

Report to the Congress: Medicare Payment Policy

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Statement of
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Chairman Tiberi, Ranking Member Levin, distinguished Committee Members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to discuss the Commission's March Report to the Congress on Medicare Payment Policy.

The Medicare Payment Advisory Commission is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

Introduction

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

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2018 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- consider post-acute care (PAC) as a whole and note that payment levels in several of the payment systems are too high and the payment systems themselves need to be revised.
- review the status of the MA plans (Medicare Part C) that beneficiaries can join in lieu of traditional FFS Medicare and recommend a change to the calculation of MA benchmarks.

- review the status of the plans that provide prescription drug coverage (Medicare Part D).

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums. Our March 2017 report to the Congress includes a recommendation on MA and provides information on Part D, but most of its content focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and aligning relative payment rates across those systems so that patients receive efficiently delivered, high-quality care. This testimony will also report some related recommendations from previous Commission reports including those on PAC, MA, and Part D from our March and June 2016 reports to the Congress.

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

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

Context for Medicare payment policy

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and view Medicare in the context of the broader health care system. In 2015, total national health care spending was \$3.2 trillion, or 17.8 percent of GDP. Private health insurance spending was \$1.1 trillion, or 5.9 percent of GDP. Medicare spending was \$646.2 billion, or 3.6 percent of GDP.

Health care spending growth shows signs of acceleration after several years of historic lows. From 1975 to 2009, total health care spending and Medicare spending grew, at average annual rates of 9.0 percent and 10.6 percent, respectively. Then from 2009 to 2013, those rates fell to 3.6 percent and 4.1 percent. From 2013 to 2015, Medicare actuaries estimate that spending grew faster: National health care spending grew at an average annual rate of 5.6 percent, and Medicare spending grew at an average annual rate of 4.6 percent.

The aging of the baby-boom generation will have a profound impact on both the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary will decline. By 2030 (the year all boomers will have aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception and from 3.3 in 2012. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2040, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt will exceed total projected federal revenues and will thus either increase federal deficits and debt or crowd out spending on all other national priorities. Projected Medicare spending has the potential to increase the national debt—which was 74 percent of the GDP in 2015—to even higher levels. The Medicare trustees project that nominal Medicare spending will grow at a rate of 7 percent per year, outpacing nominal GDP growth of 5 percent per year.

Some health care spending is inefficient. For Medicare, eliminating such spending would result in improved beneficiary health, greater fiscal sustainability for the program, and reduced federal budget pressures. Certain structural features of the Medicare program pose

challenges for targeting inefficient spending, but the Commission has a framework to address those challenges that focuses on payment accuracy and efficiency, care coordination and quality, information for patients and providers, engaged beneficiaries, and an aligned health care workforce.

Update recommendations

As required by law, the Commission annually makes payment update recommendations for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2017) 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 (policy year 2018). As part of the process, we examine payments to support the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professionals, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years using the most recent data available to make sure our recommendations accurately reflect current conditions. We may also consider recommending changes that redistribute payments among providers within a payment system to correct biases that may make patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we may also make recommendations to improve program integrity.

In light of our payment adequacy analyses, we recommend no payment update in 2018 for four FFS payment systems (long-term care hospital, hospice, ambulatory surgical center, and skilled nursing facility) and reductions of 5 percent of the base payment for the home health and inpatient rehabilitation facility payment systems. We have determined that the resulting

payments will be adequate and will not undermine beneficiaries' access to services in these sectors. For four of these sectors, we include additional elements beyond the payment update to improve payment accuracy:

- requiring ambulatory surgical centers to submit cost data;
- freezing skilled nursing facility payment rates for two years while the payment system is revised, to better tie payments to patient characteristics;
- reducing the home health base payment and revising the payment system to better tie payments to patient characteristics; and
- reducing the inpatient rehabilitation facility base payment and expanding the inpatient rehabilitation facility outlier pool to more equitably cover the cost of expensive patients.

More broadly, changes need to be made in the post-acute care payment systems (i.e., the skilled nursing facility, home health agency, inpatient rehabilitation facility, and long-term care hospital payment systems), and the cost of inaction is mounting. Ideally, the post-acute care sectors would be brought together under a unified payment system that would base payments on patient characteristics. Such a system could both lower costs and ensure access for patients who may be financially less desirable under current payment systems.

In the other sectors (acute care hospital, physician and other health professionals, and outpatient dialysis), we recommend the updates in current law. For the hospital sector, we also recommend tracking claims at off-campus stand-alone emergency department facilities to allow CMS to monitor this growing class of providers.

Hospital inpatient and outpatient services

In 2015, the Medicare FFS program paid 4,700 hospitals \$178 billion for about 10 million Medicare inpatient admissions, 200 million outpatient services, and \$8 billion of non-Medicare uncompensated care costs. This sum represents a 3 percent increase in hospital spending from 2014 to 2015. On net, inpatient payments increased by \$2 billion and outpatient payments increased by almost \$4 billion. Inpatient payments increased because of

slight increases in prices, patient severity, and inpatient volume. Outpatient payments rose because of volume increases, price increases, and the continued shift of services from lower cost physician offices to higher cost hospital outpatient settings.

Most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. However, in 2015, hospitals' aggregate Medicare margin was -7.1 percent. While average Medicare payments were lower than average costs, Medicare payments were higher than the variable costs of treating Medicare patients in 2015—resulting in a marginal profit of about 9 percent. Therefore, hospitals with excess capacity still have a financial incentive to serve more Medicare patients. Thus, the Commission recommends that the Congress update the inpatient and outpatient payment rates by the amounts specified in current law (approximately 1.85 percent) for 2018.

It is imperative that Medicare continue to restrain payment rates for hospitals. Although hospital margins on Medicare are negative, hospital all-payer margins reached a 30-year high in 2014, averaging 7.3 percent nationwide. This is possible because commercial rates on average are 50 percent higher than hospital costs and Medicare rates, in part because of hospitals' increasing market power resulting from continued hospital consolidation.

Furthermore, high commercial rates are linked to high costs. When a hospital receives higher payments from commercial payers, the financial pressure on the hospital is lower. It therefore has less incentive to keep its costs low. For example, we found that hospitals with high private-payer profits from 2009 to 2013 had higher standardized Medicare costs per case in 2014—2 percent above the national median—and lower Medicare margins (-8 percent). In contrast, hospitals with low private-payer profits over the same period had much lower costs per case (9 percent less than the national median). What is more, they were far more likely to have positive Medicare profit margins, posting a median Medicare margin of 6 percent.

A recent phenomenon is the growth in stand-alone emergency departments (EDs). In 2016 there were over 500 stand-alone EDs, almost all in metropolitan areas with existing ED capacity. Moreover, they tend to be located in ZIP codes with higher household incomes and higher shares of privately-insured patients. Some are independent facilities, while others are off-campus EDs associated with a hospital that bills Medicare. Available data suggest that

the mix of patients served by stand-alone EDs more closely resembles the mix of patients treated at urgent care centers than the mix of patients treated in on-campus hospital EDs. However, Medicare pays stand-alone EDs at the same rates as on-campus hospital EDs. An issue to investigate is whether Medicare may be paying too much for these services. (This also can be an issue for privately-insured patients, who may receive a “surprise” bill for services that they thought would be covered at an in-network urgent care rate and instead were billed at an out-of-network ED rate.) Problematically, CMS is currently unable to track growth in off-campus ED claims because the claims are not distinguished from hospitals’ on-campus ED claims. Therefore, the Commission recommends that the Secretary require hospitals to add a modifier on claims for all services provided at off-campus stand-alone EDs to allow CMS to track payments to this growing category of providers.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. In 2015, Medicare paid \$70.3 billion for physician and other health professional services, accounting for 15 percent of FFS Medicare benefit spending. About 919,000 clinicians billed Medicare—over 581,000 physicians and nearly 338,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

The Commission’s payment adequacy indicators suggest that payments for physicians and other health professionals are adequate. Access for Medicare beneficiaries is largely unchanged from prior years and comparable to access for those with private insurance. In addition, the share of providers enrolled in Medicare’s participating provider program remains high. Medicare pays for the services of physicians and other health professionals using a fee schedule. Under current law, Medicare’s conversion factor for the fee schedule will be updated by 0.5 percent in 2018. The Commission recommends an update for 2018 consistent with current law.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not

require an overnight stay after the procedure. In 2015, nearly 5,500 ASCs treated 3.4 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$4.1 billion.

Most of the available indicators of payment adequacy for ASC services are positive. For example, the number of ASCs and the volume of ASC services per beneficiary both grew in 2015, indicating increased access to these services. In addition, Medicare payments per FFS beneficiary increased by an average of 2.8 percent per year from 2010 through 2014 and by 5.2 percent in 2015. Because ASCs do not submit data on the cost of services they provide to Medicare beneficiaries, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy. Based on available indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2018. In addition, the Commission again recommends that CMS collect cost data from ASCs without further delay.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2015, nearly 388,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 6,500 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services using a prospective payment system (PPS) based on a bundle of services. The bundle includes certain dialysis drugs and ESRD-related clinical laboratory tests that were previously paid separately. In 2015, Medicare expenditures for outpatient dialysis services were \$11.2 billion, a slight decline of 0.1 percent compared with 2014 Medicare dialysis expenditures.

Our payment adequacy indicators for outpatient dialysis services, including access and quality, are generally positive. For example, growth in the number of dialysis treatment stations was slightly faster than growth in the number of dialysis beneficiaries. We estimate that the aggregate Medicare margin was 0.4 percent in 2015, and the rate of marginal profit was 16.6 percent. The Commission recommends that the Congress increase the outpatient dialysis base payment rate by the update specified in current law for 2018 (approximately 0.7 percent).

Post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2015, FFS program spending on PAC services totaled \$60 billion.

For more than a decade, the Commission has worked extensively on PAC payment reform, proposing closer alignment of costs and payments, more equitable payments across different types of patients, and tying payment to outcomes-based quality measures. But, though there has been some progress on the quality and value-based purchasing fronts, payments remain high relative to the costs of treating beneficiaries. Over the last decade, HHA and SNF Medicare margins averaged 15.6 percent, even after rebasing and productivity and other payment adjustments mandated by the Congress. IRF margins have been high as well, averaging 10.9 percent over the last decade. The average margin for LTCHs has been considerably lower, though still above 5 percent for most of the last decade and higher for stays that meet the new criteria to receive LTCH PPS payments. Within each setting, disparities in financial performance across providers reflect differences in costs, admitting practices, coding strategies, and the amount of therapy provided.

Because the level of PAC payments has been high relative to the cost of treating beneficiaries, the Commission, for many years, has recommended lowering and/or freezing Medicare's payment rates. The Commission has recommended no updates to payments (a 0 percent update) or reductions to payments each year since 2008 for HHAs, SNFs, and IRFs and since 2009 for LTCHs. Yet during this period, without Congressional action, SNF, IRF, and LTCH payments were increased. For HHAs, although the Patient Protection and Affordable Care Act of 2010 calls for annual rebasing of payments, the mandated reductions have been offset by payment updates and, consequently, do not go nearly far enough in realigning payments to costs.

In addition to the high levels of payment, there remain inequities in payments to PAC providers that encourage patient selection and financially advantage some providers over

others. The Commission has recommended key revisions to the SNF (in 2008) and HHA (in 2011) payment systems that would increase the equity of payments. The Commission's recommended changes would base payments on the clinical, functional, and demographic characteristics of patients, not on the amount of therapy furnished. The revised designs would rebalance payments between therapy cases and medically complex cases, which would shift payments from the relatively more profitable (typically for-profit and freestanding facilities) to the relatively less profitable (typically nonprofit and hospital-based) providers. For example, we estimate that a redesigned SNF PPS would have raised payments to facilities with low shares of therapy days (by 16 percent), facilities with high nontherapy ancillary costs (by 12 percent), facilities with low shares of intensive therapy (by 21 percent), and nonprofit facilities (by 4 percent). These shifts in payments would have narrowed the differences in financial performance across the industry. CMS has conducted extensive research on a new SNF PPS design and recently issued an advance notice of proposed rule-making that could make much-needed changes to the payment system. However, implementation continues to be delayed. CMS has proposed an alternative design for the HHA PPS, but there is no time line for its implementation.

For IRFs, in 2016 the Commission recommended changes to the outlier policy that would redistribute FFS payments among IRFs, ameliorating the financial burden for providers that have a relatively high share of costly cases whose acuity may not be well captured by the case-mix system. That same year, the Commission also recommended that the Secretary conduct focused medical record reviews of IRFs with unusual patterns of case mix and coding as an initial step in discerning whether observed differences reflect real differences in patient acuity. As early as 2007, the Commission identified the need to limit IRF payments to only patients appropriate for this intensive level of care and since has supported CMS's efforts to do so.

The cost to the program of not implementing the Commission's recommendations is substantial. Medicare is paying more for services than it needs to. Across the PAC settings, if this year's update recommendations were enacted, we estimate that FFS program spending would be reduced by more than \$30 billion over the next 10 years, all else being equal. Looking back, the cost of past inaction is also considerable. For example, we estimate that,

had the 2008 update recommendations for HHAs and SNFs (for fiscal year 2009) been implemented, FFS program spending would have been \$11 billion lower by 2017, all else being equal. Failure to implement payment reforms also unfairly advantages some providers over others and sends the wrong price signals, encouraging providers to furnish unnecessary care and to prefer to treat some patients over others. Further, since FFS payment rates form the basis of Medicare Advantage benchmarks and a variety of current and future alternative payment models, the overpayments and payment system design issues affect non-FFS payments as well. In addition, unnecessarily high payments contribute to the projected insolvency of the Hospital Insurance Trust Fund, estimated to occur in 2028.

The Commission has also sought to increase the equity in payments across PAC settings. In 2015, the Commission performed an extensive comparison of the patient characteristics and outcomes for 22 conditions frequently treated in both IRFs and SNFs. The Commission concluded that there were no substantial differences in the patients treated and the outcomes in the two settings and recommended that the payment differences between IRFs and SNFs for these conditions be eliminated. By paying IRFs the lower SNF payment rates for the select conditions, we estimated that spending would be lower by between \$1 billion and \$5 billion over five years. In 2014, the Commission recommended changes to LTCH payments that would restrict LTCH payments to patients who are chronically critically ill (CCI). Payments for non-CCI patients would be aligned with those paid for similar patients under the acute care hospital PPS (the hospital PPS rates are much lower).

Finally, in June 2016, as required by the Congress, the Commission outlined the key design features of a unified payment system that would span the four PAC settings. Underpinning this work is the recognition that many similar patients are treated across the four settings. Like the recommended designs for SNF and HHA PPSs, the unified PAC payment system would base payments on patient characteristics, not services furnished, and would redirect program payments toward medically complex patients and away from patients who receive therapy services unrelated to their care needs. CMS could begin to implement a uniform PAC PPS as soon as 2021, using a transition that blends setting-specific and PAC PPS rates.

In the meantime, the Congress and CMS need to correct the considerable overpayments in the existing PAC payment systems, and CMS should move forward with revisions to the SNF and HHA PPSs. With consistent incentives, those revised payment systems will give providers valuable experience in managing care under payment systems that tailor payments to the care needs of patients. The Commission's 2017 recommendations for the four PAC settings are described below.

Skilled nursing facility services

SNFs provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2015, about 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was \$29.8 billion in 2015.

Key measures indicate that Medicare payments to SNFs are adequate. Access to SNF care remains good. The number of SNFs participating in Medicare is stable, and the vast majority (88 percent) of beneficiaries live in a county with three or more SNF options; less than 1 percent of beneficiaries live in a county without a SNF option. Measures of quality are stable or improving. We also find that relatively efficient SNFs—facilities identified as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies. In 2015, the average Medicare margin was 12.6 percent—the 16th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities, reflecting differences in costs and shortcomings in the SNF PPS, which favors treating rehabilitation patients over medically complex patients. The marginal profit was at least 20.4 percent. Medicare needs to revise the PPS and rebase payments. Over time, the overpayments for therapy services have gotten larger (giving providers an even greater incentive to furnish therapy services of questionable value), and payments for nontherapy ancillary services (most notably drugs) are even more poorly targeted than in prior years. In addition, Medicare Advantage (managed care) payment rates to SNFs are considerably lower than the program's FFS payments.

The Commission recommends that no update to SNF payment rates be made for two years (2018 and 2019) while the SNF PPS is revised. Then, in 2020, the Secretary should evaluate

the need to make further adjustments to payments to bring them into better alignment with costs. This recommendation is consistent with our recommendation from 2016, and it reflects concerns about the SNF PPS that we have expressed for many years. The Commission has been frustrated by the delay in lowering the level of payments and revising the payment system.

Home health care services

HHAs provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2015, about 3.5 million Medicare beneficiaries received care, and the program spent about \$18.1 billion on home health care services. In that year, over 12,300 agencies participated in Medicare.

The indicators of payment adequacy for home health care are generally positive. Access to home health care is adequate, with 86 percent of beneficiaries living in a zip code with five or more agencies, and more than 99 percent living in a zip code with at least one agency. In 2015, agencies increased the volume of services provided to beneficiaries. Agencies' performance on quality measures improved. Medicare margins for freestanding agencies averaged 16.5 percent between 2001 and 2014 and were, on average, 15.6 percent in 2015. The marginal profit for HHAs in 2015 was 18.1 percent.

The high Medicare margins of HHAs over multiple years have led the Commission to recommend a 5 percent reduction in the home health base rate for 2018 and a two-year rebasing beginning in 2019. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and taxpayers without impeding access to home health care services.

We also are recommending, as we have for the last five years, that Medicare revise the payment system to base payments on patient characteristics and eliminate the use of the number of therapy visits as a payment factor in the home health PPS, beginning in 2019. A review of utilization trends and further research by the Commission and others suggest that this aspect of the PPS creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating the number of therapy visits as

a payment factor would base home health payment solely on patient characteristics, a more patient-focused approach to payment.

Inpatient rehabilitation facility services

IRFs provide intensive rehabilitation services to patients after an illness, injury, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology services, as well as prosthetic and orthotic services. In 2015, Medicare spent \$7.4 billion on FFS IRF care provided in about 1,180 IRFs nationwide. About 344,000 beneficiaries had more than 381,000 IRF stays. On average, Medicare accounts for about 60 percent of IRFs’ discharges.

Our indicators of Medicare payment adequacy for IRFs are generally positive. Although the volume of IRF cases increased in 2015, capacity remains adequate to meet demand. Most measures of quality are stable or improving. Between 2014 and 2015, the aggregate IRF Medicare margin rose from 12.4 percent to 13.9 percent. The aggregate margin has risen steadily since 2009. Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, indicating that hospital-based IRFs with available beds have a strong incentive to admit Medicare patients. Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent.

The Commission has recommended that the update to IRF payments be eliminated each year since fiscal year 2009. However, in the absence of legislative action, CMS has been required by statute to apply an adjusted market basket increase. Thus, payments have continued to rise.

Based on these factors, the Commission recommends that the IRF payment rate for fiscal year 2018 be reduced by 5 percent. The reduction in the payment rate should be coupled with an expansion of the high-cost outlier pool, as previously recommended by the Commission, to redistribute payments among IRFs and reduce the impact of potential misalignments between IRF payments and costs.

Long-term care hospital services

LTCHs provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and certain Medicare patients must have an average length of stay greater than 25 days. In 2015, Medicare spent \$5.3 billion on care provided in LTCHs nationwide. About 116,000 FFS beneficiaries had roughly 131,000 LTCH stays in about 426 LTCHs. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs' discharges.

The indicators for payment adequacy are stable. A Congressional moratorium on new LTCHs has limited growth in the number of providers, but the average LTCH occupancy rate suggests that capacity is adequate to meet demand. The number of LTCH cases per FFS beneficiary has declined about 2 percent per year since 2012. The aggregate 2015 Medicare margin was 4.6 percent. The 2015 margin for cases that would qualify to receive the full LTCH payment rate under new payment policies beginning in 2016 was 6.8. Marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit more Medicare patients, equaled 20 percent in 2015. We expect changes in admission patterns and cost structure will occur in response to the patient-specific criteria implemented beginning in fiscal year 2016.

Based on these indicators, the Commission concludes that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in 2018.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2015, more than 1.38 million Medicare beneficiaries (accounting for nearly 49 percent of decedents) received hospice services from about 4,200 providers, and Medicare hospice expenditures totaled about \$15.9 billion.

The indicators of payment adequacy for hospices are positive. For example, hospice use, the number of hospice providers, and the proportion of beneficiaries using hospice services at the end of life all continued to grow in 2015. The aggregate 2014 Medicare margin was 8.2 percent. In addition, the rate of marginal profit—that is, the rate at which Medicare payments exceed providers’ marginal cost—was roughly 11 percent in 2014. Because the payment adequacy indicators for which we have data are positive, the Commission recommends eliminating the update to hospice payment rates for 2018.

The Medicare Advantage program

In 2016, the MA program included 3,500 plans, enrolled more than 17.5 million beneficiaries (31 percent of all beneficiaries), and paid MA plans about \$190 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk-coding practices, and current quality indicators in MA. As a result of the analyses, we include a recommendation to improve how benchmarks are calculated. In our March 2016 report to the Congress, the Commission made additional recommendations concerning coding intensity, quality measurement, and payment for quality.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from previous levels, which were generally higher than FFS, and be set so that the payment system is neutral—not favoring either MA or the traditional FFS program.

Legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending

while enrollment in MA continues to grow. The pressure of lower benchmarks has led to improved efficiencies that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive. Lower benchmarks have also led plans to bid more competitively; bids have decreased from about 100 percent of FFS to about 90 percent of FFS in 2017. For 2017, about two-thirds of plans, accounting for about 75 percent of projected enrollment, bid below FFS.

Including quality bonuses, we estimate that 2017 MA benchmarks will average 106 percent of FFS spending, bids 90 percent of FFS, and payments 100 percent of FFS. (However, because MA plans code more intensively, we estimate payments are effectively about 104 percent of FFS rather than the nominal 100 percent.) On average, the quality bonuses in 2017 will add 4 percent to the average plan's base benchmark and will add 3 percent to plan payments. Removing quality bonuses from the benchmarks, base benchmarks would average 102 percent of FFS in 2017.

In addition, there are county-level equity issues regarding the calculation of MA benchmarks and payments. When CMS calculates the county-level FFS spending measure, on which the benchmarks are based, it includes all of a county's FFS beneficiaries, regardless of whether these FFS beneficiaries are enrolled in both Part A and Part B. MA beneficiaries, however, are required to enroll in both Part A and Part B to join an MA plan. To make the calculation equitable across counties, the Commission recommends that the Secretary calculate benchmarks using FFS spending data only for beneficiaries enrolled in both Part A and Part B.

Making this change would increase spending under the Medicare program, which could be offset by implementing our March 2016 recommendation on coding intensity. The Commission recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity. Specifically, the Commission recommended the use of two years of diagnostic data (and excluding diagnoses from health risk assessments) for risk adjustment and applying a coding adjustment that fully accounts for any remaining differences in coding between FFS and MA plans. We also

outlined a three-tier approach for that adjustment rather than the current across the board adjustment. An additional recommendation to improve equity across counties was to eliminate the cap on benchmark amounts and the doubling of the quality increases in specified counties.

The Medicare prescription drug program (Part D)

In 2015, the Medicare program spent \$80.1 billion for the Part D benefit, accounting for 12 percent of total Medicare outlays. Enrollees' out-of-pocket spending for premiums and cost sharing totaled \$11.5 billion and \$15.1 billion, respectively. In 2016, 41 million individuals (72 percent of all Medicare beneficiaries) were enrolled in Part D; of those enrolled, 60 percent were in stand-alone prescription drug plans (PDPs) and 40 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). In general, Part D has improved Medicare beneficiaries' access to prescription drugs, with plans available to all individuals.

Our status report on the Medicare prescription drug benefit established under Part D describes beneficiaries' access to prescription drugs, enrollment levels, plan benefit designs, and the quality of Part D services. For example, beneficiaries have between 18 and 24 PDPs to choose from depending on where they live, as well as typically 10 or more MA–PD options. In addition, all regions of the country continue to have at least 3 and as many as 10 PDPs available at no premium to the 12 million beneficiaries receiving the low-income subsidy. The report also analyzes changes in plan bids, premiums, and program costs.

Part D program spending grew at an annual rate of 7.1 percent from 2007 to 2015. The growth rate of its four components (reinsurance and direct, low-income, and retiree subsidies) varies widely. For example, reinsurance, the largest of the four components of Part D spending in 2015 (\$34.3 billion), grew at an annual rate of 20 percent from 2007 to 2015. In contrast, the direct portion of the Part D subsidy has grown at an annual average rate of less than 1 percent over the same period. Medicare reinsurance pays 80 percent of an enrollee's spending above the out-of-pocket threshold; the catastrophic phase of Part D's benefit. Nine percent of enrollees reached the catastrophic phase in 2014 and accounted for over half of the value of gross claims.

The Commission made a set of recommendations in its June 2016 report to the Congress to address concerns about Part D's financial sustainability and affordability for its enrollees while maintaining the program's market-based approach. One component of the Commission's June 2016 recommendations would reduce Medicare's reinsurance while, at the same time, increasing capitated payments to plan sponsors. The recommendations would also provide sponsors with greater flexibility to manage their drug formularies in return for accepting more risk.

Collectively, the recommendations make up a package of interrelated steps. One set of changes would give plan sponsors greater financial incentives and stronger tools to manage the benefits of high-cost enrollees. Medicare's overall subsidy of basic Part D benefits would remain unchanged at 74.5 percent, but plan sponsors would receive more of that subsidy through capitated payments rather than open-ended reinsurance. Over a transition period, Medicare would significantly lower the amount of reinsurance it pays plans from 80 percent of spending above Part D's out-of-pocket (OOP) threshold to 20 percent. When combined with the Commission's recommendation to provide greater OOP protection, the insurance risk that plan sponsors shoulder for catastrophic spending would rise commensurately from 15 percent to 80 percent.

At the same time, plan sponsors would be given greater flexibility to use formulary tools to manage benefits (e.g., more opportunities to update their formularies, removing some protected classes of drugs (antidepressants, immunosuppressants), better tools for managing specialty drugs). Other parts of the Commission's recommendations would exclude manufacturer discounts on brand-name drugs from counting as enrollees' true OOP spending, but would also provide greater insurance protection to all non-LIS enrollees through a real OOP cap that would have no cost sharing once a beneficiary reaches the cap (although some enrollees would incur higher OOP costs than they do today). The recommended improvements would also moderately increase financial incentives for LIS enrollees to use lower cost drugs and biologics.