

## **Report to the Congress: Medicare and the Health Care Delivery System - June 2019**

The Commission's June 2019 report examines a variety of Medicare payment system issues. In the 12 chapters of this report, we consider: beneficiary enrollment in Medicare: eligibility notification, enrollment process, and Part B late-enrollment penalties; restructuring Medicare Part D for the era of specialty drugs; Medicare payment strategies to improve price competition and value for Part B drugs; a mandated report on clinician payment in Medicare; issues in Medicare beneficiaries' access to primary care; assessing the Medicare Shared Savings Program's effect on Medicare spending; ensuring the accuracy and completeness of Medicare Advantage encounter data; redesigning the Medicare Advantage quality bonus program; payment issues in post-acute care; a mandated report on changes in post-acute and hospice care after implementation of the long-term care hospital dual payment-rate structure; options for slowing the growth of Medicare fee-for-service spending for emergency department services; and promoting integration in dual-eligible special needs plans.

### **BENEFICIARY ENROLLMENT IN MEDICARE: ELIGIBILITY NOTIFICATION, ENROLLMENT PROCESS, AND PART B LATE-ENROLLMENT PENALTIES**

- In the past, individuals became eligible for Medicare at the same time they would receive full retirement benefits from Social Security. However, the Social Security Amendments of 1983 gradually raised the full retirement age for Social Security benefits from 65 to 67.
- The notification process for Medicare eligibility is tied to eligibility for Social Security, which was not a problem when the eligibility age for both programs was 65. However, because the age at which individuals are eligible for Social Security has been increasing (while Medicare's age of eligibility has remained the same), some individuals may be unaware that they are eligible for Medicare at age 65 because of a lack of government notification. These individuals may be at risk for substantial late-enrollment penalties that could be imposed for the entire duration of their Medicare coverage.
- We estimate about 800,000 beneficiaries paid a late enrollment penalty for Part B in 2016, and we estimate that up to 20 percent of beneficiaries paying Part B late-enrollment penalties may not have known about the penalties when they turned 65.
- Policymakers could improve notification of eligible individuals about Medicare enrollment and potential late-enrollment penalties. The Secretary could work with the Social Security Administration to ensure timely notification of beneficiaries' impending Part B eligibility and the consequences of delaying enrollment. Directing more resources to State Health Insurance Assistance Programs (SHIPs) to pursue outreach efforts may also help. The Secretary could also explore the implications of delaying late-enrollment penalties until a beneficiary begins receiving Social Security benefits or Part A. The Secretary could also grant special enrollment periods to beneficiaries who have been covered by a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or Marketplace (Patient Protection and Affordable Care Act (PPACA) of 2010) plan.

### **RESTRUCTURING MEDICARE PART D FOR THE ERA OF SPECIALTY DRUGS**

- Since 2012, drug manufacturers have focused on producing specialty products that treat small patient populations for conditions such as rheumatoid arthritis, hepatitis C, and cancer. These newer therapies are often launched at extremely high prices, with annual costs per person reaching tens of thousands of dollars or more, and spending for high-cost specialty drugs has grown rapidly. In fact, more than 370,000 enrollees took a drug so expensive that a single prescription would have been sufficient to reach Part D's out-of-pocket (OOP) threshold in 2017, up from just 33,000 in 2010.

- Paying coinsurance for such high-cost drugs can pose a financial barrier to treatment, potentially affecting beneficiaries' decisions to fill their prescriptions. In addition, because patients pay coinsurance on gross prices before rebates, enrollees who fill prescriptions for rebated drugs can pay an unwarranted share of the price their Part D plan paid.
- Paying coinsurance on gross prices also tends to move enrollees more rapidly above Part D's OOP threshold—the point at which Medicare's reinsurance pays for 80 percent of benefits and plans are only liable for 15 percent of spending—more quickly. These dynamics have eroded plans' incentives to manage drug spending and have exposed beneficiaries to undue levels of cost sharing.
- In response to the concerning shift in the distribution of drug spending, Chapter 2 discusses modifications to Part D's benefit design, building on the Commission's 2016 recommendations to restructure Part D.
- The new approach would:
  - eliminate the manufacturer discount in the coverage gap, making plan sponsors responsible for a consistent 75 percent of benefits between the deductible and OOP threshold;
  - require manufacturers of brand-name drugs to provide a discount in the catastrophic phase of the benefit rather than in the coverage gap phase, as they do today (the discount would also apply to the spending of enrollees who receive Part D's low-income subsidy (LIS)); and
  - improve the affordability of high-priced drugs and provide more complete financial protection for all enrollees.
- This approach would provide stronger incentives for plans to manage enrollees' spending, restrain manufacturers' incentives to increase drug prices or launch new products at high prices, and provide more complete financial protection for all Part D enrollees.
- Consistent with the Commission's 2016 recommendations for Part D, we expect that any policy change that requires plans to take on more insurance risk would be combined with other changes that would provide plan sponsors with greater flexibility to use formulary tools.

## **MEDICARE PAYMENT STRATEGIES TO IMPROVE PRICE COMPETITION AND VALUE FOR PART B DRUGS**

- Medicare Part B covers drugs that patients typically do not administer themselves but are instead administered by a clinician in physician offices and hospital outpatient departments. Medicare's payment rate for a Part B-covered drug is generally based on the average price of a manufacturer's sales of that product, plus 6 percent (often referred to as "ASP + 6 percent"). In addition to paying ASP + 6 percent for the drug, Medicare makes a separate payment to providers for administering the drug to the patient.
- Medicare spending for drugs covered under Part B, including beneficiary cost sharing, has grown at an average rate of nearly 10 percent per year since 2009, and the Medicare program and its beneficiaries together paid \$32 billion for Part B-covered drugs in 2017. Growth in Medicare's payment rates under Part B is largely driven by rising drug prices and the launch of new expensive products. The growth reflects the significant leverage that manufacturers have when pricing their products.
- In 2017, the Commission recommended improving how Medicare pays for Part B drugs. Building on that work, we examine two elements of our recommendation: (1) reference pricing and (2) binding arbitration. We explore the potential of applying these two strategies more broadly in the Medicare program to improve price competition and value for Part B drugs.
- Reference pricing aims to reduce drug prices by spurring competition among products with similar health effects. In applying this policy to Part B drugs, Medicare could establish a single payment amount for a group of drugs that have similar health effects—drugs that are, today, each paid their own rates. Reference pricing gives providers and patients strong incentives to consider lower-cost therapeutic alternatives within a group of products.

- We also examine a policy that would permit the Secretary, under certain circumstances, to enter binding, baseball-style arbitration with drug manufacturers for high-cost Part B drugs with limited competition. The new arbitration price could become the basis of Medicare payment for the drug. Binding arbitration is one of the few tools with which Medicare could affect the price of drugs with limited competition. Arbitration allows for the consideration of value, affordability, and appropriate reward for innovation in the determination of Medicare's payment for Part B drugs.

## **MANDATED REPORT ON CLINICIAN PAYMENT IN MEDICARE**

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established permanent statutory updates for clinician services in Medicare and required the Commission to conduct a study of the updates from 2015 to 2019 and their effects on the access to, supply of, and quality of clinician services. To fulfill our mandate, we review the updates to Medicare's clinician fee schedule and examine measures of payment adequacy over the last decade.
- Each year, the Commission assesses the payment adequacy of the clinician sector and makes recommendations on any necessary payment update. To conduct its payment adequacy assessment for physician and other professional services, the Commission reviews a direct measure of access (a telephone survey), two indirect measures of access (the supply of clinicians billing Medicare and changes in the volume of services billed), measures of the quality of care furnished by clinicians to beneficiaries, and clinician input costs.
- These measures indicate that payment updates over the last decade have been associated with generally stable access to clinician services. We find that growth in the volume of clinician services furnished to beneficiaries varied by type of service. We also find that Medicare's payment rates relative to private sector payments fell from 81 percent in 2011 to 75 percent in 2017, generally due to higher growth in private sector prices for clinician services. However, we continue to find that Medicare beneficiaries' access to physician services is as good as or slightly better than access for individuals with private insurance. Our ability to detect and report national trends in the quality of care delivered by clinicians to beneficiaries is constrained, and, overall, we find that the quality of clinician services is indeterminate.
- The trends over the last decade suggest that updates of 0 percent to 1 percent have been sufficient to ensure beneficiary access to clinician services. However, there is no certainty that this relationship will hold in future years, and it is important to examine the most currently available data on payment adequacy. Thus, the Commission will continue to monitor the adequacy of clinician payments on a yearly basis and advise the Congress regarding future updates.

## **ISSUES IN MEDICARE BENEFICIARIES' ACCESS TO PRIMARY CARE**

- The Commission has a long-standing interest in ensuring that Medicare beneficiaries have good access to primary care services. In Chapter 5, we address two aspects of this issue: (1) ensuring an adequate supply of primary care physicians and (2) improving payment policies for advanced practice registered nurses (APRNs) and physician assistants (PAs).
- The Commission is concerned about the pipeline of future primary care physicians. A variety of factors influence specialty choices (including family medicine and internal medicine) by medical school graduates and residents. While the findings on the influence of medical school debt on specialty choice are mixed, almost half of medical school graduates who responded to a 2018 survey administered by the Association of American Medical Colleges planned to participate in programs to reduce their educational debt. However, existing programs are not Medicare-specific, and policymakers may want to consider establishing a scholarship or loan repayment program for physicians who provide primary care to Medicare beneficiaries, such as geriatricians.
- While the Commission is concerned about the future supply of primary care physicians, the number of APRNs and PAs has increased rapidly, and Medicare beneficiaries are increasingly reliant on APRNs and PAs for their care. However, despite their growing role in the delivery of care, Medicare often does not know when nurse practitioners (NPs), one type of APRNs, and PAs provide services to beneficiaries.

- Under current law, NPs and PAs can bill directly for the services they provide to beneficiaries, and Medicare pays 85 percent of the physician fee schedule (PFS) amount. Under certain conditions, those services can also be billed by a supervising physician under a billing convention called “incident to.” Services billed “incident to” are paid 100 percent of the PFS amount. Because of “incident to” billing, Medicare lacks information on which providers are actually furnishing care to beneficiaries, and beneficiaries and the Medicare program pay higher costs.
- The Commission recommends eliminating “incident to” billing for APRNs and PAs and requiring APRNs and PAs to bill the Medicare program directly under their own National Provider Identifier (NPI) for the services they provide. The Commission’s recommendation does not change the coverage of any services, any state supervision or collaboration requirements, nor would it change the way care is delivered.
- Also, Medicare has limited data on the specialties in which APRNs and PAs practice. The Commission also recommends improving the specialty designation information for APRNs and PAs.
- The Commission’s recommendations would update Medicare’s payment policies to better reflect current clinical practice, improve Medicare’s oversight of providers, and produce savings for Medicare and its beneficiaries.

## Recommendations

1. The Congress should require advanced practice registered nurses and physician assistants to bill the Medicare program directly, eliminating “incident to” billing for services they provide.
2. The Secretary should refine Medicare’s specialty designations for advanced practice registered nurses and physician assistants.

## ASSESSING THE MEDICARE SHARED SAVINGS PROGRAM’S EFFECT ON MEDICARE SPENDING

- Medicare accountable care organizations (ACOs) were created to reduce growth in Medicare spending and improve the quality of care for beneficiaries by giving providers greater responsibility for the cost and quality of care.
- About a third of Medicare FFS beneficiaries are now assigned to ACOs—mostly ACOs participating in the Medicare Shared Savings Program (MSSP), a permanent ACO model established by PPACA in 2010. In Chapter 6, we assess the performance on cost of the MSSP by comparing Medicare spending for beneficiaries assigned to MSSP ACOs with what that spending would have been in the absence of the MSSP.
- We find that estimates of ACO savings are sensitive to how the treatment group (those treated by an ACO) and comparison group (those not treated by an ACO) are defined. Using an approach that accounts for this sensitivity, we find that the growth in Medicare spending for beneficiaries treated by an MSSP ACO was 1 to 2 percentage points lower over a four-year period than it would have been in the absence of the MSSP. However, the Commission’s estimate does not include shared savings payments that Medicare made to ACOs over the period. We also find somewhat larger savings for beneficiaries assigned to physician-only ACOs compared with beneficiaries assigned to ACOs with both physician and hospital members.
- Significantly, we find that beneficiaries who “switch” into and out of ACOs had higher spending growth than those beneficiaries consistently assigned to an ACO. We also find that beneficiaries who “switch” (so were in an ACO for at least part of the period) had higher spending than beneficiaries never assigned to an ACO. In fact, beneficiaries who were never assigned to an ACO from 2013 (the first full year of MSSP operation) through 2016 had spending growth 1.3 percentage points *below* their market average.
- To more closely examine beneficiaries who switched, we compare the spending of beneficiaries continuously assigned to the same ACO from 2013 to 2016 to beneficiaries who were assigned to the same ACO from 2013 to 2015 but were switched out (or “dropped”) in 2016. We see very different patterns of spending growth

between the two groups. Those beneficiaries who were in an ACO over the entire period had spending growth that was 10 percentage points lower than their market average. Those beneficiaries who were in an ACO for three years but were then dropped in 2016 had spending growth that was nearly 14 percentage points above average. This dramatic difference in spending growth is likely due to significant changes in health status among beneficiaries who lost assignment to ACOs in 2016.

- Because ACO assignment is tied to use of health care services, a decline in a beneficiary’s health could cause both a change in the physicians the beneficiary sees (and thus a change in ACO assignment) and an increase in his or her use of health care services and spending. The connection between changes in beneficiary ACO assignment and changes in beneficiary spending is problematic, and this finding may have significant implications for how ACO performance is assessed and how ACO models are designed.

## **ENSURING THE ACCURACY AND COMPLETENESS OF MEDICARE ADVANTAGE ENCOUNTER DATA**

- The Medicare Advantage (MA) program gives beneficiaries the option of receiving benefits from private plans. One-third of Medicare beneficiaries are enrolled in MA, and Medicare paid about \$233 billion to MA plans in 2018. But, Medicare lacks basic information about the care MA plans provide.
- Information on the “encounters” that beneficiaries enrolled in MA plans have with their providers could be used to inform both MA and FFS payment policies. To examine the readiness of encounter data for informing policy, we assessed the validity and completeness of encounter data for 2014 and 2015 dates of service by performing several analyses.
- In general, we find that MA encounter data are incomplete. For 2014 and 2015, some plans did not submit any encounter data for certain types of services, and encounter data differed substantially from available comparison data sources.
- Complete, detailed encounter data would be of significant value to policymakers and researchers. However, given the significant data errors and gaps in the encounter data, the Commission does not currently support using the data to compare MA and FFS utilization. In Chapter 7, the Commission makes recommendations to improve the accuracy and completeness of MA encounter data to increase their utility.

### **Recommendations**

The Congress should direct the Secretary to establish thresholds for the completeness and accuracy of Medicare Advantage (MA) encounter data and:

- rigorously evaluate MA organizations’ submitted data and provide robust feedback;
- concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds; and
- institute a mechanism for direct submission of provider claims to Medicare Administrative Contractors
  - as a voluntary option for all MA organizations that prefer this method
  - starting in 2024, for MA organizations that fail to meet thresholds or for all MA organizations if program-wide thresholds are not achieved.

## **REDESIGNING THE MEDICARE ADVANTAGE QUALITY BONUS PROGRAM**

- PPACA called for CMS to institute a quality bonus program (QBP) for MA that scored plans on a five-star rating system to determine eligibility for bonus payments. However, the current MA–QBP is flawed and inconsistent with the Commission’s principles for quality measurement for several reasons:
  - The QBP includes nearly 50 quality measures, including process and administrative measures, instead of focusing on a small set of population-based outcome and patient experience measures.

- Organizations are rated at the MA contract level. Contracts cover very wide, noncontiguous geographic areas, and measuring quality at the contract level may not be a useful indicator of the quality of care provided in a beneficiary’s local area.
- The QBP uses a “tournament model” to determine plan performance, scoring plans’ performance relative to one another (e.g., even if all plans improve, some plans must be penalized) rather than determining plan performance based on absolute, prospectively set performance targets.
- The QBP does not appear to sufficiently account for differences among plans’ enrollees, and plans that have higher shares of low-income beneficiaries are thereby disadvantaged.
- The Commission discussed a MA value incentive program (MA–VIP) for assessing the quality of care received by Medicare enrollees that is consistent with the Commission’s principles for quality measurement and would:
  - use a small set of population-based outcome and patient experience measures to evaluate quality.
  - use clear, prospectively set performance standards to translate plan performance on these quality measures to rewards or penalties.
  - more equitably consider differences in plans’ enrollees by incorporating an improved “peer-grouping” risk-adjustment method under which quality-based payments are distributed to plans based on their performance for certain population groups (e.g., a plan’s population of enrollees who are fully dually-eligible for Medicare and Medicaid).
- Unlike the current MA–QBP, which in 2017 was financed with \$6 billion in additional payments to plans, the MA–VIP would be budget neutral. A budget-neutral approach is consistent with the existing budget-neutral FFS quality programs and would create consistent incentives across the Medicare program.

## **PAYMENT ISSUES IN POST-ACUTE CARE**

- Post-acute care (PAC) providers—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs)—offer Medicare beneficiaries a wide range of skilled nursing and rehabilitation services. In 2016, about 43 percent of all Medicare FFS patients discharged from an acute care hospital (ACH) were discharged to PAC providers.
- As mandated by the Congress, in June 2016, the Commission evaluated a design for a unified PAC prospective payment system (PPS) and concluded that a PAC PPS would establish accurate payments and increase the equity of payments across beneficiary conditions. In Chapter 9, we discuss additional considerations for implementing a PAC PPS, including:
  - the advantages and disadvantages of a stay-based versus an episode-based design,
  - the reliability of functional assessment data recorded by PAC providers, and
  - the current regulatory requirements for PAC providers and approaches for establishing aligned requirements under a PAC PPS.
- In our work to date on a unified PAC PPS, the Commission has evaluated a design that would establish payments for each PAC stay. In this chapter, the Commission also evaluated an episode-based design—one that makes a single payment for an entire episode of PAC (instead of paying separately for each individual PAC stay). We find that an episode-based design would produce differences in profitability based on length of an episode, and we conclude that a stay-based design is the better initial strategy for Medicare to pursue. Once providers have adapted their practice patterns under a unified payment system, the program could consider an episode-based design.
- To evaluate the quality of provider-reported functional assessment information, we examined the consistency of provider-reported functional assessment data for a given patient discharged from one PAC setting and admitted directly to another. We found large differences in the levels of function assigned to patients at their discharge from one setting and the levels of function recorded at their admission to the next

PAC setting. We also found substantial differences between assessment items collected for payment purposes and those only used for quality reporting.

- Because functional assessment information affects the payments PAC providers receive and the calculation of certain quality metrics, providers have an incentive to report information in ways that raise payments and demonstrate greater-than-warranted quality performance. Indeed, the differences we found in the assessment data suggest a provider response to those incentives.
- Finally, we examine the current regulatory requirements for PAC providers and describe a two-tiered regulatory approach to aligning requirements under a PAC PPS. Under this approach, all PAC providers would be required to meet a common set of requirements that would establish the basic provider requirements to treat PAC patients. Providers opting to treat patients with specialized needs—such as those requiring ventilator support or high-cost wound care—would be required to meet a second tier of requirements.

### **MANDATED REPORT: CHANGES IN POST-ACUTE AND HOSPICE CARE AFTER IMPLEMENTATION OF THE LONG-TERM HOSPITAL DUAL PAYMENT-RATE STRUCTURE**

- The most medically complex patients frequently need hospital-level care for extended periods of time, and some of these patients are treated in long-term care hospitals (LTCHs). LTCHs are intended to serve very sick patients, and per case payments under the LTCH PPS are very high. However, until 2016, Medicare lacked meaningful criteria for admission, resulting in the admission to LTCHs of less-complex cases that could be appropriately cared for in other, less-costly settings.
- The Pathway for SGR Reform Act of 2013 fundamentally changed how Medicare pays LTCHs for certain types of cases by creating a dual payment-rate structure. Under this structure, certain LTCH cases continue to qualify for the standard LTCH PPS rate, while cases that do not meet a set of criteria are paid a lower, “site-neutral” rate. As part of that law, the Congress mandated that the Commission report on the effect that the policy has had on LTCHs, other PAC and hospice providers, and beneficiaries.
- The Commission finds that from 2015 through 2017, LTCH spending, the number of LTCH stays, and the number of LTCH facilities decreased, but the share of LTCH cases meeting the criteria for the standard LTCH PPS payment rate increased. The LTCH quality program is relatively new, with few risk-adjusted measures currently appropriate for longitudinal comparisons. However, our examination of unadjusted measures did not find evidence that quality has been negatively affected by the new payment structure. Further, given the relatively low volume of acute care hospital discharges to LTCHs, patterns of use for other PAC and hospice providers have remained stable.
- In sum, the trends the Commission observes in the LTCH sector are consistent with the policy objectives of the dual payment-rate structure.

### **OPTIONS FOR SLOWING THE GROWTH OF MEDICARE FEE-FOR-SERVICE SPENDING FOR EMERGENCY DEPARTMENT SERVICES**

- In recent years there has been a significant increase in the share of emergency department (ED) visits by Medicare FFS beneficiaries that are coded at high-acuity levels. We find this trend may be the result of changes in provider coding practices and recommend that the Secretary create and implement national coding guidelines for hospitals for ED visits.
- Hospitals code each ED visit as one of five levels of intensity. Level 1 is the least resource intensive and receives the lowest payment rate; Level 5 is the most resource intensive and receives the highest payment rate. In recent years, coding of ED visits has steadily shifted to higher levels.
- We examined various potential reasons for this shift in coding, but we found that, while hospitals are providing more intensive care to ED patients, the conditions treated in EDs and the reasons that patients seek care in EDs have not changed over time. These results suggest that patterns of hospital coding reflect a provider response to payment incentives.

- To improve the accuracy of Medicare payments for ED visits, the Commission recommends that the Secretary create and implement national coding guidelines for ED visits.

## **Recommendation**

The Secretary should develop and implement a set of national guidelines for coding hospital emergency department visits under the outpatient prospective payment system by 2022.

## **PROMOTING INTEGRATION IN DUAL-ELIGIBLE SPECIAL NEEDS PLANS**

- Dual-eligible beneficiaries (individuals who receive both Medicare and Medicaid) often have complex health needs but are at risk of receiving fragmented or low-quality care because of the challenges in obtaining services from two distinct programs. Integrated managed care plans that provide both Medicare and Medicaid services could improve quality and reduce federal and state spending because they face stronger incentives to coordinate care than either program faces on its own.
- There are several types of integrated managed care plans. In Chapter 12, we examine the integrated plan type with the largest enrollment, the MA dual-eligible special needs plan (D–SNP). In 2019, D–SNPs are available in 42 states and the District of Columbia and have 2.2 million enrollees. However, the level of integration between D–SNPs and state Medicaid programs is generally low. Only about 18 percent of D–SNP enrollees are in plans with a significant degree of integration.
- Two changes could improve the level of Medicare–Medicaid integration in D–SNPs:
  1. Plans could be prohibited from enrolling partial-benefit dual-eligible beneficiaries (beneficiaries whose Medicaid coverage is limited to payment of the Part B premium and, in some cases, Medicare cost sharing). Alternatively, plans could be required to establish separate D–SNPs for partial-benefit and full-benefit dual-eligible beneficiaries.
  2. “Aligned enrollment” could also address barriers to greater integration. Under aligned enrollment, plan sponsors could not offer a D–SNP unless they had a companion Medicaid plan, and beneficiaries could not enroll in D–SNPs and Medicaid plans offered by separate companies. These changes would ensure that D–SNP enrollees receive their Medicare and Medicaid benefits from the same parent company and would foster greater integration.
- These policy changes would likely reduce overall enrollment in D–SNPs initially, but the number of beneficiaries enrolled in more highly integrated plans would increase. Since states vary greatly in their use of Medicaid managed care, policymakers could consider applying these changes only in states that have well-developed managed care programs.
- Some plan sponsors may circumvent such requirements by developing “look-alike” plans, which are traditional MA plans targeted at dual-eligible beneficiaries, but that do not have to meet the additional requirements that apply to D–SNPs, such as needing a contract with a state Medicaid program. The use of these plans is growing. “Look-alike” plans are available in 35 states and have about 220,000 enrollees. CMS may need new authority to address look-alike plans.