Executive summary

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

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2020 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- review the status of the MA program (Medicare Part C) through which beneficiaries can join private plans in lieu of traditional FFS Medicare.
- review the status of the Medicare program that provides prescription drug coverage (Medicare Part D).
- recommend that a hospital value incentive program be developed.
- as mandated by the Congress, report on incentives for prescribing opioid and non-opioid pain treatment under Medicare's hospital inpatient and outpatient payment systems and how opioid use in the hospital setting is monitored by Medicare.

The goal of Medicare payment policy is to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums.

The Commission recognizes that managing updates and relative payment rates alone will not solve what have historically been fundamental problems with Medicare FFS payment systems to date—that providers are paid more when they deliver more services, without regard to the value of those additional services, and that these systems do not include incentives for providers to coordinate services across time and care settings. To address these problems directly, two approaches must be pursued. First, payment reforms need to be implemented more broadly, coordinated across settings, and pursued as expeditiously as possible. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care need to be enhanced and closely monitored, and successful models need to be adopted on a broad scale.

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

For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not take into account the complete package of policy recommendations or the interactions among them. Although we include these budgetary estimates, our recommendations are not driven by any single budget target, but instead reflect our assessment of the payment rate needed to ensure adequate access to appropriate care balanced with preserving the fiscal sustainability of the Medicare program.

In Appendix A, we list all recommendations and the Commissioners' votes.

Context for Medicare payment policy

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and view Medicare in the context of the broader health care system. To help meet this mandate, Chapter 1 examines health care spending growth—for the nation at large and Medicare in

particular—and considers its effect on federal and state budgets as well as the budgets of individuals and families. The chapter also reviews recent mortality and morbidity trends; profiles the health status of the next generation of Medicare beneficiaries; and reviews evidence of inefficient health care spending, structural features of the Medicare program that contribute to inefficient spending, and the Commission's approach to combating those challenges.

In 2017, total national health care spending was $3.5 trillion, or 17.9 percent of GDP. Private health insurance spending was $1.2 trillion, or 6.1 percent of GDP. Medicare spending was $705.9 billion, or 3.6 percent of GDP.

Health care spending growth has fluctuated recently, first with several years of historic lows, followed by a period of accelerated growth, and most recently a return to modest growth. From 2009 to 2013, growth in total health care spending and Medicare spending slowed to average annual rates of 3.7 percent and 4.3 percent, respectively, and then increased to rates of 5.5 percent and 4.9 percent from 2013 to 2015 before declining to a rate of 4.2 percent (of both total and Medicare spending) from 2016 to 2017.

The aging of the baby-boom generation will continue to have a profound impact both on the Medicare program and taxpayers, who primarily finance it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary is projected to decline. By 2029 (when most boomers will have aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception and 3.0 in 2018. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2041, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt will exceed total projected federal revenues and will thus either increase federal deficits and debt further or crowd out spending on all other national priorities.

The growth in health care spending also affects state budgets and the budgets of individuals and families. States pay for a significant portion of Medicaid spending, increases in private insurance premiums have outpaced the growth of individual and family incomes over the past decade, and out-of-pocket costs for Medicare beneficiaries have grown faster than Social Security benefits.

Some health care spending is inefficient. For Medicare, if such spending could be identified and eliminated, the efficiencies achieved could result in improved beneficiary health, greater fiscal sustainability for the program, and reduced federal budget pressures. Certain structural features of the Medicare program pose challenges for targeting inefficient spending; however, the Commission has made multiple recommendations to the Congress and the Secretary that have the potential to improve the quality of care and move the Medicare program toward paying for value.

Assessing payment adequacy and updating payments in fee-for-service Medicare

As required by law, the Commission annually makes payment update recommendations for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. As described in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2019) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year, 2020). As part of the process, we examine payments to support the efficient delivery of services, consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

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

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher paid setting. The Commission has recommended equalizing rates for evaluation and management office visits and additional services provided in hospital outpatient departments and physicians' offices and recommended consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients. We have also recommended elements of a single prospective payment system (PPS) for all post-acute care to replace the four independent PPSs in use today (the skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, and home health PPSs) to make payments across all of the post-acute care payment settings comparable. The Commission will continue to analyze opportunities for applying this principle to other services and settings.

Hospital inpatient and outpatient services

In 2017, the Medicare FFS program paid 4,700 hospitals $190 billion consisting of $119 billion for about 10 million Medicare inpatient admissions, $66 billion for about 200 million outpatient services, and $6 billion for uncompensated care provided to patients who are not Medicare beneficiaries. On net, between 2016 and 2017, overall hospital spending increased $7 billion and hospital spending per FFS beneficiary rose 4.3 percent, increasing from $4,992 to $5,208.

As discussed in Chapter 3, most payment adequacy indicators (including access to care, quality of care, and access to capital) are positive. Average Medicare margins continue to be negative, although hospitals with excess capacity still have an incentive to see Medicare beneficiaries because Medicare payment rates remain about 8 percent higher than the variable costs associated with Medicare patients.

Beneficiaries' access to care—In 2017, the average hospital occupancy rate was 62.5 percent, suggesting hospitals have excess inpatient capacity in most markets. Because Medicare payments exceed the marginal cost of providing services, hospitals with excess capacity have a financial incentive to increase services provided to Medicare beneficiaries. Marginal profits were approximately 8 percent on average in 2017. After declining over the last several years, inpatient use per beneficiary in 2017 increased by 0.7 percent. Outpatient visits per beneficiary also increased by 0.7 percent, a slower pace of outpatient volume growth than in recent years.

Quality of care—From 2013 to 2017, hospital mortality and readmission rates improved slowly. Patient satisfaction also improved somewhat: The share of patients who rated their hospital a 9 or 10 on a 10-point scale increased from 71 percent to 73 percent.

Providers' access to capital—Access to bond markets has been strong, with hospital bond offerings in 2015, 2016, and 2017 ranging from $24 billion, to $38 billion, to $35 billion, respectively. While some hospitals struggle with low occupancy and limited access to capital, most hospitals have good access to capital because of strong all-payer profit margins. All-payer margins were 7.1 percent in 2017, only 0.1 percentage point below their all-time high of 7.2 percent in 2013.

Medicare payments and providers' costs—In 2017, hospitals' aggregate Medicare margin was –9.9 percent, down slightly from –9.7 percent in 2016. The profit margin for relatively efficient providers was about –2 percent. We project that the overall Medicare margin will decline to about –11 percent in 2019.

For 2020, the Commission recommends that the Congress update Medicare inpatient and outpatient payment rates by 2 percent. This update recommendation is based on indicators of beneficiaries' access to hospital care, hospitals' access to capital, hospital quality, and the relationship between Medicare payments and hospital costs. As we discuss in Chapter 15, the Commission also recommends a new hospital value incentive program (HVIP) that aligns with our principles for quality measurement and replaces the current quality incentive programs. The difference between the 2 percent update and the update amount specified in current law should be used to increase payments in the new HVIP. Together, these recommendations are expected to increase hospital payments 2.8 percent by increasing the base payment rate and the average rewards hospitals receive under the proposed Medicare HVIP. In addition, we recommend eliminating the penalties associated with the current quality incentive programs, which will have the effect of increasing payments by about 0.5 percent. On net,

hospital payment rates would be expected to increase by an average of 3.3 percent under our combined update and HVIP recommendation.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings. In 2017, Medicare paid $69.1 billion for physician and other health professional services. About 985,000 clinicians billed Medicare: roughly 596,000 physicians and 389,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

Medicare pays for the services of physicians and other health professionals using a fee schedule. Under current law, there is no update to Medicare's conversion factor for the fee schedule on January 1, 2020.

As discussed in Chapter 4, our payment adequacy indicators for physicians and other health professionals are generally positive.

***Beneficiaries' access to care*—**Overall, beneficiary access to physician and other health professional services is comparable with prior years. Most beneficiaries continue to report that they are able to find a new doctor without a problem. A small number of beneficiaries report more difficulty, with a higher share reporting problems obtaining a new primary care doctor than reporting problems obtaining a new specialist. The number of physicians per beneficiary declined slightly, the number of advanced practice registered nurses and physician assistants per beneficiary rose, and the share of providers enrolled in Medicare's participating provider program remains high. In 2017, across all services, volume per beneficiary grew by 1.6 percent.

***Quality of care*—**CMS assesses the quality of Medicare-billing physicians and other health professionals based on clinician-reported individual quality measures. We report three population-based measures: patient experience, avoidable hospitalizations for ambulatory care–sensitive conditions, and rates of low-value care in Medicare. Patient experience scores in FFS Medicare remain high, and rates of avoidable hospitalizations for ambulatory care–sensitive conditions continue to decline modestly from prior years, but there is substantial use of low-value care.

***Medicare payments and providers' costs*—**CMS currently projects that the increase in 2020 in the Medicare Economic Index (which measures input prices) will be 2.4 percent. In 2017, Medicare FFS payment rates for physician and other health professional services were 75 percent of commercial rates for preferred provider organizations, unchanged from 2016. Median compensation in 2017 was much lower for primary care physicians than for physicians in certain specialties, such as radiology and nonsurgical, procedural specialties, continuing to raise concerns about fee schedule mispricing and its impact on the future availability of primary care services for beneficiaries.

The evidence suggests that Medicare payments for physicians and other health professionals are adequate. Therefore, the Commission recommends that the 2020 payment rate for physicians and other health professional services be updated by the amount specified in current law.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2017, 3.4 million FFS Medicare beneficiaries were treated in the 5,603 ASCs certified to provide services to Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about $4.6 billion.

Our results, described in Chapter 5, indicate that beneficiaries' access to ASC services is adequate. Most of the available indicators of payment adequacy for ASC services, discussed below, are positive.

***Beneficiaries' access to care*—**Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services has generally been adequate. From 2012 to 2016, the number of ASCs increased by an average annual rate of 1.0 percent. In 2017, the number of ASCs increased 2.4 percent. Almost all new ASCs in 2017 (about 94 percent) were for-profit facilities. From 2012 through 2016, the volume of services per beneficiary increased by an average annual rate of 1.2 percent. In 2017, volume increased by 1.7 percent.

***Quality of care*—**The first four years of ASC-reported quality data show improvement in performance, but the measures used within the ASC Quality Reporting (ASCQR) Program will change substantially in the next few years. Among the 11 quality measures for which data

were available through 2016, performance among the ASCs that reported data improved for most measures.

Providers' access to capital—Because the number of ASCs has continued to increase and hospital systems and others have significantly incorporated ASCs into their business strategies, access to capital appears to be adequate.

Medicare payments and providers' costs—From 2012 to 2016, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 3.5 percent. By contrast, in 2017, payments for ASC services increased by 7.7 percent. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy.

On the basis of these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2020. In addition, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2017, nearly 395,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from approximately 7,000 dialysis facilities. In 2017, Medicare expenditures for outpatient dialysis services were $11.4 billion, a 0.4 percent increase over 2016 expenditures.

Our payment adequacy indicators for outpatient dialysis services, described in Chapter 6, are generally positive.

Beneficiaries' access to care—Measures of the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest payments are adequate. Dialysis facilities appear to have the capacity to meet demand. Between 2016 and 2017, the number of dialysis treatment stations grew faster than the number of FFS dialysis beneficiaries, and the growth in the number of FFS dialysis beneficiaries and total number of treatments was relatively flat. The 17 percent marginal profit in 2017 suggests that dialysis providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—Between 2012 and 2017, mortality, hospitalization, and 30-day readmission rates declined, though the proportion of FFS dialysis beneficiaries using the emergency department increased. With regard to anemia management, negative cardiovascular outcomes associated with the use of high levels of erythropoiesis-stimulating agents declined, and blood transfusions, which initially increased under the PPS, have trended downward since 2013. Between 2012 and 2017, beneficiaries' use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 9.5 percent to 11 percent of dialysis beneficiaries. The first-year (2016) results of the accountable care organization model specific to dialysis providers, the ESRD Seamless Care Organization model, were positive; for example, there were fewer inpatient admissions for beneficiaries, and all 13 organizations in the model produced savings relative to their benchmarks. It is not clear if this trend will continue; the results for 2017 and 2018 are not yet available.

Providers' access to capital—Access to capital for dialysis providers continues to be strong. The number of facilities, particularly for-profit facilities, continues to increase. Under the dialysis PPS, the two largest dialysis organizations have grown through acquisitions and mergers with midsized dialysis organizations.

Medicare payments and providers' costs—Between 2016 and 2017 cost per dialysis treatment increased by 2 percent, while Medicare payment per treatment increased by 0.6 percent. We estimate that the aggregate Medicare margin was –1.1 percent in 2017, and the 2019 Medicare margin is projected at –0.4 percent.

In light of these findings, the Commission recommends that for 2020, the Congress update the ESRD PPS base rate by the amount determined under current law.

Cross-cutting issues in post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2017, FFS program spending on PAC services totaled $58.5 billion.

The Commission has previously discussed the challenges to increasing the accuracy of Medicare's payments and overcoming the shortcomings of the separate FFS payment systems for PAC. Over more than a decade, the Commission has worked extensively on PAC payment reform, pushing for closer alignment of costs and payments and more equitable payments across different types of patients.

As discussed in Chapter 7, despite some actions by the Secretary and the Congress, Medicare's payments remain too high relative to the costs of treating beneficiaries in three of the four settings (SNF, HHA, and IRF). In addition, the current HHA and SNF payment systems create inequities across patients with different care needs and the providers that treat them. These overpayments and misalignments threaten the long-run sustainability of the program and create incentives for providers to treat some types of cases over others. Furthermore, they affect the benchmarks for Medicare Advantage plans and alternative payment models. However, after years of research and recommendations by the Commission, the Secretary is poised to make substantial changes to the payment systems Medicare uses to pay HHAs and SNFs that will increase the equity of Medicare's payments within each of these settings. These changes are consistent with longstanding recommendations made by the Commission.

A uniform payment system for all PAC would increase the equity of payments across patients and providers in all PAC settings, but its implementation is on a longer timetable. Until a unified PAC PPS is in place, Medicare must continue to improve its setting-specific payment systems.

To assess the quality of post-acute care, there has been progress in defining common outcome measures across PAC providers and establishing value-based purchasing policies for HHAs (on a demonstration basis) and SNFs. However, the Commission is increasingly concerned that trends in some provider-reported quality measures raise questions about the accuracy and reliability of this information. The Commission has work underway to examine the accuracy of the patient assessment–based quality measures.

Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2018, about 15,000 SNFs furnished 2.3 million Medicare-covered stays to 1.6 million FFS beneficiaries. Medicare FFS spending on SNF services was $28.4 billion in 2017, about 1 percent less than in 2016. Just over 4 percent of beneficiaries used SNF services.

As discussed in Chapter 8, most of our payment adequacy measures for SNFs are positive.

Beneficiaries' access to care—Access to SNF services remains adequate for most beneficiaries. The number of SNFs participating in the Medicare program has been stable. The vast majority (89 percent) of beneficiaries live in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and less than 1 percent live in a county without one. Between 2016 and 2017, the median occupancy rate declined slightly but remained high (85 percent). Medicare-covered admissions per FFS beneficiary decreased 2 percent between 2016 and 2017. Lengths of stay also declined by 2 percent. Both contributed to fewer covered days in 2017 compared with 2016. Lower SNF use reflects the growing presence of alternative payment models, not the adequacy of Medicare's payments. An indicator of whether freestanding SNFs have an incentive to treat more Medicare beneficiaries—marginal profit—averaged 19 percent for freestanding facilities in 2017.

Quality of care—Since 2011, SNF quality measures have shown mixed performance. The average rate of discharge to the community increased; the average rate of readmission during the SNF stay improved; the average rate of readmissions after the SNF stay worsened; and the measures of mobility remained the same. Changes in the measures between 2016 and 2017 were similarly mixed.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Despite relatively low total margins (a measure of the total financial performance across all payers and lines of business), lending and investment activities remain robust. Access to capital was adequate in 2018 and is expected to remain so in 2019. Lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—Medicare's spending in 2017 decreased 1 percent to $28.4 billion. In

2017, the average Medicare margin for freestanding SNFs was 11.2 percent—the 18th year in a row that the average was above 10 percent. Margins varied greatly across facilities, reflecting differences in costs and shortcomings in the SNF PPS that favor treating rehabilitation patients over medically complex patients.

Consistent with our previous years' recommendations, the Commission recommends that the Secretary proceed with his plans to implement a revised SNF PPS. Further, to keep the relative costs of stays aligned with payments, the Commission recommends that the relative weights of the case-mix groups be recalibrated annually.

To address the high level of Medicare's payments, the Commission recommends that the Congress eliminate the fiscal year 2020 update to the Medicare base rates. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with cost while exerting pressure on providers to keep their cost growth low.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes, but also covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities has declined slightly since 2013, by less than 1 percent, but remains close to 15,000. CMS reports total FFS spending on nursing home services declined 1.6 percent between 2016 and 2017 but projects small increases for 2019.

In 2017, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as hospice, ancillary services, home health care, and investment income)—was 0.5 percent, down from 2016 (0.7 percent). The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –2.4 percent, the same as in 2016.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2017, about 3.4 million Medicare beneficiaries received care, and the program spent $17.7 billion on home health care services. In that year, almost 12,000 HHAs participated in Medicare.

As we discuss in Chapter 9, the indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care—Access to home health care is adequate: Over 98 percent of beneficiaries lived in a ZIP code where an HHA operated in 2017, and 84 percent lived in a ZIP code with five or more HHAs. The number of HHAs fell slightly (by 3 percent) in 2017, but this decline follows a long period of growth in prior years. From 2004 to 2016, the number of HHAs increased by 60 percent. The decline in 2017 was concentrated in areas that experienced sharp increases in supply in prior years. From 2002 to 2016, home health utilization increased substantially, with the number of episodes rising nearly 60 percent and the episodes per home health user climbing from 1.6 to 1.9 episodes. In 2017, volume dropped 3.1 percent, the total number of FFS users also fell slightly, and the average number of episodes per home health user declined by 1.4 percent. Episodes not preceded by a hospitalization accounted for most of the growth since 2002, increasing from about half of episodes in 2002 to two-thirds of episodes in 2017. In 2017, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was 17.5 percent, suggesting a significant financial incentive for HHAs to serve Medicare patients.

Quality of care—In 2017, the rate of home health patients who were hospitalized or received treatment in the emergency room during an episode did not change significantly, while measures of functional status, such as improvement in walking and transferring, increased. However, the functional status measures should be interpreted cautiously because these measures are based on provider-reported data and could be affected by agency coding practices.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient

access to capital markets for their credit needs. Several acquisitions to increase capacity and expansion of capacity by publicly traded home health care firms indicate adequate access to capital. In 2017, the average all-payer margin for HHAs was 4.5 percent.

Medicare payments and providers' costs—In 2017, Medicare spending for home health care declined by 1.6 percent. However, between 2002 and 2016, spending increased by over 88 percent. For more than a decade, payments under the home health PPS have consistently and substantially exceeded costs. In 2017, Medicare margins for freestanding agencies averaged 15.2 percent. The projected margin for 2019 is 16.0 percent.

The high margins of freestanding HHAs have led the Commission to recommend that the 2020 home health PPS base payment rate be equal to the 2019 level reduced by 5 percent. However, this reduction will likely be inadequate to align Medicare payments with providers' actual costs, and further reductions through rebasing will likely be necessary. In past years, the Commission has recommended that payments be rebased in the year following a payment rate reduction, but this year's recommendation is complicated by the changes to home health payment set for 2020. A rebased payment rate should reflect the mix and level of services HHAs provide under the new payment policies because the mix of services and number of visits provided in an episode will likely change. These data will not be available until mid-2021.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2017, Medicare spent $7.9 billion on IRF care provided to FFS beneficiaries in about 1,180 IRFs nationwide. About 340,000 beneficiaries had around 380,000 IRF stays. On average, the Medicare FFS program accounted for 58 percent of IRF discharges.

As described in Chapter 10, our indicators of Medicare payment adequacy for IRFs are positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and of IRFs' marginal profit under Medicare's IRF prospective payment system suggest that capacity remains adequate to meet demand. After declining for several years, the number of IRFs increased in 2014 and continued to grow through 2016, reaching 1,188 facilities nationwide. In 2017, the number of IRFs declined slightly, to 1,178 facilities. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number of freestanding and for-profit IRFs has increased. In 2017, the average IRF occupancy rate remained at 65 percent, indicating that capacity is more than adequate to meet demand for IRF services. From 2016 to 2017, the number of Medicare FFS cases going to IRFs declined 2.7 percent, falling to 380,000 cases after having experienced small annual growth every year since 2010. The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 19.4 percent for hospital-based IRFs and 38.8 percent for freestanding IRFs—a very positive indicator of patient access.

Quality of care—The Commission tracks three broad categories of IRF quality indicators: risk-adjusted facility-level change in patients' functional and cognitive status during the IRF stay, rates of discharge to the community and to skilled nursing facilities, and rates of readmission to an acute care hospital. Most measures were steady or improved between 2012 and 2017.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for almost half of freestanding IRFs in 2017 and about a quarter of all Medicare IRF discharges, also has good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital. Access to capital in large part depends on total (all-payer) profitability. In 2017, the all-payer margin was 10.4 percent for freestanding IRFs and was 7.0 percent for hospitals with IRF units.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has grown steadily since 2009 and in 2017 stood at 13.8 percent. In 2017, Medicare margins in freestanding IRFs were 25.5 percent. In 2017, hospital-based IRF margins were comparatively low at 1.5 percent, but one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. To the extent that hospital-based IRFs routinely assess their patients as less disabled than do their freestanding

counterparts, their payments—and margins—will be systematically lower. For 2019, we project an aggregate Medicare margin of 11.6 percent for all IRFs.

This year, the Commission for the first time examined the financial performance of relatively efficient IRFs. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 18 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower costs.

On the basis of these factors, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2020. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and that (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research as necessary to improve the accuracy of payments and protect program integrity.

Long-term care hospital services

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and, for certain Medicare patients, have an average length of stay greater than 25 days. In 2017, Medicare spent $4.5 billion on care provided in LTCHs nationwide. About 103,000 FFS beneficiaries had roughly 116,000 LTCH stays. On average, Medicare FFS beneficiaries accounted for about two-thirds of LTCHs' discharges.

In fiscal year 2016, CMS began implementing a dual payment-rate structure for LTCHs that decreased payment rates for certain cases not meeting the criteria specified in the Pathway for SGR Reform Act of 2013. The extent to which LTCHs change their admission patterns to admit more cases meeting the criteria (cases that will thus be paid the standard LTCH PPS rate) will ultimately determine the industry's financial performance under Medicare. In Chapter 11, we focus some analyses on LTCHs with a high share (85 percent or more) of cases meeting the criteria in 2017, consistent with the goals of the dual payment-rate policy.

Beneficiaries' access to care—We have no direct measures of beneficiaries' access to needed LTCH services. While we consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish, we expect reductions in these metrics since the implementation of the new dual payment-rate structure that began in fiscal year 2016. The number of LTCHs began to decrease in 2013, but the decline has been more rapid since the implementation of the dual payment-rate structure. We estimate that the number of LTCHs decreased by 4.1 percent from 2016 to 2017 and by an additional 2.3 percent from 2017 to 2018. However, the average LTCH occupancy rate was 64 percent in 2017, suggesting that LTCHs have adequate capacity in the markets they serve. From 2016 to 2017, the number of LTCH cases decreased by 7.3 percent, continuing a four-year trend that began in 2013. The number of LTCH cases per FFS beneficiary also declined during this period (2016 to 2017) by 7 percent. However, from 2016 to 2017, the number of LTCH cases that met the criteria per 10,000 FFS beneficiaries increased by 3.6 percent. In 2017, marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit Medicare patients, averaged about 14 percent across all LTCHs and 16 percent for LTCHs with a high share (85 percent or more) of cases meeting the new criteria.

Quality of care—Consistent with prior years, non-risk-adjusted rates of direct LTCH to acute care hospital readmission, death in the LTCH, and death within 30 days of discharge were stable across all LTCH cases.

Providers' access to capital—LTCHs have begun altering their cost structures and referral patterns in response to the dual payment-rate structure. This transition, coupled with payment reductions to annual updates required by statute and moratoriums in effect for most of the past decade, have limited opportunities for growth in the near term and reduced the industry's need for capital.

Medicare payments and providers' costs—The aggregate Medicare margin for LTCHs was 3.9 percent across all cases in 2016. In 2017, the first year that all LTCHs began transitioning to the dual payment-rate structure, the aggregate Medicare margin was –2.2 percent. However, when we consider a cohort of LTCHs with a high share of cases that met the criteria, and thus admission patterns consistent with the goals of the dual payment-rate structure, the Medicare margin remained positive. Indeed, in 2017, LTCHs with 85 percent or more of their Medicare

cases meeting the criteria had a Medicare margin of 4.6 percent. We expect continued changes in admission patterns and cost structures of LTCHs in response to the implementation of the dual payment-rate structure. We project that LTCHs' aggregate Medicare margin for facilities with more than 85 percent of Medicare discharges meeting the criteria will be 1.2 percent in 2019.

On the basis of these indicators, and in the context of recent changes in payment policy, for fiscal year 2020 the Commission recommends that the Secretary increase the 2019 LTCH payment rate by 2 percent. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the criteria for the standard LTCH PPS rate.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2017, nearly 1.5 million Medicare beneficiaries (including more than half of decedents) received hospice services from 4,488 providers, and Medicare hospice expenditures totaled about $17.9 billion.

As discussed in Chapter 12, the indicators of payment adequacy for hospices are positive.

Beneficiaries' access to care—In 2017, hospice use increased across almost all demographic and beneficiary groups examined. In 2017, the number of hospice providers increased by about 2.4 percent due to growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers. In 2017, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased. For hospice providers, Medicare payments exceeded marginal costs by roughly 14 percent in 2016, suggesting that providers have an incentive to treat Medicare patients.

Quality of care—Limited quality data are available for hospice providers. In 2017, hospices' performance on seven quality measures related to processes of care at hospice admission was very high, but most of the measures appear to be topped out. Hospice Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey data for individual providers became available for the first time in 2018. Scores on the eight CAHPS measures were generally high; however, there is more variation and potential for improvement with the CAHPS measures than with the process measures.

Providers' access to capital—Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (5 percent increase in 2017) suggests capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers, for which capital may be more limited. Hospital-based and home health–based hospices have access to capital through their parent providers.

Medicare payments and providers' costs—The aggregate 2016 Medicare margin was 10.9 percent, up from 9.9 percent in 2015. The projected Medicare margin is 10.1 percent in 2019.

Given the margin in the industry and our other positive payment adequacy indicators, the Commission recommends that hospice payment rates be reduced by 2 percent in 2020. This recommendation would bring payment rates closer to costs, would lead to savings for beneficiaries and taxpayers, and would be consistent with the Commission's principle that it is incumbent on Medicare to maintain financial pressure on providers to constrain costs.

The Medicare Advantage program: Status report

Chapter 13 provides a status report on the Medicare Advantage (MA) program. In 2018, the MA program included about 3,100 plan options offered by 185 organizations, enrolled over 20 million beneficiaries (33 percent of all Medicare beneficiaries), and paid MA plans about $233 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and current quality indicators in MA.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from

the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the extra benefits and alternative delivery systems that private plans often provide. Because Medicare pays private plans a risk-adjusted per person predetermined rate rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which were generally higher than FFS, and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS nationally, even as plans have received increased payments because of higher risk coding and quality bonus rules. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while MA enrollment continues to grow. The pressure of lower benchmarks has led to improved efficiencies and more competitive bids that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive.

Enrollment—Between November 2017 and November 2018, enrollment in MA plans grew by 8 percent—or 1.6 million enrollees—to 20.5 million enrollees. Among plan types, HMOs continued to enroll the most beneficiaries. Special needs plan enrollment grew by 13 percent, and employer group enrollment grew by 12 percent.

Plan availability—Access to MA plans remains high in 2019; 99 percent of Medicare beneficiaries have access to an MA plan and 97 percent have an HMO or local preferred provider organization (PPO) plan operating in their county of residence. Regional PPOs are available to 74 percent of beneficiaries. Plan availability continues to grow; the average beneficiary in 2019 has 23 available plans. Compared with 2007, MA enrollment in 2018 was more heavily concentrated. The top 10 MA organizations (ranked by enrollment) had 74 percent of total enrollment in 2018, compared with 61 percent in 2007.

Plan payments—Using the 2019 plan bid data, before adjusting fully for coding intensity, we estimate that 2019 MA benchmarks (including quality bonuses), bids, and payments will average 107 percent, 89 percent, and 100 percent of FFS spending, respectively. Adjusting for uncorrected coding intensity differences would increase the ratio of MA payments to FFS spending by 1 percent to 2 percent; hence, MA payments would average about 101 percent to 102 percent of FFS spending. On average, quality bonuses in 2019 will add 4 percent to the average plan's base benchmark and will add 2.4 percent to plan payments. Lower benchmarks have led to more competitive bids from plans: Bids have dropped from roughly 100 percent of FFS before the Patient Protection and Affordable Care Act of 2010 to 89 percent of FFS in 2019.

Risk adjustment and coding intensity—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 expenditures and are based in part on diagnoses that providers code. Most claims in FFS Medicare are paid using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify ordering a procedure. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses: Higher enrollee risk scores result in higher payments to the plan.

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, leaving MA risk scores and payments about 1 percent to 2 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. The adjustment for 2019 will be 5.9 percent. The Commission previously recommended that CMS change the way diagnoses are collected for use in risk adjustment and calculate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.

Quality in MA—Chapter 13 summarizes our concerns with the MA star rating system that is the basis for plan bonuses and public reporting of plan quality. Because of the way the system has been implemented, it is not possible to accurately compare quality among plans or track changes in MA quality over time, and plans can receive quality bonus payments when they are not

warranted. In addition, we continue to lack information that would permit a comparison of MA quality with the quality of care in FFS.

MA star ratings are determined at the contract level, with many quality results determined based on a small sample of medical records. Because contracts can cover wide geographic areas and because of the sample-size issue, contract-level reporting does not capture geographic variation in quality and is unable to adequately identify variation among subgroups of the Medicare population. Using encounter data as the source of quality metrics in MA and moving to market areas as the reporting unit would address this concern. Moving to encounter-based metrics in MA would also permit comparisons between MA and claims-based metrics in FFS.

MA plans receive quality bonuses if they have a star rating of at least 4 stars on a 5-star scale. An issue of concern to the Commission has been the practice of plan sponsors consolidating contracts so that nonbonus contracts acquire the star rating of the "surviving" contract. At the end of 2018, about 550,000 beneficiaries were moved from nonbonus plans to bonus-level plans through contract consolidations, and the sponsors will receive unwarranted bonus payments for those enrollees. This concern has been partly addressed through recent legislation, which provides that, starting at the end of 2019, the star rating for consolidated contracts will be based on an enrollment-weighted average of the results of each contract that is being consolidated.

The Medicare prescription drug program (Part D): Status report

Chapter 14 provides a status report on Part D plans. In 2018, Part D plans were the primary source of outpatient prescription drug coverage for 43.9 million Medicare beneficiaries. Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing to 12.5 million individuals with low income and assets. In 2017, Part D expenditures totaled $93.9 billion. Enrollees paid $14.0 billion of that amount in plan premiums, in addition to what they paid in cost sharing.

Part D has been a success in many respects. It has improved beneficiaries' access to prescription drugs. Generic drugs now account for nearly 90 percent of the prescriptions filled. Enrollees' average premiums for basic benefits have remained around $30 per month for many years. More than 8 in 10 Part D enrollees report they are satisfied with the program.

However, changes to Part D's coverage gap and manufacturer discounts combined with the expanding role of high-cost medicines may be eroding plans' incentives for cost control. Over time, as more enrollees have reached the catastrophic phase of the benefit, a growing share of Medicare's payments to plans have taken the form of cost-based reinsurance subsidies rather than capitated payments. In addition, beginning in 2019, brand-drug manufacturers must provide a 70 percent discount in the coverage gap (an increase from 50 percent). This change correspondingly decreases what plan sponsors must cover in benefits and likely weakens sponsors' incentives to manage spending. A separate concern is that Part D's LIS may lead to plan and beneficiary incentives that increase program costs.

Policymakers are taking steps to give plan sponsors new flexibilities to manage drug spending. For example, CMS now allows for certain midyear formulary changes without prior approval. However, measures to increase the financial risk that sponsors bear (such as those recommended by the Commission in 2016) are also needed so that plan sponsors have greater incentive to use the new management tools and keep Part D financially sustainable for beneficiaries and taxpayers.

Enrollment in 2018 and benefit offerings for 2019—In 2018, 73.3 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 2.5 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 24.2 percent were divided roughly equally between those who had creditable drug coverage from other sources and those with no coverage or coverage less generous than Part D.

Between 2007 and 2018, enrollment grew faster in MA–Prescription Drug plans (MA–PDs) compared with stand-alone prescription drug plans (PDPs). In 2018, 42 percent of enrollees were in MA–PDs compared with 30 percent in 2007. Over the same period, the share of enrollees who received the LIS fell from 39 percent to 28 percent.

For 2019, beneficiaries continue to have a broad choice of plans. Sponsors are offering 15 percent more PDPs and 21 percent more MA–PDs than in 2018. MA–PDs continue to be more likely than PDPs to offer enhanced

benefits. In 2019, 215 premium-free PDPs are available to enrollees who receive the LIS. With the exception of 1 region (Florida), all regions have at least 3 and as many as 10 PDPs for LIS enrollees at no premium.

Part D program costs—Between 2007 and 2017, Medicare payments to Part D plans and employers increased from about $46 billion to about $80 billion (average annual growth of 5.6 percent). Medicare's reinsurance (which covers 80 percent of enrollees' spending in the catastrophic phase of the benefit) grew at an average annual rate of nearly 17 percent and continues to be the fastest growing component of program spending. Also in this period, the portion of the benefits paid to plans through capitated direct subsidies fell from 55 percent to 21 percent, while the portion paid through Medicare's reinsurance grew from 25 percent to 54 percent. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) continued to drive Part D spending. In 2016, high-cost enrollees accounted for 58 percent of all Part D spending, up from about 40 percent before 2011. Among high-cost enrollees, nearly all growth in spending was due to increases in the average price per prescription filled. 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 meet their out-of-pocket threshold, up from just 33,000 in 2010.

Quality in Part D—In 2019, the average star rating among Part D plans decreased somewhat for PDPs and remained about the same for MA–PDs. However, the trend among MA–PD sponsors of consolidating contracts to achieve higher star ratings leads us to question the validity of MA–PD ratings and the comparison between PDPs and MA–PDs. It is not clear that current quality metrics help beneficiaries make informed choices among their plan options. In the past, the Commission has expressed concerns about the effectiveness of plans' medication therapy management (MTM) programs to improve the quality of pharmaceutical care due to the lack of financial incentives for sponsors of stand-alone PDPs. In 2017, CMS implemented the enhanced MTM program that rewards PDPs for reducing medical spending. Initial results indicate that half of the participating plans successfully reduced medical spending by 2 percent or more, qualifying them for a higher premium subsidy in 2019. We are encouraged by the initial results.

Redesigning Medicare's hospital quality incentive programs

The quality of hospital care has improved in recent years, in part due to Medicare's four hospital quality incentive programs: the Hospital Inpatient Quality Reporting Program, Hospital Readmissions Reduction Program (HRRP), Hospital-Acquired Condition Reduction Program (HACRP), and hospital value-based purchasing (VBP) program. Nevertheless, the Commission has several concerns about the design of these programs, which we discuss in Chapter 15.

The Commission asserts that quality measurement should be patient oriented, encourage coordination, and promote delivery system change. Based on our principles for quality measurement, in our June 2018 report to the Congress we examined the potential to create a single, outcome-focused, quality-based payment program for hospitals—the hospital value incentive program (HVIP). Initially, the HVIP can incorporate existing quality measure domains such as readmissions, mortality, spending, patient experience, and hospital-acquired conditions (or infection rates). The HVIP uses clear, prospectively set performance standards to translate hospital performance on these quality measures to a reward or penalty.

Adjusting measure results for social risk factors can mask disparities in clinical performance. Therefore, the HVIP that we modeled accounts for differences in providers' patient populations by incorporating a peer-grouping methodology, in which quality-based payments are distributed 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 income). The HVIP redistributes pools of dollars to hospitals in the peer groups based on their quality performance. The pools of dollars are funded by a payment withhold from all hospitals in the peer group (e.g., 5 percent) and a portion of the current-law hospital payment update. Under the Commission's HVIP model, the use of peer grouping of hospitals that serve different populations makes payment adjustments more equitable compared with the existing quality payment programs.

Consistent with the Commission's principles, the HVIP links payment to quality of care to reward hospitals for efficiently providing high-quality care to beneficiaries. Accordingly, the Commission recommends that the

Congress replace Medicare's current hospital quality programs with this new 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; and accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping. As we discuss in Chapter 3, the Commission recommends that payments in the HVIP be increased by the difference between the Commission's update recommendation for acute care hospitals and the amount specified in current law. The increased payment in the HVIP will better reward hospitals providing higher quality care. In addition, eliminating the existing penalty-only programs (i.e., the HRRP and HACRP) would have the effect of removing about $1 billion in penalties that hospitals currently pay each year.

Mandated report: Opioids and alternatives in hospital settings—Payments, incentives, and Medicare data

Chapter 16 is the Commission's response to the mandate in the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 for the Commission to describe how Medicare pays for both opioid and non-opioid pain management treatments in hospital inpatient and outpatient settings, incentives under the inpatient and outpatient prospective payment systems 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. Bundled payments are applied differently in the two settings. The inpatient prospective payment system (IPPS) assigns stays to categories (Medicare severity–diagnosis related groups) based on patients' conditions and sets payment bundles that reflect the average costs of providing all goods and services supplied during the stay. The outpatient prospective payment system (OPPS) also groups services into categories (ambulatory payment classifications), but on the basis of clinical and cost similarity, and sets payment bundles to cover the costs of providing integral goods and services and items along with the primary service. Additional goods and services are paid separately or are not paid under the OPPS.

Some observers have questioned whether Medicare's hospital payment systems create financial incentives for providers to choose opioids over non-opioid alternatives. The IPPS and OPPS payment bundles create a financial incentive for hospitals to be cost conscious in selecting goods and services. Medicare's quality measurement and reporting programs, along with providers' clinical expertise and professionalism, are designed to balance this financial incentive. Ideally, these balanced incentives result in high-quality outcomes at the best prices for beneficiaries and other taxpayers. However, if opioids were systematically cheaper than non-opioid alternatives, providers might be more inclined to opt for them, especially if doing so did not affect performance on quality measures. We analyzed publicly available prices for opioid and non-opioid alternatives commonly used in the hospital setting and found that both opioids and non-opioids are available at a range of list prices, including expensive and inexpensive options for both. Thus, there is no clear indication that Medicare's IPPS or OPPS discriminates against non-opioids. Indeed, hospitals that select more expensive options for clinical reasons have tools available to them, such as reducing length of stay, to partially or fully offset these costs.

Our study is not intended to be an assessment of the clinical appropriateness of the use of opioids versus non-opioid alternatives. Clinicians' decisions about which analgesic drugs to prescribe are based on a multitude of patient-specific factors. Furthermore, we recognize that there are incentives in addition to financial ones that may have an even greater influence on clinicians' choice of pain treatments, such as effects on patient experience, length of stay, need for additional nursing services, and—most important—the management of potential risks and clinical efficacy. However, these motivations are not unique to the Medicare IPPS and OPPS, so to comply with the mandate's due date, we focused on the extent to which these payment systems introduce financial incentives.

CMS monitors opioid use through claims and other data in the Part D program. The tools used in the Part D program include the Medicare Part D Overutilization Monitoring System, which ensures that Part D plan sponsors implement the opioid overutilization policy effectively; quality measures to track trends in opioid overuse across the Medicare Part D program and to drive performance improvement among plan sponsors; and the publicly available Medicare Part D opioid prescribing mapping tool.

Medicare does not operate similar tracking programs in Part A or Part B. Given concerns about the opioid crisis,

policymakers may wish to direct CMS to track opioid use in 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 monitoring program. There are at least three options for implementing a Part A and Part B opioid tracking program: (1) require prescription drug event–type reporting, (2) include all pain management drugs in Part A and Part B claims, and (3) link Part D opioid use to hospitals responsible for its initiation. ■