
Executive summary

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As part of its mandate from the Congress, each June the Commission reports on refinements to Medicare payment systems and issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services. The 12 chapters of this report include:

- ***Beneficiary enrollment in Medicare: Eligibility notification, enrollment process, and Part B late-enrollment penalties.*** Under current law, the government does not notify all individuals that they are eligible for Medicare. As a result, eligible persons who are not notified might not enroll in Part B when required to do so and then have to pay a late-enrollment penalty. We suggest several steps to help rectify this issue.
- ***Restructuring Medicare Part D for the era of specialty drugs.*** We explore a new policy approach to improve plan sponsors' financial incentives for managing drug spending and to potentially restrain manufacturers' incentives to increase prices.
- ***Medicare payment strategies to improve price competition and value for Part B drugs.*** We explore the potential of applying reference pricing and binding arbitration more broadly in an effort to improve price competition and value for Part B drugs.
- ***Mandated report on clinician payment in Medicare.*** We conclude that the statutory updates for clinician services from 2015 through 2019 have been sufficient to maintain beneficiary access to clinician services. However, there is no certainty this relationship will continue to hold in future years.
- ***Issues in Medicare beneficiaries' access to primary care.*** The Commission recommends eliminating "incident to" billing for advanced practice registered nurses and physician assistants and refining their specialty designations to give Medicare a fuller accounting of the services provided by these clinicians and to improve policymakers' ability to target resources toward primary care. Policymakers may also want to explore a scholarship or loan repayment program for geriatricians to increase access to their services.
- ***Assessing the Medicare Shared Savings Program's effect on Medicare spending.*** We estimate that Medicare spending on beneficiaries in the Medicare Shared Savings Program (MSSP) treatment group grew slightly less than it would have in the absence of the MSSP and note that this estimate is sensitive to how the treatment and comparison groups are defined.
- ***Ensuring the accuracy and completeness of Medicare Advantage encounter data.*** To improve encounter data so that they can be used for program oversight and comparisons with traditional fee-for-service (FFS) Medicare, we recommend that the Congress direct the Secretary to establish thresholds for the completeness and accuracy of Medicare Advantage (MA) encounter data, a payment withhold to encourage MA plans to submit the data, and a mechanism for provider submission of claims to Medicare Administrative Contractors.
- ***Redesigning the Medicare Advantage quality bonus program.*** We find that the current MA quality bonus program is flawed and propose to replace it with an MA value incentive program that is consistent with the Commission's quality measurement principles.
- ***Payment issues in post-acute care.*** Following up on our June 2016 evaluation that concluded that a unified post-acute care (PAC) prospective payment system (PPS) design would establish accurate payments and increase the equity of payments across conditions, we examine three further issues—stay-based versus episode-based designs, functional assessment data, and approaches for establishing aligned requirements for providers under a PAC PPS.
- ***Mandated report: Changes in post-acute and hospice care after implementation of the long-term care hospital dual payment-rate structure.*** For long-term care hospitals (LTCHs), we found—consistent with the objectives of the dual payment-rate structure enacted by the Pathway for SGR Reform Act of 2013—that from 2015 through 2017, spending, the number of LTCH stays, and the number of facilities decreased, but the share of cases meeting the criteria for the standard LTCH PPS rate increased.
- ***Options for slowing the growth of Medicare fee-for-service spending for emergency department services.*** The volume of services per Medicare FFS beneficiary and spending for hospital emergency department (ED) visits have increased in recent years. We find

these changes may in part be the result of providers coding visits at high acuity levels and recommend that the Secretary create and implement national coding guidelines for ED visits that would result in more accurate payments.

- **Promoting integration in dual-eligible special needs plans.** We examine the type of integrated managed care plan with the largest enrollment that provides both Medicare and Medicaid services, the MA dual-eligible special needs plan (D–SNP). We describe several policy changes that could improve the low level of integration between D–SNPs and state Medicaid programs.

Beneficiary enrollment in Medicare: Eligibility notification, enrollment process, and Part B late-enrollment penalties

Some individuals may be at risk for substantial late-enrollment penalties in Medicare because of a lack of government notification. Although some individuals (those who applied for or are receiving Social Security payments 4 months before they turn 65 years old) are notified and automatically enrolled in Part A and Part B of the Medicare program when they turn 65, individuals who have not applied for or received Social Security benefit payments before they turn 65 do not get a notification from either the Social Security Administration (SSA) or CMS alerting them that they are eligible to enroll in Medicare when they turn 65. (In fact, the SSA does not notify CMS of an individual’s eligibility for Medicare until he or she applies for Social Security benefits.) Because full retirement age for Social Security benefits is gradually increasing from age 65 to age 67 by year 2027, full retirement age is becoming increasingly greater than the age of Medicare entitlement, and more individuals may not be notified and thus may have to pay a late-enrollment penalty.

In Chapter 1, we look specifically at enrollment in Part B of Medicare. We are concerned that a significant number of newly eligible Medicare beneficiaries do not know that they might incur late-enrollment penalties added to their Part B premiums for the duration of their Medicare enrollment if they do not enroll in the program when first eligible. We estimate about 800,000 beneficiaries were paying a late-enrollment penalty for Part B in 2016. We also estimate that up to about 20 percent of beneficiaries paying Part B late-enrollment penalties may not have known about the penalties when they turned age 65. We

do not know how many of these beneficiaries would have enrolled on time had they been aware of the potential for penalties.

Also, there is a growing trend of beneficiaries enrolling in Part A but not Part B. The number of beneficiaries enrolled in Part A only has increased from about 3 million in 2006 (about 7 percent of beneficiaries) to about 5 million in 2017 (about 9 percent of beneficiaries). We do not know how many of those “Part A–only” beneficiaries would enroll in Part B as well if there were no late-enrollment penalty.

The lack of a notification process ensuring that individuals are aware of their eligibility for and their need to enroll in Medicare as they turn 65 should be addressed. Improvement in the timeliness of notification to eligible individuals about Medicare enrollment and potential late-enrollment penalties is essential. The Secretary could work with the SSA to ensure that prospective beneficiaries receive adequate and timely notification of their pending Part B eligibility and the consequences of delaying enrollment. CMS could also work with State Health Insurance Assistance Programs to address the notification issue.

The Secretary could explore the implications of delaying the late-enrollment penalties until the beneficiary begins receiving Social Security benefits or Part A. The Secretary could also explore granting special enrollment periods to beneficiaries who had been covered by either a Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or Marketplace (Patient Protection and Affordable Care Act of 2010) plan because they can be unaware that they may be subject to late-enrollment penalties when they enroll in Medicare. These actions could help address the unexpected late-enrollment penalties for unnotified beneficiaries.

More broadly, the Secretary could examine whether the late-enrollment penalties are having the desired effects. Currently it is not known whether, or to what extent, the penalties are causing beneficiaries to further delay enrollment.

Restructuring Medicare Part D for the era of specialty drugs

Since the start of the Part D program in 2006, the distribution of drug spending has changed dramatically. Early on, the vast majority of spending was attributable to prescriptions for widely prevalent conditions. After the 2012 wave of patent expirations of small-molecule

brand-name drugs, manufacturers turned to producing drugs that treat smaller patient populations for conditions such as rheumatoid arthritis, hepatitis C, and cancer. These newer therapies are often launched at very high prices, with annual costs per person sometimes reaching tens of thousands of dollars or more, and spending for specialty drugs and biologics has risen rapidly.

Most plan sponsors use formularies that include a specialty tier with coinsurance of 25 percent to 33 percent for expensive therapies, and above Part D's out-of-pocket (OOP) threshold, enrollees who do not receive Medicare's low-income subsidy (LIS) pay 5 percent coinsurance with no OOP maximum. Although many specialty drugs have no rebates, when patients use rebated drugs, they pay effective rates of coinsurance (as a percentage of a drug's net price) that are even higher than the stated coinsurance amount because manufacturers provide rebates to plans long after patients fill their prescriptions, and plans charge coinsurance on the higher "gross" price at the pharmacy. There is some evidence that high patient cost sharing can pose a financial hurdle to treatment, potentially affecting certain beneficiaries' decisions to fill their prescriptions. Further, paying coinsurance on gross prices tends to move enrollees toward Part D's OOP threshold—the point at which Medicare's reinsurance pays for 80 percent of benefits—more quickly.

Chapter 2 introduces a new policy approach that would modify Part D's defined standard benefit and its catastrophic phase to improve plan sponsors' financial incentives for managing drug spending and potentially restrain manufacturers' incentives to increase prices. The approach would retain certain features of the Commission's 2016 recommendations for Part D, such as requiring plans to bear more risk for catastrophic spending, but the new design would also eliminate the need for some previously recommended measures. The new changes would also create a more consistently defined standard basic benefit to apply to both enrollees without Part D's LIS as well as those with the LIS.

The new approach would restructure the Part D benefit in several ways. First, it would eliminate the coverage-gap discount that currently applies to non-LIS enrollees, making plan sponsors responsible for a consistent 75 percent of benefits between the deductible and OOP threshold. Second, the new design would require manufacturers of brand-name drugs to provide a discount

in the catastrophic phase of the benefit rather than in the gap phase, as they do today. The manufacturer discount would be newly applicable to the spending of LIS beneficiaries. Third, the new design would lower enrollee cost sharing or include a hard overall OOP cap to improve the affordability of high-priced drugs and provide more complete financial protection for all enrollees. Plan sponsors would be responsible for a larger share of catastrophic benefits, and Medicare's reinsurance would be smaller. In general, we expect the approach would provide stronger incentives for plan sponsors to manage enrollees' spending and potentially restrain manufacturers' incentives to increase drug prices or launch new products at high prices.

Consistent with the Commission's 2016 recommendations for Part D, we expect that any policy change that requires plan sponsors to take on more insurance risk would be combined with other changes that would provide sponsors with greater flexibility to use formulary tools. Part D's risk adjustment system would need to be recalibrated to counterbalance plan incentives for selection. Finally, Chapter 2 discusses a key parameter of this policy approach: where to set the OOP threshold. The approach's financial impact on stakeholders, including Part D beneficiaries and taxpayers who finance the Medicare program, would depend on the specific threshold chosen and behavioral responses to the changes.

Medicare payment strategies to improve price competition and value for Part B drugs

Medicare Part B covers drugs and biologics that are administered by infusion or injection in physician offices and hospital outpatient departments (HOPDs). Medicare Part B also covers certain other drugs provided by pharmacies and suppliers. Medicare pays for most Part B drugs and biologics at a rate of 106 percent of the average sales price (ASP). In 2017, the Medicare program and beneficiaries together paid about \$32 billion for Part B-covered drugs and biologics.

Medicare Part B drug spending has grown rapidly, with more than half of the growth in Part B drug spending between 2009 and 2016 accounted for by price growth, which reflects increased prices for existing products and shifts in the mix of drugs, including the launch of new high-cost drugs. In 2017, the Commission recommended several improvements to payment for Part B drugs including an ASP inflation rebate that would address price growth in the years after products launch, consolidated

billing codes for biosimilars and originator biologics that would spur price competition among these products, and a voluntary alternative to the ASP payment system that would use vendors to negotiate lower prices and share savings with providers and beneficiaries.

Building on our June 2017 recommendation, Chapter 3 examines two strategies that were elements of that recommendation—reference pricing and binding arbitration. We explore the potential to apply these two approaches more broadly in the Medicare program in an effort to improve price competition and value for Part B drugs. Both approaches could also be applied in Part D, although there would be operational differences from their use in Part B.

We have found that the structure of the ASP payment system does not promote price competition among some groups of drugs with similar health effects. Building on the Commission’s 2017 consolidated billing code recommendation—under which an originator biologic and its biosimilars would be assigned the same billing code and paid the same rate—we discuss Medicare’s use of internal reference pricing, a policy that aims to reduce drug prices by spurring price competition among single-source products with similar health effects. Applying this policy to Part B drugs, Medicare would establish a reference payment amount for groups of drugs with similar health effects currently assigned to separate billing codes. Internal reference pricing gives the provider and patient strong incentives to consider lower cost therapeutic alternatives within each group.

For costly new drugs that face limited competition, such as the first drug in a class or a product that offers added clinical benefit over existing treatments, manufacturers have significant market power to set prices and payers currently have very limited ability to influence those prices. In Chapter 3, we explore a potential policy that would permit the Secretary, under certain circumstances, to enter into binding, baseball-style (i.e., final-offer) 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 Part B drug, which could be operationalized by reducing the Medicare payment rate (with a requirement that the manufacturer honor that price for Medicare patients) or by instituting a manufacturer rebate.

Binding arbitration is one of the few potential tools with which Medicare could affect the price of drugs with

limited competition. Binding arbitration has the potential to incorporate value, affordability, and an appropriate reward for innovation into the determination of Medicare’s payment for Part B drugs. Because Part A providers such as inpatient hospitals also face challenges negotiating prices for drugs with few alternatives, there could also be benefits to Part A providers in extending prices achieved through binding arbitration.

Mandated report on clinician payment in Medicare

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the previous formula for setting clinician fees (the sustainable growth rate), established permanent statutory updates for clinician services in Medicare, created an incentive payment for clinicians who participate in certain types of payment arrangements, and created a new value-based purchasing program for all other clinicians. MACRA also required the Commission to conduct a study of the statutory updates to clinician services from 2015 through 2019 and the effect these payment updates have on the access to and supply and quality of clinician services.

To fulfill this mandate, in Chapter 4, we review the rate-setting and update process for Medicare’s fee schedule for clinicians and measures of payment adequacy over the last decade. Over that time, annual fee schedule updates ranged from 0 percent to 1 percent. The Commission assesses the payment adequacy of the clinician sector every year and makes a recommendation on any necessary update. To conduct the payment adequacy assessment for physician and other health professional services, the Commission reviews a direct measure of access to care (a telephone survey), two indirect access measures (the supply of clinicians billing Medicare and changes in the volume of services billed), quality measures, and clinician input costs. Using these measures, we find that payment updates over the last decade have been associated with generally stable measures of access to clinician services for Medicare beneficiaries and that access for Medicare beneficiaries continues to be as good as or slightly better than access for individuals with private insurance. Our ability to detect and report national trends for Medicare clinician quality is limited.

The statutory mandate directing the Commission to conduct this evaluation requires us to make recommendations for future updates to fee schedule rates that would be necessary to ensure Medicare beneficiaries’ access to care. The trends we have observed over the last

decade suggest that updates in the range of 0 percent to 1 percent have been sufficient to ensure beneficiary access to care. However, there is no certainty that this relationship will hold in future years. Therefore, each year we will continue to evaluate the most currently available data on measures of payment adequacy and advise the Congress annually on our recommended payment updates as we have in the past. We will also monitor other factors (e.g., site-of-service shifts) in our annual assessment.

Issues in Medicare beneficiaries' access to primary care

High-quality primary care is essential for creating a coordinated health care delivery system. Primary care services—such as ambulatory evaluation and management visits—are provided by physicians and other health professionals, such as advanced practice registered nurses (APRNs) and physician assistants (PAs). Physicians who focus on primary care are generally trained in family medicine, internal medicine, geriatric medicine, and pediatrics.

The Commission has a long-standing interest in ensuring that Medicare beneficiaries have good access to primary care services. This goal includes ensuring payments for primary care services are accurate and that the supply of primary care clinicians remains adequate to support access. In Chapter 5, we address two aspects of this issue, ensuring an adequate supply of primary care physicians and improving information on APRNs and PAs, who provide an increasing share of services to Medicare beneficiaries.

To date, based on beneficiary surveys, we find that beneficiaries have access to clinician services that is largely comparable with (or in some cases, better than) access for privately insured individuals, although a small number of beneficiaries report problems finding a new primary care doctor. However, we have concerns about the pipeline of future primary care physicians. Though the number of family medicine and internal medicine residents has grown in recent years, the majority of internal medicine residents plan careers in a subspecialty such as cardiology or oncology. Significant disparities in expected compensation between primary care physicians and other specialists could be deterring medical residents from pursuing primary care careers.

Although the findings on the influence of medical school debt on specialty choice are mixed, some studies find

that debt is modestly related to medical students' career decisions. Almost half of medical school graduates in 2018 planned to participate in programs to reduce their educational debt. However, existing programs are not Medicare specific, and policymakers may wish to consider establishing a scholarship or loan repayment program for physicians who provide primary care to Medicare beneficiaries. Although physicians in several specialties furnish primary care to beneficiaries, to ensure the best use of scarce resources, a Medicare-specific scholarship or loan repayment program should target those physicians most likely to treat beneficiaries. Therefore, a Medicare-specific program could target geriatricians because they specialize in managing the unique health and treatment needs of elderly individuals. In 2017, only a little more than 1,800 geriatricians treated beneficiaries in traditional FFS Medicare (less than 1 percent of all physicians who treated FFS beneficiaries in that year). Between the 2013–2014 academic year and the 2017–2018 academic year, the number of residents in geriatric medicine declined by 2 percent, which raises concerns about the future pipeline of geriatricians. By reducing or eliminating educational debt, a Medicare-specific scholarship or loan repayment program could provide medical students and residents with a financial incentive to choose geriatrics. We begin exploring design choices for this program in Chapter 5 and plan to continue examining them in future work.

Although the Commission has concerns about the supply of primary care physicians, the number of APRNs and PAs has increased rapidly and is projected to continue to do so in the future. The growth in the number of nurse practitioners (NPs)—one type of APRN—and PAs who bill Medicare has been particularly rapid. From 2010 to 2017, the combined number of NPs and PAs who billed Medicare more than doubled, reaching 212,000 in 2017. However, because of the way some NPs and PAs bill, Medicare does not have a full accounting of the services provided by these clinicians. In addition, the share of NPs and PAs who furnish primary care is obscured because CMS collects little up-to-date information regarding the specialty in which NPs and PAs practice. We make two recommendations to address these concerns.

First, Medicare allows NPs and PAs to bill under the national provider identifier (NPI) of a supervising physician if certain conditions are met, a practice known as “incident to” billing. While the existing literature on the prevalence of “incident to” billing is limited, we conducted

two analyses that suggest that a substantial share of services furnished by NPs and PAs to FFS beneficiaries were likely billed “incident to” in 2016. Therefore, the Commission recommends that the Congress require APRNs and PAs to bill the Medicare program directly, eliminating “incident to” billing for services they provide.

Second, Medicare collects little up-to-date information regarding the specialty in which NPs and PAs practice. While NPs and PAs have historically been concentrated in primary care, more recent patterns suggest that NPs and PAs are increasingly practicing in specialty fields. Therefore, the Commission recommends that the Secretary refine Medicare’s specialty designations for APRNs and PAs. Together, these recommendations are designed to give the Medicare program a fuller accounting of the breadth and depth of services provided by NPs and PAs and improve policymakers’ ability to target resources toward primary care.

Assessing the Medicare Shared Savings Program’s effect on Medicare spending

Organizations of providers that agree to be held accountable for cost and quality of care in Medicare FFS are called accountable care organizations (ACOs). About a third of Medicare fee-for-service beneficiaries are now assigned to ACOs, mostly those in the MSSP, a permanent ACO model established in the Patient Protection and Affordable Care Act of 2010. The first MSSP ACO started in April 2012, and the MSSP has grown rapidly to 561 ACOs in 2018. In Chapter 6, we assess the cost performance of the MSSP through 2016.

An individual ACO’s financial reward—called “shared savings”—is determined by comparing its spending with the benchmark set for it by CMS. In contrast, evaluations of MSSP performance in the literature use a “counterfactual,” that is, an estimate of what spending growth would have been if the MSSP did not exist. Benchmarks and counterfactuals differ because benchmarks are set in advance and designed to create incentives for individual ACOs and to fulfill policy goals. Counterfactual analysis is done after the fact using trends in expenditures for beneficiaries in comparison groups.

To evaluate the effect of the MSSP on Medicare program spending, the Commission used a counterfactual approach to compare spending for beneficiaries assigned to MSSP ACOs with what spending would have been in the absence of the MSSP. We found that decisions on how the treatment group (those treated by the ACO) and comparison group (those not treated by the ACO) are

defined can affect the magnitude and validity of estimates of program savings.

CMS assigns beneficiaries to ACOs by service use, and a change in health care status that alters a beneficiary’s service use can lead to a change in assignment (either into or out of the ACO). We found that beneficiaries who are assigned into and out of ACOs tend to have high spending and growing risk scores and are more likely to be hospitalized in the year of reassignment. Defining the treatment group as “beneficiaries ever assigned to an ACO” places a large number of these reassigned beneficiaries in the treatment group and will thus be unlikely to find savings from ACOs. Conversely, defining the treatment group as “beneficiaries continuously assigned to ACOs” (which places reassigned beneficiaries in the control group) would be biased toward finding large savings from ACOs.

Using an approach that mitigates the effects of reassigned beneficiaries by including some in the treatment group and some in the comparison group, we found that the growth in Medicare spending for beneficiaries in the MSSP treatment group was 1 percentage point to 2 percentage points lower over a four-year period than it would have been without the MSSP, with somewhat larger savings for beneficiaries assigned to physician-only ACOs than for beneficiaries assigned to ACOs with physicians and hospitals as members. This estimate does not include any shared savings payments that were made to ACOs during that period. The program will generate net savings only if MSSP bonus payments (shared savings) are less than spending reductions resulting from lower service use.

If MSSP reductions in spending on health services continue to be small, unintended consequences will have to be carefully monitored. Although it appears that patient selection was not a significant issue in the early years of the MSSP, recent changes to the program give all ACOs the option of retrospective assignment of beneficiaries, which could result in increased patient selection. To limit the risk to the program, CMS could require use of prospective assignment. In addition, under prospective assignment, ACOs would have some protection from adverse selection.

Ensuring the accuracy and completeness of Medicare Advantage encounter data

Information on the “encounters” beneficiaries enrolled in MA plans have with their providers (interactions that would create a claim in the traditional FFS program)

could be used to inform both FFS and MA payment policies. Analysis of MA encounter data could inform improvements to MA payment policy, provide a useful comparator with the FFS Medicare program, and generate new policy ideas that could be applied more broadly to the Medicare program.

Chapter 7 describes how MA encounter data could be used to improve the administration of the MA program and inform potential refinements to the traditional FFS Medicare program. For example, it could be used to help determine the risk adjustment factors used to adjust payments to plans and to conduct quality review and improvement activities. We also make recommendations to improve the accuracy and completeness of MA encounter data to increase their utility for CMS.

MA encounter data for 2012, 2013, and 2014 and preliminary data for 2015 were available in time to be included in Chapter 7. For 2014 and preliminary 2015 data, we assessed the face validity and completeness of the data by counting the number of unique MA plans and unique MA enrollees and comparing the MA encounter data with other Medicare data sets. Based on our evaluation of the 2014 and 2015 MA encounter data, we conclude that encounter data are a promising source of information and should continue to be collected. We believe having complete, detailed encounter data about the one-third of Medicare beneficiaries enrolled in MA would be of significant value to policymakers and researchers. CMS has released the preliminary 2015 encounter data to researchers for specified analyses. However, given the data errors and omissions that we found, the Commission does not currently support using the data to compare MA and FFS utilization.

Given the value of complete encounter data for the Medicare program and the significant gaps we found in the encounter data, the Commission recommends that the Congress direct the Secretary to establish thresholds for the completeness and accuracy of MA encounter data and:

- rigorously evaluate MA organizations' submitted data and provide robust feedback and
- concurrently apply a payment withhold and provide refunds to MA organizations that meet thresholds.

Further, the Secretary should 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 and, starting in 2024, for MA organizations that fail to meet thresholds or for all MA organizations if program-wide thresholds are not achieved.

Together these policy changes are designed to improve the completeness and accuracy of encounter data so that they can be used for program oversight; performance comparisons across FFS, MA, and ACOs; and additional policy priorities.

Redesigning the Medicare Advantage quality bonus program

The Commission has formalized a set of principles for quality measurement in the Medicare program. The Commission recently applied these principles to design a hospital value incentive program 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; and accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping.

In Chapter 8, we find that the current MA quality bonus program (QBP) is flawed and is inconsistent with the Commission's principles for quality measurement. First, the QBP includes almost 50 quality measures, including process and administrative measures, instead of focusing on a small set of population-based outcome and patient experience measures. Second, the QBP ratings apply to MA contracts, which cover very wide areas—including noncontiguous states. Thus, the ratings are often not a useful indicator of the quality of care provided in a beneficiary's local area. Third, the QBP uses a "tournament model," scoring plans' performance relative to one another rather than in relation to predetermined performance targets. Fourth, the QBP's version of peer grouping to adjust for differences in plans' enrolled populations does not appear to sufficiently capture variation in quality among Medicare population groups (such as low-income beneficiaries and beneficiaries with disabilities).

We propose an MA value incentive program (MA–VIP) that is consistent with the Commission's quality measurement principles and is designed to be patient oriented, encourage coordination across providers and time, and promote improvement in the delivery system. An MA–VIP would use a small set of population-based outcome and patient experience measures to evaluate MA

quality; clear, prospectively set performance standards to translate MA performance on these quality measures into rewards and penalties; and an improved peer-grouping method in which quality-based payments are distributed to plans based on their performance for population groups, such as a plan's population of beneficiaries who are fully dual eligible for Medicare and Medicaid. Performance would be evaluated at the local market area, not by contract.

Unlike most quality incentive programs in FFS Medicare, which are budget neutral or produce program savings through penalties, the QBP is financed with about \$6 billion a year in additional spending. The proposed MA–VIP would be budget neutral, financed through a small percentage of plan payments. This design would better align MA and FFS quality incentives and would produce program savings. It should not be assumed that a budget-neutral MA–VIP that decreases aggregate plan revenues would lead to a decrease in extra benefits. The recent growth in MA enrollment and increased levels of extra benefits—during a period when MA payments were being reduced—suggests that plan revenues may have a limited effect on the level of extra benefits. Plans that recently received a bonus passed only a small share of their payment increases on to beneficiaries in the form of extra benefits. Plans could become more efficient if faced with greater financial pressure and could thus continue to provide generous extra benefits.

Ideally, an evaluation of quality in MA would be based in part on a comparison with the quality of care in traditional FFS Medicare, including ACOs, in local market areas. However, due to the lack of data sources for comparing MA with traditional FFS at the local market level, our proposed MA–VIP design does not yet include a component for FFS comparison. In the future, better encounter data from MA and expanded patient experience surveys would help enable comparisons of the two programs.

Payment issues in post-care 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 were discharged

to PAC, and in 2017, the program spent about \$60 billion across the four PAC sectors.

As mandated by the Congress, in June 2016, the Commission evaluated a prototype design and concluded a unified PAC prospective payment system (PPS), as opposed to the four separate payment systems used currently, would establish accurate payments and increase the equity of payments across conditions. Because the variation in profitability by clinical condition would be narrower compared with current payment policy, providers would have less incentive to selectively admit certain types of patients over others. Since 2016, the Commission has continued to examine various issues regarding a PAC PPS, including the level of aggregate PAC spending to base payments, the need for a transition, the monitoring required to keep payments aligned with the cost of care, and a way to increase the equity of PAC payments before a PAC PPS is implemented.

In Chapter 9, we examine three additional issues for a unified PAC PPS:

- the advantages and disadvantages of stay-based versus episode-based designs,
- the functional assessment data recorded by PAC providers, and
- current requirements for PAC providers and approaches for establishing aligned requirements under a PAC PPS.

The Commission evaluated an episode-based design and compared it with a stay-based design—that is, one that would pay for each PAC stay. An episode-based design would result in large overpayments for relatively short episodes and underpayments for long ones. An outlier policy could be designed to narrow the differences in profitability across episodes but would be unlikely to correct the large overpayments and underpayments based on episode length. Having evaluated the tradeoffs between the two designs, the Commission believes that a stay-based design is the better initial strategy for CMS to pursue. Once providers have adapted to the new PPS and practice patterns have converged, CMS could consider an episode-based design.

To evaluate the quality of the provider-reported functional assessment information, we examined the consistency of its reporting for the same beneficiaries discharged from one PAC setting and directly admitted to another

and between the new information recorded for quality reporting and the information used to establish payments. Though other administrative data, such as diagnoses included in claims data, are also provider reported and may be vulnerable to misreporting, patient functional status is more subjective and may be more difficult to audit. We found large differences in the broad levels of function assigned to patients at their discharge from one setting and at their admission to the next PAC setting, and between assessment items collected for payment purposes and the uniform items used in quality reporting. Further, the differences in the functional categories favored recording function that would raise payments in three of the settings and that would show larger improvement in quality performance, suggesting that Medicare should not rely on these data for payment purposes. We discuss possible strategies to improve the reporting of assessment data, the importance of monitoring the reporting of these data, and alternative measures of function that do not rely on provider-completed assessments.

Finally, we examine current requirements for PAC providers and discuss approaches for establishing aligned requirements under a PAC PPS. Because a unified PAC PPS would establish a common payment system, Medicare's existing setting-specific regulations would need to be aligned so that PAC providers face the same set of requirements for treating similar patients. Chapter 9 discusses a two-tiered regulatory approach. All PAC providers would be required to meet a common set of requirements that would establish the basic provider competencies to treat the average PAC patient. Providers opting to treat patients with specialized or very high care needs—such as those who require ventilator support or high-cost wound care—would be required to meet a second tier of requirements that would vary by the specialized care need. Medicare would periodically need to update the conditions assigned to the second tier to reflect changes in medical practice. Chapter 9 also discusses the changes that would be required to align coverage requirements across the PAC settings.

Mandated report: Changes in post-acute and hospice care after implementation of the long-term care hospital dual payment-rate structure

The most medically complex patients frequently need hospital-level care for extended periods, and some of these patients are treated in LTCHs. LTCHs are defined by Medicare as hospitals with an average length of stay

exceeding 25 days. Because LTCHs are intended to serve very sick patients, per case payments under the LTCH PPS are very high. However, until 2016, lack of meaningful criteria for admission resulted in admissions of less complex cases that could be cared for appropriately in other 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 (“cases meeting the criteria”), while cases that do not meet a set of criteria are paid a lower, “site-neutral” rate. The site-neutral rate is the lower of a cost-based payment or a rate based on the inpatient PPS that is used to pay acute care hospitals (ACHs). The impact of this policy on LTCHs was expected to be substantial given that the base payment rate is 85 percent lower for ACHs than for LTCHs. The Congress, therefore, requested that the Commission report on the effect that the policy has had on LTCHs, other PAC and hospice providers, and beneficiaries. The Commission was also asked to opine on the necessity of the 25 percent rule, which limits the share of cases that can be admitted to certain LTCHs from a referring ACH. The Secretary eliminated the rule in fiscal year 2019. Chapter 10 summarizes our findings.

The Commission found 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. Although nearly 50 LTCHs have closed since fiscal year 2016, most of these closures occurred in markets with multiple LTCHs. In aggregate, LTCHs that closed had a lower share of Medicare discharges that met the criteria and a lower occupancy rate in their last year of operation compared with the facilities that remained open. Because the payment rate for cases not meeting the criteria is substantially lower than that for cases that meet the criteria, an LTCH's financial stability under Medicare relies, in part, on the share of cases that meet the criteria. LTCHs with more than 85 percent of their Medicare population meeting the criteria continued to have positive financial performance under Medicare in 2017.

The LTCH quality program is relatively new, with few risk-adjusted measures currently appropriate for longitudinal comparisons. However, for cases cared for in

an LTCH, our examination of unadjusted measures—even after focusing on cases that met the criteria—did not find evidence that quality has been negatively affected by the dual payment-rate structure. Given the relatively small number of LTCH referrals, observing meaningful changes in discharge patterns to other PAC providers and hospice in response to the implementation of the dual payment-rate structure is challenging. We did, however, observe some small differences in certain Medicare severity–diagnosis related groups, including those involving wound care and, in some markets, tracheostomy.

In sum, the Commission observed changes in the LTCH setting consistent with the policy objectives of the dual payment-rate structure since its implementation for cost reporting periods beginning on or after October 1, 2015. Given the decades of concern regarding increases in LTCH use and the relatively high cost of LTCH services without a clear benefit for many case types, the trends we observed in the LTCH sector align with the Commission’s goal of paying for expensive LTCH care only for the sickest patients. Changes in the trends of LTCH use and spending following the policy’s implementation were expected, and the Commission expects to see further continuation of these trends as the dual payment-rate structure becomes fully implemented in 2020. Given the current partial policy phase-in, the Commission will continue to monitor changes in use and trends across other PAC and hospice providers, LTCH facility closures, and quality of care metrics for LTCH providers.

In regard to the 25 percent rule, the Commission posits that even under the LTCH dual payment-rate structure, ACHs continue to have an incentive to reduce their costs by shortening lengths of stay and shifting costly patients to LTCHs (and other PAC providers). Our analysis of data through 2017 suggests that, since 2016, the trends in LTCH use have begun to shift toward cases meeting the criteria, indicating a general shift away from lower severity cases and an underlying change in admission patterns in LTCHs, reducing the necessity for the 25 percent rule. The Commission expects additional changes in ACH referrals to LTCHs as the dual payment-rate structure is fully phased in, further reducing the need for the 25 percent rule.

Options for slowing the growth of Medicare fee-for-service spending for emergency department services

Medicare FFS beneficiaries’ use of hospital emergency departments (EDs) has increased in recent years, in both volume of services per beneficiary and overall program

and beneficiary spending. One driver of this increase is the increase in the share of ED visits that are coded at high acuity levels. In Chapter 11, we find these changes may be the result of changes in provider coding practices and recommend that the Secretary create and implement national coding guidelines for ED visits that would result in more accurate payments.

Under the hospital outpatient prospective payment system (OPPS), hospitals code each ED visit into one of five levels of intensity, with Level 1 as the least resource intensive and the lowest payment rate, and Level 5 as the most resource intensive and the highest payment rate. In 2005, Level 3 was the most frequently coded level, and Levels 1 and 5 were the least frequently coded. However, in recent years, coding of ED visits has steadily shifted to higher levels. In 2017, Level 4 was the most frequently coded level, and Level 5 was the second most frequently coded.

We examined various potential reasons for coding to have shifted, such as coding of ED visits to higher levels reflecting ED patients being older and sicker, or that the increased presence of urgent care centers pulls lower acuity patients away from EDs and results in an increased level of acuity among remaining ED patients. However, we found that hospitals are providing more intensive care to ED patients, but the conditions treated in EDs and the reasons that patients gave for seeking care in EDs were largely unchanged over time. These results suggest that hospitals are potentially coding ED patients in response to payment incentives and that Medicare is paying more than necessary for many patients who present in the ED setting.

Medicare could change the system of ED codes to improve its payment accuracy. Medicare could begin by developing a system of ED codes that are based on national coding guidelines and reflect the resources hospitals use to treat ED patients. The Current Procedural Terminology (CPT) codes that hospitals use to code ED visits reflect the work and resources of physicians, not hospitals. CMS has responded to this lack of CPT codes for hospitals by directing hospitals to develop their own internal guidelines for coding ED visits. Therefore, to improve the accuracy of Medicare payments for ED visits, the Commission recommends that the Secretary create and implement national coding guidelines. If done properly, the benefits of effective national coding guidelines for ED visits would include payments for ED visits that accurately reflect the resources hospitals expend when providing care in the ED setting, a clear set of rules for hospitals to code ED visits,

and a firm foundation for CMS to assess and audit the coding behavior of hospitals.

Promoting integration in dual-eligible special needs plans

Individuals who qualify for both Medicare and Medicaid, known as dual-eligible beneficiaries or “dual eligibles,” can receive care that is fragmented or poorly coordinated because of the challenges in dealing with two distinct and complex programs. Integrated managed care plans that provide both Medicare and Medicaid services could improve quality and reduce spending for this population because they would have stronger incentives to coordinate care than either program does when acting on its own. In fact, integrated plans have shown some ability to reduce enrollees’ use of inpatient and nursing home care, and CMS is testing the use of integrated plans on a broader scale through its financial alignment demonstration.

The Commission began an examination of integrated plans in its June 2018 report, noting that Medicare has several types of integrated plans. This chapter continues our analysis by examining the integrated plan type with the largest enrollment, the MA D–SNP. In 2019, D–SNPs are available in 42 states and the District of Columbia and have 2.2 million enrollees, which accounts for between 15 percent and 20 percent of the dual-eligible population. This popularity is partly due to the extra benefits that D–SNPs provide using MA rebates. These benefits typically differ from those offered by traditional MA plans, with D–SNPs spending a much larger share of their rebates on supplemental benefits such as dental, hearing, and vision services. However, the level of integration between D–SNPs and Medicaid is generally low; only about 18 percent of D–SNP enrollees are in plans with a significant degree of integration.

The low level of integration between D–SNPs and state Medicaid programs has three underlying causes. First, D–SNPs provide little obvious benefit in terms of integrating Medicare and Medicaid coverage for the 27 percent of enrollees who are “partial-benefit” dual eligibles, meaning they have Medicaid coverage that is limited to payment of the Part B premium and, in

some cases, Medicare cost sharing. Second, 41 percent of D–SNP enrollees qualify for full Medicaid benefits but are enrolled in plans that do not have capitated Medicaid contracts for the delivery of long-term services and supports (LTSS), such as nursing home care and community-based care, which account for about 80 percent of Medicaid spending on dual eligibles. Third, 14 percent of D–SNP enrollees qualify for full Medicaid benefits but are not enrolled in a companion Medicaid plan run by the same parent company.

Several policy changes could improve the level of Medicare–Medicaid integration in D–SNPs. Plan sponsors could be prohibited from enrolling partial-benefit dual eligibles in D–SNPs or be required to establish separate D–SNPs for partial-benefit and full-benefit dual eligibles. The other barriers to greater integration could be addressed by using a practice known as aligned enrollment, where plan sponsors could not offer a D–SNP unless they had a companion Medicaid plan, and beneficiaries would not be able to enroll in D–SNPs and Medicaid plans from separate companies.

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, such as those that make capitated payments for LTSS.

Finally, some plan sponsors might circumvent these requirements by developing “look-alike” plans, which are traditional MA plans targeted at dual eligibles. Since look-alike plans operate as traditional MA plans instead of D–SNPs, they do not have to meet the additional requirements that apply to D–SNPs, such as having a Medicaid contract. The use of these plans has been growing; they are now available in 35 states and have about 220,000 enrollees. CMS may need new authority to prevent sponsors from using look-alike plans to undermine efforts to develop more highly integrated D–SNPs. ■

