them).

D–SNPs have the potential to integrate Medicare and Medicaid benefits for dual-eligible beneficiaries—that is, assume clinical and financial responsibility for Medicare benefits and some or all of Medicaid’s long-term care services and supports (LTSS), behavioral health services, or both. Through integrating Medicaid benefits, D–SNPs can offer a more cohesive delivery system than FFS by eliminating the incentives that exist in both Medicare and Medicaid to shift costs to one another (Medicare Payment Advisory Commission 2010), improving quality of care, and possibly reducing costs.

The Commission’s 2008 recommendation for D–SNPs to contract with states reflected the Commission’s concern that D–SNPs were not clinically or financially integrating Medicaid benefits. D–SNPs were subsequently required by the Medicare Improvements for Patients and Providers Act of 2008 to contract with states. However, generally, the contracts have not resulted in the desired integration of Medicaid benefits. Most D–SNP contracts do not cover some or all of Medicaid’s LTSS or behavioral health services. Instead, the contracts call for D–SNPs to coordinate, but not furnish, Medicaid benefits; furnish Medicaid payments of dual eligibles’ cost sharing for Medicare services; or furnish some of the Medicaid acute care benefits not covered under Medicare, such as transportation, vision, and dental services. Some states have been reluctant to contract with D–SNPs to cover some or all of Medicaid’s LTSS and behavioral health services for several reasons. Legislation prohibits some states from moving LTSS or behavioral health services

into managed care programs. Other states without such legislative prohibitions are nevertheless adverse to providing Medicaid benefits through managed care. Still other states lack the staff resources or technical capabilities to develop, for D–SNPs, contracts that cover LTSS or behavioral health services.

We found exceptions under two D–SNP models in which an incentive exists for D–SNPs to clinically and financially integrate Medicaid benefits. Under one model, a single plan—the D–SNP—covers some or all of Medicaid’s LTSS or behavioral health services through its contract with the state. We estimate that fewer than 25 plans, or about 8 percent of D–SNPs, currently follow this model. Collectively, these D–SNPs enroll approximately 65,000 dual-eligible beneficiaries, or about 5 percent of all dual-eligible beneficiaries enrolled in D–SNPs.

Under the other model, one managed care organization administers a Medicaid plan that furnishes some or all LTSS or behavioral health services and a D–SNP; the same dual-eligible beneficiaries are enrolled in both plans. Under this model, integration occurs at the level of the managed care organization across the two plans. The D–SNP in this scenario does not need to have a state contract to furnish some or all of Medicaid LTSS or behavioral health benefits. The managed care organization is financially responsible for providing these benefits through the Medicaid plan. Approximately 35 D–SNPs, or 11 percent of D–SNPs, currently are administered under this model.<sup>4</sup> These D–SNPs enroll an estimated 235,000 dual-eligible beneficiaries, or about 19 percent of all dual-eligible beneficiaries enrolled in D–SNPs. Under both models, one managed care organization has a financial incentive to manage and coordinate the Medicare and Medicaid services because they are financially at risk for those services. It also has an advantage in managing and coordinating services. For example, when D–SNP staff are notified of a hospitalization, they can begin discharge planning and the transition to post-acute care settings or to the home. If the D–SNP or its companion Medicaid plan covers some LTSS, staff can coordinate and ensure that necessary services, such as home modifications or personal care attendant hours, are in place when the beneficiary returns home.

#### RECOMMENDATION 14-3

**The Congress should permanently reauthorize dual-eligible special needs plans (D–SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D–SNPs to expire.**



## RATIONALE 14-3

Consistent with the Commission's 2008 recommendation on D-SNPs, the intention of this recommendation is to move D-SNPs toward clinical and financial integration of Medicare and Medicaid benefits for dual-eligible beneficiaries. Under this recommendation, the D-SNPs that would become permanent MA offerings would be those that clinically and financially integrate Medicare with Medicaid's LTSS, behavioral health services, or both. This recommendation includes D-SNPs that fall under the two models discussed above where we observe that incentives exist for the clinical and financial integration of Medicare and Medicaid benefits.

D-SNPs that do not currently meet the clinical and financial criteria for integrating with Medicaid benefits will not be reauthorized under this recommendation. However, they can work with states now or at a later time to become integrated. Alternatively, they can convert to regular MA plans.

## IMPLICATIONS 14-3

### Spending

- This recommendation will not change Medicare spending in 2014 because D-SNPs are reauthorized through the end of that year. This recommendation will increase spending relative to current law by less than \$1 billion over five years. We expect the five-year spending increase to be much lower than \$1 billion. The current Medicare baseline assumes that authority for integrated D-SNPs will expire at the end of 2014. If this termination occurs, some of the beneficiaries enrolled in D-SNPs would likely return to FFS Medicare, which would lower Medicare spending relative to MA spending for these beneficiaries. However, if the integrated D-SNPs were made permanent, beneficiaries who otherwise would have returned to FFS would remain enrolled in those plans, raising Medicare spending relative to FFS Medicare spending.

### Beneficiary and plan

- Dual-eligible beneficiaries enrolled in D-SNPs that clinically and financially integrate Medicaid benefits will benefit by continuing to remain enrolled in those programs. Beneficiaries currently enrolled in D-SNPs that will not be reauthorized can remain in the MA program (either in the same plan, if it continues as a regular plan, or in another MA organization) or can enroll in FFS Medicare.

- Clinically and financially integrated D-SNPs will benefit from this recommendation because those plans will convert to a permanent status. Nonintegrated D-SNPs have the option to convert to regular MA plans, in which case they could keep some or most of their enrollees, exit the MA program, or work with states to become integrated D-SNPs.

### Several administrative policies are barriers to D-SNP integration

Several administrative policies act as barriers to integrating Medicare and Medicaid benefits (Medicare Payment Advisory Commission 2010). One barrier is how D-SNPs are allowed to market their benefits to beneficiaries. D-SNPs that furnish Medicaid benefits are not currently able to describe the combination of Medicare and Medicaid benefits they cover in their marketing materials. This situation can lead to confusion for beneficiaries and make the advantages of joining an integrated D-SNP less clear. The Secretary has the authority to address this problem. Specifically, the Secretary could permit D-SNPs to describe—in the same section of the plan's marketing materials—the Medicaid and Medicare benefits they cover.

Multiple enrollment cards are another administrative barrier to the coordination of benefits. Dual-eligible beneficiaries are sometimes given two enrollment cards—one to cover their Medicare benefits and a second to cover their Medicaid benefits—even though they are enrolled in one plan or with one organization that covers both sets of benefits. The Secretary also has the authority to address this misalignment by helping D-SNPs overcome some of the barriers to using a single enrollment card. For example, Medicare and a state Medicaid program may have different effective dates of enrollment, out-of-pocket costs, contact numbers for authorization or member services, and claims submission processes. A single enrollment card could be less burdensome and confusing to beneficiaries; however, it may be difficult to place all the necessary and relevant Medicare and Medicaid information on one enrollment card if the information between the two programs is not coordinated. Another barrier—the state's lack of resources and expertise to include its Medicaid benefits in contracts with D-SNPs—could also be addressed under the Secretary's authority by providing states with a model Medicaid contract with D-SNPs. The model contract would serve as a form of technical assistance and states would have the option to refer to the model contract as a resource guide when developing Medicaid contracts with D-SNPs.

Separate appeals and grievances processes for Medicare and Medicaid services are another barrier to integration. The current appeals and grievances processes for Medicare Part A and Part B have different rules and timelines from the appeals and grievances processes for Medicaid. It can be confusing and time-consuming for beneficiaries to navigate these separate processes. An aligned appeals and grievances process would alleviate this barrier, but the Secretary does not have the authority to do so, as it would require a change in law by the Congress. The current MA standards for appeals and grievances should represent a minimum standard. An alignment with the Medicaid process should result in an appeals and grievances standard that is an improvement over what is currently available through MA.<sup>5</sup>

#### RECOMMENDATION 14-4

**For dual-eligible special needs plans (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should:**

- **grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;**
- **direct the Secretary to allow these D-SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;**
- **direct the Secretary to allow these D-SNPs to use a single enrollment card that covers beneficiaries' Medicare and Medicaid benefits; and**
- **direct the Secretary to develop a model D-SNP contract.**

#### RATIONALE 14-4

This recommendation would alleviate misalignments between the Medicare and Medicaid programs that are barriers to an integration of program benefits. Under this recommendation, D-SNPs that are clinically and financially integrated would have aligned appeals and grievances processes for Medicare and Medicaid benefits. They would also be able to market all the benefits they cover as a combined benefit package, and it would be easier for them to give enrollees a single enrollment card to access their Medicare and Medicaid services. Under this recommendation, the Secretary would develop an example of a model Medicaid contract with a D-SNP for states to use as a resource.

#### IMPLICATIONS 14-4

##### Spending

- This recommendation would not affect program spending but would alleviate administrative barriers between the Medicare and Medicaid programs.

##### Beneficiary and plan

- We expect this recommendation to have a positive effect on beneficiaries and plans by fostering the coordination of Medicare's and Medicaid's separate benefits for the beneficiaries who are dually eligible for both sets of benefits. ■

## Endnotes

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- 1 Employer plans are another type of MA plan that can limit enrollment. They are not included in the analysis in this chapter.
- 2 Fifteen conditions are currently approved by CMS for C-SNPs: chronic alcohol and other drug dependence; autoimmune disorders; cancer, excluding precancer conditions or in situ status; cardiovascular disorders; chronic heart failure; dementia; diabetes mellitus; end-stage liver disease; end-stage renal disease requiring dialysis; severe hematologic disorders; HIV/AIDS; chronic lung disorders; chronic and disabling mental health conditions; neurologic disorders; and stroke.
- 3 The NCQA approval process, required as of 2012, evaluates the extent to which plans adhere to these “model of care” requirements. A separate NCQA process evaluates the structure and processes of SNPs.
- 4 MedPAC analysis of plan participation of Medicaid managed long-term care programs and SNP enrollment files from CMS.
- 5 CMS is currently working with a number of states on demonstrations for integrated care programs for dual-eligible beneficiaries and will likely alleviate many of these misalignments for the plans that participate in the demonstrations.

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CHAPTER

# 15

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**Status report  
on Part D**

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## 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 beneficiary survey results—program costs, and the quality of Part D services; and
- analyze changes in plan bids, premiums, benefit designs, and formularies.

Part D is now in its eighth year. In 2011, Medicare spent about \$60 billion for the Part D program, accounting for over 10 percent of total Medicare outlays. In 2012, over 30 million Medicare beneficiaries were enrolled in Part D, with about 63 percent of Part D enrollees in stand-alone prescription drug plans (PDPs) and the remaining 37 percent in Medicare Advantage–Prescription Drug plans (MA–PDs). In 2013, a total of 1,033 PDPs are offered nationwide along with 1,627 MA–PDs. 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.

**Access to prescription drug coverage**—In 2012, nearly 65 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 9 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. CMS reports that, in 2010, about 17 percent of beneficiaries received their drug coverage through other sources and 10

### In this chapter

- Part D enrollees' access to prescription drug benefits
- Benefit offerings for 2013
- Costs of Part D
- Use of generic drugs
- Quality in Part D
- Role of competition in Part D
- Relationship between medical and drug spending

percent had no drug coverage or coverage less generous than Part D. Beneficiaries with no creditable coverage tended to be healthier, on average. More than half reported not joining Part D because they did not take enough medications to need such coverage. Among Part D plan enrollees, 10.8 million individuals (about 34 percent) received the low-income subsidy (LIS).

***Benefit offerings for 2013***—The number of plan offerings remained stable between 2012 and 2013. Sponsors are offering slightly fewer stand-alone PDPs (a decrease of just under 1 percent) and 6 percent more MA-PDs than in 2012. Beneficiaries will continue to have between 23 and 38 PDPs to choose from, 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 in the gap. For 2013, slightly more premium-free PDPs are available to enrollees who receive the LIS; 331 plans qualify compared with 327 in 2012. In most regions, LIS enrollees will continue to have many premium-free plans available. In two regions, Florida and Nevada, only two plans qualified as premium free in each region.

***Part D spending***—Between 2007 and 2011, Part D spending increased from \$46.7 billion to \$60 billion (an average annual growth of about 7 percent), and CMS expects it will have reached \$62 billion in 2012. These expenditures include the direct monthly subsidy plans receive for their Part D enrollees, reinsurance paid for very-high-cost enrollees, premiums and cost sharing for LIS enrollees, and payments to employers that continue to provide drug coverage to their Medicare beneficiary retirees. In 2011, LIS payments continued to be the largest single component of Part D spending, while Medicare's reinsurance payments were the fastest growing component. Changes made by the Patient Protection and Affordable Care Act of 2010 to gradually close the coverage gap likely contributed to the higher growth in reinsurance payments between 2010 and 2011.

***Change in Part D bids and premiums***—While the average costs for basic Part D benefits are expected to remain stable (a growth of less than 1 percent) between 2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease of over 9 percent for the direct subsidy and an increase of about 14 percent for the reinsurance component. In 2013, the base beneficiary premium is about the same as in 2012 (\$31). It reflects the basic portion of the benefit and does not include premiums for enhanced, or supplemental, benefits. The actual premium paid depends on the beneficiary's choice of plan.

***Role of competition in Part D***—Part D uses a competitive design to give plan sponsors incentives to offer beneficiaries attractive prescription drug coverage while



controlling growth in drug spending. Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not. We find that a higher share of enrollees have switched plans voluntarily in recent years than was reported by CMS during the first few years of the program. ■



**TABLE  
15-1**

**Parameters of the defined standard benefit increased, 2006–2013**

	2006	2012	2013
Deductible	\$250.00	\$320.00	\$325.00
Initial coverage limit	2,250.00	2,930.00	2,970.00
Annual out-of-pocket spending threshold	3,600.00	4,700.00	4,750.00
Total covered drug spending at annual out-of-pocket threshold	5,100.00	6,730.39*	6,954.52*
Maximum amount of cost sharing in the coverage gap	2,850.00	3,727.50	3,763.75
Minimum cost sharing above annual out-of-pocket threshold:			
Copay for generic/preferred multisource drug prescription	2.00	2.60	2.65
Copay for other prescription drugs	5.00	6.50	6.60

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 2012 and 2013 are for an individual not receiving Part D’s low-income subsidy who has no other sources of supplemental coverage.

Source: CMS, Office of the Actuary.

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 2013), program costs, and quality of services.

## Background

Medicare’s payment system for Part D is very 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 15-1). For 2013, the defined standard benefit includes a \$325 deductible and 25 percent coinsurance until the enrollee reaches \$2,970 in total covered drug spending. Enrollees exceeding that spending total face a coverage gap up to an annual threshold of \$4,750 in out-of-pocket (OOP)

spending that excludes 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 \$2.65 to \$6.60 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), beginning in 2011, beneficiaries in the coverage gap face reduced cost sharing for both brand-name and generic drugs in the coverage gap.<sup>1</sup> In 2013, cost sharing for drugs filled during the gap phase is 47.5 percent for brand-name drugs and 79 percent for generic drugs.<sup>2</sup> An individual with no other sources of drug coverage reaches the \$4,750 limit at \$6,954.52 in total drug expenses (the sum of the enrollee’s spending plus spending the Part D plan covers).<sup>3</sup>

### 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.<sup>4</sup> 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 rebates with pharmaceutical manufacturers, and by managing enrollees’ utilization. Part D sponsors rely on clinicians—generally physicians

**TABLE 15-2**

**Over 70 percent of Medicare beneficiaries received drug coverage through Part D plans or RDS in 2012**

	Beneficiaries	
	In millions	Percent of Medicare enrollment
Medicare enrollment	50.7	100%
Part D enrollment		
Part D plans	32.7	64.5*
Plans receiving RDS**	4.5	8.9
Total Part D	37.2	73.4

Note: RDS (retiree drug subsidy). Totals may not sum due to rounding.  
 \*About 40 percent in prescription drug plans and 24 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.B3 of the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

and pharmacists who participate on a pharmacy and therapeutics committee—when deciding which drugs to list. 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, subject to CMS review and approval. In constructing formularies, sponsors consider both clinical and financial factors (such as how tier-placement decisions might affect sponsors’ rebates from drug manufacturers). Making all medications readily accessible at preferred (i.e., 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 may make the plan less attractive to potential enrollees because it covers a limited number of drugs.

**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.<sup>5</sup> In

general, Part D has improved Medicare beneficiaries’ access to prescription drugs. All individuals have access to Part D plan options, and many continue to receive drug coverage through former employers.

**In 2012, over 70 percent of Medicare beneficiaries were in Part D plans or employer plans receiving Medicare’s retiree drug subsidy**

In 2012, nearly 65 percent of an estimated 50.7 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 2012. An additional 9 percent of Medicare beneficiaries received their drug coverage through employer-sponsored plans that received Medicare’s retiree drug subsidy (RDS) (Table 15-2).<sup>6</sup> 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.<sup>7</sup>

About 10 percent of beneficiaries had no drug coverage or coverage less generous than Part D’s standard benefit in 2010, the most recent year for which data are available. Research indicates that beneficiaries who do not enroll in Part D tend to be healthier and have lower drug spending (see text box).

In 2012, about 11 million individuals, or 34 percent of Part D enrollees, received the low-income subsidy (LIS). Of them, nearly 7 million were dually eligible for Medicare

**TABLE 15-3**

**Part D enrollment by plan type and LIS status, 2012**

	Plan type		
	All Part D	PDP	MA-PD
Beneficiaries (in millions)	31.5	19.7	11.7
By LIS status			
LIS	10.8	8.3	2.5
Non-LIS	20.6	11.4	9.2

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA-PD (Medicare Advantage–Prescription Drug [plan]). Totals may not sum due to rounding.

Source: MedPAC based on monthly Part D enrollment data as of April 2012 (<https://www.cms.gov/MCRAdvPartD/EnrolData/>).

## Characteristics of Medicare beneficiaries with no creditable drug coverage

The share of Medicare beneficiaries who have no drug coverage or coverage less generous than Part D's defined standard benefit (not creditable coverage) has remained at around 10 percent since the Part D program began in 2006.<sup>8</sup> To compare the characteristics of beneficiaries with no creditable drug coverage to those with creditable coverage, we relied on responses from Medicare beneficiaries in the 2010 Medicare Current Beneficiary Survey.

Beneficiaries with no creditable coverage differ from those enrolled in Part D in many respects. For example, among beneficiaries with no creditable coverage, there is a higher concentration of beneficiaries in the 65-year to 74-year age range and fewer beneficiaries age 75 or older compared with Part D enrollees (Table 15-4, p. 340). There are fewer racial and ethnic minorities

among beneficiaries with no creditable coverage compared with Part D enrollees. Overall, beneficiaries with no creditable coverage tended to have higher socioeconomic status than beneficiaries enrolled in Part D, with higher proportions reporting college and postgraduate education and an annual income of more than \$25,000.

A greater proportion of beneficiaries with no creditable coverage rated their health as excellent (26 percent) compared with beneficiaries enrolled in Part D (13 percent) and beneficiaries with the retiree drug subsidy and other creditable coverage (18 percent and 19 percent, respectively). The share of beneficiaries without creditable coverage reporting having had prescriptions for medications that they did not obtain

*(continued next page)*

and Medicaid. Another 4 million qualified for the LIS either because they received benefits through the Medicare Savings Program or the Supplemental Security Income program or because they were determined to be eligible by the Social Security Administration after applying directly to that agency. Among LIS beneficiaries, more than three-quarters (8.3 million) were enrolled in stand-alone prescription drug plans (PDPs) and the rest (2.5 million) were in Medicare Advantage–Prescription Drug plans (MA–PDs) (Table 15-3). CMS randomly assigns most LIS beneficiaries to PDPs that qualify as premium-free plans, unless the beneficiary chooses a plan that is different from the assigned plan. As a result, a much smaller share of LIS beneficiaries are enrolled in MA–PDs.

### Distribution of enrollment varies across regions

Part D enrollment varies geographically. In 2011, enrollment ranged between 39 percent and 70 percent of Medicare beneficiaries across the 34 PDP regions (Table 15-5, p. 341). Part D enrollment tends to be lower in states with large employers that receive Medicare's RDS—Michigan and Alaska, for example. In most regions, Medicare beneficiaries received their drug coverage through Part D plans or through drug coverage provided by former employers that receive the RDS. Between 2010 and 2011, 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 14 (Ohio), where the reduction was 11 percent. In region 5 (Delaware–District of Columbia–Maryland), region 7 (Virginia), and region 34 (Alaska), less than 65 percent of beneficiaries were in Part D plans or in plans receiving the RDS. In these regions, a higher proportion of Medicare beneficiaries may have received drug coverage from other sources, such as the Federal Employee Health Benefits Program or the Indian Health Service.

Most beneficiaries have access to many PDPs and MA–PDs. In general, MA–PD enrollment is high in regions with higher MA penetration. For example, in 2011, more than 45 percent of Part D enrollees were in MA–PDs in parts of the West (Arizona, California, Colorado, Idaho, Nevada, Utah) and in Florida, Hawaii, and New York. By comparison, in other parts of the Northeast, Midwest, and central states, less 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 2011, the share of Part D enrollees receiving the LIS ranged from 27 percent in the upper Midwest and several central western states to 62 percent in Alaska (Table 15-5, p. 341). The number

## Characteristics of Medicare beneficiaries with no creditable drug coverage (cont.)

was comparable to that for Part D enrollees (nearly 7 percent compared with 6 percent).

Of the beneficiaries with no creditable coverage, survey responses indicate that slightly over 40 percent had some drug coverage, while the remainder did not indicate having had any drug coverage in 2010 (data

not shown). When asked why they did not enroll in a Medicare prescription drug plan, slightly over half with no drug coverage responded that they did not have enough prescriptions to need such a plan, or they would not benefit from enrolling in Part D. Seventeen percent reported cost as a reason for not enrolling in a Part D plan.<sup>9</sup> ■

**TABLE  
15-4**

**Characteristics of Medicare beneficiaries by type of drug coverage, 2010**

	No creditable coverage	Creditable coverage		
		Part D	RDS	Other coverage
<b>Demographic characteristics</b>				
Age				
64 or younger	15%	20%	4%	14%
65-74	51	40	45	48
75-84	22	28	36	26
85 or older	11	12	14	11
Female	55	60	54	37
Race				
White	87	81	92	88
African American	8	12	7	8
Asian/other	4	4	1	3
Hispanic	3	2	1	2
Education*				
Less than high school	20	29	13	14
High school graduate	27	29	29	27
Postsecondary education	29	26	28	35
College graduate	12	9	15	13
Postgraduate	11	6	15	10
Income				
\$25,000 or less	43	62	29	29
\$25,001-\$50,000	49	32	59	61
\$50,001 or more	7	5	11	10
Unknown	<1	1	1	1
<b>Health/medications</b>				
Self-rated health				
Excellent	26	13	18	19
Very good/good	54	58	65	60
Fair/poor	20	28	17	21
Medications prescribed but not obtained	7	6	3	3

Note: RDS (retiree drug subsidy). Totals may not sum due to rounding.

\*Postsecondary education includes individuals with certificates from vocational and other technical schools, associate's degrees, or some college education but no diploma. One percent or fewer did not indicate the highest level of education achieved.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey Access to Care file.

**TABLE  
15-5**

**Part D enrollment varies widely across regions, 2011**

PDP region	State(s)	Percent of Part D enrollment					
		Percent of Medicare enrollment		Plan type		Subsidy status	
		Part D	RDS	PDP	MA-PD	LIS	Non-LIS
1	ME, NH	57%	11%	84%	16%	47%	53%
2	CT, MA, RI, VT	60	16	70	30	43	57
3	NY	62	18	54	46	45	55
4	NJ	54	21	80	20	35	65
5	DE, DC, MD	48	17	86	14	41	59
6	PA, WV	65	12	56	44	33	67
7	VA	54	9	78	22	36	64
8	NC	60	15	74	26	42	58
9	SC	56	16	73	27	44	56
10	GA	62	9	67	33	43	57
11	FL	63	12	52	48	35	65
12	AL, TN	62	12	65	35	45	55
13	MI	50	30	72	28	39	61
14	OH	66	13	68	32	30	70
15	IN, KY	63	12	79	21	38	62
16	WI	57	13	61	39	32	68
17	IL	57	19	87	13	38	62
18	MO	64	10	69	31	35	65
19	AR	62	7	79	21	45	55
20	MS	66	5	87	13	53	47
21	LA	63	13	64	36	49	51
22	TX	57	14	69	31	45	55
23	OK	60	7	79	21	38	62
24	KS	63	6	84	16	29	71
25	IA, MN, MT, NE, ND, SD, WY	67	8	74	26	27	73
26	NM	64	6	61	39	39	61
27	CO	59	12	50	50	29	71
28	AZ	62	10	45	55	32	68
29	NV	58	10	50	50	29	71
30	OR, WA	60	10	57	43	31	69
31	ID, UT	59	9	55	45	27	73
32	CA	70	9	50	50	39	61
33	HI	67	4	41	59	29	71
34	AK	39	26	99	1	62	38

Note: PDP (prescription drug plan), RDS (retiree drug subsidy), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). Definition of regions based on PDP regions used in Part D.

Source: MedPAC analysis of Part D enrollment data from CMS.

of beneficiaries who receive Part D's LIS is related to many factors, such as underlying rates of poverty and health status 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. For example, states can increase the number of residents eligible for the Medicare Savings Program by not counting certain types of assets or sources of income in their eligibility criteria for Medicaid benefits.

**TABLE  
15-6****MA-PD enrollees more likely to be in enhanced plans with no deductible, 2012**

	PDP		MA-PD	
	Number (in millions)	Percent	Number (in millions)	Percent
Total	17.5	100%	8.5	100%
Type of benefit				
Defined standard	1.0	5	0.1	1
Actuarially equivalent*	13.2	75	0.5	6
Enhanced	3.3	19	7.9	94
Type of deductible				
Zero	7.3	42	7.5	88
Reduced	1.8	11	0.8	9
Defined standard**	8.3	48	0.2	2

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-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.

\*\*\$320 in 2012.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

### Distribution of enrollment across plan types

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.<sup>10</sup> 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 in the gap, and an expanded drug formulary that includes non-Part D-covered drugs.<sup>11</sup> Since Medicare does not subsidize supplemental benefits, enrollees must pay the full premium for any enhanced benefits.

In 2012, 75 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard

benefit, most with tiered copayments. Another 19 percent of PDP enrollees had enhanced benefits—the typical enhancement being a lower deductible rather than benefits in the coverage gap beyond what is required by PPACA. Five percent were in defined standard plans. MA-PD enrollees were predominantly in plans that used copayments, with 99 percent in actuarially equivalent or enhanced plans (Table 15-6).

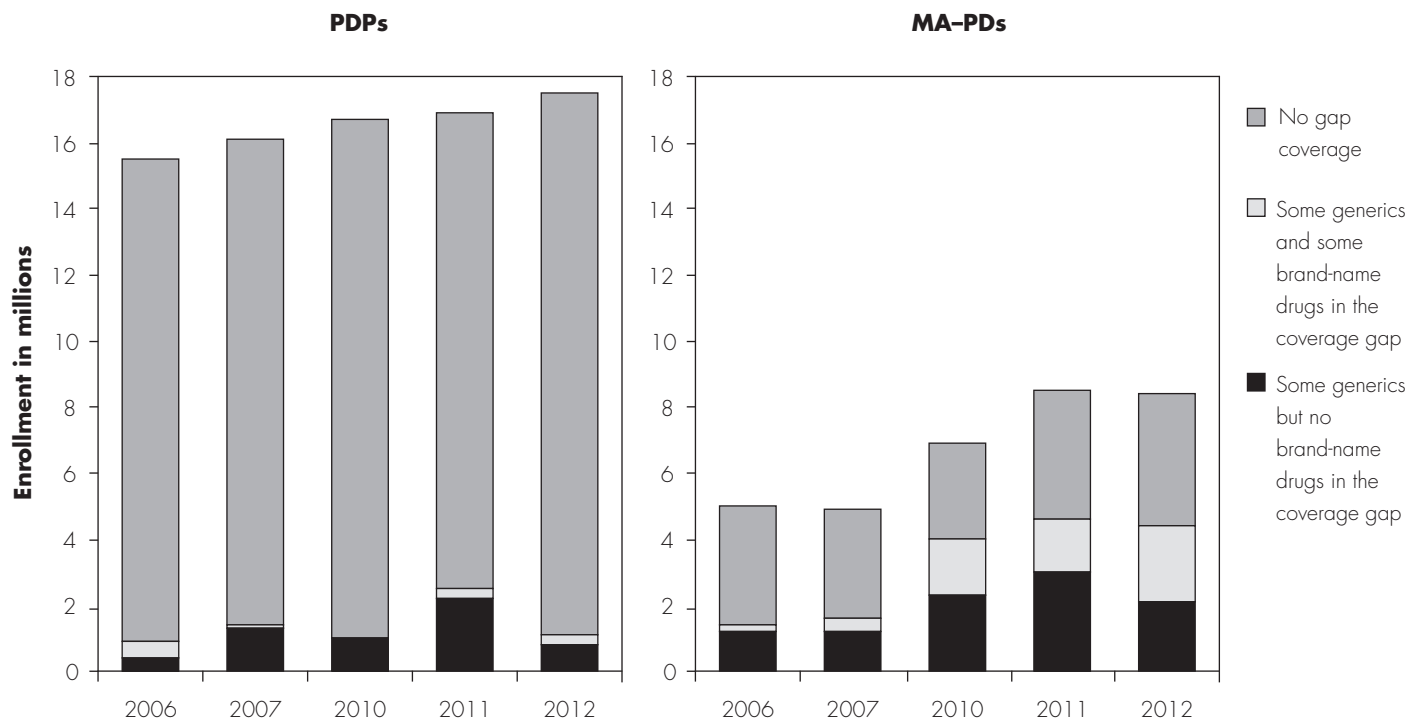
Enrollees in stand-alone PDPs are more likely to have a deductible in their plans' benefit design than enrollees in MA-PDs. In 2012, slightly more than half of PDP enrollees paid no deductible or a lower deductible than was prescribed in the defined standard benefit; the remaining enrollees were in plans with the standard \$320 deductible. By comparison, 98 percent of MA-PD enrollees had a reduced deductible or no deductible at all (Table 15-6), which reflects the ability of MA-PDs to use MA (Part C) rebate dollars to supplement benefits or lower premiums.<sup>12</sup>

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 15-1). In 2012, 6 percent of PDP enrollees (about 1 million beneficiaries)



**FIGURE 15-1**

**PDP enrollees are less likely to have benefits in the coverage gap**



Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

were in plans that offered benefits in the coverage gap beyond what is required by PPACA. However, over 40 percent of PDP enrollees received Part D’s LIS, which effectively eliminated their coverage gap. By comparison, 52 percent of MA-PD enrollees were in plans offering gap coverage. About half of these enrollees were in plans that covered some generics but not brand-name drugs in the gap.

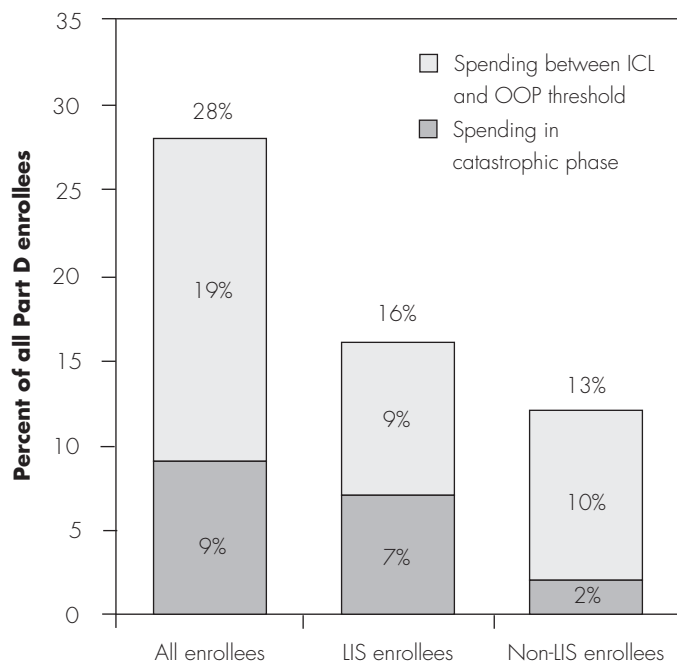
**Use of Part D benefits and share of enrollees reaching the coverage gap**

Prescription drugs are used widely by Medicare beneficiaries. According to the Commission’s analysis of 2010 prescription drug event data taken from Part D claims, about 93 percent of Part D enrollees filled at least one prescription during the year. Enrollees filled an average of 4.2 prescriptions per month, with considerably higher average utilization among those who received the LIS (5.1 per month) than among beneficiaries who did not (3.7 per month).

In 2010, about 28 percent of Part D enrollees had spending high enough to put them in the coverage gap, a decrease from over 30 percent in previous years (Figure 15-2, p. 344). Part D enrollees who entered the coverage gap in 2010 faced 100 percent of the plan’s negotiated price of the drug for prescriptions filled in the coverage gap, unless they were in a plan that provided some benefits in the gap or were an LIS enrollee, for whom the gap is eliminated. LIS enrollees accounted for more than half of the enrollees with spending high enough to reach the coverage gap (nearly 4.7 million, or about 16 percent of all Part D enrollees). Slightly over 2.6 million, or about 9 percent of Part D enrollees, had spending high enough to reach Part D’s catastrophic coverage phase. About 2 million of them (7 percent of Part D enrollees) received the LIS.

**Most Part D enrollees have good access to prescription drugs**

Surveys indicate that beneficiaries enrolled in Part D are generally satisfied with the Part D program and with their

**FIGURE  
15-2****Part D enrollees with spending in the coverage gap and catastrophic phase, 2010**

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 2010, Part D enrollees reached the ICL at \$2,830 in gross drug spending. If they had no supplemental coverage, enrollees reached the annual OOP threshold at \$4,550 of OOP spending. Some non-LIS enrollees who reached the catastrophic phase of the benefit may have had some gap coverage. Sums may not add to totals due to rounding.

Source: MedPAC analysis of Part D prescription drug event data and Part D denominator file from CMS.

plans (Department of Health and Human Services 2010, Keenan 2007, *Medical News Today* 2009, PRNewswire 2010, Weems 2008). Our analysis of the 2010 Medicare Current Beneficiary Survey shows that most enrollees are satisfied with the drug benefit (94 percent) and think the level of coverage meets their medication needs (95 percent). The level of satisfaction does not vary significantly by plan type (PDP vs. MA–PD) or by enrollees’ LIS status (Table 15-7).

Most Part D enrollees appear to have good access to prescription drugs. In 2010, more than 80 percent were satisfied with the drugs listed on plan formularies and 95 percent had good access to pharmacies (Table 15-7). Slightly over 10 percent were dissatisfied with the list of covered drugs, while the remainder (between 6 percent and 8 percent) indicated that they did not know or had

no experience related to the question (data not shown). Only 6 percent reported having had prescriptions for some medications they did not obtain during the year. Cost was the main reason for not obtaining medications for both PDP and MA–PD enrollees and for non-LIS enrollees, accounting for about 40 percent of those who did not obtain medications. A smaller share of LIS enrollees reported cost as the main reason for not obtaining medications. Between 20 percent and 30 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.

Other measures of access include plan formularies and pharmacy network requirements. The trend toward sponsors’ use of preferred and nonpreferred networks, since 2010, may have a larger effect on access to prescription drugs for individuals residing in rural areas than for those residing in urban areas. We will continue to monitor the plans’ use of tiered networks and the effects on beneficiaries’ access to medications. In the future, we will look at exceptions and appeals processes to evaluate the effectiveness of these processes in ensuring access to needed medications.

## Benefit offerings for 2013

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 2013

Between 2012 and 2013, the number of stand-alone PDPs decreased by just under 1 percent—from 1,041 to 1,033—while the number of MA–PDs increased by 6 percent—from 1,541 to 1,627 (Figure 15-3).<sup>13</sup> The number of plans offered has fluctuated over the years. The largest reduction in the number of plans occurred between 2010 and 2011. It was primarily the result of CMS’s policies that intended to differentiate more clearly between basic and enhanced benefit plans and to discourage plans with low enrollment.<sup>14</sup> In 2013, Medicare beneficiaries continue to have many plans to choose from, ranging from 23 PDP options in Hawaii and Alaska to 38 PDP options in the Pennsylvania–West

**TABLE  
15-7**

**Part D enrollees' access to prescription drugs, 2010**

	All Part D	Plan type		Subsidy status	
		PDP	MA-PD	LIS	Non-LIS
Percent:					
Satisfied with drug coverage	94%	94%	95%	96%	94%
Confident the level of coverage meets needs	95	94	96	94	95
Satisfied with plan list of drugs covered*	83	82	84	84	82
Satisfied with the ease of finding pharmacy that accepts drug plan*	95	95	93	94	95
With medication(s) not obtained	6	6	5	8	5

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. Between 6 percent and 8 percent of respondents did not answer the question about the plan list of drugs. Between 4 percent and 5 percent did not answer the question about the ease of finding a pharmacy that accepts the drug plan.

Source: MedPAC analysis of 2010 Medicare Current Beneficiary Survey Access to Care file.

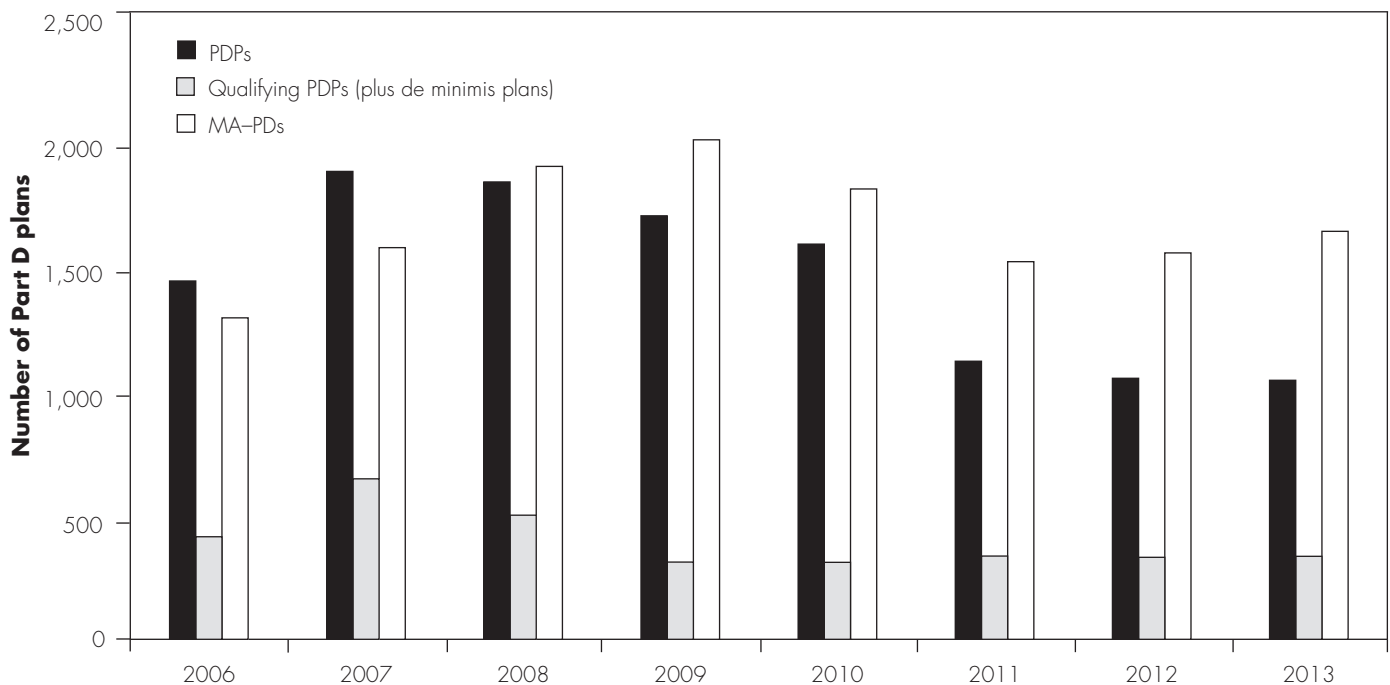
Virginia region, along with MA-PD options in most areas of the country. The number of MA-PDs available to a beneficiary varies by the county of residence, with a typical county having between 5 and 10 MA-PD plans

to choose from. A handful of counties have no MA-PD plans available.

In 2013, 331 PDPs are available to LIS enrollees with no premium, compared with 327 in 2012 (Figure 15-

**FIGURE  
15-3**

**Number of Part D plans remains stable between 2012 and 2013**



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 from the regional LIS premium threshold.

Source: CMS landscape and plan report files.

3). Most regions continue to have many premium-free plans available. However, in two regions (Florida and Nevada), only two premium-free plans are available in each region. About 2.7 million LIS enrollees were in plans that do not qualify as premium free in 2013 (Hoadley et al. 2012). As of October 2012, CMS estimated that it will have reassigned about 850,000 LIS enrollees to different plans because their previous plan's premium no longer falls below the 2013 threshold. About 90 percent of the reassigned LIS enrollees will be in plans offered by different sponsors (Centers for Medicare & Medicaid Services 2012b). LIS enrollees who selected a plan that differed from their randomly assigned plan are not reassigned.

### **Notable changes for 2013 in benefit design**

Beneficiaries are encouraged to reexamine their 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.

#### **Benefit designs**

For the 2013 benefit year, the structure of drug benefits for both stand-alone PDPs and MA-PDs held fairly steady. As in previous years, a smaller share of PDPs have no deductible (45 percent) compared with MA-PDs (86 percent). More than half of PDPs continue to charge a deductible in 2013, with most charging the defined standard amount (\$325).

In 2013, more PDPs are offering gap coverage beyond that required by PPACA than in 2012—34 percent compared with 26 percent. The extent of coverage in the gap varies from plan to plan. In previous years, a majority of PDPs that offered gap coverage limited their coverage to generic medications. In 2013, about half of PDPs that offer gap coverage include some brand-name drugs in the coverage gap. By contrast, the share of MA-PDs with gap coverage held steady at about 50 percent in 2013. Among MA-PDs that offer gap coverage, a slightly larger share includes some brand-name drugs in the coverage gap (55 percent) in 2013 than in 2012 (52 percent). But most of this brand coverage includes only a few brand-name drugs, typically less than 10 percent of brand-name drugs listed on the formulary.

As a result of changes made by PPACA, the coverage gap will be gradually phased out by 2020, and supplemental

benefits to provide coverage during the gap phase of the benefit will become less important over time. In 2013, the basic Part D benefit will cover 21 percent of the cost of generic drugs and 2.5 percent of the cost of brand-name drugs in the gap phase. The 50 percent discount paid by pharmaceutical manufacturers for brand-name drugs further reduces the beneficiary's cost sharing for brand-name drugs to about 47.5 percent.<sup>15</sup>

#### **Plan formularies**

Under contract with the Commission, researchers from NORC at the University of Chicago and from Social & Scientific Systems analyzed Part D formulary data for 2013. CMS generally requires that plan formularies include at least two drugs in each therapeutic category and class unless only one drug is available. For this analysis, drugs are defined at the level of chemical entities—a broad grouping that encompasses all of a chemical's forms, strengths, and package sizes—that combine brand-name and generic versions of specific chemicals (Medicare Payment Advisory Commission 2008).

The number of drugs that sponsors list on a formulary is one way to measure beneficiaries' access to prescription drugs under Part D. A plan's use of utilization management tools—such as its processes for obtaining nonformulary exceptions, prior authorization, quantity limits, and step therapy requirements—is another way to measure access.<sup>16</sup> However, these measures of access are imperfect. For example, formularies that list fewer drugs could still provide adequate access to appropriate medications. In some cases, unlisted drugs are covered through the nonformulary exceptions process. Other factors, such as the amount of cost sharing, can significantly affect beneficiaries' access to medications, regardless of the size of the formulary. Finally, utilization management tools, if used appropriately, can reduce the use of inappropriate medications. 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 intend to look into how well the exceptions and appeals processes are working to ensure that beneficiaries continue to have access to the medications they need.

For the seven largest nationwide PDPs, which accounted for over 60 percent of the enrollment in stand-alone PDPs in 2012, the shares of all distinct chemical entities (drugs) listed on their formularies remained stable or saw modest

**TABLE  
15-8**

**Formularies for stand-alone PDPs with highest 2012 enrollment**

Stand-alone PDPs with the highest 2012 enrollment	Enrollment, 2012 (in millions)	Percent of drugs on formulary		Percent of formulary drugs with any utilization management*	
		2012	2013	2012	2013
AARP MedicareRx Preferred	4.0	92%	92%	34%	21%
SilverScript Basic**	3.5	76	77	46	40
Humana Walmart-Preferred Rx Plan	1.5	85	83	40	48
Humana Enhanced	1.4	94	89	41	49
First Health Part D Premier	0.9	83	80	39	40
WellCare Classic	0.9	69	74	30	34
HealthSpring Prescription Drug Plan	0.6	81	79	43	42

Note: PDP (prescription drug plan). Enrollment figures are for September 2012 and exclude employer plans and U.S. territories. The number of drugs on the formulary for 2012 is 1,180; for 2013, the number is 1,174.

\*Any utilization management includes the use of prior authorization, quantity limits, and step therapy requirements.

\*\*CVS Caremark acquired Community CCRx Basic in 2011. In 2013, three plans—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1—all operated by CVS Caremark Corporation were consolidated into one plan to form SilverScript. Figures for 2012 are for Community CCRx Basic, which was the largest of the three plans by enrollment in 2012.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

changes between 2012 and 2013 (Table 15-8). Among the top seven PDPs, four plans—Humana Walmart-Preferred Rx Plan, Humana Enhanced, First Health Part D Premier, and HealthSpring Prescription Drug Plan—saw a decrease in the share of drugs listed in 2013.

The use of utilization management tools in Part D—including quantity limits, step therapy, and prior authorization—has grown in the past few years. Sponsors use such tools for drugs that are expensive, potentially risky, or subject to abuse, misuse, and experimental use. They are also often used to encourage the use of lower cost therapies. Between 2012 and 2013, among the top seven PDPs, four increased the share of drugs on plan formularies with some type of utilization management, while three decreased the share. In 2013, among the top seven PDPs, those operated by Humana Inc. (Humana Walmart-Preferred Rx Plan and Humana Enhanced) have the highest share of drugs with utilization management.

**Costs of Part D**

To monitor Part D’s costs, we examine aggregate program spending, trends in plans’ bid amounts and enrollees’ premiums, plans’ cost-sharing requirements, per capita spending, and trends in the prices at the pharmacy counter.

In our analysis of the 2009 Part D prescription drug event data, we found that beneficiaries with spending high enough to reach the catastrophic phase of the benefit filled more prescriptions, on average, and the cost of each prescription tended to be higher because more of them were for brand-name drugs. We also found that over 80 percent of beneficiaries with high drug spending received 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 2012b).

**Aggregate program costs**

Medicare pays plan sponsors three major subsidies on behalf of each enrollee in their plans:

- *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.

**TABLE  
15-9**

**Medicare's reimbursement amounts for Part D on an incurred basis**

	Calendar year					
	2007	2008	2009	2010	2011	2012*
<b>In billions of dollars</b>						
Direct subsidy	\$18.1	\$17.7	\$18.9	\$19.7	\$20.0	\$21.6
Reinsurance	8.0	9.4	10.1	11.2	13.9	14.8
Low-income subsidy	16.8	18.0	19.6	21.0	22.3	22.8
Retiree drug subsidy	3.9	3.8	3.9	4.0	3.7	2.8
<b>Total</b>	<b>\$46.7</b>	<b>\$48.9</b>	<b>\$52.4</b>	<b>\$55.9</b>	<b>\$60.0</b>	<b>\$62.0</b>
<b>Annual percentage change</b>						
Direct subsidy	2.7%	-2.0%	6.5%	4.5%	1.5%	8.1%
Reinsurance	33.0	17.8	7.1	10.7	24.1	6.4
Low-income subsidy	11.1	7.6	8.5	7.4	6.2	2.1
Retiree drug subsidy	2.4	-3.3	3.5	1.8	-5.5	-25.1
<b>Total</b>	<b>10.0</b>	<b>4.7</b>	<b>7.1</b>	<b>6.6</b>	<b>7.3</b>	<b>3.4</b>

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 estimate that premiums paid by enrollees totaled \$4.1 billion in 2007, \$5 billion in 2008, \$6.3 billion in 2009, \$6.5 billion in 2010, \$7.7 billion in 2011, and \$8.7 billion in 2012. Totals may not sum due to rounding.

\*Estimated by CMS Office of the Actuary.

Source: MedPAC based on Table IV.B10 of the 2012 annual report of the Boards of Trustees of the Medicare trust funds.

- **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.<sup>17</sup> 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 limits plans' potential losses and gains by financing a portion of any costs that are higher than expected or by recouping a portion of profits that are higher than expected.

**Low-income subsidy continues to be the largest single share of Part D costs**

Between 2007 and 2011, incurred reimbursements for Part D (including spending for the RDS) grew from \$46.7

billion to \$60 billion (Table 15-9). In 2011, the total was made up of \$20 billion in direct subsidy payments to plans, \$13.9 billion in payments for individual reinsurance, \$22.3 billion for the LIS, and \$3.7 billion in RDS payments. CMS's Office of the Actuary estimated that Part D spending would be about \$62 billion in 2012 (Boards of Trustees 2012).

In 2011, LIS payments continued to be the largest component of Part D spending. Moreover, substantial portions of other categories were spent on behalf of LIS enrollees. Because these individuals tend to use more medications than other Part D enrollees, a disproportionate share of spending for the direct subsidy and for individual reinsurance also reflects benefits for LIS enrollees.

**Individual reinsurance has been the fastest growing component of Part D spending**

Medicare payments for individual reinsurance have grown considerably faster than other components of Part D spending, increasing at an average annual rate of nearly 15 percent between 2007 and 2011, compared with 7 percent for overall Part D spending. Between 2010 and 2011,

## Gradual phase-out of the coverage gap

The Patient Protection and Affordable Care Act of 2010 (PPACA) gradually phases out the coverage gap. In 2020, when the phase-out is completed, enrollees' cost sharing in the coverage gap will be 25 percent—the same share as in the initial coverage phase of the defined standard benefit.<sup>2</sup>

The law uses different approaches to reduce cost sharing in the coverage gap for brand-name drugs and generic drugs. For brand-name drugs, manufacturers that want to continue including their products in the Part D program must sign contracts with CMS to participate in the coverage gap discount program. Since 2011, manufacturers have been required to provide Part D enrollees with a 50 percent discount for brand-name drugs while enrollees are in the coverage gap. Between 2013 and 2020, Part D will cover an increasing share of the cost of the drugs filled in the coverage gap until the enrollees' cost sharing reaches 25 percent (Table 15-10). A different phase-in schedule applies to generic drugs. The Part D benefit covered 7 percent when phase-out of the coverage gap began in 2011. The share

covered by the Part D benefit increases gradually until the enrollees' cost sharing is reduced to 25 percent in 2020 (Table 15-10).

In addition to the reduction in the cost-sharing amounts in the coverage gap, two changes made by PPACA will likely have the effect of increasing the share of Part D enrollees who reach the catastrophic phase of the benefit. First, the portion of the cost of the drugs in the coverage gap paid by manufacturers counts toward Part D's annual out-of-pocket (OOP) threshold.<sup>18</sup> Second, PPACA temporarily reduces the annual rate of growth in Part D's OOP threshold between 2014 and 2019. On the other hand, the reduction in OOP costs would tend to lengthen the time it takes to meet the OOP threshold, reducing the number of non-LIS beneficiaries who reach the catastrophic phase of the benefit. These changes may affect beneficiaries' decisions about the type of drug therapy they choose (e.g., brand-name drugs vs. generic drugs). We intend to analyze the impact of the changes made by PPACA once the data become available. ■

**TABLE  
15-10**

**Phase-in of reduced cost sharing for brand-name and generic drugs**

	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020
Brand-name drugs	50%	50%	47.5%	47.5%	45%	45%	40%	35%	30%	25%
Generic drugs	93	86	79	72	65	58	51	44	37	25

Note: The actual cost-sharing amount for brand-name drugs in the coverage gap depends on the amount of dispensing fee charged by a plan since the portion covered by the Part D benefit (2.5 percent in 2013) applies to both the ingredient cost and the dispensing fee, while the 50 percent manufacturer discount applies only to the ingredient cost.

Source: MedPAC based on CMS. <http://www.cms.gov/Outreach-and-Education/Outreach/Partnerships/downloads/11522-P.pdf>.

payments for individual reinsurance grew by 24 percent, a rate much higher than the growth rates for direct subsidy payments (1.5 percent) and for LIS payments (about 6 percent) (Table 15-9).

Multiple factors likely contribute to the growth in reinsurance spending. Our analysis of 2009 drug utilization for Part D enrollees with high spending suggests that growth in reinsurance spending is driven, in large part, by the volume of prescriptions filled rather than by the use of higher priced products that have

few, or no, therapeutic substitutes (Medicare Payment Advisory Commission 2012b). Two changes made by PPACA likely contributed to the even higher growth for reinsurance payments between 2010 and 2011 (see text box). First, beginning with the 2011 benefit year, pharmaceutical manufacturers are required to offer a 50 percent discount on brand-name drugs filled by non-LIS enrollees in the coverage gap, thereby reducing beneficiary cost sharing for brand-name drugs by half in 2011. Since the manufacturer discounts for brand-name drugs count

**TABLE  
15-11****National average bid and components of average prospective monthly payments per enrollee for basic coverage**

	2008*	2009	2010	2011	2012	2013
<b>Amount in dollars</b>						
National average monthly bid						
Base beneficiary premium	\$27.93	\$30.36	\$31.94	\$32.34	\$31.08	\$31.17
Monthly payment to sponsors	52.59	53.97	56.39	54.71	53.42	48.47
Subtotal	80.52	84.33	88.33	87.05	84.50	79.64
Expected individual reinsurance	29.01	34.73	36.92	39.77	37.38	42.60
Total average benefit cost	109.53	119.06	125.25	126.82	121.88	122.24
<b>Annual percent change</b>						
National average monthly bid						
Base beneficiary premium	2.1%	8.7%	5.2%	1.3%	-3.9%	0.3%
Monthly payment to sponsors	-0.9	2.6	4.5	-3.0	-2.4	-9.3
Subtotal	0.1	4.7	4.7	-1.4	-2.9	-5.8
Expected individual reinsurance	8.2	19.7	6.3	7.7	-6.0	13.9
Total average benefit cost	2.1	8.7	5.2	1.3	-3.9	0.3

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 make up 74.5 percent of total average monthly benefit costs. Bids are fully weighted by prior year enrollment.

\*CMS used its general demonstration authority to calculate these values using 60 percent enrollment weighting and 40 percent weighting as in the 2006 approach.

Source: MedPAC based on CMS releases of Part D national average monthly bid amounts and base beneficiary premiums for 2008 through 2013, as well as other data provided by CMS.

toward the OOP threshold, individuals taking brand-name medications will reach the catastrophic phase of the benefit without having spent the full amount specified by the OOP threshold. Second, the gradual phase-down of cost sharing for generic drugs filled by Part D enrollees in the coverage gap began in 2011. As a result, cost sharing dropped from 100 percent to 93 percent for generic drugs filled by enrollees in the coverage gap.

### **Decrease in retiree drug subsidy payments likely to continue**

The number of Medicare beneficiaries who receive primary prescription drug coverage through former employers has been decreasing, from over 7 million in 2006 to about 6 million in 2011. The largest drop (9 percent) occurred between 2010 and 2011, resulting in a 5.5 percent decrease in spending for the RDS. Employers

no longer offering drug coverage to their retirees typically move their Medicare-eligible members to Part D.

Before 2013, the subsidy provided employers with two tax advantages. First, the RDS 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.<sup>6</sup> This change may accelerate the decline in beneficiaries receiving prescription drug coverage through former employers.

### **National average bid**

Between 2012 and 2013, national average costs for basic Part D benefits are projected to grow by less than 1 percent (Table 15-11). During this period, the monthly payment to



sponsors (i.e., the direct subsidy component) is projected to decrease by over 9 percent, while the reinsurance component is expected to grow by about 14 percent. The higher growth in the reinsurance component of the bid between 2012 and 2013 may, in part, be due to the expectation that the gradual phase-out of the coverage gap under PPACA will result in higher reinsurance costs.

Growth in expected per capita benefit costs for Part D has fluctuated. The expected growth in benefit costs was 5 percent between 2009 and 2010 and 1 percent between 2010 and 2011. For 2012, the expected costs were projected to decrease by 4 percent (Table 15-11). Although year-to-year trends in the national average bid provide some information about costs of the drug benefit, those trends are an imperfect measure of spending. Since bids are projections of sponsors' estimated costs and not actual costs, reconciliation at the end of the year could result in a higher or lower trend in spending for Part D.

### **Average Part D premium**

In 2013, the base beneficiary premium is \$31.17, a slight increase from \$31.08 in 2012. The actual average monthly premium in 2013 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 (Medicare Payment Advisory Commission 2012a).

As a result of changes made by PPACA, 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 the threshold amount pays an income-related monthly adjustment amount in addition to the normal Part D premium paid to a plan. The adjustment amount varies based on income, ranging from \$11.60 to \$66.60 per month in 2013. About 1.14 million beneficiaries were subject to the reduced premium subsidy in 2012.<sup>19</sup>

### **Plans' cost-sharing requirements**

Cost-sharing requirements have generally been rising over the years. For plan sponsors, cost sharing plays an

important role in attracting potential enrollees (or retaining current enrollees) while managing drug utilization to remain competitive. From an enrollee's perspective, cost sharing can have a significant effect on access to and affordability of their medications.

### **Changes in cost sharing for the top seven PDPs vary across plans for 2013**

In 2013, changes in cost-sharing requirements for the top seven nationwide PDPs based on enrollment in 2012 are modest for the most part, with a few notable exceptions. The stability of the copayments and coinsurance amounts from year to year is, in part, due to CMS's formulary review process. During the review process, CMS determines, for example, whether there are plans that appear to be outliers and require that the cost-sharing amounts be brought in line with those of other plans.

Four of the top seven PDPs lowered cost sharing for generic drugs, while one plan (WellCare Classic) increased cost sharing from \$0 to \$6. Two plans—Humana Enhanced and First Health Part D Premier—increased cost sharing for brand-name drugs, while the rest tended to keep cost sharing at about the same level as in 2012 (Table 15-12, p. 352). Some enrollees in SilverScript Basic, a consolidated plan previously consisting of three separate plans, may experience significant change in their OOP spending as some will be changing from fixed copayments to coinsurance.<sup>20</sup>

For 2013, Humana Walmart-Preferred Rx Plan introduced a specialty tier with a 25 percent coinsurance, which is higher than its cost sharing for preferred brands (20 percent) but lower than its cost sharing for nonpreferred brands (35 percent). Typically, for actuarially equivalent plans, coinsurance amounts for specialty tiers are restricted to no more than 33 percent, which tends to be lower than the cost-sharing amounts for nonpreferred brands. Of the top seven PDPs, two plans—First Health Part D Premier and HealthSpring Prescription Drug Plan—do not have a specialty tier.

From an enrollee's perspective, cost-sharing requirements for specialty-tier drugs can be high until the enrollee reaches the catastrophic phase of the benefit. In addition, under CMS's regulations, enrollees may not appeal specialty-tier cost sharing as 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

**TABLE  
15-12**

**Cost-sharing amounts for stand-alone PDPs with highest 2012 enrollment**

Stand-alone PDPs with the highest 2012 enrollment	Enrollment, 2012 (in millions)	Generic		Preferred brand		Nonpreferred brand		Specialty	
		2012	2013	2012	2013	2012	2013	2012	2013
AARP MedicareRx Preferred*	4.0	\$4/\$8	\$3/\$5	\$41	\$40	\$95	\$85	33%	33%
SilverScript Basic**	3.5	\$2	\$2	25%	23.5%	46%	45%	25%	25%
Humana Walmart-Preferred Rx Plan*	1.5	\$1/\$5	\$1/\$4.5	20%	20%	35%	35%	N/A	25%
Humana Enhanced*	1.4	\$7	\$2/\$5	\$38	\$41	\$73	\$90	33%	33%
First Health Part D Premier	0.9	\$5	\$1	20%	25%	36%	45%	26%	N/A
WellCare Classic	0.9	\$0	\$6	\$41	\$42	\$95	\$94	25%	33%
HealthSpring Prescription Drug Plan	0.6	25%	25%	25%	25%	25%	25%	N/A	N/A

Note: PDP (prescription drug plan). Enrollment figures are for September 2012 and exclude employer plans and U.S. territories. When plans vary cost-sharing amounts across regions, we report unweighted median cost-sharing amounts.

\*Indicates plans with two tiers, preferred and nonpreferred, for generic drugs in 2012 and/or 2013.

\*\*CVS Caremark acquired Community CCRx Basic in 2011. In 2013, three plans operated by CVS Caremark Corporation—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1—were consolidated into one plan to form SilverScript. Figures for 2012 are for Community CCRx Basic, which was the largest of the three plans by enrollment in 2012.

Source: NORC/Social & Scientific Systems analysis for MedPAC of formularies submitted to CMS.

sclerosis, patients who need these drugs can face relatively high cost sharing for medications on top of significant OOP costs for their medical care. From a sponsor's perspective, high-cost 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.

### Pharmacy networks and cost-sharing requirements

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 (in-network), whereas any others are considered out-of-network. In-network pharmacies can be further classified as preferred or nonpreferred pharmacies. 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. 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 (see text box). Sponsors' use of preferred and nonpreferred

networks may have a larger effect on access to prescription drugs for individuals residing in rural areas than for those residing in urban areas.

In general, plans do not cover drugs bought from out-of-network pharmacies. Exceptions may include the following: (1) the beneficiary does not live reasonably close to an in-network pharmacy, (2) the beneficiary is traveling, and (3) the in-network pharmacy does not have the drug in stock. 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.<sup>21</sup> (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.) Because of these restrictions, plans' networks are usually wide. Eighty-three percent of PDPs contract with over 95 percent of pharmacies in their respective regions. Only one plan lists less than 70 percent of the pharmacies in its area as in-network.

## Use of preferred pharmacy networks by Part D plans

Plans that have preferred pharmacy networks are a small but growing portion of all Part D plans. For this analysis, plans are considered to have “true” preferred networks if the network includes both preferred and nonpreferred pharmacies and there is differential cost sharing for preferred and nonpreferred pharmacies.<sup>22</sup> The stratification of cost sharing for beneficiaries in plans with preferred networks is such that copayments and coinsurance are less for an in-network pharmacy than for an out-of-network pharmacy and are less for preferred in-network pharmacies than for nonpreferred in-network pharmacies. In 2012, six plans offered preferred networks with corresponding differences in cost sharing. These plans accounted for 12.5 percent of prescription drug plan enrollment (Table 15-13) and 3 percent of Medicare Advantage–Prescription Drug plan enrollment (data not shown). For all such plans, no more than one-third of in-network pharmacies are preferred (i.e., have the lowest cost-sharing amounts).

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 2011). Different plans have interpreted this rule in different ways. Most have cost-sharing differentials between preferred and nonpreferred pharmacies ranging from \$5 to \$10 for generics and from 0 percentage point to 19 percentage points for brand-name drugs.<sup>23</sup> The impact of these costs, especially for beneficiaries who are unaware of or do not understand the distinction between preferred and nonpreferred pharmacies, may be significant. Although the population affected by the tiered pharmacy network in 2012 was relatively small, many more beneficiaries could be affected in the coming years. At least five plans had announced the addition of preferred pharmacies in 2013 at the time this analysis was conducted. Depending on how many beneficiaries choose to enroll in those plans, they could represent a sizeable share of Part D enrollees. ■

**TABLE  
15-13**

**Enrollment in PDPs with preferred and nonpreferred pharmacies, 2012**

	Share of all PDP enrollment	Average share of pharmacies that the plan lists as preferred
Humana Walmart-Preferred	8.0%	7.7%
First Health Part D Value Plus	2.0	24.0
Aetna CVS	1.9	13.8
BlueMedicare Rx-Option 1 (FL)	0.3	30.6
CVS Caremark Plus	0.3	13.1
Rite Aid EnvisionRxPlus	0.0	12.0
Total	12.5	

Note: PDP (prescription drug plan). Average shares of pharmacies are weighted by the number of pharmacies in each region and include only regions where the plan is offered.

Source: Analysis of formularies submitted to CMS conducted by NORC/Social & Scientific Systems for MedPAC.

### Per capita spending and use

Under Part D, payments to plans are based on the average of the bids 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. The actual costs of the program may be higher or lower than the prospective payments CMS makes to plans based on the bids.

Between 2007 and 2010, the average per capita spending for Part D–covered drugs for MA–PD enrollees has been consistently lower than that for stand-alone PDP

**TABLE  
15-14**

**Average per capita spending and use per month for Part D-covered drugs, 2007-2010**

**Part D spending and utilization per enrollee**

	Average spending				AAGR, 2007-2010		Average number of prescriptions				AAGR, 2007-2010 (in percent)
	2007	2008	2009	2010	In dollars	In percent	2007	2008	2009	2010	
All Part D	\$212	\$221	\$228	\$231	\$6	2.9%	3.9	4.1	4.1	4.2	2.3%
By plan type											
PDP	239	250	260	265	9	3.6	4.1	4.3	4.4	4.4	2.3
MA-PD	151	162	169	172	7	4.4	3.4	3.6	3.7	3.8	3.3
By LIS status											
LIS	301	324	339	348	16	4.9	4.6	4.9	5.0	5.1	3.2
Non-LIS	156	159	163	163	2	1.4	3.4	3.6	3.6	3.7	2.7

Note: AAGR (average annual growth rate), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). 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 to classify the PDE records by LIS status. Estimates are sensitive to the method used to classify PDE records 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 spending. Prescriptions standardized to a 30-day supply.

Source: MedPAC analysis of Medicare Part D PDE data and denominator file from CMS.

enrollees—by about \$90 per member per month. The average per capita spending for LIS enrollees has been about double that of non-LIS enrollees, with the difference between the two groups growing over time (Table 15-14).

Growth in average per capita spending slowed from 3.6 percent in the past few years to 1.5 percent in 2010—a trend consistent with that of general drug costs measured in national health expenditures. Between 2007 and 2010, spending for non-LIS enrollees remained relatively flat (1.4 percent growth) compared with LIS enrollees (4.9 percent growth). The difference in growth in per capita spending between LIS and non-LIS enrollees is due to higher growth in the average cost per prescription and higher growth in the average number of prescriptions filled by LIS enrollees. Although the growth in per capita drug spending among MA-PD enrollees was greater than for stand-alone PDP enrollees (4.4 percent compared with 3.6 percent), the average growth was lower for MA-PD enrollees in terms of the dollar increase (\$7 compared with \$9).

**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 over the prices the plan will pay them for drug ingredient costs and dispensing fees.
- The second involves the terms under which manufacturers pay retrospective rebates.

The average manufacturer rebate as a percentage of total prescription drug costs increased from less than 9 percent to 11.3 percent between 2006 and 2010 (Boards of Trustees 2012). In general, plan sponsors do not receive rebates from manufacturers of generic drugs, which accounted for about three-quarters of the prescriptions dispensed under Part D in 2010. 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 2012). Plan sponsors tend to use rebate revenues to offset plans’ benefit spending (reducing plan

premiums) rather than lowering the price of prescriptions at the pharmacy counter. 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). 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 drug and biologic products.

To track drug prices, the Commission contracted with researchers at Acumen, LLC, to construct a series of volume-weighted price indexes (Figure 15-4, p. 356). The indexes do not reflect retrospective rebates from manufacturers but do reflect the prices sponsors and beneficiaries pay to pharmacies at the point of sale (including ingredient costs and dispensing fees).

Measured by individual national drug codes (NDCs), Part D drug prices rose by an average of 23 percent cumulatively between January 2006 and December 2010.<sup>24</sup> At the same time, Part D sponsors have had success at 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 2 percent between January 2006 and December 2010.<sup>25</sup> Therefore, nongeneric drug prices appear to be growing aggressively. For drugs with few or no generic substitutes, prices have grown rapidly. Prices for biologics, for example, increased by 43 percent over the same period (data not shown).<sup>26</sup> The increase in prices was the same even after generic substitution was taken into account.

For most drug classes, CMS requires plan formularies to cover at least two drugs in every therapeutic class and key drug type that are not therapeutic substitutes unless only one drug is approved for that class. This policy is intended to protect beneficiaries who need a drug that is the only one available to treat a certain condition and allows competition in classes with multiple products. For six drug classes, CMS requires Part D plans to cover “all or substantially all” drugs in the class. Those classes are antineoplastics, antidepressants, antipsychotics, antiretrovirals, anticonvulsants, and immunosuppressants used by transplant patients. 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 utilization of these classes of drugs.

As measured by individual NDCs, prices for drugs in the six protected classes showed a trend similar to that for all Part D drugs, rising by a cumulative 21 percent over the five-year period (Figure 15-4, p. 356). This growth is influenced heavily by two classes of drugs: antidepressant medications, which account for about half of the volume in the six classes and had many generics on the market during this period, and anticonvulsants, which account 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 6 percent and 17 percent, respectively, during the five-year period (data not shown). Growth in the price index 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 nearly 30 percent for antiretrovirals to over 60 percent for antineoplastics.<sup>27</sup>

When protected class drugs were grouped to take generic substitution into account, their prices fell by a cumulative 2 percent over the five-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, it is possible that the drugs’ protected status may limit plan sponsors’ ability to negotiate rebates from manufacturers in classes in which one brand-name drug can be a therapeutic substitute for another brand-name drug. We lack rebate information to test this hypothesis.

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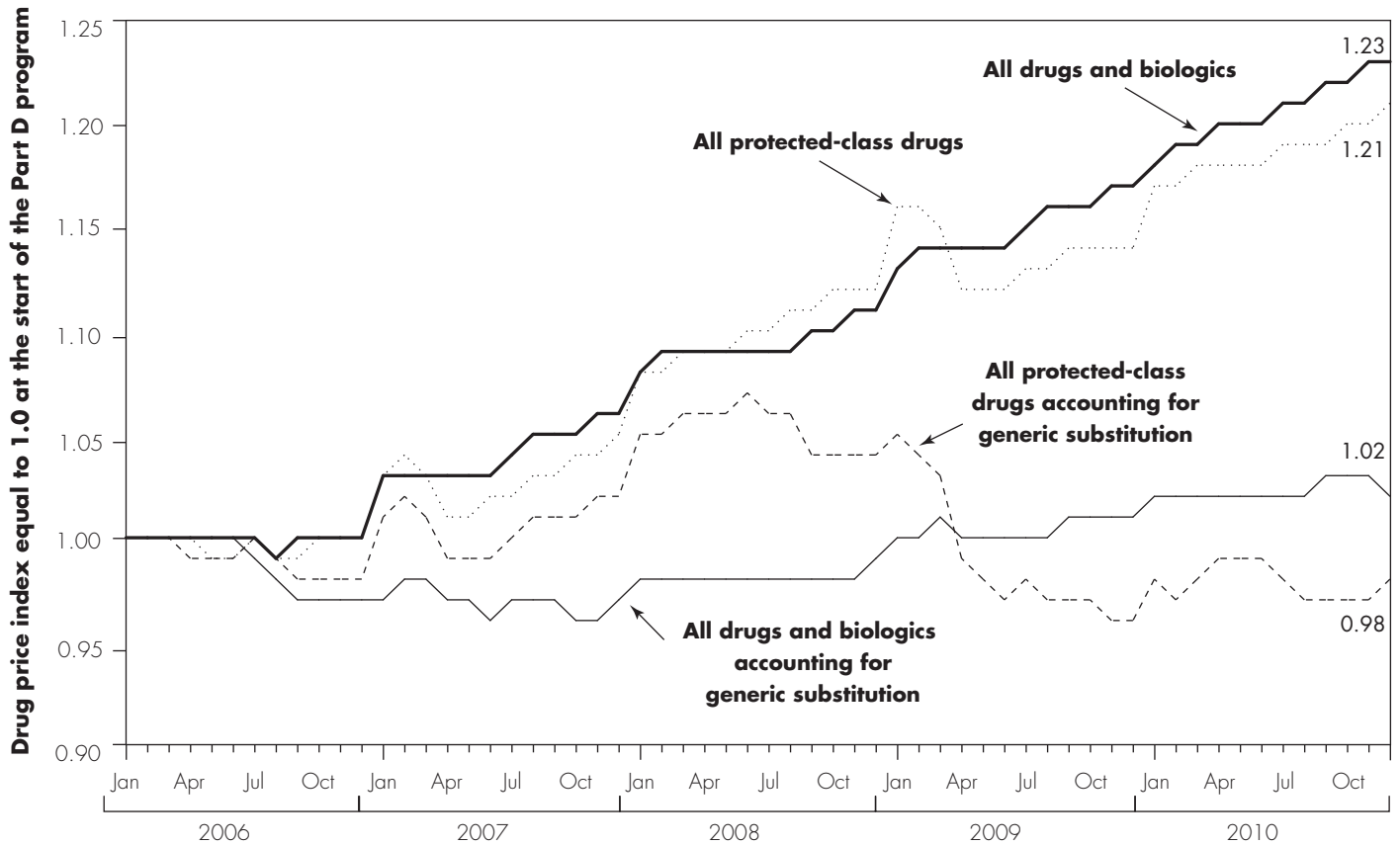
## Use of generic drugs

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Generic substitution can result in significant reductions in spending. The Commission’s set of volume-weighted indexes shows that, when taking into account generic substitution, prices for Part D drugs grew cumulatively by just 2 percent between January 2006 and December 2010, while the prices of individual drugs (measured by NDCs) grew by 23 percent, on average, during the same period. The Congressional Budget Office estimates that, in 2007, dispensing generic drugs rather than their brand-name counterparts reduced total prescription drug costs for

**FIGURE  
15-4**

**Availability of generics, rather than protected status,  
key to slower price growth under Part D**



Note: Chain-weighted Fisher price indexes.

Source: Acumen, LLC, analysis for MedPAC.

Part D by about \$33 billion (Congressional Budget Office 2010). Even so, for the same year, the Congressional Budget Office estimates that Part D could have saved an additional \$900 million if all prescriptions for multiple-source brand-name drugs had instead been filled with their generic counterparts and an additional \$4 billion if generics had been dispensed as therapeutic substitutes.

The use of generic medications has increased. According to the Commission's analysis, the overall average generic dispensing rate (GDR) increased from 61 percent in 2007 to 74 percent in 2010 (Table 15-15). During this period, some of the most popular brand-name drugs lost patent protection so there were more opportunities for generic substitution. GDRs vary across different groups of beneficiaries. For example, MA-PD enrollees are more likely to use generic drugs than enrollees in PDPs. Between 2007 and 2010, MA-PDs consistently exceeded

the GDR for PDPs by about 5 percentage points. LIS enrollees have had a consistently lower GDR than non-LIS enrollees, and that difference grew between 2007 and 2010 from 2 percent to 5 percent.

Multiple factors likely contribute to the higher or lower GDRs among groups of beneficiaries. For example, differences in health status may limit the opportunity for clinically appropriate therapeutic substitutions for some beneficiaries. There may 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, since one of the key tools plan sponsors use to manage drug

**TABLE  
15-15**

**Generic dispensing rate by plan type and LIS status, 2007-2010**

	2007	2008	2009	2010
All Part D	61%	67%	70%	74%
By plan type				
PDP	60	66	69	72
MA-PD	66	71	74	77
By LIS status				
LIS	60	65	68	71
Non-LIS	62	69	72	76

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 drugs dispensed that are generics. 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.

spending—using cost-sharing differentials between drugs on different tiers to encourage enrollees to use lower cost drugs—is not available to manage the drug spending of LIS enrollees, sponsors have limited ability to manage spending for this population.

**Quality in Part D**

CMS collects quality and performance data for Part D plans to monitor sponsors’ operations and help beneficiaries choose among plans. CMS relies on several sources for these data—the Consumer Assessment of Healthcare Providers and Systems survey, agency monitoring of plans, data furnished by sponsors, and claims information (Centers for Medicare & Medicaid Services 2012c). For 2013, 18 metrics are grouped into four domains (Centers for Medicare & Medicaid Services 2012a):

- drug plan customer service (five measures);
- member complaints, problems getting services, and improvement in the drug plan’s performance (four measures);

- member experience with the drug plan (three 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 49 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. Similar to the 2012 plan ratings, the 2013 plan ratings put more emphasis on patient safety and appropriate medication use, such as the use of medications with a high risk of serious side effects and the percentage of enrollees obtaining medications that are recommended to treat selected conditions. CMS aggregates individual scores for each of the measures (18 for PDPs and 49 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 2013, 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 3.3, compared with 2.96 for 2012, and the average among MA-PD sponsors is 3.66, compared with 3.44 for 2012 (Centers for Medicare & Medicaid Services 2012a). Ratings for contracts (only stand-alone PDPs that are eligible to receive LIS autoassignments) range from 2.5 stars to 4 stars; no 5-star plans are available. Compared with last year, fewer LIS plans have ratings below 3 stars, indicating potential improvement in quality. However, because of the addition of two new Part D measures in 2013 (measure of drug plan quality improvement and accuracy of prices on plan finder) and because plan ratings are determined relative to other plans, 2013 Part D plan ratings are not directly comparable to other years.

**Role of competition in Part D**

Medicare’s payment system for Part D uses competing private plans to deliver prescription drug benefits. When designing Part D, policymakers envisioned that plans would compete for enrollees based on their premiums, formularies, quality of services, and network of pharmacies. Medicare’s payments to plans are based on bids submitted by plan sponsors, and Part D requires

## Voluntary switchers

Each year, Part D enrollees have an opportunity to reevaluate their Part D plan selection for the coming year during the annual open enrollment period. Although some low-income subsidy (LIS) enrollees choose plans on their own, many are randomly assigned to prescription drug plans (PDPs) with premiums that are below the regional thresholds (i.e., premium free to beneficiaries receiving the LIS). We limited our analysis of plan switching to non-LIS enrollees to ensure that the change in plans reflected a voluntary switch rather than random assignments by CMS. We further restricted our analysis to exclude individuals enrolled in employer group plans and individuals who switched plans due to plan terminations or service area reductions.

Between 2009 and 2010, 13.6 percent of the non-LIS enrollees in our analysis voluntarily switched plans. Younger enrollees were more likely than older enrollees to switch plans, with about 16 percent of enrollees between 65 and 69 years old switching compared with 11 percent of enrollees 80 years or older (Table 15-16). White enrollees were more likely than non-White enrollees to switch plans. Hispanic enrollees were less likely than non-Hispanic enrollees to switch plans. Gender did not affect the rate of switching (data not shown). Enrollees residing in nonmetropolitan areas were more likely (17 percent) to switch plans than enrollees residing in metropolitan areas (13 percent). The results were similar for the 2010–2011 period.

The share of enrollees who voluntarily switched plans differed between Medicare Advantage–Prescription Drug plan (MA–PD) enrollees (15 percent) and PDP enrollees (13 percent) between 2009 and 2010 but not between 2010 and 2011 (13 percent of enrollees in both plan types). For the two plan types (PDP and

**TABLE  
15-16**

### Non-LIS beneficiaries who voluntarily switched plans, 2009–2011

	2009–2010	2010–2011
All non-LIS enrollees	13.6%	13.0%
By age		
64 or younger	14	14
65–69	16	15
70–74	14	14
75–79	13	12
80 or older	11	10
By race		
White	14	13
African American	12	12
Asian/other	11	13
Hispanic	10	10
By urbanicity		
Metropolitan	13	12
Micropolitan	17	16
Rural	17	16
By plan type		
PDP	13	13
MA–PD	15	13

Note: LIS (low-income subsidy), PDP (prescription drug plan), MA–PD (Medicare Advantage–Prescription Drug [plan]). The figures in the table exclude individuals enrolled in employer group plans and those enrolled in terminated plans or plans that experienced service area reductions.

Source: MedPAC analysis of Medicare enrollment and Part D denominator files.

MA–PD), most switchers—90 percent of MA–PD enrollees and about 80 percent of PDP enrollees—changed to plans of the same plan type (data not shown). ■

sponsors to bear insurance risk for the benefit spending of their enrollees. The idea was for competition among plans to provide strong incentives for plan sponsors to manage drug use and keep spending growth in check. Plans that are able to manage drug spending and bid more competitively are supposed to be rewarded with higher enrollment than plans that do not.

During the first few years of the program, according to CMS, only about 6 percent of non-LIS Part D enrollees switched plans voluntarily each year. A low rate of switching among beneficiaries could reflect general satisfaction with their plan choices or difficulty in choosing plans. Beneficiaries may be reluctant to switch plans if they face transition issues arising from changes



to formularies, benefit structure, and administrative processes. If beneficiaries are unwilling to switch, even when faced with significant premium increases, sponsors will have less of an incentive to compete on premiums and control drug spending. On the other hand, if enough beneficiaries switch plans to maximize coverage of their medications, it could increase costs for the plans and in turn increase Medicare spending for Part D, as Medicare subsidizes a significant portion of Part D benefit costs.

On the basis of the Commission's analysis of enrollment data, we find that a higher share of enrollees than was reported earlier has switched plans voluntarily—13.6 percent between 2009 and 2010 and 13 percent between 2010 and 2011 (see text box).<sup>28</sup> Although many beneficiaries who participated in our focus groups found the annual open enrollment process for selecting or changing plans to be confusing, more beneficiaries reported using the Internet to research and compare plan options than in previous years. Several participants knew about the Medicare Plan Finder and CMS's star rating system (Hargrave et al. 2012). Some beneficiaries reported

researching their plan options regularly to compare cost-sharing amounts and the formulary status of specific medications, although researching their plan options did not always lead beneficiaries to switch plans.

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## **Relationship between medical and drug spending**

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Policymakers and health services researchers have given much attention to the relationship between drug spending and medical spending. The results of studies that examined this relationship have been mixed (e.g., McWilliams et al. 2011, Stuart et al. 2013, Zhang et al. 2009). Our analysis of the patterns of service use for Part A and Part B of Medicare and for Part D across metropolitan statistical areas showed no consistent relationship between medical service use and drug use (Suzuki and Zabinski 2010). We may not have been able to observe the relationship between medical and drug spending because that study aggregated Part D spending to the level of a metropolitan statistical area. For future work, the Commission will investigate the relationship between medical and drug spending at the individual beneficiary level and explore whether better adherence to drugs used for certain conditions reduces Medicare Part A and Part B spending. ■

## Endnotes

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- 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 true OOP spending over the 2014 to 2019 period.
- 2 PPACA requires pharmaceutical manufacturers of brand-name drugs to provide a 50 percent discount for drugs filled while beneficiaries are in the coverage gap. In 2013, the Part D benefit provides coverage of 2.5 percent for brand-name drugs, reducing the cost sharing for drugs filled during the coverage gap to about 47.5 percent in 2013. The actual cost-sharing amount for brand-name drugs in the coverage gap depends on the amount of 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 drugs an individual fills during the coverage gap. The 2013 amount of total drug expenses at the annual OOP threshold of \$6,954.52 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 85.6 percent of total drug spending in the coverage gap.
- 4 Often plan sponsors often use the same formulary across multiple plans they operate; furthermore, sponsors cannot apply different formularies to enrollees in a given plan.
- 5 The prescription drug coverage beneficiaries had before 2006 may or may not have been as generous as the Part D benefit. Since the implementation of Part D, 90 percent of beneficiaries have drug coverage that is at least as generous as the Part D basic benefit.
- 6 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 would 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).
- 7 Creditable coverage refers to prescription drug benefits, through sources such as a former employer that are at least as generous as the standard Part D benefit.
- 8 Based on CMS presentations and publications (e.g., a 2007 presentation by Cynthia Tudor, Director, Medicare Drug Benefit Group, before the National Health Policy Forum; CMS Management Information Integrated Repository data as of January 2008; CMS Management Information Integrated Repository data as of February 2009; and 2010 enrollment information).
- 9 These responses are not mutually exclusive. Individuals could list both "not taking enough prescriptions" and "too expensive" as reasons for not enrolling in Part D.
- 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 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 in the gap must provide coverage in the gap beyond what is required by PPACA.
- 12 Under the Part C payment system, which is used to pay MA plans, a portion (between 67 percent and 73 percent in 2012) 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 Two PDPs have withdrawn from Part D since CMS released revised landscape files in October of 2012, which was used for our analysis for this chapter.
- 14 CMS allows a sponsor to offer multiple plans in any given service area only if those offerings are substantially different from one another. To be considered "substantially different," for 2013, plans must have a difference of at least \$23 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 2013, the second enhanced plan must have a higher value than the first.

- with a difference of at least \$12 in a beneficiary's expected monthly OOP costs between the two enhanced plan offerings.
- 15 The actual cost-sharing amount for brand-name drugs will depend on the amount of 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.
  - 16 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.
  - 17 Lower subsidy rates apply to higher income beneficiaries. For more information, refer to the section on enrollee premiums.
  - 18 Manufacturer discounts may also affect employers' decisions about retiree drug coverage. If an employer provides a gap coverage that wraps around the Part D benefit, the discount is calculated as 50 percent of a beneficiary's cost-sharing amount after taking into account the gap coverage offered by the employer.
  - 19 Based on CMS's estimate as of September 30, 2012.
  - 20 In 2013, three plans—CVS Caremark Value, Community CCRx Basic, and Health Net Orange Option 1 (all operated by CVS Caremark Corporation)—were consolidated into one plan to form SilverScript. In 2012, CVS Caremark Value used copays (\$6 for generics, \$45 for preferred brands, and \$95 for nonpreferred brands), while Community CCRx Basic used both copays (\$2 for generics) and coinsurance (25 percent for preferred brands and 46 percent for nonpreferred brands).
  - 21 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.
  - 22 Several plans report having preferred pharmacies in their network, but they either consider all in-network pharmacies as preferred or have no cost-sharing differential between preferred and nonpreferred pharmacies.
  - 23 Cost-sharing amounts are for region 12 (Alabama–Tennessee region), with the exception of one plan that was offered only in region 11 (Florida). Plans have slight differences in cost sharing from region to region.
  - 24 An individual NDC uniquely identifies the drug's labeler, drug, dosage form, strength, and package size. Because each specific drug often is available in different dosages, strengths, and package sizes, the same drug typically has many different NDCs.
  - 25 For this index, Acumen grouped NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and the median price more closely reflects the degree to which market share has moved between the two.
  - 26 Because most biologics are injected or infused directly into the patient, they are more likely to be covered under Medicare Part B. Consequently, biologics account for a relatively small share of gross Part D spending. Based on the Commission's analysis of 2007 Part D data, spending on biologics totaled approximately \$3.9 billion, or about 6 percent of gross Part D spending.
  - 27 An antineoplastic drug (Armidex) with about 20 percent market share lost its patent in the summer of 2010. As a result, the price index that takes into account generic substitution dropped during the latter half of 2010 but does not appear to have significantly affected the price index measured at the individual NDC level.
  - 28 The Commission's estimate of the share of enrollees who voluntarily switched plans may not be directly comparable to the 6 percent reported by CMS because of methodological differences.

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A P P E N D I X

A

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**Commissioners' voting  
on recommendations**

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## 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 increase payment rates for the inpatient and outpatient prospective payment systems in 2014 by 1 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services to use the difference between the statutory update and the recommended 1 percent update to offset increases in payment rates due to documentation and coding changes and to recover past overpayments.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

*Absent:* Armstrong

### Chapter 4: Physician and other health professional services

The Commission reiterates its previous recommendations on improving Medicare's payments to physicians and other health professionals. See Appendix B, pp. 371–392.

## **Chapter 5: Ambulatory surgical center services**

The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2014. The Congress should also require ambulatory surgical centers to submit cost data.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

## **Chapter 6: Outpatient dialysis services**

The Congress should not increase the outpatient dialysis bundled payment rate for calendar year 2014.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

## **Chapter 7: Post-acute care providers: Shortcomings in Medicare's fee-for-service highlight the need for broad reforms**

No recommendations

## **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. 178.

## **Chapter 9: Home health care services**

The Commission reiterates its previous recommendations on improving the home health payment system. See text box, pp. 207–209.

## **Chapter 10: Inpatient rehabilitation facility services**

The Congress should eliminate the update to the Medicare payment rates for inpatient rehabilitation facilities in fiscal year 2014.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

## **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 2014.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong



## Chapter 12: Hospice services

The Congress should eliminate the update to the hospice payment rates for fiscal year 2014.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

## Chapter 13: The Medicare Advantage program: Status report

No recommendations

## Chapter 14: Medicare Advantage special needs plans

**14-1** The Congress should permanently reauthorize institutional special needs plans.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

**14-2** The Congress should:

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

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

**14-3** The Congress should permanently reauthorize dual-eligible special needs plans (D–SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits and allow the authority for all other D–SNPs to expire.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello  
*Absent:* Armstrong

**14-4** For dual-eligible special needs plans (D–SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits, the Congress should:

- grant the Secretary authority to align the Medicare and Medicaid appeals and grievances processes;
- direct the Secretary to allow these D–SNPs to market the Medicare and Medicaid benefits they cover as a combined benefit package;
- direct the Secretary to allow these D–SNPs to use a single enrollment card that covers beneficiaries’ Medicare and Medicaid benefits; and
- direct the Secretary to develop a model D–SNP contract.

*Yes:* Baicker, Butler, Coombs, Chernew, Dean, Gradison, Hackbarth, Hall, Hoadley, Kuhn, Miller, Naylor, Nerenz, Redberg, Samitt, Uccello

*Absent:* Armstrong

## **Chapter 15: Status report on Part D**

No recommendations

A P P E N D I X

# B

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**Moving forward from the  
sustainable growth rate  
(SGR) system**

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601 New Jersey Avenue, N.W. • Suite 9000  
Washington, DC 20001  
202-220-3700 • Fax: 202-220-3759  
www.medpac.gov

Glenn M. Hackbarth, J.D., Chairman  
Robert A. Berenson, M.D., F.A.C.P., Vice Chairman  
Mark E. Miller, Ph.D., Executive Director

October 14, 2011

The Honorable Max Baucus  
Chairman, Committee on Finance  
U.S. Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Orrin G. Hatch  
Ranking Member, Committee on Finance  
U.S. Senate  
104 Hart Senate Office Building  
Washington, DC 20510

The Honorable Dave Camp  
Chairman, Committee on Ways and Means  
U.S. House of Representatives  
1102 Longworth House Office Building  
Washington, DC 20515

The Honorable Sander M. Levin  
Ranking Member, Committee on Ways and Means  
U.S. House of Representatives  
1139E Longworth House Office Building  
Washington, DC 20515

The Honorable Fred Upton  
Chairman, Committee on Energy and Commerce  
U.S. House of Representatives  
2125 Rayburn House Office Building  
Washington, DC 20515

The Honorable Henry A. Waxman  
Ranking Member, Committee on Energy and  
Commerce  
U.S. House of Representatives  
2322A Rayburn House Office Building  
Washington, DC 20515

**RE: Moving forward from the sustainable growth rate (SGR) system**

Dear Chairmen and Ranking Members:

The sustainable growth rate (SGR) system—Medicare’s formulaic payment method for services provided by physicians and other health professionals—is fundamentally flawed and is creating instability in the Medicare program for providers and beneficiaries. This system, which ties annual updates to cumulative expenditures since 1996, has failed to restrain volume growth and, in fact, may have exacerbated it. Although the pressure of the SGR likely minimized fee increases in the last decade, this effect disproportionately burdened physicians and health professionals in specialties with less ability to increase volume. Additionally, temporary, stop-gap “fixes” to override the SGR are undermining the credibility of Medicare because they engender uncertainty and anger among physicians and other health professionals, which may be causing anxiety among beneficiaries. The risks of retaining the SGR now clearly outweigh the benefits. Moreover, the cost of full repeal, as

well as the cost of temporary reprieves, grows inexorably. It will never be less expensive to repeal the SGR than it is right now.

With this assessment, the Commission recommends that the Congress repeal the SGR system and replace it with a 10-year schedule of specified updates for the physician fee schedule. The Commission drew on three governing principles to form our proposal. First, the link between cumulative fee-schedule expenditures and annual updates is unworkable and should be eliminated. Second, beneficiary access to care must be protected. Third, proposals to replace the SGR must be fiscally responsible.

From these principles, we recommend complete repeal of the SGR system and propose a series of updates that would no longer be based on an expenditure- or volume-control formula. These legislated updates would allow total Medicare expenditures for fee-schedule services to increase annually—roughly doubling over the next ten years. Approximately two-thirds of this increase would be attributable to growth in beneficiary enrollment and one-third would be attributable to growth in per beneficiary service use. Although our proposed updates reduce fees for most services, current law calls for far greater fee reductions and could lead to potential access problems under the SGR. The Commission finds it crucial to protect primary care from fee reductions, considering that the most recent data show that access risks are concentrated in primary care.

As is our charge, each year MedPAC will continue to review annually whether payments to physicians and other health professionals are adequate. To this end, we will continue to survey beneficiaries, conduct physician focus groups, track physician and practitioner participation in Medicare, and examine changes in volume and quality of ambulatory care. If, through these analyses, we determine that a future increase in fee-schedule rates is needed to ensure beneficiary access to care, then the Commission would submit such a recommendation to the Congress. Enacting our recommendation would eliminate the SGR and would alter the trajectory of fee-schedule spending in Medicare's baseline. Therefore, future fee increases relative to this new baseline would require new legislation and would carry a budgetary cost.

Our recommendation for repealing the SGR carries a high budgetary cost. The Congress, of course, may seek offsets for repealing the SGR inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily

recommend that the Congress offset the repeal of the SGR entirely through Medicare. The steep price of this effort, and the constraint that we imposed on ourselves to offset it within Medicare, compels difficult choices, including fee-schedule reductions and offsets that we might not otherwise support.

The Commission is also proposing refinements to the accuracy of Medicare’s physician fee schedule through targeted data collection and reducing payments for overpriced services. Even with improvements to the fee schedule’s pricing, moreover, Medicare must implement payment policies that shift providers away from fee-for-service (FFS) and toward delivery models that reward improvements in quality, efficiency, and care coordination, particularly for chronic conditions. The Commission is also recommending incentives in Medicare’s accountable care organization (ACO) program to accelerate this shift because new payment models—distinct from FFS and the SGR—have greater potential to slow volume growth while also improving care quality. Similarly, incentives for physicians and health professionals to participate in the newly established Medicare bundling pilot projects could also improve efficiency across sectors of care.

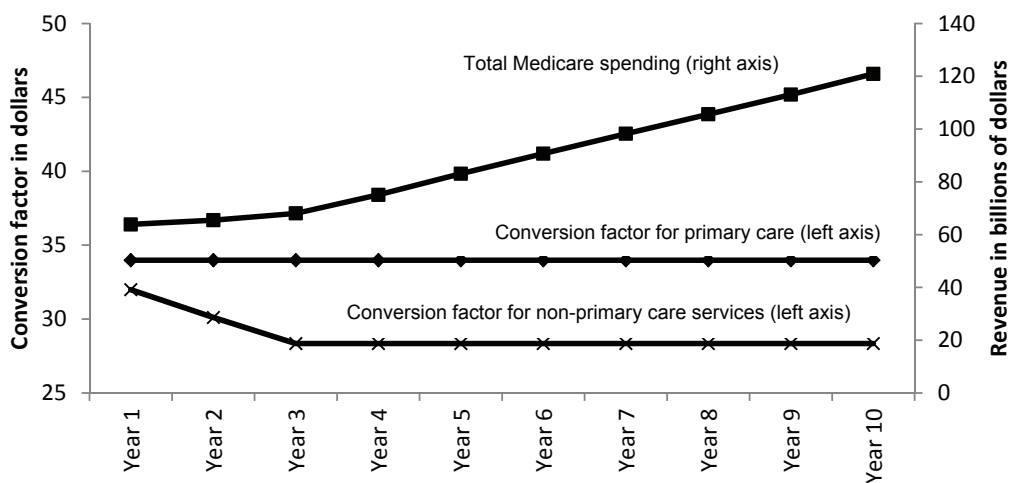
Respectfully, we submit the recommendations described below. Several of them are interrelated. Our willingness to recommend difficult measures underscores the urgency we attach to repealing the SGR. The cost of repealing the SGR, as well as the cost of any short-term reprieves, will only increase. Meanwhile, the opportunities for offsetting that cost by reducing Medicare expenditures will only shrink if Medicare savings are used for other purposes (such as, to help finance coverage for the currently uninsured or for deficit reduction). Our concern is that repealing the SGR will become increasingly difficult unless the Congress acts soon.

### **Repealing the SGR formula and realigning fee-schedule payments to maintain access to primary care**

Repealing the SGR formula ultimately severs the link between future payment updates and cumulative expenditures for services provided by physicians and other health professionals. In place of the SGR, the Commission proposes a 10-year path of legislated updates (Figure 1). This path is consistent with the principles of an affordable repeal of the SGR, continued annual growth in Medicare spending for physician services, and maintaining access to care. For primary care, which we define more specifically later in this section, the Commission recommends that

payments rates be frozen at their current levels. For all other services, there would be reductions in the fee schedule’s conversion factor in each of the first three years, and then a freeze in the conversion factor for the subsequent seven years.<sup>1</sup> While there would be decreases in payment rates for most services, projected growth in the volume of services—due to increases in both beneficiary enrollment in Medicare and per beneficiary service use—would lead to continued annual increases in total Medicare expenditures for fee-schedule services. We describe previous spending trends in Appendix Figure A-1.

**Figure 1. Potential update path for fee schedule services**



Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary. See text for details.

The rationale for exempting primary care from fee-schedule cuts comes from recent research suggesting that the greatest threat to access over the next decade is concentrated in primary care services.<sup>2</sup> In both patient surveys and physician surveys, access to primary care providers is more

<sup>1</sup>Alternative update paths with the same approximate cost are possible. For example, fees for non-primary care services could receive smaller reductions over more years. Under this alternative, however, by year 10, the conversion factor for non-primary care services would be lower than that proposed in Figure 1.

<sup>2</sup>Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC; Friedberg, M. et al. 2010. Primary care: A critical review of the evidence on quality and costs of health care. *Health Affairs* 29, no. 5 (May): 766-772; Vaughn, B. et al. 2010. Can we close the income and wealth



problematic than access to specialists. These findings hold for both Medicare and privately insured patients, magnifying the vulnerability of access to primary care services.

One example of this research comes from MedPAC's annual patient survey that we use to obtain the most timely data possible for analyzing access to physician services. This survey interviews Medicare beneficiaries age 65 and over and privately insured individuals age 50 to 64. (For more details on the survey's methodology, please see Chapter 4 our March 2011 Report to the Congress.) Results from this annual survey consistently find that both Medicare beneficiaries and privately insured individuals are more likely to report problems finding a new primary care physician compared with finding a new specialist (Appendix Table A-2). For instance, in 2010, although only 7 percent of beneficiaries reported looking for a new primary care physician in the past year, among those looking, 79 percent stated that they experienced no problems finding one. In contrast 87 percent of the beneficiaries who were looking for a new specialist reported that they had no problems finding one. Among privately insured individuals looking for a new primary care physician, 69 percent reported no problems finding one compared with 82 percent of those looking for a new specialist.

Consistent with this patient survey, physician surveys have also found that primary care physicians are less likely than specialists to accept new patients. Again, this discrepancy holds for both Medicare and privately insured patients. For example, the 2008 National Ambulatory Medical Care Survey finds that 83 percent of primary care physicians accept new Medicare patients, compared with 95 percent of specialists (Appendix Table A-3). Acceptance rates are lower for patients with other insurance as well. Specifically, 76 percent of primary care physicians accepted new patients with private (non-capitated) insurance compared with 81 percent of specialists. In a 2008 survey conducted by the Center for Studying Health System Change, physicians who classified themselves in surgical or medical specialties were more likely

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gap between specialists and primary care physicians? *Health Affairs* 29, no. 5 (May): 933-940; Bodenheimer, T. et al. 2009. A lifeline for primary care. *New England Journal of Medicine* 360, no. 26 (June 25): 2693-2696; Grumbach, K. and J. Mold. 2009. A health care cooperative extension service. *Journal of the American Medical Association* 301 no. 24 (June 24): 2589-2591; Rittenhouse, D. et al. 2009. Primary care and accountable care—two essential elements of delivery-system reform. *New England Journal of Medicine* 361, no. 24 (December 10): 2301-2303; Colwill, J. et al. 2008. Will generalist physician supply meet demands of an increasing and aging population? *Health Affairs* 27, no. 3 (April 29): w232-w241.

than primary care physicians (classifying themselves as either in internal medicine or family/general practice) to accept all new Medicare, Medicaid, and privately insured patients.<sup>3</sup>

Exempting primary care from the reductions would mean that Medicare payments for those services would not be based entirely on resource-based relative values. Although resources used to furnish a service (e.g., the time and intensity of effort or practice expenses incurred) are appropriately considered in establishing the fee schedule, other considerations may also be important, including ensuring access or recognizing the value of the services in terms of improving health outcomes or avoiding more costly services in the future. Market prices for goods and services outside health care often reflect such factors. The Congress has demonstrated precedent for this approach in the Medicare fee schedule, such as through the primary care and general surgery bonuses included in the Patient Protection and Affordable Care Act of 2010 (PPACA), as well as floors established for work and practice expense values and bonuses for services provided in health professional services shortage areas.

Regarding the proposed updates included in our recommendation to repeal the SGR, we specify a definition of primary care that focuses on protecting the practitioners and services which make up the core of primary care. The Commission limits the primary care update path to physicians and other health professionals who meet both of the following criteria:

- *Practitioner specialty designation*: Physicians who—when enrolling to bill Medicare—designated their specialty as geriatrics, internal medicine, family medicine, or pediatrics. Eligible practitioners would also include nurse practitioners, clinical nurse specialists, and physician assistants.
- *Practice focused on primary care*: Physicians and practitioners who have annual allowed Medicare charges for selected primary care services equal to at least 60 percent of their total allowed charges for fee-schedule services. Primary care services used to determine eligibility are: office visits, home visits, and visits to patients in nursing facilities, domiciliaries, and rest homes.

Under our proposal, the legislated updates for primary care would apply to the following services when provided by eligible primary care practitioners: office visits, home visits, and visits to

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<sup>3</sup>Boukus, E. et al. 2009. *A snapshot of U.S. physicians: Key findings from the 2008 Health Tracking Physician Survey*. Data bulletin no. 35. Washington, DC: HSC.

patients in hospitals, nursing facilities, domiciliaries, and rest homes.<sup>4</sup> MedPAC analysis of claims data finds that under these specifications, about 9 percent of fee-schedule spending would be protected from fee reductions each year. For eligible primary care practitioners, these protected services typically account for the vast majority of their Medicare billing. Payment rates for other services—such as laceration repairs and endoscopies—furnished by all fee-schedule providers, including primary care practitioners, would be subject to the fee reductions in the first three years.<sup>5</sup>

**Table 1. Potential update path for fee-schedule services**

Year	Primary care		Other services		Annual payments (billion)
	Payment rate change	Conversion factor	Payment rate change	Conversion factor	
Y1	0.0%	\$33.98	-5.9%	\$31.99	\$64
Y2	0.0	33.98	-5.9	30.11	66
Y3	0.0	33.98	-5.9	28.34	68
Y4	0.0	33.98	0.0	28.34	75
Y5	0.0	33.98	0.0	28.34	83
Y6	0.0	33.98	0.0	28.34	91
Y7	0.0	33.98	0.0	28.34	98
Y8	0.0	33.98	0.0	28.34	106
Y9	0.0	33.98	0.0	28.34	113
Y10	0.0	33.98	0.0	28.34	121

Note: The current (2011) conversion factor is \$33.98.

Source: MedPAC analysis of Part B fee-for-service spending per beneficiary, enrollment growth, and growth in the volume of fee-schedule services per beneficiary 2004-2009.

Medicare fees for non-primary care services would be reduced by 5.9 percent each year for 3 years (Table 1). We arrive at this path after satisfying two requirements: protecting core primary care services that are furnished by primary care providers from payment reductions, and

<sup>4</sup>Expanded definitions of primary care are possible. For example, the range of specialties could be expanded. However, protecting more services from the fee reduction will result in either a higher cost (and the need for more offsets) or a deeper fee reduction for the non-primary care services. Alternative definitions of protected services are also possible, such as using the number of unique diagnosis codes that a provider sees over the course of a year to distinguish between highly specialized providers and those that provide a more comprehensive range of care.

<sup>5</sup>The freeze on payment rates for primary care could be implemented either with a separate conversion factor, or with a claims-based payment modifier. If the freeze is implemented with a claims-based payment modifier, a single, reduced conversion factor would apply to all services; but, for eligible primary care services, the payment modifier would increase the fee and effectively reverse the conversion factor reduction.

achieving a total estimated 10-year cost that is no more than \$200 billion. If the update paths depicted in Figure 1 were implemented in 2012, the conversion factor for non-primary care would decrease over a period of three years from the current level of \$33.98 to about \$28.34. It would then stay at that level for the remaining seven years of the budget window. By contrast, under current law, the conversion factor would be \$24.27 at the end of the budget window. Taking into account the increase in the number of Medicare beneficiaries over the next 10 years and growth in the volume of services provided per beneficiary, total practitioner payments from Medicare would rise from \$64 billion to \$121 billion. On a per beneficiary basis, practitioner payments would continue to rise at an average rate of 2.2 percent per year. The \$200 billion estimated cost of this proposed update path accounts for the cost of eliminating the significantly larger SGR cuts and replacing them with the updates specified in Table 1.

A freeze in payment levels for primary care is not sufficient to support a robust system of primary care. Payment approaches that recognize the benefits of non-face-to-face care coordination between visits and among providers may be more appropriate for primary care, particularly for patients with chronic conditions. The Centers for Medicare & Medicaid Services (CMS) is embarking on several projects to examine the results (patient health and total spending outcomes) of monthly per-patient payments to primary care providers for their care coordination activities. These include the Comprehensive Primary Care Initiative, the Multipayer Advanced Primary Care Initiative, and the Federally Qualified Health Center Advanced Primary Care Practice Demonstration. Issues that this work will help to inform include patient involvement in selecting these providers and effective ways for attributing one eligible provider per patient.

**Recommendation 1:**

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

## Collecting data to improve payment accuracy

In addition to a conversion factor, the physician fee schedule includes relative value units (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. To arrive at the payment amount for a given service, its RVUs are adjusted for variations in the input prices in different markets, and then the total of the adjusted RVUs is multiplied by the conversion factor.

The Secretary lacks current, objective data needed to set the fee schedule's RVUs for practitioner work and practice expenses.<sup>6</sup> The fee schedule's time estimates are an example. The RVUs for practitioner work are largely a function of estimates of the time it takes a practitioner to perform each service. However, research for CMS and for the Assistant Secretary for Planning and Evaluation of the Department of Health and Human Services has shown that the time estimates are likely too high for some services. In addition, anecdotal evidence and the experience of clinicians on the Commission suggest problems with the accuracy of the time estimates. Furthermore, under CMS's recent potentially misvalued services initiative, time estimates for a number of services have been revised downward after consultation with the Relative Value Scale Update Committee (RUC). These revisions suggest that current time estimates—which rely primarily on surveys conducted by physician specialty societies that have a financial stake in the process—are subject to bias.

Reliable, objective data are also needed for the fee schedule's practice expense RVUs. CMS's methodology for determining these RVUs relies on various types of data: time estimates for clinical employees who work in practitioners' offices, prices for equipment and supplies used in practitioners' offices, and total practice costs for each physician specialty. The Commission questions the accuracy and timeliness of these data.<sup>7</sup>

The Commission evaluated sources of data the Secretary could consider. Surveys might be an alternative, but they are costly and response rates are likely to be low. Time and motion studies

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<sup>6</sup>Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

<sup>7</sup>Medicare Payment Advisory Commission. 2011. *Report to the Congress: Medicare and the health care delivery system*. Washington, DC: MedPAC.

would be costly, too, and they are subject to bias. And mandatory data reporting—analogue to the cost reports submitted by institutional providers—would raise issues of administrative burden on practitioners.

Instead of these approaches, the Secretary could collect data on a recurring basis from a cohort of practitioner offices and other settings where practitioners work. Participating practices and other settings could be recruited through a process that would require participation in data reporting among those selected. The cohort would consist of practices with a range of specialties, practitioner types, patient populations, and furnished services. Further, the cohort should consist of practices with features that make them efficient (e.g., economies of scale, reorganized delivery systems). If necessary, practices could be paid to participate. The Commission is working with contractors to assess the potential of using electronic health records, patient scheduling systems, cost accounting, and other systems as sources of data in physician practices and integrated delivery systems.

**Recommendation 2:**

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

**Identifying overpriced services**

Moving forward from the SGR could also include a change in the process for identifying overpriced services in the physician fee schedule. The current process for identifying potentially misvalued services is time consuming, occurring over several years. In addition, the process has inherent conflicts. The process relies on surveys conducted by physician specialty societies. Those societies and their members have a financial stake in the RVUs assigned to services.

To accelerate the review process, the Secretary should be directed to analyze the data collected under recommendation 2, identify overpriced services, and adjust the RVUs of those services. Further, the Congress should direct the Secretary to achieve an annual numeric goal equivalent to

a percentage of fee-schedule spending. This would be a goal for reducing the RVUs of overpriced services. These adjustments should be implemented in a budget neutral manner. Therefore, while payments could decrease considerably for any given overpriced service, they would increase slightly for all other services.

As mentioned earlier, the RUC and CMS have started a potentially misvalued services initiative, and there is some evidence that this effort has drawn attention to inaccurate pricing. As an example, for fee schedule payments in 2011, CMS received work RVU recommendations from the RUC for 291 billing codes and made decisions after considering all of those recommendations.<sup>8</sup> In some cases, comprehensive billing codes were established that bundled component services, thereby recognizing that efficiencies can arise when multiple services are furnished during a single patient encounter. Other recommendations did not include a change in billing codes. Instead, the RUC had addressed the question of whether current RVUs are too high or too low for certain services because of a change in technology or other factors. The net effect of the increases and decreases in work RVUs—had the changes not been budget neutral, as required by statute—would have been a reduction in spending under the fee schedule of 0.4 percent. Previously, the net effects of work RVU changes had been smaller: 0.1 percent per year in both 2009 and 2010.

The American Medical Association's (AMA's) position is that the process for identifying potentially misvalued services has been broader in scope than that suggested by these budget neutrality adjustments.<sup>9</sup> The AMA reports that in addition to about \$400 million that was redistributed for 2011 due to changes in work RVUs, another \$40 million was redistributed due to changes in the RVUs for professional liability insurance, and \$565 million was redistributed due to changes in practice expense RVUs.

An annual numeric goal for RVU reductions—stated in terms of a percentage of spending for practitioner services—could foster further collaboration between the RUC and CMS in improving

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<sup>8</sup>Centers for Medicare and Medicaid Services, Department of Health and Human Services. 2010. Medicare program; payment policies under the physician fee schedule and other revisions to Part B for CY 2011. Final rule. Federal Register 75, no. 228 (November 29): 73169-73860.

<sup>9</sup>American Medical Association. undated. The RUC Relativity Assessment Workgroup Progress Report. <http://www.ama-assn.org/resources/doc/rbrvs/five-year-progress.pdf>.

payment accuracy. For example, such a goal should focus the effort on high-expenditure services, thereby making a time-consuming and resource-intensive review process more efficient. In addition, collecting objective data to improve payment accuracy—the data collection addressed by recommendation 2—will make the process more effective. As to the level of the numeric goal, judgment is required. If the AMA’s estimates are accurate, RVU changes for 2011 led to a redistribution of payments equaling almost 1.2 percent of total allowed charges.

### **Recommendation 3:**

**The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.**

### **Accelerate delivery system changes to emphasize accountability and value over volume**

Even with more accurate RVU assignments, the FFS payment system inherently encourages volume over quality and efficiency. Indeed, rapid volume growth in the last decade is due, in large part, to the underlying volume incentives in FFS reimbursement. New payment models, such as the ACO program and new bundled payment initiatives, present an opportunity to correct some of the undesirable incentives in FFS and reward providers who are doing their part to control costs and improve quality.

Repealing the SGR provides an opportunity for Medicare to implement policies that encourage physicians and other health professionals to move toward delivery models with better accountability for quality and value. With this shift, we should see a greater focus on population health and care coordination—thereby improving patient experience and aligning incentives for beneficiaries to become more engaged with their own care management. Through the ACO program and bundled payment approaches, Medicare is taking important steps in this direction—embarking on new payment models that can encourage providers to work together across sectors to maximize quality and efficiency.



Within the ACO program, incentives for these improvements are strongest for ACOs which bear financial risk, often called two-sided risk ACOs. These ACOs are eligible for both rewards and penalties based on their performance on quality and spending measures. In contrast, bonus-only ACOs are not subject to performance-based penalties. Therefore, the Commission recommends aligning policies related to Medicare's fee schedule with incentives for physicians and health professionals to join or lead two-sided risk ACOs.

Specifically, 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 to those in bonus-only ACOs and those who do not join any ACO. The greater opportunity for shared savings would come from calculating the two-sided risk ACO's spending benchmark using higher-than-actual fee-schedule growth rates.

More precisely, assuming the initial reduction in fee-schedule rates outlined in our first recommendation, the Commission recommends that the spending benchmarks for assessing the performance of two-sided risk ACOs be calculated using a freeze in fee-schedule rates, rather than the actual fee reductions. Under this circumstance, two-sided risk ACOs would have a greater opportunity to produce spending that is below their benchmark, and thus be more likely to enjoy shared-savings payments from Medicare.<sup>10</sup>

This recommendation might increase the willingness of physicians and other health professionals to join or lead two-sided risk ACOs. In doing so, it would accelerate delivery system reform toward models with greater accountability for health care quality and spending. As ACO models develop and make strides in improving quality and efficiency, the volume-based FFS environment should be made increasingly less attractive for Medicare providers. Accordingly, the advantage offered to the two-sided risk ACOs would increase in the second and third year that the fee-schedule reductions are in place.

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<sup>10</sup>One issue to examine under this policy would be to monitor the effect of differential payments for services provided by ACO and non-ACO providers. The differential shared savings opportunities are intended to hasten improvements in our delivery system and shift payments away from FFS. The incentives should be revisited as enrollment increases to ensure that ACOs are having the desired effect of encouraging more organized care delivery and lowering overall spending growth.

Final regulations on the ACO program are not yet completed. Therefore, it is difficult to determine the effects of this recommendation, relative to current law. Theoretically, by offering providers a greater opportunity to share in Medicare savings, the Commission's recommendation could reduce total Medicare savings. However, more importantly, if more providers decided to join two-sided risk ACOs as a result of greater shared savings opportunities in this recommendation, total Medicare savings could increase over the long term.

**Recommendation 4:**

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

The Secretary could also consider developing analogous pricing incentives in Medicare's new bundled payment initiatives. That is, in the context of fee-reductions, bundled pricing would assume a rate freeze across all fee-schedule services. In testing this approach for improvements in quality and efficiency, the Secretary could, at the same time, assess the effect that bundled payments have on growth in the total number of episodes.

**Offsetting the cost of the SGR package**

The Commission describes a budget-neutral package for repealing the SGR, offsetting the cost within the Medicare program (Appendix Table A-4). Under current law, the SGR calls for a very large fee reduction (30 percent on January 1, 2012) and the budget score associated with repealing the SGR has grown exponentially. Given the high cost of repealing the SGR and the current economic environment, the Commission's proposal must be fiscally responsible.

The list of options offered by the Commission spreads the cost of repealing the SGR across physicians and other practitioners, as well as other providers and Medicare beneficiaries. Under the Commission's approach, physicians and other practitioners who provide non-primary care services will experience a series of Medicare fee reductions, followed by a freeze in payment

rates. Primary care physicians and other primary care practitioners would experience a freeze in rates for the primary care services they provide. Through these reductions and freezes, physicians and other health professionals are shouldering a large part of the cost of repealing the SGR. The cost of repealing the SGR and replacing it with a complete freeze in fee-schedule payment rates would be approximately \$300 billion over ten years, but the Commission's approach would cost approximately \$200 billion, with most physicians and practitioners absorbing \$100 billion in the form of lower payments than they would receive under a freeze.

To offset this \$200 billion in higher Medicare spending relative to current law (which applies the SGR fee cuts), the Congress may seek offsets inside or outside of the Medicare program. Because MedPAC was established to advise the Congress on Medicare policies, we are offering a set of savings options that are limited to the Medicare program. We do not necessarily recommend that the Congress offset the repeal of the SGR entirely through Medicare. Also, we offer this set of options with the express purpose of assisting the Congress in evaluating ways to repeal the SGR. The steep price of this effort, and the constraint that we are under to offset it within Medicare, compels difficult choices, including fee-schedule payment reductions and offsets that we might not otherwise support.

The offset options listed in Appendix Table A-4 would spread the impact of the reductions across other providers and Medicare beneficiaries. They are grouped in two categories. Those in Tier I—about \$50 billion—are MedPAC recommendations not yet enacted by the Congress. Those in Tier II—about \$168 billion—are informed by analyses done by MedPAC, other commissions, and government agencies. Several of the options in Tier II are designed to make changes to Medicare payments to encourage the use of more cost effective care. The estimates of savings are preliminary staff estimates and do not represent official scores.

The Commission has not voted on each individual item in the Tier II list, and their inclusion should not be construed as a recommendation. Tier II does not include all of the proposals that have been offered for reducing long-term Medicare spending—e.g., increasing the age of eligibility, or requiring higher contributions from beneficiaries with higher-than-average incomes, or premium support. The exclusion of such policies should not be construed as a

statement of MedPAC’s position on these policies. Such policies raise complex issues that are beyond the scope of Tier II offsets.

To reiterate, we offer the list of offset options to assist the Congress in its deliberations on resolving the SGR problem. The Congress could choose different directions to offset the related cost—for example, other spending or revenue offsets, even from outside the Medicare program.

In closing, given the urgency of the need to resolve the SGR policy, the Commission is submitting this letter to the Congress in advance of our usual March and June publication schedule. At a minimum our proposal underscores the exigency of the matter, the complexity of deriving any solution, and the degree of sacrifice a resolution entails. If you have further questions or otherwise wish to discuss this important issue, please feel free to contact me or Mark E. Miller, MedPAC’s Executive Director.

Sincerely,

A handwritten signature in black ink, appearing to read "Glenn M. Hackbarth". The signature is fluid and cursive, with a large initial "G" and "H".

Glenn M. Hackbarth, J.D.  
Chairman

## Appendix

**TABLE  
A-1**

### Commissioners' voting on recommendations

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

*Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello*  
*No: Borman, Castellanos*
- 2** The Congress should direct the Secretary to regularly collect data—including service volume and work time—to establish more accurate work and practice expense values. To help assess whether Medicare's fees are adequate for efficient care delivery, the data should be collected from a cohort of efficient practices rather than a sample of all practices. The initial round of data collection should be completed within three years.

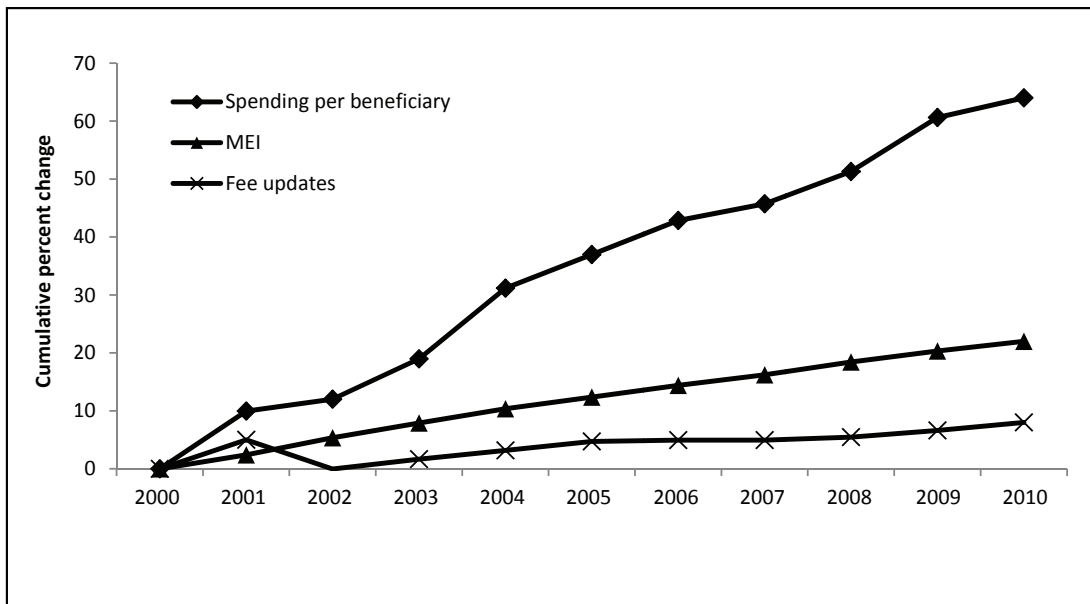
*Yes: Armstrong, Baicker, Behroozi, Berenson, Borman, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello*
- 3** The Congress should direct the Secretary to identify overpriced fee-schedule services and reduce their relative value units (RVUs) accordingly. To fulfill this requirement, the Secretary could use the data collected under the process in recommendation 2. These reductions should be budget neutral within the fee schedule. Starting in 2015, the Congress should specify that the RVU reductions achieve an annual numeric goal—for each of five consecutive years—of at least 1.0 percent of fee-schedule spending.

*Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Chernew, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello*  
*No: Borman*
- 4** Under the 10-year update path specified in recommendation 1, the Congress should direct the Secretary to increase the shared savings opportunity for physicians and health professionals who join or lead two-sided risk accountable care organizations (ACOs). The Secretary should compute spending benchmarks for these ACOs using 2011 fee-schedule rates.

*Yes: Armstrong, Baicker, Behroozi, Berenson, Butler, Castellanos, Dean, Gradison, Hackbarth, Hall, Kuhn, Miller, Naylor, Stuart, Uccello*  
*No: Borman*  
*Not voting: Chernew*

**FIGURE  
A-1**

**Growth in spending for fee-schedule services, 2000–2010**



- Spending for fee-schedule services grew from \$37 billion in 2000 to \$64 billion in 2010—an increase of 72 percent.
- On a per beneficiary basis, spending grew over this period from \$1,200 to \$2,000—an increase of 64 percent. This increase amounts to an average annual spending increase of 5 percent per beneficiary, per year.
- Medicare spending on fee-schedule services grew much more rapidly over this period than both the payment rate updates and the Medicare Economic Index (MEI). The cumulative increase in fee-schedule updates from 2000 to 2010 was 8 percent. The comparable cumulative increase in the MEI was 22 percent.
- The growth in spending per beneficiary was due more to growth in the volume and intensity of services provided than to fee increases. The volume of imaging, tests, and “other procedures” (procedures other than major procedures) grew more rapidly than the volume of major procedures and evaluation and management services.

**TABLE  
A-2**

**Most aged Medicare beneficiaries and older privately insured individuals have good access to physician care, 2007-2010**

Survey question	Medicare (age 65 or older)				Private insurance (age 50-64)			
	2007	2008	2009	2010	2007	2008	2009	2010
<b>Unwanted delay in getting an appointment:</b>								
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?"								
<b>For routine care</b>								
Never	75%*	76%*	77%*	75%*	67%*	69%*	71%*	72%*
Sometimes	18*	17*	17*	17*	24*	24*	22*	21*
Usually	3	3*	2*	3*	4	5*	3*	4*
Always	3	2	2	2	3	2	3	3
<b>For illness or injury</b>								
Never	82*	84*	85*	83*	76*	79*	79*	80*
Sometimes	13*	12*	11*	13*	17*	16*	17*	15*
Usually	3	1	2	2	3	2	2	2
Always	2	1*	1	1*	3	2*	2	2*
<b>Looking for a new primary care physician:</b>								
"In the past 12 months, have you tried to get a new primary care doctor?"								
Yes	9	6	6	7	10	7	8	7
No	91	93	93	93	90	93	92	93
<b>Looking for a new specialist:</b> "In the past 12 months, have you tried to get a new specialist?"								
Yes	14	14*	14*	13*	15	19*	19*	15*
No	86	85*	86*	87*	84	81*	81*	84*
<b>Getting a new physician:</b> 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..."								
<b>Primary care physician</b>								
No problem	70*	71	78	79*	82*	72	71	69*
Small problem	12	10	10	8	7	13	8	12
Big problem	17	18	12*	12	10	13	21*	19
<b>Specialist</b>								
No problem	85	88	88	87*	79	83	84	82*
Small problem	6	7	7	6*	11	9	9	11*
Big problem	9	4	5	5	10	7	7	6
<b>Not accessing a doctor for medical problems:</b>								
"During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?" (Percent answering "Yes")								
	10*	8*	7*	8*	12*	12*	11*	12*

Note: Numbers may not sum to 100 percent because missing responses ("Don't know" or "Refused") are not presented. Overall sample sizes for each group (Medicare and privately insured) were 2,000 in 2007, 3,000 in 2008, and 4,000 in 2009 and 2010. Sample sizes for individual questions varied.  
\*Statistically significant difference between the Medicare and privately insured samples in the given year at a 95 percent confidence level.

Source: MedPAC-sponsored telephone survey conducted in 2007, 2008, 2009, and 2010.

**TABLE  
A-3****Acceptance of new patients is lower among  
primary care physicians, across most insurers**

<b>Accepting new patients, type of insurance</b>	<b>Primary care specialties</b>	<b>All other specialties</b>
Any new patients	89.5%	97.8%
Medicare	83.0	95.2
Medicaid	55.1	68.7
Capitated private insurance	58.3	43.7
Non-capitated private insurance	76.4	81.3
Workers' compensation	53.4	61.2
Self-pay	85.7	95.1
No charge	39.7	52.2

Note: Results include office-based physicians with at least 10 percent of practice revenue coming from Medicare.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Ambulatory Medical Care Survey (2008).



**TABLE  
A-4**

**Potential Medicare offset options for repealing the SGR system**

- Along with the recommendations included in this letter, the Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR system. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.
- The options are divided into two tiers. Tier I—about \$50 billion—contains proposals that have been recommended by the Commission in previous reports or comment letters. Tier II—about \$170 billion—contains options informed by outside (e.g., the Office of Inspector General, Department of Health and Human Services; Congressional Budget Office options) and MedPAC staff analysis. The Commission has not voted on or recommended the items on the Tier II list. The exclusion of policies from this list should not be construed as a statement of MedPAC’s position on such policies.
- In the statute creating MedPAC, the Congress charges the Commission with reviewing Medicare policies, including their relationship to access and quality of care for Medicare beneficiaries. Therefore, all of the offset options on this list are Medicare policies; the Congress could choose to employ other savings or revenue offsets including those from outside of Medicare.

**Note:** The availability and scoring of these options may have changed based on legislative or regulatory action since October 2011.

**TABLE  
A-4**

**Potential Medicare offset options for repealing the SGR system**

Tier I: MedPAC work		5-year savings (\$ in billions)	10-year savings (\$ in billions)	Reference
1	Copayment for home health episode	2	4	MedPAC March 2011
2	Hospital update of 1 percent for 2012 and DCI recovery	7	14	MedPAC March 2011
3	Dialysis update of 1 percent for 2012	0	1	MedPAC March 2011
4	Hospice update of 1 percent for 2012	1	2	MedPAC March 2011
5	Apply the competitive bidding offset to all competition-eligible DME categories starting in 2013	1	1	MedPAC June 2003
6	Apply the competitive bidding offset to the DME categories never subject to competitive bidding starting in 2013	2	7	MedPAC June 2003
7	Repeal MA quality bonus demonstration	6	6	MedPAC comment letter, 2011
8	Rebase HH in 2013 and no update in 2012	5	10	MedPAC March 2011
9	No IRF update in 2012	0	1	MedPAC March 2011
10	No LTCH update for 2012	0	1	MedPAC March 2011
11	Raise the compliance threshold for IRFs to 75 percent	1	3	MedPAC comment letter, 2003
12	ASC update of 0.5 percent for 2012 and report on cost and quality	0.1	0.1	MedPAC March 2011
13	Program integrity: prior authorization for imaging by outlier physicians	0	0.1	MedPAC June 2011
<b>Subtotal, MedPAC work</b>		<b>25</b>	<b>50</b>	

Tier II: Other Medicare		5-year savings (\$ in billions)	10-year savings (\$ in billions)	Reference
14	Part D LIS cost-sharing policy to encourage substitution	6	17	Staff
15	Apply an excise tax to medigap plans (5 percent)	5	12	CBO: Budget Options 2008
16	Program integrity: pre-payment review of power wheelchairs	0.1	0.2	PB 2012, HHS OIG
17	Require manufacturers to provide Medicaid-level rebates for dual eligibles	25	75	CBO: Budget Options 2011
18	Bundled payment for hospital and physician during the admission	0	1	CBO: Budget Options 2008
19	Pay E&M visits in hospital outpatient departments at physician fee schedule rates	5	10	Staff
20	Reduce payments by 10 percent for clinical lab services	4	10	Staff
21	Risk-adjustment validation audits in the MA program	2	3	PB 2012
22	Bring employer group plan bids closer to other MA plan bids	0	1	Staff
23	Hold the trust funds harmless for MA advance capitation payments	2	3	HHS OIG
24	Restore the Secretary's authority to apply a least costly alternative policy	0	1	Staff
25	Additional reductions through competitive bidding or fee schedule reductions to payments for home oxygen	3	5	HHS OIG
26	Rebase payments to SNFs	10	23	Staff
27	Apply readmissions policy to SNFs, HH, LTCHs, and IRFs	1	4	Staff
28	Targeted 3 percent reduction for hospice care provided in nursing homes for hospices with a significant volume of nursing home patients	0.5	1	HHS OIG
29	Program integrity: validate physician orders for high-cost services	0	2	PB 2012
<b>Subtotal, Other Medicare</b>		<b>64</b>	<b>168</b>	
<b>Total, Tier I and Tier II</b>		<b>89</b>	<b>219</b>	

Note: ASC (ambulatory surgical centers), CBO (Congressional Budget Office), DCI (documentation and coding improvements), DME (durable medical equipment), E&M (evaluation and management), HH (home health), HHS (Department of Health and Human Services), IRF (inpatient rehabilitation facilities), LTCH (long-term care hospitals), LIS (low-income subsidy), MA (Medicare Advantage), OIG (Office of Inspector General), PB (provider bulletin), SNF (skilled nursing facility). The Commission is offering a set of savings options for the purpose of assisting the Congress in offsetting the budgetary cost of repealing the SGR. The projected savings amounts are unofficial, based on MedPAC staff estimates, and subject to change.

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# **Acronyms**

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## Acronyms

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<b>AAGR</b>	average annual growth rate	<b>CDC</b>	Centers for Disease Control and Prevention
<b>AARP</b>	(formerly) American Association of Retired Persons	<b>CEA</b>	carotid endarterectomy
<b>ABIM</b>	American Board of Internal Medicine	<b>CEO</b>	chief executive officer
<b>ACC</b>	American College of Cardiology	<b>CHC</b>	continuous home care
<b>ACCF</b>	American College of Cardiology Foundation	<b>CHF</b>	congestive heart failure
<b>ACH</b>	acute care hospital	<b>CHIP</b>	Children’s Health Insurance Program
<b>ACO</b>	accountable care organization	<b>CMG</b>	case-mix group
<b>ADL</b>	activity of daily living	<b>CMI</b>	case-mix index
<b>AHA</b>	American Hospital Association	<b>CMS</b>	Centers for Medicare & Medicaid Services
<b>AHRQ</b>	Agency for Healthcare Research and Quality	<b>CMS–HCC</b>	CMS–hierarchical condition category
<b>AIDS</b>	acquired immunodeficiency syndrome	<b>CON</b>	certificate of need
<b>ALOS</b>	average length of stay	<b>COP</b>	condition of participation
<b>AMA</b>	American Medical Association	<b>COPD</b>	chronic obstructive pulmonary disease
<b>AMI</b>	acute myocardial infarction	<b>CPI–U</b>	consumer price index for all urban consumers
<b>APC</b>	ambulatory payment classification	<b>C–SNP</b>	chronic condition special needs plan
<b>APCP</b>	advanced primary care practice	<b>CT</b>	computed tomography
<b>AQNHC</b>	Alliance for Quality Nursing Home Care	<b>CXR</b>	chest X-ray
<b>ASC</b>	ambulatory surgical center	<b>DME</b>	durable medical equipment
<b>ASP</b>	average sales price	<b>DRG</b>	diagnosis related group
<b>ASPE</b>	Assistant Secretary for Planning and Evaluation	<b>DSH</b>	disproportionate share
<b>ATRA</b>	American Taxpayer Relief Act of 2012	<b>DSH</b>	disproportionate share hospital
<b>AV</b>	arteriovenous	<b>D–SNP</b>	dual-eligible special needs plan
<b>BCBSM</b>	BlueCross BlueShield of Michigan	<b>DVT</b>	deep vein thrombosis
<b>BLS</b>	Bureau of Labor Statistics	<b>E&amp;M</b>	evaluation and management
<b>BMI</b>	body mass index	<b>EBITDA</b>	earnings before interest, taxes, depreciation, and amortization
<b>CAD</b>	coronary artery disease	<b>ED</b>	emergency department
<b>CAH</b>	critical access hospital	<b>EGHP</b>	employer group health plan
<b>CAHPS®</b>	Consumer Assessment of Healthcare Providers and Systems	<b>EHR</b>	electronic health record
<b>CAHPS®–MA</b>	Consumer Assessment of Healthcare Providers and Systems for Medicare Advantage	<b>EKG</b>	electrocardiogram
<b>CAPD</b>	continuous ambulatory peritoneal dialysis	<b>eRx</b>	electronic prescribing
<b>CARE</b>	Continuity Assessment Record and Evaluation [tool]	<b>ESA</b>	erythropoiesis-stimulating agent
<b>CBO</b>	Congressional Budget Office	<b>ESRD</b>	end-stage renal disease
<b>CBSA</b>	core-based statistical area	<b>FAQ</b>	frequently asked question
<b>CC</b>	complication or comorbidity	<b>FDA</b>	Food and Drug Administration
<b>CCI</b>	chronically critically ill	<b>FFS</b>	fee-for-service
<b>CCI</b>	Correct Coding Initiative	<b>FIM™</b>	Functional Independence Measure™
<b>CCP</b>	coordinated care plan	<b>FQHC</b>	federally qualified health center
<b>CCPD</b>	continuous cycler-assisted peritoneal dialysis	<b>FY</b>	fiscal year
<b>CCU</b>	cardiac care unit	<b>g/dL</b>	grams per deciliter
		<b>GAO</b>	Government Accountability Office
		<b>GDP</b>	gross domestic product

<b>GDR</b>	generic dispensing rate	<b>MACIE</b>	Medicare Ambulatory Care Indicators for the Elderly
<b>GI</b>	gastrointestinal	<b>MACPAC</b>	Medicaid and CHIP Payment and Access Commission
<b>H-CAHPS®</b>	Hospital Consumer Assessment of Healthcare Providers and Systems	<b>MA-PD</b>	Medicare Advantage–Prescription Drug [plan]
<b>HCCI</b>	Health Care Cost Institute	<b>MCBS</b>	Medicare Current Beneficiary Survey
<b>HEDIS®</b>	Healthcare Effectiveness Data and Information Set®	<b>MCC</b>	major complication or comorbidity
<b>HHA</b>	home health agency	<b>MDH</b>	Medicare-dependent hospital
<b>HHS</b>	Department of Health and Human Services	<b>MDS</b>	Minimum Data Set
<b>HI</b>	Hospital Insurance (Medicare Part A)	<b>MedPAC</b>	Medicare Payment Advisory Commission
<b>HITECH</b>	Health Information Technology for Economic and Clinical Health [Act]	<b>MedPAR</b>	Medicare Provider Analysis and Review [file]
<b>HIV</b>	human immunodeficiency virus	<b>MEI</b>	Medicare Economic Index
<b>HMO</b>	health maintenance organization	<b>MGMA</b>	Medical Group Management Association
<b>HOPD</b>	hospital outpatient department	<b>MHA</b>	Missouri Hospital Association
<b>HOS</b>	Health Outcomes Survey	<b>MI</b>	myocardial infarction
<b>HPSA</b>	health professional shortage area	<b>MIPPA</b>	Medicare Improvements for Patients and Providers Act of 2008
<b>HRET</b>	Health Research and Educational Trust	<b>MMS</b>	Massachusetts Medical Society
<b>HUD</b>	Department of Housing and Urban Development	<b>MMSEA</b>	Medicare, Medicaid, and SCHIP Extension Act of 2007
<b>ICD-9</b>	International Classification of Diseases, Ninth Revision	<b>MRI</b>	magnetic resonance imaging
<b>ICD-9-CM</b>	International Classification of Diseases, Ninth Revision, Clinical Modification	<b>MS-DRG</b>	Medicare severity–diagnosis related group
<b>ICL</b>	initial coverage limit	<b>MS-LTC-DRG</b>	Medicare severity long-term care diagnosis related group
<b>ICU</b>	intensive care unit	<b>MSS</b>	medical social services
<b>IOL</b>	intraocular lens	<b>N/A</b>	not applicable
<b>IOM</b>	Institute of Medicine	<b>N/A</b>	not available
<b>IPPS</b>	inpatient prospective payment system	<b>NASBO</b>	National Association of State Budget Officers
<b>IPS</b>	interim payment system	<b>NBER</b>	National Bureau of Economic Research
<b>IQI</b>	inpatient quality indicator	<b>NCHS</b>	National Center for Health Statistics
<b>IRF</b>	inpatient rehabilitation facility	<b>NCQA</b>	National Committee for Quality Assurance
<b>IRF-PAI</b>	Inpatient Rehabilitation Facility–Patient Assessment Instrument	<b>NDC</b>	national drug code
<b>I-SNP</b>	institutional special needs plan	<b>NGA</b>	National Governors Association
<b>KFF</b>	Kaiser Family Foundation	<b>NHE</b>	national health expenditure
<b>LCD</b>	local coverage determination	<b>NIDDK</b>	National Institute of Diabetes and Digestive and Kidney Diseases
<b>LDKT</b>	live-donor kidney transplantation	<b>NIH</b>	National Institutes of Health
<b>LIS</b>	low-income [drug] subsidy	<b>NQF</b>	National Quality Forum
<b>LPN</b>	licensed practical nurse	<b>NSAS</b>	National Survey of Ambulatory Surgery
<b>LTC</b>	long-term care	<b>NTA</b>	nontherapy ancillary
<b>LTCH</b>	long-term care hospital	<b>NTIOL</b>	new technology intraocular lens
<b>LTSS</b>	long-term care services and supports	<b>OASIS</b>	Outcome and Assessment Information Set
<b>LUPA</b>	low utilization payment adjustment	<b>OECD</b>	Organisation for Economic Co-operation and Development
<b>LVEF</b>	left ventricular ejection fraction	<b>OIG</b>	Office of Inspector General
<b>M&amp;A</b>	mergers and acquisitions	<b>OOP</b>	out-of-pocket
<b>MA</b>	Medicare Advantage		

<b>OP</b>	outpatient	<b>RCT</b>	randomized clinical trial
<b>OPD</b>	hospital outpatient department	<b>RDS</b>	retiree drug subsidy
<b>OPPS</b>	outpatient prospective payment system	<b>RN</b>	registered nurse
<b>OR</b>	operating room	<b>RPA</b>	Renal Physicians Association
<b>OT</b>	occupational therapy	<b>RUG</b>	resource utilization group
<b>PAC</b>	post-acute care	<b>RVG</b>	radionuclide ventriculography
<b>PAC-PRD</b>	Post-Acute Care Payment Reform Demonstration	<b>RVU</b>	relative value unit
<b>PCMH</b>	patient-centered medical home	<b>SCHIP</b>	State Children’s Health Insurance Program
<b>PD</b>	peritoneal dialysis	<b>SGR</b>	sustainable growth rate
<b>PDE</b>	prescription drug event	<b>SMI</b>	Supplementary Medical Insurance
<b>PDP</b>	prescription drug plan	<b>SNF</b>	skilled nursing facility
<b>PDQ</b>	Providing Data Quickly [system]	<b>SNP</b>	special needs plan
<b>PET</b>	positron emission tomography	<b>SSI</b>	Supplemental Security Income
<b>PFFS</b>	private fee-for-service	<b>SSI</b>	surgical site infection
<b>PFS</b>	physician fee schedule	<b>SSO</b>	short-stay outlier
<b>PHC4</b>	Pennsylvania Health Care Cost Containment Council	<b>TEFRA</b>	Tax Equity and Fiscal Responsibility Act of 1982
<b>PMV</b>	prolonged mechanical ventilation	<b>TIA</b>	transient ischemic attack
<b>POS</b>	Provider of Services	<b>TTY/TDD</b>	Telecommunications device for the deaf/ teletypewriter
<b>PPACA</b>	Patient Protection and Affordable Care Act of 2010	<b>UCSF</b>	University of California at San Francisco
<b>PPO</b>	preferred provider organization	<b>U.S.</b>	United States
<b>PPS</b>	prospective payment system	<b>USRDS</b>	United States Renal Data System
<b>PQRS</b>	Physician Quality Reporting System	<b>VBP</b>	value-based purchasing [program]
<b>PSI</b>	patient safety indicator	<b>VSSO</b>	very short-stay outlier





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## **More about MedPAC**

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## Commission members

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**Glenn M. Hackbarth, J.D., chairman**

Bend, OR

**Michael Chernew, Ph.D., vice chairman**

Harvard Medical School

Boston, MA

*Term expires April 2013*

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**Scott Armstrong, M.B.A.,  
F.A.C.H.E.**

Group Health Cooperative  
Seattle, WA

**Katherine Baicker, Ph.D.**

Harvard School of Public Health  
Boston, MA

**Thomas M. Dean, M.D.**

Horizon Health Care, Inc.  
Wessington Springs, SD

**Herb Kuhn**

Missouri Hospital Association  
Jefferson City, MO

**Mary Naylor, Ph.D., R.N.,  
F.A.A.N.**

University of Pennsylvania, School of  
Nursing  
Philadelphia, PA

**Cori Uccello, F.S.A., M.A.A.A.,  
M.P.P.**

American Academy of Actuaries  
Washington, DC

*Term expires April 2014*

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**Peter W. Butler, M.H.S.A.**

Rush University  
Chicago, IL

**Michael Chernew, Ph.D.**

**Bill Gradison, M.B.A.**

Fuqua School of Business, Duke  
University  
McLean, VA

**William J. Hall, M.D., M.A.C.P.**

University of Rochester School of  
Medicine  
Rochester, NY

**George N. Miller, Jr., M.H.S.A.**

Okmulgee Memorial Hospital  
Okmulgee, OK

*Term expires April 2015*

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**Alice Coombs, M.D.**

Milton Hospital and South Shore Hospital  
Weymouth, MA

**Glenn M. Hackbarth, J.D.**

**Jack Hoadley, Ph.D.**

Health Policy Institute, Georgetown  
University  
Washington, DC

**David Nerenz, Ph.D.**

Henry Ford Health System  
Detroit, MI

**Rita Redberg, M.D.**

University of California at San Francisco  
Medical Center  
San Francisco, CA

**Craig Samitt, M.D., M.B.A.**

Dean Health System, Inc.  
Madison, WI



## Commissioners' biographies

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**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 SCHIP 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 chair 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. She serves on the editorial boards of *Health Affairs*, the *Journal of Health Economics*, the *Journal of Economic Perspectives*, and the Forum for Health Economics and Policy, and is chair of the Board of Directors of Academy Health. 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. From 2005 to 2007, Professor Baicker served as a Senate-confirmed member of the President's Council of Economic Advisers. 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 served as chairman of the board of University HealthSystem Consortium. He also currently serves as chairman of the board of the National Center for Healthcare Leadership. Mr. Butler holds an undergraduate degree in psychology from Amherst College and a master's degree in health services administration from the University of Michigan.

**Michael Chernew, Ph.D.,** is a professor 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 Advisers 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 co-edits 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 serves 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.

**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, which 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.

**Thomas M. Dean, M.D.**, is a board-certified family physician who has practiced in Wessington Springs, SD, since 1978. He is chief of staff at Avera Wesskota Memorial Medical Center. Dr. Dean is on the Board of Directors of Avera Health Plan and is past-president of the South Dakota Academy of Family Physicians. He was president of the National Rural Health Association, and he published articles and presented on health care in rural areas. Dr. Dean received the Dr. Robert Hayes Memorial Award for outstanding rural health provider, received the Pioneer Award from the South Dakota Perinatal Association, and was awarded a Bush Foundation Medical Fellowship to study leadership and health policy. He was also named the 2009 National Rural Health Association's Practitioner of the Year. Dr. Dean earned his medical degree from the University of Rochester School of Medicine and Dentistry. His undergraduate degree is from Carleton College.

**Bill Gradison, M.B.A., D.C.S.**, is 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 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 doctor of internal medicine and professor of medicine at the University of Rochester School of Medicine where he directs the Center for Healthy Aging. Dr. Hall's subspecialty is in the field of geriatrics, with a major research interest in the development and promotion of programs in healthy aging, emphasizing preventive and wellness strategies for older adults. He has published over 150 scientific articles, reviews, and book chapters. He was instrumental in establishing a Program of All-Inclusive Care for the Elderly in Rochester, New York, and has directed the Division of Geriatrics at the University of Rochester School of Medicine. His contributions to physician education in the care of the elderly have been recognized nationally by the American Geriatrics Society, the John A. Hartford Foundation, and the Donald W. Reynolds Foundation. More recently his career has focused on systems of health care for older adults. Dr. Hall's prior service and positions include serving as a member of the Board of Directors of AARP, serving as president of the American College of Physicians, and serving in leadership positions in the American Geriatrics Society. He is the immediate past-president of the International Society of Internal 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 (HHS) 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 CHIP; pharmacoeconomics and prescription drug benefit programs; and private sector insurance coverage. Dr. Hoadley has published widely on health care financing and pharmacoeconomics 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 as deputy administrator from 2006 to 2009 and as 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 the chief executive officer of Okmulgee Memorial Hospital in Okmulgee, OK. Previously, he was the president and chief executive officer of First Diversity Healthcare Group, a national health care consulting firm helping health care organizations improve their operations; 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, 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, 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, the National Quality Forum Board of

Directors, and the immediate past-chair of the Board of the Long-Term Quality Alliance. Dr. Naylor received her M.S.N. and Ph.D. from the University of Pennsylvania and her B.S. in nursing from Villanova University.

**David Nerenz, Ph.D.**, is director of the Center for Health Policy and Health Services Research at the Henry Ford Health System in Detroit, MI, as well as director of outcomes research at the Neuroscience Institute and vice-chair for research of the Department of Neurosurgery at Henry Ford Hospital. He has served on the National Committee for Quality Assurance's Culturally and Linguistically Appropriate Services Workgroup and on the Accountable Care Organization Technical Advisory Committee of the American Medical Group Association and has served as a principal on the Hospital Quality Alliance. Dr. Nerenz has served on several committees of the Institute of Medicine, including as chair of the Committee on Leading Health Indicators for Healthy People 2020. He serves on the editorial boards of *Population Health Management* and *Medical Care Research and Review*.

**Rita Redberg, M.D.**, is professor of clinical medicine at the University of California at San Francisco (UCSF) Medical Center in San Francisco, CA. A cardiologist, Dr. Redberg is also director of Women's Cardiovascular Services at UCSF and adjunct associate at Stanford University's Center for Health Policy/Center for Primary Care and Outcomes Research. She is editor of *JAMA Internal Medicine* and a panel member on CMS's Medicare Evidence Development and Coverage Advisory Committee. Dr. Redberg has served in numerous positions on committees of the American Heart Association and the American College of Cardiology and was a Robert Wood Johnson Foundation Health Policy Fellow.

**Craig Samitt, M.D., M.B.A.**, is president and chief executive officer of Dean Health System, Inc., an integrated delivery system and provider-sponsored health plan headquartered in Madison, WI. He has worked at Dean since 2006 and has led the organization through a transformation aimed at maximizing the system's focus as a national leader in "better care at a lower cost." Before joining Dean, Dr. Samitt served as chief operating officer of the Fallon Clinic (Reliant Medical), senior vice president at Harvard Pilgrim Health Care, and chairman of Medicine and executive director of the Kenmore Center at Harvard Vanguard (Atrius Health). He is chair-emeritus at the Group Practice Improvement Network, a learning consortium of large multispecialty groups, is a director

on the Advocate Physician Partners Board, and has served as an advisory and faculty member of the Centers for Medicare & Medicaid Services' Accountable Care Organization Accelerated Development Learning Sessions. Dr. Samitt received his M.D. from Columbia University and his M.B.A. from the Wharton School.

**Cori E. Uccello, F.S.A., M.A.A.A., M.P.P.,** is senior health fellow of the American Academy of Actuaries, serving as the actuarial profession's chief public policy liaison on health issues. Ms. Uccello focuses on issues related to health insurance financing, coverage and market reforms, and risk-sharing mechanisms. She recently served as a

member of the Technical Review Panel on the Medicare Trustees' Report. Before joining the Academy in 2001, she was a senior research associate at the Urban Institute where she focused on health insurance and retirement policy issues. She previously held the position of actuarial fellow at the John Hancock Life Insurance Company. Ms. Uccello is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. She received an undergraduate degree in math and biology from Boston College and a master's degree in public policy from Georgetown University.



## Commission staff

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**Mark E. Miller, Ph.D.**

*Executive director*

**James E. Mathews, Ph.D.**

*Deputy director*

*Analytic staff*

Christine Aguiar, M.P.H.

Catherine Bloniarz, M.S.

Carol Carter, Ph.D.

Evan Christman, M.P.Aff.

Zachary Gaumer, M.P.S.

David V. Glass, M.S.

Scott Harrison, Ph.D.

Kevin Hayes, Ph.D.

Dana Kelley, M.P.A.

Julie Lee, Ph.D.

Craig K. Lisk, M.S.

Kim Neuman, M.A.

Nancy Ray, M.S.

John Richardson, M.P.P.

Sara Sadownik, M.Sc.

Joan Sokolovsky, Ph.D.

Julie Somers, Ph.D.

Jeffrey Stensland, Ph.D.

Shinobu Suzuki, M.A.

Ariel Winter, M.P.P.

Daniel Zabinski, Ph.D.

*Research assistants*

Lauren Metayer

Katelyn Smalley

*Assistant director*

Arielle Mir, M.P.A.

*Communications and policy assistant*

Kahlie Dufresne

*Administrative staff*

Reda H. Broadnax, B.S.,

*Executive officer*

Wylene Carlyle

Paula Crowell

Timothy Gulley

Tina Jennings, MTESL

Rachel Macias

Cynthia Wilson

*Staff consultants*

Julian Pettengill

Carlos Zarabozo, A.B.



