

Report to the Congress • March 2019

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. In its March 2019 report to the Congress, MedPAC makes payment policy recommendations for nine provider sectors in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and Medicare’s prescription drug benefit (Part D). MedPAC also recommends that the Congress replace the four current hospital quality payment programs with a single streamlined program—the hospital value incentive program (HVIP). Lastly, as mandated by the Congress, we report on incentives for prescribing opioid and non-opioid pain treatment under Medicare’s hospital inpatient and outpatient payment systems.

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

To meet its legislative mandate, the principal focus of the March report is MedPAC’s recommendations for annual payment rate adjustments (or “updates”) under Medicare’s various FFS payment systems. MedPAC assesses payment adequacy by examining beneficiary access to care (supply of providers, service use, and access surveys); quality of care; providers’ access to capital; and provider costs and Medicare payments, where available. MedPAC’s recommendations for the 2020 payment year are listed below.

Hospitals: Inpatient and outpatient services

The Congress should:

- Replace Medicare’s current hospital quality programs with a new hospital value incentive program (HVIP) that:
 - includes a small set of population-based outcome, patient experience, and value measures;
 - scores all hospitals based on the same absolute and prospectively set performance targets;
 - accounts for differences in patients’ social risk factors by distributing payment adjustments through peer grouping, and
- For 2020, update the 2019 base payment rates for acute care hospitals by 2 percent. The difference between the update recommendation and the amount specified in current law should be used to increase payments in a new HVIP.

Physicians and other health professional services

- For calendar year 2020, the Congress should increase the calendar year 2019 Medicare payment rates for physician and other health professional services by the amount specified in current law.

Ambulatory surgical center services

- The Congress should eliminate the calendar year 2020 update to the Medicare conversion factor for ambulatory surgical centers.
- The Secretary should require ambulatory surgical centers to report cost data.

Outpatient dialysis services

- For calendar year (CY) 2020, the Congress should update the CY 2019 Medicare end-stage renal disease prospective payment system base rate by the amount determined in current law.

Skilled nursing facility services

- The Secretary should proceed to revise the skilled nursing facility prospective payment system in fiscal year 2020 and should annually recalibrate the relative weights of the case mix groups to maintain alignment of payments and costs.
- The Congress should eliminate the fiscal year 2020 update to the Medicare base payment rates for skilled nursing facilities.

Home health agency services

- For 2020, the Congress should reduce the calendar year 2019 Medicare base payment rate for home health agencies by 5 percent.

Inpatient rehabilitation facility services

- For 2020, Congress should reduce the fiscal year 2019 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Long-term care hospital services

- For 2020, the Secretary should increase the fiscal year 2019 Medicare base payment rates for long-term care hospitals by 2 percent.

Hospice services

- For 2020, the Congress should reduce the fiscal year 2019 Medicare base payment rates for hospice providers by 2 percent.

REDESIGNING MEDICARE'S HOSPITAL QUALITY PROGRAMS

- For several years, Medicare has encouraged higher-quality hospital care by adjusting hospitals' payments based on their participation and performance in a set of four quality programs: The Hospital Inpatient Quality Reporting Program (IQRP), the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Condition Reduction Program (HACRP), and the Hospital Value-Based Purchasing (VBP) Program. The quality of hospital care provided to beneficiaries has improved over the last decade, in part, because of these programs.
- However, despite their successes, the designs of the current hospital quality payment programs are complex, in instances duplicative, and send different performance signals to hospitals. In last year's June 2018 report to the Congress, the Commission developed a streamlined program—the hospital value incentive program, or HVIP—for rewarding quality hospital care, based on a set of principles for measuring quality across the Medicare program. In this year's report, the Commission recommends the Congress replace the four current programs for measuring and rewarding hospital quality with the HVIP.
- The HVIP includes a small set of population-based outcome, patient experience, and value measures; scores all hospitals based on the same absolute and prospectively set performance targets; and accounts for differences in patients' social risk factors through peer grouping. The HVIP is simpler to administer, reduces provider burden, and more equitably considers differences in providers' patient populations compared with existing programs.
- The HVIP includes five CMS-administered measure domains: mortality, readmissions, Medicare spending per beneficiary (MSPB), patient experience, and hospital-acquired conditions. These measures are included in the existing hospital quality programs and are both meaningful to Medicare beneficiaries and familiar to providers.
- Adjusting measure results for social risk factors can mask disparities in clinician performance and implicitly accepts a lower standard of care for low-income patients. Instead of adjusting measure results, the HVIP accounts for differences in providers' patient populations by using peer grouping, which distributes quality-

based payments to hospitals separated into 10 peer groups, defined by the share of fully dual-eligible beneficiaries treated (using full Medicaid eligibility as a proxy for low income). Peer grouping hospitals that serve different populations makes payment adjustments more equitable compared with the existing quality payment programs, while still presenting beneficiaries with accurate, unadjusted measure performance.

- Payments under the HVIP would be financed by a payment withhold from each hospital's base operating payments (e.g., 5 percent) and increased by the difference between the Commission's update recommendation for acute care hospitals and the amount specified in current law. The increased payment under the HVIP will better reward hospitals providing high-quality care to beneficiaries. In addition, eliminating the existing penalty-only programs (i.e., the HRRP and HACRP) will remove about \$1 billion in overall penalties that hospitals currently incur each year. Taken together, our recommendations to update hospital payments and implement the HVIP are expected to increase Medicare's overall payments to hospitals relative to current law.

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- Between 2017 and 2018, enrollment in MA plans grew by 8 percent to 20.5 million enrollees. In 2018, 33 percent of all Medicare beneficiaries were enrolled in MA, and Medicare paid plans about \$233 billion (not including Part D drug plan payments) to manage beneficiaries' care. Among plan types, HMOs continue to enroll the most beneficiaries (13.1 million enrollees).
- In 2019, access to MA plans remains high: 99 percent of Medicare beneficiaries have access to an MA plan. Nearly all Medicare beneficiaries (97 percent) have an HMO or a local preferred provider organization (PPO) plan operating in their county of residence. In 2019, 90 percent of Medicare beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). The average beneficiary in 2019 has 23 available plans to choose from.
- Medicare payments to MA plans are enrollee specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical costs and are based on diagnoses that providers code. MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan. For several years, the Commission has observed that risk scores for MA enrollees are higher than the risk scores of similar beneficiaries in FFS. Our updated analysis for 2017 shows that higher diagnosis coding intensity resulted in MA risk scores that were 7 percent higher than scores for similar FFS beneficiaries. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding. In 2017, the adjustment reduced MA risk scores by 5.66 percent. However, in the aggregate, MA risk scores and payments were still about 1 percent to 2 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. The Commission previously 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.
- In 2019, MA benchmarks, bids, and payments (including quality bonuses), average 107 percent, 89 percent, and 100 percent of FFS spending, respectively. However, all these values increase by 1 to 2 percentage points if coding intensity (discussed above) is fully reflected (e.g., payments for MA plans would average 101 to 102 percent of FFS spending). On average, quality bonuses in 2019 will add 4 percent to the average plan's base benchmark and 2.4 percent to plan payments.
- Plans receive bonus payments if their contract has an overall rating of 4 stars or higher on CMS's 5-star rating system. Plans in a lower-performing contract can receive a bonus payment if their contract is absorbed by a contract that is rated 4 stars or higher. At the end of 2018, 550,000 beneficiaries were in non-bonus contracts that were absorbed by other contracts with a rating of 4 stars or higher, and the sponsors will receive unwarranted bonus payments for those enrollees as a result. In addition to unwarranted bonus payments, contract consolidations result in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area. The Commission previously recommended curtailing the practice of MA plan consolidation to obtain unwarranted quality bonus payments. This concern was

partly addressed in the Bipartisan Budget Act of 2018, which provides that, beginning at the end of 2019, the quality rating for consolidated contracts be based on an enrollment-weighted average of the results of each contract.

- However, the Commission continues to have concerns with the MA star rating system, which serves as the basis for plan quality bonuses and public reporting of plan quality. MA star ratings continue to be determined at the contract level. Because contracts can cover wide (and discontinuous) geographic areas and quality results are often determined based on only a small sample of beneficiary medical records, Medicare and beneficiaries lack important information about the quality of care of MA plans in their markets. It is difficult to reliably compare quality among plans, and the MA star rating system continues to award unwarranted quality bonus payments. Medicare also continues to lack the information necessary to compare MA quality with the quality of care in FFS. To address these issues, the Commission discusses using encounter data as the source of quality metrics in MA and moving to market areas as the reporting unit.

STATUS OF THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)

- In 2018, over 73 percent of all Medicare beneficiaries (43.9 million beneficiaries) were enrolled in Part D plans. Among Part D plan enrollees, 12.5 million individuals received the low-income subsidy (LIS). An additional 2.5 percent of all Medicare beneficiaries received drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. The remaining 24.2 percent of Medicare beneficiaries were divided about equally between those who had other sources of coverage at least as generous as Part D and those with no coverage or less generous coverage.
- Of those Medicare beneficiaries enrolled in Part D in 2018, 42 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). Between 2007 and 2018, enrollment in MA–PDs grew at an average rate of 9 percent annually, while enrollment in stand alone prescription drug plans (PDPs) grew at an average annual rate of 4 percent. This trend in MA–PD enrollment is consistent generally with more rapid growth in MA enrollment than in FFS Medicare. For 2019, beneficiaries continue to have broad choice among plans, ranging from 22 to 30 PDPs depending on where they live. The average beneficiary also has 23 MA plans available to them, most of which offer prescription drug coverage. In 2017, Medicare spending for Part D benefits totaled \$93.9 billion. Enrollee premiums made up \$14.0 billion of that total (enrollees also paid cost sharing). Between 2007 and 2017, Part D spending increased at an average annual rate of about 6 percent. The relatively small share of enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) continued to drive Part D program costs, accounting for 58 percent of gross spending in 2016. Spending for these high-cost individuals was driven almost entirely by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used). In 2016, nearly 360,000 enrollees filled a prescription that was so expensive that their cost sharing for a single fill would have been sufficient to put them into the catastrophic phase of the benefit.
- There are three types of payments Medicare makes to plan sponsors: direct subsidy payments (capitated monthly payments to plans that pay for expected benefit costs and reduce premiums for all enrollees), low-income subsidy payments (which pay for most of the premiums and cost sharing for LIS enrollees), and reinsurance payments (which pay for 80 percent of spending in the catastrophic portion of the benefit). Spending on reinsurance became the largest component of program spending in 2014 and has remained the fastest growing component.
- Part D has improved beneficiaries' access to prescription drugs, generic drugs now account for nearly 90 percent of the prescriptions filled, and enrollees' average premiums for basic benefits have remained steady for many years (around \$30 per month).
- However, changes to Part D's benefit design combined with the expanding role of high-cost medicines may be eroding plans' incentives to manage benefit costs. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based reinsurance instead of fixed-dollar payments (which provide incentives to control spending). Between 2007 and 2017, reinsurance payments increased at an average

annual rate of nearly 17 percent. Over the same period, Medicare’s fixed-dollar direct subsidy payments decreased nearly 2 percent per year. In addition, beginning in 2019, brand-drug manufacturers must provide a 70 percent discount in the coverage gap (an increase from 50 percent), decreasing plans’ financial responsibility. This change further weakens plans’ incentives to manage spending.

- Policymakers are taking steps to give plans new flexibilities to manage drug spending. However, measures to increase the financial risk that plans bear (such as those recommended by the Commission in 2016) are essential to ensure plans have incentives to use their new management tools to reduce spending growth for Medicare and its beneficiaries.

MANDATED REPORT: OPIOIDS AND ALTERNATIVES IN HOSPITAL SETTINGS—PAYMENTS, INCENTIVES, AND MEDICARE DATA

- The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 mandated that the Commission describe how Medicare pays for both opioid and non-opioid pain management treatments in hospital inpatient and outpatient settings, the existing incentives under the inpatient and outpatient prospective payment systems (the IPPS and OPSS, respectively) for prescribing opioids and non-opioids, and how opioid use is monitored through Medicare claims data.
- Medicare uses bundled payments to pay for pain management drugs and services in both the inpatient and outpatient settings. The IPPS and OPSS payment bundles create a financial incentive for hospitals to be cost conscious when purchasing items and services. Medicare’s quality measurement and reporting programs are designed to balance this financial incentive. Ideally, these balanced incentives, along with providers’ clinical expertise, are designed to result in high-quality outcomes at the best prices for beneficiaries and taxpayers. However, if opioids are systematically cheaper than non-opioid alternatives, providers might be more inclined to opt for them, especially if doing so does not affect performance on quality measures.
- The Commission analyzed certain list prices for opioids and non-opioid alternatives commonly used in the hospital setting and found that both opioids and non-opioids are available at a range of prices, and there are expensive and inexpensive options for both. Thus, the Commission concludes that there is no clear indication that Medicare’s IPPS or OPSS discriminates against non-opioid medications.
- This study is not intended to be an assessment of the clinical appropriateness of the use of opioids versus non-opioid alternatives, and we recognize that clinicians’ decisions about which pain management drug to prescribe are based on a multitude of patient-specific factors. Also, we recognize that there are incentives in addition to financial ones that may have an influence on clinicians’ choice of pain treatments, such as effects on patient experience, length of stay, or need for additional nursing services. However, these motivations are not unique to the Medicare IPPS and OPSS.
- CMS monitors opioid use through tracking programs in Part D, but Medicare does not operate similar tracking programs in Part A or Part B. Policymakers may wish to direct CMS to track opioid use in the hospital inpatient and outpatient settings. If Medicare were to undertake an opioid monitoring program in Part A and Part B, there are structural differences from Part D that would require adaptation of CMS’s current Part D monitoring programs.
- The Commission discusses three options for implementing a Part A and Part B opioid tracking program: (1) require prescription drug event-type reporting, (2) require hospitals to report all pain management drugs on Part A and Part B claims, and (3) link Part D opioid use to any prior hospital stays in which opioid use was initiated.