MARCH 2012

REPORT TO THE CONGRESS

Medicare Payment Policy

MEDPAC Medicare Payment Advisory Commission

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

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

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

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

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601 New Jersey Avenue, NW • Suite 9000 • Washington, DC 20001
(202) 220-3700 • Fax: (202) 220-3759 • www.medpac.gov

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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

March 15, 2012

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. Vice President and Mr. Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2012 *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 13 chapters:

- a chapter that provides a broader context for the report by documenting Medicare and total health care spending;
- a chapter that describes the Commission's analytical framework for assessing payment adequacy;
- nine chapters that describe the Commission's recommendations on rate updates and related issues, such as distribution of payments and increasing efficiency, for the major payment systems used by traditional Medicare;
- a chapter with updated statistics on enrollment, plan offerings, and payments in Medicare Advantage plans; and
- a chapter with updated statistics on enrollment and plan offerings for plans that provide prescription drug coverage and a recommendation to modify copayments for beneficiaries receiving the low-income subsidy to encourage use of generic drugs.

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. I draw your attention to four areas in particular.

First, we provide a series of fee-for-service payment system update recommendations that result in net savings to Medicare while maintaining access and quality.

Second, we make a recommendation to equalize payment rates for evaluation and management office visits provided in hospital outpatient departments (OPDs) and physician offices. In 2011, Medicare paid about 80 percent more for a 15-minute office visit in an OPD than in a freestanding physician office. The Commission maintains that Medicare should seek to pay similar amounts for similar services, taking into account differences

in the definitions of services and differences in patient severity. Setting the payment rate equal to the rate in the more efficient sector would save money for the Medicare program, lower cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid sector.

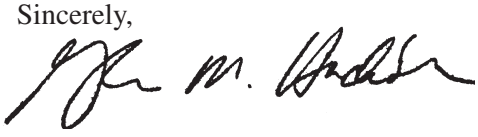
Third, we recommend revising and rebasing the skilled nursing facility (SNF) prospective payment system to more closely match SNFs' costs. Revising the payment system to more accurately pay for nontherapy ancillary services and to base therapy payments on patient characteristics will shift payment from facilities that concentrate on intensive therapy to facilities that treat medically complex patients. Rebasing will reduce Medicare spending and bring Medicare's payments more in line with SNFs' costs. We also recommend reducing payments to SNFs with relatively high rates of rehospitalizations. Avoidable rehospitalizations of SNF patients increase Medicare's spending, expose beneficiaries to additional disruptive care transitions, and can result in hospital-acquired infections or other adverse health consequences.

Fourth, we recommend modifying the Part D low-income subsidy (LIS) copayments to encourage the use of generic drugs when available in selected therapeutic classes. Switching from brand-name drugs to generic drugs can result in significant cost savings. Part D drug plan sponsors have been more successful at encouraging generic substitution among non-LIS enrollees than among LIS enrollees. Plans often use cost-sharing differentials to motivate beneficiaries to use generic drugs. However, since cost sharing for LIS enrollees is set by law rather than by each plan, sponsors have limited ability to manage drug spending for this population. By revising the LIS copayment structure, Medicare may be able to reduce program spending without substantially affecting access to needed medications. The policy would take into account the limited income of this population and retain the existing exceptions and appeals process.

Finally, I draw your attention to Appendix B, which addresses a long-standing problem in Medicare: the sustainable growth rate (SGR) system. In this Appendix, we reproduce the Commission's October 2011 letter to the Congress in which we recommended repealing the SGR (Medicare's method for updating physician fee schedule services) and replacing it with specified updates that would no longer be based on an expenditure-control formula. Under this approach, the resulting Medicare rates would favor primary care, in light of our recent findings on beneficiaries' access to those services. We also recommended that specialists be allowed to mitigate this effect by providing services through an accountable care organization and that the Secretary work to increase the accuracy of the fee schedule, in particular by reducing rates for overpriced services. It is critical for the Congress to act now to resolve the SGR for three reasons. First, the total cost of repealing the SGR grows inexorably with each passing year, as does the cost of temporary fixes. Second, growth in the size of the deficit has increased pressure to fully offset the cost of repealing the SGR. And third, opportunities to offset the costs of the SGR within Medicare are becoming more difficult to identify and are being used for other purposes. The Commission concluded that the risks of retaining the SGR outweigh its benefits. While the SGR may have resulted in lower updates for Medicare's physician payments, it has failed to restrain volume growth. In addition, temporary, stop-gap "fixes" to override the SGR are undermining the credibility of Medicare by engendering uncertainty and frustration among providers, which may be causing anxiety among beneficiaries.

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,



Glenn M. Hackbarth, J.D.

Enclosure

Acknowledgments

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Finally, the Commission wishes to thank Cay Butler and Hannah Fein for their help in editing and producing this report. ■

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Executive summary

Executive summary

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

- consider the context of Medicare program spending in terms of the federal budget and national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2013 for: hospital inpatient, hospital outpatient, physician and other health professional, ambulatory surgical center, outpatient dialysis, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice.
- take the first steps toward paying the same amount for the same service in different sectors by recommending that payment rates for evaluation and management (E&M) office visits be made equal in hospital outpatient departments and physician offices.
- review the status of the MA plans beneficiaries can join in lieu of traditional FFS Medicare.
- review the status of the plans that provide prescription drug coverage and recommend modifying copayments for beneficiaries receiving the low-income subsidy.
- review recent Commission recommendations on repealing the sustainable growth rate system.

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 for the annual rate updates under Medicare's various fee-for-service 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. Second, delivery system reforms, such as medical homes, bundling, and accountable care organizations, need to be tested 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, if unit prices were constrained, that could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

Each chapter presents the payment adequacy information that informs our FFS update recommendations. 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, they do not take into account the complete package of policy recommendations or the interactions among them. All of the recommendations in this report were developed and voted on before the effective date of the sequester provision in the Budget Control Act of 2011. The sequester provision is scheduled to take effect starting February 1, 2013. If a Medicare sequester does occur, it will change the spending implications of the recommendations. In addition, the report was prepared prior to passage of the The Middle Class Tax Relief and Job Creation Act of 2012; the provisions of this act defer the effect of the sustainable growth rate (SGR) system and reduce Medicare bad debt payments in certain other sectors (hospitals, skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals). These small changes are not reflected in this report.

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 SGR system (Medicare's 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 recent findings on beneficiaries' access to those 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 overall health care spending and the realities of the federal budget. Health care accounts for a large and growing share of total economic activity in the United States, nearly doubling as a share of GDP in the past 30 years, from 9.2 percent in 1980 to 17.9 percent in 2010. Although growth in health care spending in 2010 slowed to the second lowest rate since 1960, much of the slowdown was due to the lingering effects of the financial crisis that peaked in 2008. Projections of health care spending through 2020 show it to continue growing as a share of GDP.

Growing health care costs have a significant fiscal impact on federal, state, and local governments, as government payers directly sponsor nearly half of all health care spending. Furthermore, the federal government may be less able to provide financial support to fiscally strapped states as a result of its own long-term deficit picture. While the federal government's short-term fiscal outlook could modestly improve as the economy recovers, the United States faces a long-term deficit that needs to be addressed by cutting spending, by increasing revenue, or by some combination of the two. Growth in health care spending in the Medicare and Medicaid programs contributes materially to that deficit.

Over the next 10 years, the Medicare population is projected to grow by a third, about twice the rate seen in recent years. The average age of the Medicare population will decline slightly as the baby boom generation turns 65. The new beneficiaries may have fewer retirement assets as a result of the economic recession and may be more likely to still be working. New Medicare beneficiaries also may be more receptive to managed care as a result of changes in the health insurance market.

However, even as the number of Medicare beneficiaries grows rapidly, Medicare's spending over the next 10 years is projected to grow at 5.9 percent annually, a much slower rate than the 8.8 percent annual growth in the 10 prior years. This slower expected growth results largely from smaller projected updates in the prices that Medicare pays relative to past updates. The projected updates are smaller because by law they adjust for economy-wide multifactor productivity. Nonetheless, the Medicare program still faces substantial deficits over the long term, the Hospital Insurance trust fund is projected to be exhausted within 15 years, and beneficiaries' cost sharing and premiums are projected to grow faster than Social Security benefits.

There are indications that some share of health care dollars is misspent, which if true potentially opens an avenue for controlling the growth in health care spending. There is significant variation in the use of health care in different regions of the United States and yet the high-use regions are not clearly associated with better outcomes, even after adjusting for health status, calling some of the use into question. In addition, comparisons between the United States and other countries suggest the potential to achieve similar levels of quality with lower spending.

Pressure from growth in health care spending, combined with the rise in the number of beneficiaries and indications that potential savings are possible, makes it incumbent on the Medicare program to spend limited funds wisely by providing incentives for beneficiaries to seek, and providers to deliver, high-value services.

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 (PPS) is changed. In Chapter 2, we describe the general approach we use to determine an update. We first assess the adequacy of Medicare payments for providers in the current year (2012) 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—2013). 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.

These update recommendations can significantly change the revenues providers receive from Medicare and 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 without regard to the quality or value of those additional services. Each year, the

Commission looks at all available indicators of payment adequacy and reevaluates any prior year assumptions using the most recent data available to make sure its 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 services or procedures unusually profitable.

The principle that Medicare should pay the same rate for the same service across sectors is a good guide for the Commission's thinking as it considers changes to Medicare's payment systems. Medicare often pays different amounts for similar services across sectors. Setting the payment rate equal to the rate in the more 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 this principle 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. This year we make a recommendation to equalize payment rates for E&M office visits provided in hospital outpatient departments (OPDs) and physician offices. Our analysis shows that the definition of the service and the characteristics of the patients are sufficiently similar to allow this service to be compared across these two sectors. We are beginning to analyze opportunities for applying this principle to other services and sectors, such as the sectors that provide post-acute care (discussed below and in Chapter 3).

Hospital inpatient and outpatient services

From 2009 to 2010, Medicare payments per FFS beneficiary for inpatient and outpatient services in acute care hospitals grew by over 3 percent. As a result, the 4,800 hospitals paid under the Medicare PPS and critical access payment systems received $153 billion for roughly 10 million Medicare inpatient admissions and 166 million outpatient services.

In Chapter 3, we review our findings on hospital payment adequacy:

- Access measures were positive for the period reviewed. The number of hospitals and the range of services offered continued to grow. Inpatient admissions per FFS beneficiary declined 1 percent per year from 2004 to 2010 while the volume of hospital outpatient services per Medicare FFS beneficiary grew on average by 4 percent per year, reflecting a long-standing shift from inpatient to outpatient care.
- Quality continues to improve on most measures. Hospitals reduced in-hospital and 30-day mortality rates across 5 prevalent clinical conditions. Patient safety indicators have generally improved, but readmission rates have not improved significantly.
- Access to capital has been volatile over recent years because of the economic downturn but appears adequate at this time. As inpatient use and hospital occupancy declined, hospitals slowed the pace of new construction and shifted spending toward outpatient facilities and remodeling existing inpatient facilities.
- Overall aggregate Medicare profit margins improved from –7.1 percent in 2008 to –4.5 percent in 2010 for two reasons: First, hospitals slowed their cost growth in reaction to the economic downturn, and second they made changes in documentation and coding that led to higher hospital payments. Although the average hospital Medicare margin is negative, we find that Medicare payments more than covered the fully allocated costs of the median efficient hospital, which operated with a 4 percent Medicare margin in 2010. We project overall aggregate margins of –7 percent in 2012.

The Commission recommends that the Congress should increase payment rates for the inpatient and outpatient PPSs in 2013 by 1.0 percent. For inpatient services, the Congress should also require the Secretary of Health and Human Services, beginning in 2013, to use the difference between the increase under current law and the Commission's recommended update to gradually recover past overpayments due to documentation and coding changes.

The Commission balanced three factors in reaching its inpatient update recommendation. First, most payment adequacy indicators are positive. Second, hospitals' documentation and coding changes led to overpayments in 2010, 2011, and 2012. Updates must be lowered to recover these overpayments. Third, while relatively efficient hospitals generated positive overall Medicare margins in 2010, most hospitals have negative overall Medicare margins.

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 the outpatient update in current law is too high. On the other hand, overall hospital margins are

negative, suggesting a positive update is appropriate. A 1 percent update would balance these two considerations and also help limit growth in the disparity in payment rates between services provided in outpatient departments and payment rates in other sectors.

Paying the same for the same service in different sectors

The Commission maintains that Medicare should seek to pay similar amounts for similar services, taking into account differences in the definitions of services and patient severity. Under current payment systems this is not always the case. For example, in 2011, Medicare paid 80 percent more for a 15-minute office visit in an OPD than in a freestanding physician office. This payment difference creates a financial incentive for hospitals to purchase freestanding physician offices and convert them to OPDs without changing their location or patient mix. Indeed, E&M clinic visits provided in OPDs increased 6.7 percent in 2010, potentially increasing Medicare program and beneficiary expenditures without any change in patient care. Beneficiary cost sharing is substantially higher when E&M office visits are billed as OPD visits, and beneficiaries' Part B premiums increase as services shift to OPDs due to higher OPD rates.

To begin paying the same rates for the same service across different sectors, the Commission recommends that the Congress direct the Secretary of Health and Human Services to reduce payment rates for E&M office visits provided in OPDs so that the payment rates for these visits are the same whether the service is provided in an OPD or a physician office. These changes should be phased in over three years. During the phase-in, payment reductions to hospitals with a higher than usual share of poor patients (i.e., those with a disproportionate share patient percentage at or above the median) should be limited to 2 percent of their overall Medicare payments. This action would limit the policy's impact on those hospitals. Further, the Secretary should study the policy's impact on low-income patients' access to ambulatory physician and other health professional services.

Equalizing office visit E&M rates in OPDs and physician offices will reduce beneficiary cost sharing and eliminate one incentive to convert physician offices to OPDs. In the future, we plan to examine payment differentials between OPDs and physician offices for other services and among the sectors providing post-acute care services.

Physician and other health professional services

Physicians and other health professionals perform a broad range of services, including office visits, surgical procedures, and a variety of diagnostic and therapeutic services furnished in all health care settings. In 2010, FFS Medicare spent about $62 billion under the physician fee schedule for physician and other health professional services. Approximately 900,000 health professionals billed Medicare for fee schedule services in 2010. Almost all FFS Medicare beneficiaries (97 percent) received at least one fee schedule service in 2010.

In Chapter 4 we find that most indicators of payment adequacy for Medicare fee schedule services are positive, suggesting that most beneficiaries can obtain care from physicians and other health professionals when needed.

- We found in our survey in the fall of 2011 that beneficiary access to fee schedule services is good and generally similar to access reported by privately insured patients age 50 to 64. Among the small share of beneficiaries looking for a new physician, most could find one without major problems; however, finding a new primary care physician was more difficult in 2011 than it was in 2010 and continues to be more difficult than finding a new specialist.
- The number of physicians and other health professionals billing Medicare grew almost 4 percent in 2010. In addition, the 2009 National Ambulatory Medical Care Survey found that among physicians with at least 10 percent of their practice revenue coming from Medicare, 90 percent accepted new Medicare patients.
- The number of services per FFS beneficiary decreased by 0.2 percent in 2010, consistent with recent trends among the privately insured.
- Most claims-based indicators for ambulatory care quality that we examined for the elderly improved slightly or did not change significantly from 2008 to 2010.
- Medicare's payment for physician fee schedule services in 2010 averaged 81 percent of private insurer preferred provider organization (PPO) payments. This rate is very similar to the rate calculated for the previous year—80 percent.

Although payments may be adequate at the moment, the major issue concerning payment for physicians and other health professionals is the SGR system and the consequent urgent need to move beyond it.

Moving forward from the sustainable growth rate system

Medicare faces increased urgency to resolve the growing problems created by the SGR system—Medicare's formulaic method for updating fee schedule services—and its destabilizing short-term "fixes." In an October 2011 letter to the Congress (Appendix B), the Commission recommended repealing the SGR and replacing it with specified updates that would no longer be based on an expenditure-control formula. Specifically, these updates would include a freeze in current payment levels for primary care where potential access problems are most readily apparent, and for all other services annual payment reductions of 5.9 percent for three years, followed by a freeze.

It is critical for the Congress to act now to resolve the SGR for three reasons. First, the total cost of repealing the SGR grows inexorably with each passing year, as does the cost of temporary "fixes." Second, growth in the size of the deficit has increased pressure to fully offset the cost of repealing the SGR. And third, opportunities to offset the costs of the SGR within Medicare are becoming more difficult to identify and are being used for other purposes.

In considering its recommendation, the Commission concluded that the risks of retaining the SGR outweigh the benefits. While the SGR may have resulted in lower updates, it has failed to restrain volume growth and, in fact, in some specialties may have exacerbated it. In addition, temporary, stop-gap "fixes" to override the SGR are undermining the credibility of Medicare by engendering uncertainty and frustration among providers, which may be causing anxiety among beneficiaries.

The Commission's recommendation carries a high budgetary score—roughly $200 billion over 10 years. Understanding the need for fiscal responsibility, the Commission offered the Congress a list of potential offsets within the Medicare program including some that in other contexts we might not consider. However, the Congress is not limited by our charter and can choose offsets outside Medicare; it may also determine, as evidence on access develops, that a different schedule of updates is appropriate in future years.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) furnish outpatient surgical services to patients not requiring hospitalization and for whom an overnight stay is not expected after surgery. In 2010, just over 5,300 Medicare-certified ASCs served 3.3 million FFS Medicare beneficiaries. Medicare program spending on ASC services was about $2.7 billion.

Our results in Chapter 5 indicate that most of the available indicators of payment adequacy for ASC services are positive. However, our results also indicate slower growth in the number of ASCs and volume of services in 2010 than in previous years.

- Beneficiaries' access to ASC care is adequate. From 2005 through 2009, the number of Medicare-certified ASCs grew by an average annual rate of 4.6 percent and the volume of services per FFS beneficiary grew by an average annual rate of 7.6 percent. However, facility growth slowed to 1.9 percent in 2010 and volume growth slowed to 1.6 percent. The relatively slow growth in 2010 may reflect the sluggish recovery from the financial crisis that peaked in 2008 and the substantial revisions to the ASC payment system that same year. In addition, Medicare payment rates in 2012 are 74 percent higher in OPDs than in ASCs. This payment gap may have influenced some ASC owners to sell their facilities to hospitals.
- Although CMS has established a program for ASCs to submit data on quality of care, ASCs will not begin submitting these data until October 2012. Consequently, we do not have data to assess ASCs' quality of care.
- ASCs' access to capital appears to be adequate, as the number of ASCs has continued to increase.
- 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 in other sectors to help assess payment adequacy. From 2005 through 2009, Medicare payments per FFS beneficiary increased at an average annual rate of 6.8 percent and in 2010, by 2.6 percent.

The Commission recommends that the Congress should update payment rates for ASCs by 0.5 percent for calendar year 2013. The Congress should also require ASCs to submit cost data.

The indicators we have suggest that payments have been at least adequate. However, it is vital that CMS begin collecting cost data from ASCs without further delay. The lack of such data for ASCs is a major reason why our recommended update for ASCs is lower than that for OPDs (1 percent). Cost data from ASCs would help determine the costs of an efficient provider and inform decisions about the ASC update. Such data are also needed to examine whether an ASC-specific market basket should be developed or if an existing input price index is an adequate proxy for ASC costs.

The Commission also recommends that the Congress should direct the Secretary to implement a value-based purchasing program for ASC services no later than 2016.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2010, more than 355,000 ESRD beneficiaries on dialysis were covered under FFS Medicare and received dialysis from about 5,500 facilities. Medicare expenditures in 2010 for outpatient dialysis services were $9.5 billion. For most facilities, 2010 was the last year that Medicare paid a prospective payment for each dialysis treatment and separate payments for certain drugs during dialysis. The modernized PPS began in 2011 and now includes dialysis drugs in the payment bundle.

As we discuss in Chapter 6, our payment adequacy indicators for outpatient dialysis services are generally positive:

- Dialysis facilities appear to have the capacity to meet demand. Growth in the number of dialysis treatment stations has generally kept pace with growth in the number of dialysis patients.
- Between 2009 and 2010, the number of FFS dialysis patients and dialysis treatments grew at similar rates (4 percent and 5 percent, respectively).
- In 2010, per capita use of erythropoiesis-stimulating agents, the drug class accounting for three-quarters of dialysis drug spending, declined. This decline is linked to clinical evidence showing that higher use of these drugs is associated with increased risk of cardiovascular events. It also may be linked to facilities' and physicians' modifying their prescribing patterns in anticipation of the new payment method that began in 2011 that no longer pays separately for these drugs.
- 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 hemodialysis. Other measures, such as rates of rehospitalization within 30 days, suggest that improvements in quality are still needed.
- Access to capital for dialysis providers continues to be adequate, and the number of facilities, particularly for-profit facilities, continues to increase.
- In 2010, the Medicare margin for dialysis services and drugs was 2.3 percent for freestanding dialysis facilities. We project the Medicare margin for outpatient dialysis services will be 2.7 percent in 2012.

The Commission recommends that the Congress update the outpatient dialysis payment rate by 1 percent for calendar year 2013. The evidence on payment adequacy suggests that a moderate update of the outpatient dialysis payment rate is in order to ensure continued beneficiary access to outpatient dialysis services.

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 2010, more than 15,000 SNFs furnished covered care to almost 1.7 million FFS beneficiaries. In 2011, Medicare spent almost $32 billion on SNF care.

We find in Chapter 7 that most indicators of payment adequacy for SNFs are positive:

- Access to SNF services remains stable for most beneficiaries. The number of SNFs participating in the Medicare program decreased less than 1 percent between 2010 and 2011. Available SNF bed days in freestanding facilities remained unchanged between 2009 and 2010 and days and admissions per FFS beneficiary decreased slightly, reflecting fewer hospital admissions (a prerequisite for Medicare coverage of a SNF stay).
- SNF quality of care in 2009 was basically unchanged from the prior year and has improved only slightly since 2000. Two indicators of quality in SNFs are the rates at which patients are discharged to the community within 100 days of admission and the rates of rehospitalization of patients with any of five potentially avoidable conditions.

- Because most SNFs are parts of larger nursing homes, we examine nursing homes' access to capital. Lending is expected to be slow in 2012. Uncertainties surrounding federal and state budgets and possible rate freezes or reductions have made borrowers and lenders wary. This lending environment reflects the economy in general, not the adequacy of Medicare payments. Medicare remains a preferred payer.
- Increases in payments between 2009 and 2010 outpaced increases in providers' costs, reflecting the continued concentration of days in the highest payment case-mix groups. In 2010, the aggregate Medicare margin for freestanding SNFs was 18.5 percent.
- We project the Medicare margin to be 14.6 percent in fiscal year 2012 continuing a pattern of high and sustained Medicare margins.

We conclude that Medicare should revise and rebase the SNF PPS to more closely match provider costs. In 2008, the Commission recommended revising the PPS to more accurately pay for nontherapy ancillary services and to base therapy payments on patient characteristics, not service provision. Such a revised design would shift payment from facilities that concentrate on intensive therapy to facilities that treat medically complex patients. The recommended changes should improve access to services for beneficiaries who are disadvantaged by the current design of the payment system. Rebasing is indicated because we find:

- cost growth well above the market basket that reflects little fiscal pressure from the Medicare program.
- relatively efficient SNFs that have below-average costs, above-average quality, and more than adequate Medicare margins.
- the continued ability of the industry to maintain high margins despite changing policies.
- MA payments to SNFs that, in some cases, are considerably lower than the program's FFS payments.

Therefore, the Commission recommends that the Congress should eliminate the market basket update and direct the Secretary to revise the SNF PPS 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.

Avoidable rehospitalizations of SNF patients increase Medicare's spending, expose beneficiaries to additional disruptive care transitions, and can result in hospital-acquired infections or other adverse health consequences. The Commission recommends that the Congress should direct the Secretary to reduce payments to SNFs with relatively high rates of rehospitalization. Initially, the time period for the rate calculation should be the Medicare-covered stay; as measures are developed, the time period should be expanded to include the stay plus some period of time (e.g., 30 days after discharge from the facility).

Our recommendation would help counter the financial incentive SNFs have to rehospitalize beneficiaries. Because a readmission policy will penalize hospitals with high readmission rates beginning in October 2012, a SNF rehospitalization policy would better align hospitals' and SNFs' incentives to reduce avoidable rehospitalizations, encourage providers in both sectors to work together to better manage transitions between them, and represent a step toward payments for larger bundles of services.

As required by the Patient Protection and Affordable Care Act of 2010 (PPACA), we also report SNF 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 dual-eligible beneficiaries who stay 21 or more days in a SNF. The number of Medicaid-certified facilities decreased slightly between 2010 and 2011. Between 2009 and 2010, Medicaid-covered days increased slightly, while spending decreased slightly. Non-Medicare margins improved between 2008 and 2010, although they were still negative (–1.2 percent), while total margins (for all payers and all lines of business) improved to 3.6 percent in 2010.

Home health care services

Home health agencies provide services to beneficiaries who are homebound and need skilled care (nursing or therapy). In 2011, about 3.4 million Medicare beneficiaries received home health services from almost 11,900 home health agencies. Medicare spent about $19.4 billion on home health services in 2010.

The indicators of payment adequacy for home health care are generally positive, as we discuss in Chapter 8.

- Access to home health care is generally adequate: 99 percent of beneficiaries live in a ZIP code where a Medicare home health agency operates and 98 percent

live in an area with two or more agencies. The number of agencies continues to increase, with more than 420 new agencies in 2011. Most new agencies are for profit and concentrated in a few states. The volume of services continues to rise and a larger share of beneficiaries are receiving home health care.

- In 2011, most beneficiaries who were not hospitalized at the end of their home health stay showed some improvement in function. The risk-adjusted rate of hospitalization from home health agencies declined slightly between 2006 and 2008.
- The major publicly traded for-profit home health companies have sufficient access to capital markets for their credit needs, although not as favorable as prior years. For smaller agencies, the significant number of new agencies in 2011 suggests that they have access to capital necessary for start-up.
- Payments have consistently and substantially exceeded costs in the home health PPS. For 2010, costs declined slightly while payments increased. Medicare margins for freestanding providers in 2010 were 19.4 percent.

Because these indicators are similar to last year, the Commission is repeating our recommendations from our March 2011 report to the Congress that the home health payment system be rebased commencing in 2013. This policy would lower payments beginning in 2013. We also recommended: changes to the home health case-mix system that would base payments for therapy services on patient characteristics and reduce incentives for selection of certain types of patients, that the Congress implement a copay for certain home health episodes to address the volume-rewarding aspects of the PPS, and that the Secretary use her authority to investigate and stop fraud and abuse in areas with aberrant patterns of utilization.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after an injury, illness, or surgery. These services include physical and occupational therapy, rehabilitation nursing, prosthetic and orthotic services, and speech–language pathology. In 2010, almost 360,000 Medicare FFS beneficiaries received care in IRFs and Medicare spent over $6.3 billion for IRF services.

Our indicators of Medicare payment adequacy for IRFs are generally positive, as discussed in Chapter 9:

- Beneficiaries have maintained access to IRF services. The aggregate supply of IRFs remained relatively stable in 2010 as did the volume of Medicare FFS beneficiaries treated in IRFs.
- Preliminary quality measures from 2004 through 2009 indicate that there was some improvement in IRF patients' quality of care as measured by functional improvement between admission and discharge, rates of discharge to community, rates of discharge from an IRF directly to an acute care hospital, admission to an acute care hospital within 30 days of discharge to the community, and admission to a SNF within 30 days of discharge to the community. Ongoing refinements to risk adjustment for these measures may produce different results.
- Hospital-based units, through their parent institutions, have adequate access to capital. One major freestanding IRF chain that accounts for about 50 percent of freestanding IRF revenues also appears to have adequate access to capital. We are not able to determine the ability of independent freestanding facilities to raise capital.
- Total Medicare payments to IRFs grew slightly faster than aggregate costs in 2010. The IRF aggregate Medicare margin for 2010 was 8.8 percent. We project that the 2012 Medicare IRF margin will be 8.0 percent.

The Commission recommends that the Congress eliminate the update to the Medicare payment rates for IRFs in fiscal year 2013. Our analyses show that IRFs should be able to absorb cost increases and continue to provide care to clinically appropriate Medicare cases with no update to payments in 2013.

Long-term care hospital services

Long-term care hospitals (LTCHs) furnish care to patients with medically complex problems 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 of greater than 25 days for its Medicare patients. Medicare is the predominant payer for most LTCHs, accounting for about two-thirds of LTCH discharges. In 2010, Medicare spent $5.2 billion on care furnished in roughly 412 LTCHs nationwide. About 118,300 beneficiaries had almost 134,700 LTCH stays.

In Chapter 10, we review Medicare payment adequacy for LTCHs:

- In spite of the moratorium imposed by law, the number of LTCHs increased 6.1 percent between 2008 and 2010. Almost all of this growth took place in 2009. As expected, the entry of new LTCHs into the market slowed significantly during the later years of the moratorium. Only one new LTCH entered in 2010. Controlling for the number of FFS beneficiaries, we found that the number of LTCH stays rose 3.5 percent between 2009 and 2010, suggesting that access to care is not a problem.
- LTCHs do not submit quality data to CMS. Using claims data, we found stable or declining rates of readmission, death in the LTCH, and death within 30 days of discharge for most of the top 25 diagnoses in 2010.
- The moratorium on new beds and facilities reduces the need for capital in the industry by eliminating opportunities for LTCH expansion. However, in 2011 the two major LTCH chains, which together own slightly more than half of all LTCHs, acquired the capital needed to purchase other LTCHs as well as other post-acute care providers. Smaller LTCH chains and nonchain LTCHs likely do not have the same access to capital.
- Between 2009 and 2010, cost growth was under 1 percent. The 2010 Medicare margin for LTCHs was 6.4 percent. We expect growth in costs to be modest, albeit somewhat greater than the current pace. As a result, we estimate LTCHs' aggregate Medicare margin will be 4.8 percent in 2012.

Our analyses suggest that LTCHs are able to operate within current payment rates. The Commission recommends that the Secretary should eliminate the update to the payment rate for LTCHs for fiscal year 2013.

Research by the Commission and others has been unable to clearly distinguish LTCH patients from the medically complex patients receiving care in acute care hospitals and some SNFs. If medically complex cases in LTCHs are, in essence, indistinguishable from medically complex cases in acute care hospitals or SNFs, then Medicare must ensure that its payments for the same set of services are equitable, regardless of where the services are provided. In addition, policymakers must consider whether certain models of care will best serve the needs of medically complex patients. These steps will help ensure that Medicare beneficiaries receive appropriate, high-quality care in the least costly setting consistent with their clinical conditions.

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 2010, more than 1.1 million Medicare beneficiaries received hospice services from more than 3,500 providers, and Medicare expenditures totaled about $13 billion.

The indicators of payment adequacy for hospices, discussed in Chapter 11, are generally positive.

- Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. The supply of hospices increased 53 percent between 2000 and 2010, with an increase of almost 3 percent in 2010. For-profit providers accounted for almost the entire increase in the number of hospices, both over the past decade and in the past year. Use of Medicare hospice services continues to increase, with growth in both the number of hospice users and the average length of stay. In 2010, 44 percent of Medicare beneficiaries who died that year used hospice, up from 23 percent in 2000. Average length of stay among decedents grew from 54 days in 2000 to 86 days in 2010 while the median length of stay remained stable at about 17 days. The increase in average length of stay over the last decade mostly reflects longer stays among patients with the longest stays.
- We do not have sufficient data to assess the quality of hospice care provided to Medicare beneficiaries. PPACA mandates that CMS publish hospice 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.
- Hospices are less capital intensive than some other provider types because they generally do not require extensive physical infrastructure. Continued entry of new for-profit freestanding providers (a 5 percent increase in 2010), and modest (1 percent) growth in the number of nonprofit freestanding providers,

suggests that access to capital is adequate. Hospital-based and home-health-based hospices have access to capital through their parent providers.

- The aggregate Medicare margin was 7.1 percent in 2009, up from 5.1 percent in 2008. The projected 2012 margin is 5.1 percent.

The Commission recommends that the Congress update the payment rates for hospice for fiscal year 2013 by 0.5 percent. Our indicators of payment adequacy in 2012 are generally positive. The Commission maintains hospices can operate within the Medicare payment system with a modest update in fiscal year 2013.

The Medicare Advantage program: Status report

In Chapter 12, we provide a status report on the MA program. 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 to use care management techniques. However, to encourage efficiency and innovation, Medicare should place some degree of financial pressure on MA plans, just as the Commission has recommended for providers in the traditional FFS program.

In 2011, MA enrollment increased to 12.1 million beneficiaries (25 percent of all Medicare beneficiaries) and MA program payments were about $124 billion. Enrollment in HMO plans—the largest plan type—increased 6 percent. Enrollment in private FFS (PFFS) plans declined from about 1.7 million to about 0.6 million enrollees, continuing the expected decline resulting from the new network requirements for PFFS plans required by law that began in 2011. Beginning in 2010, many plan sponsors reduced PFFS offerings and transitioned their enrollment to network-based PPO plans; others changed their PFFS offerings to network plans. As a result, PPOs exhibited rapid growth in enrollment between 2010 and 2011, with local PPO enrollment growing about 65 percent and enrollment in regional PPOs growing about 34 percent. The MA plan bids submitted to CMS project an increase in overall enrollment for 2012, primarily in HMOs.

In 2012, virtually all Medicare beneficiaries have access to an MA plan, and 99 percent have access to a network-based coordinated care plan (CCP). Eighty-eight 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 choose from an average of 12 MA plan options, including 8 CCPs in 2012.

For 2012, the base county benchmarks used to set plans' payment rates average approximately 3 percent less than the benchmarks for 2011. However, 93 percent of 2012 plan enrollment is projected to be in plans that will receive add-ons to their benchmarks through a CMS MA quality bonus demonstration program (the statutory provisions would have given bonuses only to plans with about 25 percent of the projected MA enrollment). These add-ons will range from 3 percent to 10 percent in 2012, substantially offsetting the statutory PPACA benchmark reductions and resulting in additional program costs of $2.8 billion.

We estimate that Medicare will pay MA plans 7 percent more for their enrollees than the program would have paid had those beneficiaries remained in FFS in 2012. MA benchmarks (including the quality bonuses), bids, and payments in 2012 will average 112 percent, 98 percent, and 107 percent of FFS spending, respectively (assuming no SGR reduction in Medicare physician payment rates during 2012). Last year, we estimated that, for 2011, these figures would be 113 percent, 100 percent, and 110 percent, respectively. There is considerable variation over geography and plan type for each of these parameters. For example, the average bid for HMOs in 2012 was 95 percent of FFS, well below that for other plan types.

Overall, some improvement occurred in the quality indicators for MA plans in 2011. A larger number of process measures and outcome measures showed improvement compared with past years. The health outcomes survey of MA enrollees showed some improvement in outcomes, accompanied by a small number of plans showing worse-than-expected outcomes. Because quality indicators are now the basis of bonus payments, we expect to see continued improvement in measures, as plans pay closer attention to quality initiatives and seek to improve their documentation and record keeping.

The continued increase in MA enrollment, wide access to plans, movement of benchmarks and payments toward

FFS levels, bids below FFS in many areas, and improving quality are all promising trends for the MA program. Those trends should be continued by encouraging efficiency and innovation in MA plans through financial pressure and ensuring that Medicare spending is controlled, beneficiary choice is preserved, and quality of care is high.

Status report on Part D, with focus on beneficiaries with high drug spending

In Chapter 13, we provide a status report on Part D including enrollment, plan bids and availability, premiums, benefit designs, formularies, quality, and program costs. This year, we focus on program attributes for beneficiaries who receive the low-income subsidy (LIS) and also report on beneficiaries with high drug spending and the relationship between the high use of drugs and quality of care in Part D.

In 2011, more than 70 percent of Medicare beneficiaries (about 35 million) were enrolled in Part D plans or in employer plans that receive Medicare's retiree drug subsidy. Other beneficiaries receive their drug coverage through other sources of creditable coverage. In 2010, about 10 percent of beneficiaries had no drug coverage or coverage less generous than Part D. Roughly two-thirds of Part D enrollees are in stand-alone prescription drug plans (PDPs); the rest are in Medicare Advantage–Prescription Drug plans, or MA–PDs. MA–PD enrollees are much more likely than those in PDPs to receive basic and supplemental benefits combined in their drug plan that often include some coverage in the gap. Most enrollees report high satisfaction with the Part D program and with their plans. Among those in Part D plans, 10.6 million low-income individuals (about 36 percent of Part D enrollees) received the LIS.

The number of plan offerings remained relatively stable from 2011 to 2012. Sponsors are offering about 6 percent fewer stand-alone PDPs and about 2 percent more MA–PDs than in 2011. Beneficiaries will continue to have between 25 and 36 different PDP options to choose from, along with many MA–PDs. For 2012, most LIS enrollees will continue to have many premium-free plans available. However, in two regions, Florida and Nevada, only a handful of plans qualified despite changes made in PPACA to increase the number of qualifying plans.

In 2012, the base beneficiary premium will be $31.08, which is a slight decrease from $32.34 in 2011. The base beneficiary premium reflects the basic portion of the benefit (that which does not include premiums for enhanced, or supplemental, benefits). The actual monthly premium paid depends on which plan a beneficiary chooses.

Between 2006 and 2010, Part D spending increased from $42.5 billion to $56 billion, and CMS expects it will have reached $59 billion in 2011. 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 retirees who are Medicare beneficiaries. In 2010, LIS payments continued to be the largest component of Part D spending. Medicare's reinsurance payments were the fastest growing component of Part D spending, driven primarily by LIS enrollees, who tend to use more medications than non-LIS enrollees. Between 2007 and 2009, average annual per capita gross spending for Part D–covered drugs grew by 3.6 percent. Growth in per capita spending was much greater for LIS enrollees (6.1 percent per year) than for other enrollees (2.2 percent per year).

Switching from brand-name drugs to generic drugs can result in significant cost savings. Plan sponsors have been more successful at encouraging generic substitution among non-LIS enrollees than among LIS enrollees, who have little incentive to switch because their cost-sharing is minimal. For example, in 2009 among prescriptions filled for diabetic therapies, the generic dispensing rate was 67 percent for non-LIS enrollees and 53 percent for LIS enrollees. Multiple factors contribute to the difference in generic use rate across populations, including financial incentives. Plans often use cost-sharing differentials to motivate beneficiaries to use generic drugs. However, since cost sharing for LIS enrollees is set by law rather than by each plan, sponsors have limited ability to manage drug spending for this population. Although copays for LIS enrollees are structured to encourage the use of lower cost generics when they are available, the financial incentives are much weaker than those typically faced by non-LIS enrollees. By revising the LIS copayment structure, Medicare may be able to reduce program spending without substantially affecting access to needed medications. The policy would retain the existing exceptions and appeals process allowing beneficiaries to appeal the coverage and/or cost-sharing amounts.

Therefore, the Commission recommends that the Congress should modify the Part D LIS copayments for Medicare beneficiaries with incomes at or below 135 percent of

poverty to encourage the use of generic drugs when available in selected therapeutic classes. The Congress should direct the Secretary to develop a copay structure, giving special consideration to eliminating the cost sharing for generic drugs. The Congress should also direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years. The policy would give the Secretary the authority to provide stronger financial incentives to use lower cost generics when they are available, while taking into account the limited income of this population.

Part D plans are required to implement medication therapy management programs (MTMPs) to improve the quality of the pharmaceutical care that high-risk beneficiaries receive. Patients with high use of medications may have medical problems caused or exacerbated by their heavy use of medications (polypharmacy). In addition, research shows that high use of medication is associated with lower adherence to medication therapies. Our earlier review of MTMPs revealed wide variations in eligibility criteria, the kinds of interventions provided to enrollees, and the outcomes sponsors measured. Since 2010, CMS has tightened criteria for MTMPs. The agency has begun an evaluation of the impact of MTMPs on high-risk, chronically ill beneficiaries. We currently do not have sufficient data to determine whether the programs increase the quality of pharmaceutical care to participants but will continue to monitor this program. ■