
Executive summary

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As required by the Congress, each March the Medicare Payment Advisory Commission reviews and makes recommendations for Medicare fee-for-service (FFS) payment systems and the Medicare Advantage (MA) program. In this report, we:

- consider the context of the Medicare program in terms of its spending and the federal budget and national gross domestic product;
- consider Medicare FFS payment policy in 2010 for: hospital inpatient and outpatient services, physician services and ambulatory surgical centers (ASCs), outpatient dialysis services, skilled nursing facility services, home health services, inpatient rehabilitation facility services, and long-term care hospital services;
- discuss the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare and review our MA recommendations;
- review the status of the plans that provide prescription drug coverage;
- make recommendations on public reporting of physicians' financial relationships with pharmaceutical and device manufacturers and health care providers; and
- make recommendations on reforming Medicare's hospice payment system.

With each passing year, the Commission's concern about Medicare's long-term sustainability intensifies. To slow the growth in Medicare expenditures, we have concluded that the Congress and CMS will need to make changes across a broad front. This report focuses on policy recommendations that would limit provider updates to create incentives for greater efficiency, reward quality, and modify payment rates to private plans and providers to improve payment accuracy. Other changes, which we discussed in our June 2008 report, include ideas for altering Medicare's payment systems to reward better coordination of care and efficiency over time and investing in information about comparative effectiveness. Changes in Medicare are complex to develop and implement. Time, therefore, is of the essence.

At the beginning of each chapter, we list the recommendations it contains. Within the chapters, we present each recommendation; its rationale; and its

implications for beneficiaries, providers, and program spending. The spending implications are presented as ranges over one- and five-year periods and, unlike official budget estimates, do not take into account the complete package of policy recommendations or the interactions among them. In Appendix A, we list all recommendations and the Commissioners' votes.

Context for Medicare payment policy

Medicare and other purchasers of health care in our nation face enormous challenges. As discussed in Chapter 1, health care costs are increasing for individuals and private and public payers, while quality frequently falls short of patients' needs. The Commission has recommended a number of measures to increase the accountability of providers and the value of care, such as pay for performance, measuring resource use, and comparing the effectiveness of medical treatments. The marked variation in both service use and quality of care across the nation suggests that opportunities exist for reducing waste while improving quality for beneficiaries. But realizing those opportunities will require addressing the myriad factors that drive the current health care system and may well require fundamental reform of the organization of health care delivery.

As is true for other purchasers of health care, Medicare's spending has been growing much faster than the economy. The growth in national income, the availability of newer medical technologies, and the cost-increasing effects of health insurance are thought to account for much of this long-term growth, and some of those forces will likely push future spending even higher. Medicare will have the additional challenge of higher enrollment associated with retiring baby boomers as will other programs that benefit the elderly, such as Social Security and Medicaid, creating additional competition for funds within the federal budget.

Because of these forces, the Medicare trustees and others warn of a serious mismatch between the benefits and payments the program currently provides and the financial resources available for the future. If Medicare benefits and payment systems remain as they are today, the trustees note that over time the program will require major new sources of financing and impose a significant financial liability on taxpayers. Medicare beneficiaries will pay for rising expenditures through higher premiums and cost sharing. Analysts across the political spectrum have raised

concerns that the current programs may become too heavy a fiscal burden and squeeze the funding for other federal priorities. The Congressional Budget Office finds that any feasible set of policy solutions will require a slowdown in the growth rate of spending on health care and may also require a substantial increase in taxes as a share of our nation's economy.

Delaying action would constrain the options for addressing Medicare's problems. Many changes, such as reconfiguring the delivery system to slow cost growth and increase quality, will take time to implement. As cost increases continue to outstrip revenue and the retirement of the baby boom generation draws closer, the time for phasing in major changes is growing shorter.

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

The Commission makes payment update recommendations annually for 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. In Chapter 2, for each sector, we first assess the adequacy of Medicare payments for efficient providers in the current year (2009), taking into account policy changes (other than the update) that are scheduled to take effect in the policy year (2010) under current law. Next, we assess how those providers' costs are likely to change in 2010, the year the update will take effect. Finally, we make a judgment as to what, if any, update is needed.

The Commission may adjust the update to link Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. Competitive markets demand continual improvements in processes and quality from those workers and firms. Medicare's payment systems should exert the same pressure on providers of health services.

Hospital inpatient and outpatient services

Most indicators of payment adequacy for hospital services are positive. Access to hospital services continues to be good with more hospitals opening than closing. In fact, the overall level of hospital construction was at a record high in 2007. Many hospitals are expanding the services they offer their communities. Despite increasing competition from independent diagnostic testing facilities and ambulatory surgical centers, the volume of hospital outpatient services furnished to Medicare beneficiaries has grown, indicating that access is strong. Another

positive indicator is that quality-of-care measures are generally improving.

Access to capital has been erratic in 2008. Bond offerings and construction started off at a record pace in January but froze in September 2008 due to an economy-wide freeze of the credit markets. The difficulties in accessing capital resulted from a sudden economy-wide breakdown of the credit markets rather than any change in the level of Medicare hospital payments. Recently, hospitals with robust fundamentals have been able to issue debt, but even financially sound hospitals face higher interest rates.

While most payment adequacy indicators are positive, Medicare margins remain low. Average Medicare margins, which were -5.9 percent in 2007, are projected to fall to -6.9 percent in 2009 (after accounting for the effects of payment policy changes scheduled for 2010 under current law). While average margins are negative, some hospitals are able to generate profits treating Medicare patients.

Two observations inform our assessment of negative Medicare margins. First, unusually high hospital margins on private-payer patients can lead to more construction, higher hospital costs, and lower Medicare margins. The data suggest that when non-Medicare margins are high, hospitals face less pressure to constrain costs, costs rise, and Medicare margins tend to be low. In 2007, hospitals' non-Medicare profits, total (all-payer) profits, and hospital construction were at the highest levels in a decade—and Medicare margins were negative. Because not all hospitals had high margins on non-Medicare patients, we were able to investigate how hospitals reacted to differing levels of financial pressure. We found that hospitals facing significant financial challenges in recent years (2004 through 2006) tended to have lower costs and hence higher Medicare margins in 2007 than hospitals with high private payer margins and less financial pressure.

The second observation is that while Medicare margins for hospitals may be negative in aggregate, Medicare payments may still be adequate to cover the costs of efficient hospitals. To explore this question, we have examined financial outcomes for a set of hospitals that consistently perform well on cost, mortality, and readmission measures and have exemplary performance on at least one of the measures. We found that Medicare payments on average roughly equaled the costs of these relatively efficient hospitals.

Balancing the findings of our payment adequacy indicators, the Commission recommends an update equal to the projected increase in the market basket for inpatient and outpatient services, with this update implemented concurrently with a quality improvement program. Given the mixed payment adequacy indicators, a hospital's quality performance should determine whether its payments increase more or less than the market basket.

In 2007, indirect medical education (IME) payments to teaching hospitals totaled \$6 billion. We find that these payments exceed the estimated indirect costs associated with teaching residents. Therefore, we again recommend a reduction in the IME adjustment equivalent to 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio. The savings would be used to help fund a quality improvement program.

Physician services and ambulatory surgical centers

We assess overall payment adequacy for physician services in FFS Medicare, examine payments for expensive imaging services, and assess payment adequacy for ASCs—facilities that are typically owned all or in part by physicians.

Physician update and primary care Our analysis of physician services provided in FFS Medicare finds that, overall, most indicators of payment adequacy are positive and stable, ensuring that most beneficiaries can obtain physician care when they need it. However, the Commission remains concerned about access to primary care services and providers.

- Our survey of beneficiaries in the fall of 2008 indicates that beneficiary access to physicians is generally good and—in several measures—better than that reported by privately insured patients age 54 to 60. The one exception is among the small share of beneficiaries (6 percent) who reported that they looked for a new primary care physician—28 percent reported problems finding one.
- Physicians continue to accept and treat Medicare patients: 92 percent of office-based physicians who receive 10 percent or more of their practice revenue from Medicare were accepting new Medicare patients in 2007, and the share of physicians signing participation agreements with Medicare was 95 percent in 2008.

- Medicare payment rates continue to be about 80 percent of private insurance payment rates as they have for the past decade.
- In 2007, the volume of physician services provided per beneficiary grew almost 3 percent.

In light of these findings, the Commission recommends that for 2010 the Congress update payments for physician services by 1.1 percent—the same percentage increase as the Congress set for 2009.

The Commission remains concerned that primary care services are undervalued and at a significant risk of being underprovided, despite some recent increases in payments for primary care services. To underscore the urgency of this issue, the Commission voted to reiterate its previous recommendation that payments for primary care services be increased when provided by practitioners who focus on primary care. This adjustment would be budget neutral within the fee schedule. It would require statutory authority.

Changing payments for expensive imaging services

The Commission recognizes that there has been rapid technological progress in diagnostic imaging over the past several years, which has enabled physicians to diagnose and treat illness with greater speed and precision. However, we are concerned that the rapid volume growth of costly imaging services in recent years may signal that they are mispriced. High rates for imaging services lead to lower rates for primary care and other services.

CMS's method for setting practice expense (PE) relative value units (RVUs) for advanced imaging services assumes that imaging machines are operated 25 hours per week, or 50 percent of the time that practices are open for business. Setting the equipment use factor at 25 hours per week—rather than at a higher level—has led to higher PE RVUs for these services. Higher payment rates encourage providers with low expected volumes to purchase expensive imaging machines. Once providers purchase machines, they have an incentive to use them as frequently as possible. Indeed, there is evidence that MRI and computed tomography machines are used much more frequently than Medicare assumes.

The Commission recommends that Medicare adopt a normative standard in which providers are assumed to use costly imaging machines at close to full capacity (45 hours per week, or 90 percent of the time that providers

are assumed to be open). Such a normative standard would discourage providers from purchasing expensive imaging equipment unless they had sufficient volume to justify the purchase. The Secretary should start by adopting a standard of 45 hours per week for all diagnostic imaging machines that cost at least \$1 million and should explore applying this standard to imaging equipment that costs less. This change would reduce PE RVUs for costly imaging services and increase RVUs for other physician services.

Payment adequacy for ambulatory surgical centers

Physicians furnish outpatient surgical services in their offices, hospital outpatient departments (HOPDs), and increasingly, ASCs. ASCs are a source of revenue for many physicians, as over 90 percent of ASCs have at least one physician owner. ASCs offer several advantages to physicians and patients over HOPDs. Physicians have greater control and may be able to perform more surgeries per day in ASCs because they often have customized surgical environments and specialized staffing. Patients may be able to schedule surgery more quickly, experience shorter waiting times, and find ASCs that are more conveniently located.

We find that the indicators suggest that ASC Medicare payment rates are adequate. From 2002 to 2007:

- Medicare revenue increased from \$1.9 billion to \$2.9 billion.
- The number of ASCs grew by an average of 6.7 percent per year.
- Volume per beneficiary grew by 9.8 percent per year.
- The number of Medicare beneficiaries served in ASCs increased by 7.5 percent per year.

CMS made substantial changes to the ASC payment system in 2008. The most significant changes include a different method for setting payment rates, allowing separate payment for certain ancillaries, and a 32 percent increase in the number of surgical procedure codes covered under the ASC payment system. Under the revised payment system, 86 percent of all procedures have a higher payment rate than under the old system. However, the highest volume procedures have lower payment rates. If ASCs diversify the procedures they provide to Medicare beneficiaries over the four-year transition period to the new payment system, they should be able to maintain or increase their Medicare revenue.

Weighing our findings on payment adequacy and the revised payment system, the Commission recommends that ASCs receive a payment update of 0.6 percent in calendar year 2010. The Commission also recommends that ASCs be required to submit cost and quality data to the Secretary.

Outpatient dialysis services

Most of our indicators of payment adequacy for outpatient dialysis services are positive. The growth in the number of dialysis facilities and treatment stations has kept pace with the growth in the number of dialysis patients, suggesting continued access to care for most dialysis beneficiaries. The growth in the number of dialysis treatments—one indicator of the volume of services—has kept pace with patient growth between 2006 and 2007. The total volume of most dialysis drugs administered grew between 2004 and 2007 but more slowly than in the past because of statutory and regulatory changes that lowered the payment rate for most dialysis drugs.

Some measures of quality of care are improving. Use of the recommended type of vascular access—the site on the patient’s body where blood is removed and returned during hemodialysis—has improved since 2000. More patients receive adequate dialysis and have their anemia under control. However, improvements in quality are still needed. For example, the proportion of dialysis patients registered for the kidney transplant wait list does not meet the goal set forth by the Centers for Disease Control and Prevention’s Healthy People 2010.

Recent evidence about trends in the increase in the number of dialysis facilities suggests that providers have sufficient access to capital. Both the large dialysis organizations and smaller chains have obtained capital to fund acquisitions.

The Medicare margin for composite rate services and dialysis drugs for freestanding dialysis facilities was 4.8 percent in 2007. The two largest dialysis chains (which may benefit from economies of scale) realized a higher Medicare margin than other freestanding providers (6.9 percent versus 0.2 percent). We project the overall Medicare margin for freestanding dialysis facilities will be 1.2 percent in 2009.

The sum of these indicators suggests that a moderate update of the composite rate is in order. Therefore, the Commission recommends that the Congress maintain current law and update the composite rate by 1 percent for calendar year 2010.

Skilled nursing facility services

Our indicators of the adequacy of Medicare payments to cover the costs of skilled nursing facility (SNF) services to beneficiaries are generally positive. These indicators include a stable supply of providers, a slight increase in service volume, and growth in Medicare margins. Quality indicators were mixed. Access to capital is tight, reflecting general uncertainty in the financial markets, not the adequacy of Medicare payments. Most beneficiaries continue to have good access to services, especially rehabilitation services. However, patients seeking medically complex care may experience delays in placement. In 2006, fewer facilities admitted medically complex patients than admitted rehabilitation patients and, since 2002, these types of admissions have been increasingly concentrated in fewer facilities. This trend reflects distortions in the current payment system and we made recommendations to correct them in our June 2008 report.

Between 2006 and 2007, Medicare costs for freestanding SNFs grew faster than in the period between the two previous years. However, Medicare payments continued to outpace SNF costs, in part because of the increase in the days classified into the highest payment case-mix groups. As a result, the aggregate Medicare margin for freestanding SNFs was 14.5 percent in 2007, making this the seventh consecutive year that the aggregate Medicare margin was above 10 percent. The aggregate margin for 2009 is projected to be 12.6 percent.

Because indicators are generally positive and SNF payments are more than adequate to accommodate anticipated cost growth, the Commission recommends a zero update for 2010. Hand-in-hand with this recommendation about the level of payments, we reiterate recommendations in two of our previous reports that would affect the distribution of payments: to revise the SNF payment system to more accurately reflect providers' costs (June 2008) and to adopt a pay-for-performance program to improve quality (March 2008). The growing concentration of medically complex cases in fewer SNFs, the continued growth and intensity of rehabilitation days, and the wide variation in Medicare margins underscore the inequities and poor incentives of the current prospective payment system (PPS) design. Recommended revisions to the PPS would more accurately reflect providers' costs to treat different types of cases, thereby reducing the incentive to admit certain patients over others and narrowing the Medicare margins across facilities.

Home health services

Indicators of payment adequacy for home health services are positive. Access, volume, and the supply of agencies remained stable or increased, suggesting that Medicare beneficiaries have adequate access to care. Quality continued to improve, and the turmoil in the financial markets does not appear to have significantly impaired access to capital for this industry. Home health agencies continued to be paid significantly more than cost, with margins of 16.6 percent in 2007. The home health industry has maintained average Medicare margins of about 16.5 percent a year since 2002. In part because the product has changed, the average number of visits per episode has dropped 30 percent from 1998 to 2007.

In 2007, volume and average payment per episode continued to rise, with total payments growing 12 percent to \$16 billion. The number of home health users also rose, even as enrollment in Medicare FFS declined. The type of episodes provided continued to shift to higher paying services. At the same time, home health agency costs have remained low. We estimate home health margins to be 12.2 percent for 2009.

Because of the consistently high margins and other positive indicators, the Commission has concluded that home health payments should be significantly reduced in 2010 and 2011 to ensure that Medicare does not continue to overpay home health providers. Therefore, the Commission recommends that the Congress should eliminate the market basket increase for 2010 and advance the planned reductions for coding adjustments from 2011 to 2010, so that payments in 2010 are reduced by 5.5 percent from 2009 levels. Home health payments will be more than adequate in 2009, and efficient providers should be able to absorb increases in the cost of care even at reduced payment levels in 2010.

The Commission also recommends that the Congress should direct the Secretary to rebase rates for home health care services in 2011 to reflect the average cost of providing care. The home health product has changed substantially since the PPS was established, and the current rates are well in excess of the efficient provider's costs. The reduction in 2010 will begin the process of reducing payments to appropriate levels, but current margins suggest that further reductions will be necessary. The recommendation for 2011 will require that the Secretary base the rates for that year on the estimated cost of care for the average home health episode.

However, the Commission is concerned that quality of care be maintained when the rebasing is implemented. Thus, the Commission also recommends that the Congress should direct the Secretary to develop payment measures that protect beneficiary care. Two types of safeguards need to be developed: financial safeguards that can be proposed concurrently with the rebasing recommended for 2011, and quality-of-care safeguards linking payment to avoidance of adverse events that can be implemented as soon as practicable.

Inpatient rehabilitation facility services

Our assessment of payment adequacy for inpatient rehabilitation facilities (IRFs), which provide intensive rehabilitation services in an inpatient setting, reflects recent changes in Medicare policy that significantly affect the volume of IRF services. In 2004, CMS renewed enforcement of the 75 percent rule, which required IRFs to have a certain percentage of admissions with one or more of a specified list of conditions. The compliance threshold was to be phased in from 50 percent to 75 percent over several years. Before the phase-in to 75 percent was complete, the Congress set the compliance threshold permanently at 60 percent from July 2007 going forward, in one of several provisions of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA) related to IRF services. The overall policy goal of the rule is to direct the most clinically appropriate cases to this intensive, costly setting. The renewed implementation of this rule was expected to result in a decline in IRF volume for certain types of cases and an increase in IRF average patient complexity, and hence case mix.

Our indicators of Medicare payment adequacy on net were more positive than negative. From 2004 to 2007, Medicare IRF discharges declined as was expected, but the number of IRF beds did not decline as much—suggesting that capacity remains adequate to meet demand. With the decline in IRF volume, there has been a corresponding increase in the volume of patients in home health and SNFs, suggesting that beneficiaries who would have received care in an IRF are receiving care in other settings. Access to capital has tightened in 2008 due to the economy-wide credit crisis. However, the changes in the credit markets are not related to Medicare payment changes. Measures of quality (functional gain between admission and discharge) continue to show improvement. However, changes over time in the mix of IRF patients make it difficult to draw definitive conclusions about quality trends.

Our projected 2009 aggregate Medicare margin is 4.5 percent, down from 11.7 percent in 2007. The projected decrease in the margin is the result of a MMSEA provision that eliminated the IRF payment update for the second half of 2008 and all of 2009. The margin projection for 2009 does not assume increased cost control efforts by IRFs in response to the MMSEA's elimination of the IRF update or the decline in discharges in recent years. To the extent that IRFs restrain their cost growth in response to these changes, the projected 2009 margin would be higher than we have estimated.

Based on our analysis of payment adequacy, the Commission recommends eliminating the update to payment rates for inpatient rehabilitation services for fiscal year 2010. We will closely monitor indicators within our update framework and will reassess our recommendation for the IRF payment update in the next fiscal year, as we do for all sectors.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with clinically complex problems who need hospital-level care for relatively extended periods (average length of stay for Medicare patients must be greater than 25 days). Medicare is the dominant payer for LTCH services, accounting for about 70 percent of LTCH discharges. This sector has been very dynamic and concerns about rapid growth, geographic concentration, and the appropriateness and necessity of admissions have spurred two actions. First, CMS imposed the 25 percent rule, under which Medicare generally pays less if more than a specified percentage of a hospital-within-hospital's (HWH's) or satellite LTCH's patients is referred from its host hospital. Second, the MMSEA imposed a three-year limited moratorium on new LTCHs and new beds in existing LTCHs.

Our assessment of payment adequacy is informed by these actions. Growth in the number of LTCHs has remained relatively flat between 2005 and 2007 and the number of HWHs has fallen an average of 2 percent per year as the 25 percent rule takes effect. Beneficiaries' use of services suggests that access has not been a problem. We found that LTCH use per FFS beneficiary increased slightly between 2005 and 2007. The evidence on quality is mostly positive. Readmission rates for the top 15 LTCH diagnoses have been stable or declining. Rates of death in the LTCH and death within 30 days of discharge also have been declining for most diagnoses. LTCH patients appear

to have experienced fewer infections due to medical care and fewer cases of postoperative sepsis. However, patients appear to have experienced more decubitus ulcers and more cases of postoperative pulmonary embolisms and deep vein thrombosis.

In the current economy-wide credit crisis, LTCHs' access to capital tells us little about Medicare payment adequacy, and the three-year moratorium on new beds and facilities imposed by the MMSEA will reduce the need for capital in any case.

LTCHs' Medicare margin for 2007 is 4.7 percent and we estimate LTCHs' aggregate Medicare margin will be 0.5 percent in 2009.

On balance, our indicators of payment adequacy are positive and the Commission recommends that the Secretary update payment rates for LTCH services by the market basket index, less the Commission's adjustment of 1.3 percent, designed to provide an incentive to control costs while maintaining quality. Under the current forecast of the rehabilitation, psychiatric, and LTCH market basket, the Commission's recommendation would update the LTCH payment rates by about 1.6 percent in 2010.

The Medicare Advantage program

The MA program provides Medicare beneficiaries with an alternative to the FFS Medicare program. It enables them to choose a private plan to provide their health care. Those private plans can use alternative delivery systems and care management techniques, and—if paid appropriately—they have the incentive to innovate. The Commission supports private plans in the Medicare program but has concerns about the current MA payment system.

In our analyses of data on enrollment, availability, payments, benefits, and quality, presented in Chapter 3, we find:

- About 22 percent of Medicare beneficiaries were enrolled in MA plans in 2008 and all beneficiaries have access to an MA plan in 2009.
- In 2009, payments to MA plans continue to exceed what Medicare would spend for similar beneficiaries in FFS. MA payments per enrollee are projected to be 114 percent of comparable FFS spending for 2009.
- In aggregate, the MA program continues to be more costly than the traditional program. Plan bids for the

traditional Medicare benefit package are 102 percent of FFS in 2009. As an exception, HMOs continue to bid below FFS, bidding 98 percent of FFS.

- Plans provide enhanced benefits to enrollees, but except for HMOs, those benefits are financed entirely by the Medicare program and other beneficiaries, and at a high cost. For example, each dollar's worth of enhanced benefits in private FFS plans costs the Medicare program over three dollars.
- Quality is not uniform among MA plans or plan types. High-quality plans tend to be established HMOs; more recent plans have lower rankings on many measures.

We are concerned that the average MA bid for Medicare Part A and Part B services is above average FFS spending and still increasing. This means that, in aggregate, enhanced benefits are funded by the taxpayers and all beneficiaries (whether they belong to MA plans or not), not by plan cost efficiencies. In addition, a portion of the value of the enhanced benefits funds plan administration and profits, not direct health care services for beneficiaries. Paying a plan more than FFS spending for delivering the same services is not an efficient use of Medicare funds in the absence of evidence that such payments result in better quality compared to FFS.

To be clear, even though we use the FFS Medicare spending level as a measure of parity for the MA program, this should not be taken as a conclusion that the Commission believes that FFS Medicare is an efficient delivery system in most markets. In fact, much of our work is devoted to identifying inefficiencies in FFS Medicare and suggesting improvements in the program.

High MA payments allow plans to be less cost efficient than they would be if they faced the financial pressure of payments closer to Medicare FFS levels. As the Commission has stated in the past, organizations are more likely to be efficient when they face financial pressure. The Medicare program needs to exert consistent financial pressure on the FFS and MA programs, coupled with meaningful quality measurement and pay-for-performance programs, to increase the value it receives for the dollars it spends. The Commission has made recommendations in previous years to further these aims in the MA program, and those recommendations are reiterated in Chapter 3.

A status report on Part D for 2009

Part D uses competing private plans to deliver outpatient prescription drug benefits.

Each year, sponsors submit plan bids for providing Part D benefits. Part D sponsors may change plans' benefit designs, formularies, and cost-sharing requirements. Policymakers need to stay informed about changes to ensure that Part D meets the broader goal of giving beneficiaries access to appropriate drug therapies. Year-to-year changes in bids and enrollee premiums give policymakers information about how well sponsors are managing drug benefit costs for beneficiaries and for taxpayers.

In Chapter 4 we describe Part D enrollment in 2008 and plan offerings for 2009. The chapter also reports on one aspect of Part D intended to promote quality: medication therapy management programs. We find:

- Ninety percent of Medicare beneficiaries received some form of drug coverage in 2008. Fifty-eight percent of all Medicare beneficiaries enrolled in Part D plans; 32 percent had drug coverage at least as generous as Part D through employer-sponsored plans or other sources. Twenty-one percent of Medicare beneficiaries received Part D's extra help with premiums and cost sharing (called the low-income subsidy or LIS). An estimated 6 percent of beneficiaries (about 2.6 million) were eligible for the LIS but were not enrolled.
- In 2009, the number of stand-alone prescription drug plan (PDP) options declined by 7 percent, but beneficiaries can still choose among a median of 49 PDPs. Sponsors are offering 6 percent more Medicare Advantage–Prescription Drug plans (MA–PDs) than in 2008.
- For 2009, Part D premiums are significantly higher than in 2008. If enrollees stayed in the same plan, they saw premiums rise by an average of \$6 (24 percent) above 2008 levels to nearly \$31 per month.
- For 2009, we estimate that more than 80 percent of enrollees are in plans that use one generic tier and separate tiers for preferred and nonpreferred brand-name drugs in their formulary.
- Cost sharing tended to rise among PDPs for 2009. Copays for the median enrollee in a PDP rose to \$7 per 30-day supply of a generic drug, \$38

for a preferred brand-name drug, and \$75 for a nonpreferred brand. MA–PD cost sharing was more likely to remain at 2008 levels, with the exception of increased coinsurance for specialty-tier drugs.

- For 2009, fewer premium-free PDPs will be available to enrollees who receive the LIS: 308 plans qualified, compared with 495 in 2008. CMS estimated that it needed to reassign about 1.6 million LIS enrollees to new plans for individuals to avoid paying some of the premium. Another 0.6 million LIS enrollees previously picked a plan on their own and were responsible for switching themselves into a qualifying plan for 2009 or begin paying part of the premium.

We also explored medication therapy management programs (MTMPs) in Part D. All PDPs and MA–PDs are required to offer MTMPs to enrollees with several chronic conditions who take multiple drugs and are expected to average at least \$4,000 per year in drug costs. CMS does not provide much guidance on designing or implementing these programs.

MTMPs differ in the number and type of chronic conditions and prescriptions a beneficiary must have to be eligible, the kinds of interventions provided to enrollees, and the outcomes sponsors measure. A small percentage of beneficiaries are enrolled in MTMPs, and we do not have sufficient data to determine whether the programs are increasing the quality of pharmaceutical care to them.

More standardized collection and reporting of outcome measures could be used to determine whether programs are meeting their goals of improving the quality of pharmaceutical care, what patient populations benefit from these programs, and what interventions are most successful. CMS has initiated research that has the potential to answer many important questions about Part D medication therapy management. The Commission will closely follow the results, but we are unlikely to know the results from this study for several years.

Public reporting of physicians' financial relationships

Drug and device manufacturers have extensive financial relationships with physicians, academic medical centers, professional organizations, and other health care entities. These financial ties have led to many advances in medical research, technology, and patient care. However, they may also create conflicts between the commercial interests of manufacturers and physicians' obligation to do what is

best for their patients. We examine this issue in Chapter 5. The line between appropriate and inappropriate interactions may not always be clear, but there is no doubt that they should be transparent. Transparency does not imply that all—or even most—of these financial ties undermine physician–patient relationships.

Requiring manufacturers to publicly report their financial relationships with physicians and other health care entities should have several important benefits. It should discourage physicians from accepting gifts or payments that violate professional guidelines. It would also help CMS and other payers determine whether physicians’ practice patterns are influenced by their interactions with industry. Therefore, the Commission recommends that the Congress mandate the reporting of comprehensive information on industry relationships with physicians and other health care entities and that the Secretary post this information on a public, searchable website.

In 2005, pharmaceutical manufacturers provided free samples with a retail value of more than \$18 billion to physicians and other providers. While free samples may benefit the patient, there are concerns they may influence physicians’ prescribing decisions and lead physicians and patients to rely on more expensive drugs when less expensive medications might be equally effective. More information about the distribution of samples would enable researchers to study their impact on prescribing patterns and overall drug costs and could help payers and health plans target their counterdetailing programs. Therefore, the Commission recommends that the Congress require pharmaceutical manufacturers to report information about drug samples and their recipients. The Secretary would make this information available for research and legitimate business purposes through data use agreements.

In addition to financial relationships with drug and device manufacturers, physicians may also have financial ties to health care facilities. There has been rapid growth in physician investment in hospitals and ambulatory surgical centers, for example. Although physician ownership of facilities may improve access and convenience for patients, evidence suggests that physician-owned hospitals are associated with a higher volume of services within a market. The Commission recommends that the Secretary collect information on physician investment in hospitals and other health care providers and make it available in a public database, which would facilitate research on how physician ownership might influence patient referrals, quality of care, volume, and overall spending.

Physicians have a wide variety of financial relationships with hospitals besides investment interests, yet we know very little about the prevalence of these arrangements. If information on these relationships were publicly available, payers and researchers could use it to examine their impact on referral patterns, volume, quality, and cost. Through the Disclosure of Financial Relationships Report, CMS plans to collect detailed data from a sample of hospitals on their ownership, investment, and compensation arrangements with physicians. We recommend that the Secretary use data from this survey to report to the Congress on the prevalence of various arrangements. This report could help guide future decisions on what types of physician–hospital relationships—in addition to ownership—should be publicly reported. The goal of hospital disclosure is to gain a better understanding of how physician–hospital relationships can affect the cost and quality of care.

Reforming Medicare’s hospice benefit

The Medicare hospice benefit was established in 1983 to allow beneficiaries to choose palliative care and other benefits consistent with their personal preferences for end-of-life care as an alternative to conventional medical interventions. The creation of the Medicare hospice benefit was more than just a change to the Medicare benefits package; it was a statement recognizing and respecting social values and patient preferences at the end of life. Since Medicare began covering hospice care, the share of beneficiaries electing hospice has grown as there has been increased recognition that hospice can appropriately care for patients with noncancer diagnoses.

Along with this expansion, hospice stays have grown longer, with especially rapid growth occurring since 2000. Medicare hospice spending also rose rapidly, more than tripling between 2000 and 2007, when it reached \$10 billion. Over this time, the number of Medicare-participating hospices increased by more than 1,000 providers, nearly all of which were for-profit entities. The Commission’s analysis of the hospice benefit in our June 2008 report shows that Medicare’s hospice payment system contains incentives that make very long stays in hospice profitable for the provider, which may have led to inappropriate utilization of the benefit among some hospices. We also find that the benefit lacks adequate administrative and other controls to check the incentives for long stays in hospice and that CMS lacks data vital to the effective management of the benefit.

To address these problems, in Chapter 6 we propose recommendations to reform the payment system, to ensure greater accountability within the hospice benefit, and to improve data collection and accuracy. In making these recommendations, the Commission recognizes the importance of the hospice benefit and its substantial contribution to end-of-life care for beneficiaries. The goal of these recommendations is to strengthen the hospice payment system and not discourage enrollment in hospice, while deterring program abuse. Thus, the Commission's recommendations are intended to encourage hospices to admit patients at a point in their terminal disease that provides the most benefit for the patient. The Commission recommends:

- A conceptual model for a revised hospice payment system under which per diem payments begin at a relatively higher rate, decline as length of stay increases, and provide an additional payment at the end of the episode. This model would better reflect hospices' level of effort in providing care throughout the course of a hospice episode and promote stays of a length consistent with hospice as an end-of-life benefit. Changes would be made in a budget-neutral manner in the first year.
- Greater physician engagement in the process of certifying and recertifying patients' eligibility for the Medicare hospice benefit and more oversight of hospices' compliance with Medicare eligibility criteria. These measures are directed at hospices that tend to enroll very-long-stay patients. This recommendation would help ensure that hospice is used to provide the most appropriate care for eligible patients. In addition, potential conflicts of interest among hospices and other providers caring for hospice patients should be addressed.
- Hospice claims should contain information on the kind and duration of visits provided to a patient to better understand care provided and to differentiate patterns of care among different types of patients and hospices. Hospice cost reports should include additional information on revenues and be subject to additional reviews to ensure they serve as accurate fiscal documents. ■