
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 on issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services. In the nine chapters of this report we consider the following:

- ***Using competitive pricing to set beneficiary premiums in Medicare***—Medicare could seek to encourage beneficiaries to choose the more efficient option (traditional fee-for-service (FFS) or Medicare Advantage (MA)) for receiving Medicare benefits in different geographic areas. The incentives for beneficiaries to choose more efficient (high quality, low cost) models would be designed to reinforce the incentives that encourage providers and plans to provide care in a more efficient manner. We examine three illustrative designs that could be considered for achieving these goals.
- ***Medicare’s new framework for paying clinicians***—The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) system and established a new approach to updating payments to clinicians. This approach creates incentives for clinicians to participate in alternative payment models (APMs). We present basic principles to guide the implementation of the APM provisions and discuss some key considerations for the Merit-based Incentive Payment System also created by MACRA.
- ***Developing a unified payment system for post-acute care***—The Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT) requires the Commission to develop a prototype prospective payment system (PPS) spanning the post-acute care (PAC) settings. Our work confirms that a PAC PPS is feasible and within reach. Given the long-standing problems with Medicare’s payment for PAC, moving to a unified PAC PPS is desirable, and the chapter outlines a series of design considerations. A truly reformed PAC payment system will ultimately need to embrace episode-based payments.
- ***Medicare drug spending in its broader context***—The Commission remains concerned about the rapid growth in drug prices because that growth can affect beneficiary access to needed medications as well as the financial sustainability of the Medicare program. But Medicare is part of a larger drug marketplace, and the program’s drug payment policies can only affect drug pricing indirectly. Here, we consider external factors that influence the prices Medicare pays for prescription drugs.
- ***Medicare Part B drug and oncology payment policy issues***—Medicare Part B covers drugs that are administered by infusion or injection in clinicians’ offices and hospital outpatient departments. It also covers certain drugs furnished by suppliers. We discuss several broad issues: potential modifications to the way Medicare Part B pays for drugs in general (e.g., reducing dispensing and supplying fees) and approaches to improve the quality and efficiency of oncology care in particular (e.g., clinical pathways and bundling) since more than half of Medicare Part B drug spending is associated with anticancer drugs.
- ***Improving the Medicare Part D prescription drug program***—The Commission has documented several years of rapid growth in the reinsurance portion of Part D. Here, we recommend improvements intended to put Part D on a more stable financial path. One set of changes would give plan sponsors greater financial incentives and stronger tools to manage the benefits of high-cost enrollees. Other parts of the Commission’s recommendations would exclude manufacturer discounts on brand-name drugs from counting as enrollees’ true out-of-pocket (OOP) spending, while providing greater insurance protection through a real cap on OOP spending. The recommended improvements would also moderately increase financial incentives for enrollees who receive the low-income subsidy (LIS) to use lower cost drugs and biologics.
- ***Improving efficiency and preserving access to emergency care in rural areas***—Efficiently providing access to inpatient and emergency services is a growing challenge in sparsely populated rural areas. We discuss giving isolated rural hospitals the option of converting to an outpatient-only model that may be more sustainable in communities with declining inpatient volumes. The objectives of a new outpatient-only option would be to ensure access to essential services. We outline two potential options for communities that lack the population to

support efficient high-quality inpatient services: a 24/7 emergency department model and a clinic with ambulance services model.

- ***Telehealth services and the Medicare program***—We present our analysis of telehealth services—a multidimensional set of health care services delivered through a range of online, video, and telephone communication. This chapter is intended to inform policymakers as they consider how telehealth services will fit into the Medicare program in the future. The Commission raises issues for policymakers to consider in addressing the question of expanding telehealth services in Medicare under the MA program, under bundled and accountable care payment models, and under the traditional FFS model.
- ***Issues affecting dual-eligible beneficiaries: CMS’s financial alignment demonstration and the Medicare Savings Programs***—We provide a status report on the financial alignment demonstration project—an initiative by CMS and states to test new models of care for dual eligibles—and examine the potential cost of three illustrative scenarios for expanding the Medicare Savings Programs (MSPs), which are Medicaid programs that provide assistance with Medicare premiums and cost sharing to certain low-income Medicare beneficiaries.

Using competitive pricing to set beneficiary premiums in Medicare

Medicare has different payment rules for its FFS and MA programs that can create inequities and inefficiencies for beneficiaries and taxpayers. The Commission has been studying how Medicare could structure its premium designs to encourage beneficiaries to choose the most efficient (high quality, low cost) option for receiving Medicare benefits across different geographic market areas. It will be important to understand the options available for the determination of beneficiary premiums if the Congress considers a premium support model in Part A and Part B of Medicare. (Medicare already uses a premium support model for its Part D drug benefit.)

In Chapter 1, we examine the potential of three illustrative premium designs to encourage beneficiaries to use the more efficient delivery system (FFS Medicare—which includes accountable care organizations (ACOs)—or MA) in their area. These designs are:

- a nationally set base premium that buys FFS Medicare in every market;

- a nationally set base premium that buys either FFS Medicare or a reference MA plan—whichever costs less—in each market; and
- locally set base premiums that buy either FFS Medicare or a reference MA plan—whichever costs less—in each market.

Under each design, beneficiaries can enroll in either FFS or MA, but the premium they pay will differ depending on the underlying per capita spending for FFS and MA. The federal contribution will be financially neutral across payment systems—that is, equal for FFS and MA in each market.

Under the second and third designs, beneficiaries who choose the more costly payment system will pay a higher premium. How much higher that premium would be depends on the difference between average FFS costs and the cost of the reference MA plan in the geographic market area. Under either design, policymakers could choose to mitigate the increase in beneficiary premiums in a number of ways, such as by limiting how much premiums can vary across delivery systems or by phasing in any increase over time.

The statutory and structural differences between MA and FFS (and ACOs, although they are considered part of FFS), including elements beyond premium design, raise important issues of equity and implementation that will need to be resolved to maximize the value of the Medicare program to beneficiaries and taxpayers. Medicare needs to determine whether and how to establish payment and quality rules that reward the more efficient system of care in a market, how to encourage beneficiaries to receive care through that system, and how to provide the information beneficiaries need to make informed decisions.

Medicare’s new framework for paying clinicians

MACRA repealed the SGR system and established a new approach to updating payments to clinicians. This new approach creates incentives for clinicians to participate in APMs such as ACOs, bundled payment models, and medical homes. Essentially, MACRA establishes two paths for payment updates—a path for clinicians who participate in eligible alternative payment entities and a path for all other clinicians.

Beginning in 2019 and continuing through 2024, payment updates are set to zero, but clinicians will receive a 5

percent add-on payment if the level of revenue they receive through eligible alternative payment entities meets a certain threshold. From 2026 on, clinicians meeting the revenue threshold will receive a higher update than other clinicians. A separate program for assessing the performance of clinicians who do not qualify for the APM incentive payment—the Merit-based Incentive Payment System (MIPS)—will determine whether those clinicians receive a bonus or a penalty on their FFS payments. Thus, how CMS defines eligible alternative payment entities and how clinicians qualify for the incentive payment are of great interest to clinicians. At the same time, MIPS bonuses and penalties—although budget neutral in aggregate—could have a large effect on payments for individual clinicians and hence on the relative attractiveness of the APM and MIPS paths.

Chapter 2 presents the Commission’s principles that should guide the development of APMs and discusses some key considerations for the design of MIPS. The Commission intends its discussion to be a road map to thinking through the issues raised in MACRA and helping move the Medicare program from one oriented toward FFS payment to one that encourages delivery system reform oriented toward payment for value. The Commission’s basic principles for APMs are the following:

- Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
- The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
- The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
- The eligible alternative payment entity should have the ability to share savings with beneficiaries.
- CMS should give eligible alternative payment entities certain regulatory relief.
- Each eligible alternative payment entity should assume financial risk and enroll clinicians.

With regard to MIPS, we outline some lessons that can be learned from CMS’s experience with the existing performance incentive programs that may be incorporated into the eventual MIPS program, and we discuss how to consider factors such as quality and resource use

at the individual clinician level. We also reinforce the Commission’s position that quality measures should emphasize population-based outcomes.

We conclude with observations on the importance of coordinating MIPS and APM implementation to reduce the chance of unintended consequences. In developing and implementing these programs, the broader challenge will be to further the sustainability of the Medicare program and ensure access to services for Medicare beneficiaries.

Mandated report: Developing a unified payment system for post-acute care

IMPACT requires the Commission to develop a PPS that spans the four PAC settings—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities, and long-term care hospitals. The Act requires the Commission to recommend features of a unified PAC PPS and, to the extent feasible, consider the impact of moving to such a payment system. Chapter 3 meets this requirement.

In Chapter 3, we report that a PAC PPS is within reach. The Commission’s research found that it is feasible to develop a common unit of payment for PAC services, with patient and stay characteristics forming the basis of risk adjustment. Available administrative data can accurately predict the costs (and establish payments) for most of the patient groups we examined, but patient assessment data collected using a common assessment tool would increase the accuracy for certain types of stays. We conclude the following:

- Because of differences in Medicare’s coverage policies across the PAC settings, separate models will be needed to establish payments for nontherapy ancillary services and for the combination of routine and therapy services.
- Because costs are so much lower in HHAs compared with institutional PAC settings, payments for stays in HHAs will need to be adjusted to avoid large overpayments.
- A short-stay outlier policy (to prevent large overpayments) and a high-cost outlier policy (to prevent large losses by providers and protect beneficiary access to care) will be necessary components of a PAC PPS.
- Payment adjustments to capture differences in costs beyond providers’ control (such as the cost of labor)

should be made on an empirical basis only and should apply to all stays, regardless of setting.

- Initial payments can be based on current practices and costs, but over time, payments should be revised to reflect appropriate, high-quality care provided as efficiently as possible.

We estimate that a PAC PPS would redistribute payments among types of stays (e.g., from physical rehabilitation to medically complex care). Under a PAC PPS, profitability would be more uniform across different types of stays or patients; therefore, providers would have less financial incentive to admit certain types of patients over others. At the same time, payment would no longer be based in part on the number of services furnished, so providers would have less financial incentive to provide unnecessary services. A PAC PPS would also redistribute payments from higher cost settings and providers to lower cost settings and providers. We would expect PAC providers to be responsive to the policy changes that would accompany a PAC PPS. Specifically, we would expect that high-cost providers would lower their costs to match the PAC PPS payments and that all providers would change their coding practices to record patient diagnoses more completely.

To temper the initial impact of the PAC PPS, policymakers may wish to consider a transition period for implementation of a new payment system for PAC to give providers time to adjust their costs to PAC PPS payments. Conversely, given our encouraging results using currently available data, the Secretary could consider implementing a unified PAC PPS sooner than is currently legislated, with refinements made over time to incorporate patient assessment data.

Policymakers will also need to consider the level of payments. The Commission estimates that, in 2013, payments for PAC were 19 percent higher than the cost of stays, suggesting the continued need for rebasing. A transition policy should consider when and how large the rebasing should be. The Secretary should also have the authority to periodically rebase payments so they remain aligned with costs. As in any payment system, the relative weights that adjust the base payments would need to be recalibrated regularly to reflect changes in practice patterns. The Secretary would need to monitor the impacts of the new PAC PPS carefully to detect inappropriate provider responses and other adverse effects and to make refinements as warranted.

Next, we discuss setting-specific regulations that might be waived at the same time the PAC PPS is implemented to “level the playing field” among providers in different settings. Over the longer term, the Secretary should consider developing a “core” set of conditions of participation for all PAC providers and a limited set of additional requirements for providers that opt to treat patients who require specialized care. Regulations should focus on what is required to treat specific types of patients rather than on requirements geared to specific institutional settings. In addition, as Medicare moves to a unified PAC PPS, the program should consider standard cost sharing when beneficiaries use any PAC service.

Although a common PPS for PAC stays would begin to rationalize Medicare’s payments, it would not correct the underlying incentives in FFS payment to increase volume or provide low-quality care if it is less costly to do so. Therefore, along with a PAC PPS, the Secretary should implement a readmission policy to prevent unnecessary hospital readmissions and a value-based purchasing policy to tie payments to outcomes (to protect beneficiaries against stinting) and resource use (to prevent unnecessary service use, including serial PAC stays).

In the longer term, however, Medicare needs to move providers toward greater accountability for spending and quality over an episode of care. Providers would be at financial risk for the entire episode of care, thereby dampening the incentive to provide unnecessary care and encouraging care coordination. A unified PAC PPS should be considered a good transition to broader episode-based payment reforms that encourage care organized around the episodes. Finally, the Commission emphasizes that until a PAC PPS is implemented, CMS and the Congress need to move forward with standing recommendations that would improve the accuracy and equity of payments within each setting.

Medicare drug spending in its broader context

It is becoming increasingly difficult for Medicare to ensure that access to medications remains affordable for beneficiaries while keeping Medicare financially sustainable for taxpayers. Medicare’s influence on drug pricing is indirect: Providers, private health plans, and pharmacy benefit managers negotiate drug prices, and these market-based dynamics largely determine Medicare drug costs. At the same time, factors external to Medicare significantly influence the prices the program pays for prescription drugs.

Chapter 4 provides this context for better understanding the Commission’s analyses of Medicare’s payments for drugs covered by Part B and Part D (which are presented in subsequent chapters). The chapter describes the roles of other government agencies involved in funding basic pharmaceutical research and in the process of regulating the market for drugs in the United States.

Medicare Part B drug and oncology payment policy issues

Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. It also covers certain drugs furnished by suppliers. Medicare pays for most Part B–covered drugs based on the average sales price (ASP) plus a 6 percent add-on. In 2014, Medicare and its beneficiaries paid nearly \$21 billion dollars for Part B–covered drugs paid under this method. Chapter 5 explores potential modifications to the way Medicare pays for Part B drugs, including the following:

- **Restructuring the ASP add-on payment**—There are concerns that the 6 percent add-on to ASP may create incentives for use of higher priced drugs when lower priced alternatives exist, although few studies have looked at this issue. We modeled a policy option that changes part of the 6 percent add-on to a flat fee.
- **Promoting price competition**—By definition, the largest component of Medicare’s payments for Part B drugs is the ASP, not the 6 percent add-on. If policymakers wish to influence Part B drug payments to a larger degree than possible through add-on payments, they could consider Medicare payment policies that create more incentives for price competition among drugs or that put downward pressure on the ASP. We examine three such policy options. The first would limit the amount that Medicare’s ASP-based payment for a drug could grow during a specified period of time, which could help insulate the program from substantial price increases. The second would combine billing codes for Part B drugs with similar health effects into consolidated codes, to spur price competition among those drugs. The third policy would restructure Medicare’s prior competitive acquisition program (through which physicians could obtain Part B drugs from a Medicare-selected vendor) as a way to create more robust incentives for efficient, high-quality care than currently exist under the ASP payment system.

- **Reducing dispensing and supplying fees**—Medicare Part B pays substantially higher dispensing fees for inhalation drugs and supplying fees for oral anticancer, oral antiemetic, and immunosuppressive drugs than the rates paid by Medicare Part D plans and Medicaid. The Commission recommends reducing the Part B dispensing and supplying fees to rates similar to those paid by other payers.

Chapter 5 also considers approaches to improve the quality and efficiency of oncology care since more than half of Medicare Part B drug spending is associated with anticancer drugs. In the Commission’s June 2015 report to the Congress, we began to examine bundled approaches as a mechanism to make providers sensitive to the cost of the entire episode of care for the oncology patient (e.g., the hospitalization as well as the Part B drugs associated with a cancer care treatment regimen). For this report, we examined four approaches designed to improve the efficiency of oncology care. Two of these approaches are oncology clinical pathways and risk-sharing agreements made between product manufacturers and payers. Two broader approaches take a more holistic view of cancer care by improving care management and coordination. These approaches include oncology medical homes and bundling Part B oncology drugs with non-oncology services, which would hold providers accountable for the total cost of services across an episode of care.

Improving Medicare Part D

In 2015, more than 39 million Medicare beneficiaries received outpatient prescription drug coverage through Part D. A key goal for the Part D program is to ensure that beneficiaries have access to appropriate medications while keeping the program financially sustainable for beneficiaries and taxpayers. The current structure of Part D (which started in 2006) reflects a system of federal protections designed to encourage broad participation of private plan sponsors in a (then) new program. The markets for both Medicare Advantage prescription drug plans and stand-alone prescription drug plans are now firmly established, and it is time to consider whether the program’s incentives need to be restructured to better ensure financial sustainability.

The Commission has documented many years of spending increases in Medicare’s open-ended reinsurance subsidy paid to plans for their enrollees’ catastrophic drug spending. Much of those spending increases have been driven by the growing number of enrollees without the LIS who reach the OOP threshold and by increases in

the average price of drugs (which reflects both growth in drug prices and changes in the mix of drugs used). Going forward, many new biopharmaceutical products in the development pipeline will have substantially higher prices than previous treatments, even if the drugs have therapeutic competitors. These new, more expensive products will exert strong upward pressure on beneficiary premiums and program costs borne by the taxpayer.

In keeping with the Part D program's market-based approach, in Chapter 6 the Commission recommends improvements intended to prepare Part D for the future. Together, the recommendations make up a package of interrelated steps. One set of changes would give plan sponsors greater financial incentives and stronger tools to manage the benefits of high-cost enrollees. Medicare's overall subsidy of basic Part D benefits would remain unchanged at 74.5 percent, but plan sponsors would receive more of that subsidy through capitated payments rather than open-ended reinsurance payments. Over a transition period, Medicare would significantly lower the amount of reinsurance it pays plans from 80 percent of spending above Part D's OOP threshold to 20 percent. When combined with the Commission's recommendation to provide greater OOP protection for beneficiaries, the insurance risk that plan sponsors bear for catastrophic spending would rise from 15 percent to 80 percent. At the same time, we recommend that plan sponsors be given greater flexibility to use formulary tools to manage benefits. Other parts of the Commission's recommendations would exclude manufacturer discounts on brand-name drugs from counting as enrollees' true OOP spending, while providing greater insurance protection to all non-LIS enrollees through a real OOP cap. Although some enrollees would incur higher OOP costs than they do today, beneficiaries with the highest levels of drug spending would see reductions in OOP costs. The recommended improvements would also moderately increase financial incentives for enrollees who receive the LIS to use lower cost drugs and biologics.

Under the combined recommendations, Part D's set of risk adjusters would become more important as a tool for counterbalancing plan incentives for selection, and CMS would need to take steps to recalibrate the risk adjustment system. Similarly, because plans would have greater flexibility to use management tools, CMS would need to continue monitoring plan operations to ensure appropriate beneficiary access, such as reviewing formularies and pharmacy networks. The agency would also need to ensure

that the appeals and grievance procedures under Part D function effectively.

Improving efficiency and preserving access to emergency care in rural areas

Efficiently providing access to inpatient and emergency services is a growing challenge in sparsely populated rural areas. Declining populations can lead to fewer hospital admissions and reductions in efficiency, which can cause financial and staffing difficulties for hospitals. Low volumes may also make it difficult for clinicians at rural hospitals to have enough experience with different types of patients and clinical situations to provide outcomes equal to neighboring facilities with higher volume.

Most rural hospitals are critical access hospitals (CAHs), which receive cost-based payment for Medicare inpatient and outpatient services. The CAH model requires a hospital to maintain acute inpatient services, which is not the best solution for all rural communities. Many small towns do not have a population size sufficient to support efficient, high-quality inpatient services. However, such communities may be reluctant to discontinue providing inpatient services because doing so would mean giving up the supplemental payments that their hospitals receive through the CAH cost-based payment model. Other hospitals are paid under the PPS, and their supplemental payments for being small rural providers are also tied to maintaining inpatient services. Chapter 7 discusses two models that would allow communities in which CAHs and PPS hospitals lack the patient volume needed to support efficient, high-quality inpatient services to voluntarily shift to an outpatient-only model while maintaining some supplemental Medicare funding that would keep these entities financially viable:

- **24/7 emergency department model**—Under this model, the supplemental payments hospitals currently get for maintaining CAH inpatient services are redirected to support stable access to emergency care. A rural hospital that gives up acute inpatient services and cost-based payment would receive an annual grant or fixed payment from Medicare to help cover the standby costs of 24/7 emergency services. The facility would also be paid Medicare outpatient hospital PPS rates for outpatient services (including emergency care, radiology services, lab services, and telehealth services). The facility would be paid Medicare SNF PPS rates if it chose to use inpatient beds as SNF beds.

- **Clinic and ambulance model**—Under this model, communities that cannot support a 24/7 emergency department could opt to convert their existing inpatient facilities into a primary care clinic with an affiliated ambulance service. Similar to the federally qualified health center model, Medicare would pay prospective rates for primary care visits and ambulance transports. It would also provide an annual grant or fixed payment to support the capital costs of having a primary care practice, the standby costs of the ambulance service, and uncompensated care costs.

As the Commission has maintained in previous reports, supplemental payments beyond the standard PPS rates should be targeted to isolated rural providers that are essential for access to care. Keeping an emergency department open that is a short distance (e.g., 2 or 10 miles) away from a competitor is not the same public policy priority as keeping an emergency department open that is a larger distance (e.g., 30 or 60 miles) away from all other providers. Therefore, a new program to support stand-alone emergency departments in rural areas should be limited to facilities that are located at some minimum distance in road miles from the nearest hospital (or comparable level of care).

Telehealth services and the Medicare program

Chapter 8 provides the Commission’s analysis of telehealth services—a multidimensional set of health care services delivered through a range of online, video, and telephone communication. The chapter is intended to inform policymakers as they consider how telehealth services will fit into the Medicare program in the future. Certain forms of telehealth may have the ability to improve access to and quality of care while reducing costs. Two key issues affecting costs are whether telehealth services are a supplement to or a substitute for existing services and whether the potential for more convenient services would generate new utilization.

Medicare’s coverage of telehealth under FFS is limited to certain services and providers and to care provided in rural locations. MA plans must cover telehealth services that are covered under FFS Medicare and can provide telehealth services that are adjunct to delivering services covered under FFS Medicare. In addition, MA plans can cover telehealth services as extra benefits beyond what FFS Medicare covers, if approved by CMS. Medicare also permits providers participating in certain special programs run by the Center for Medicare & Medicaid Innovation

to provide telehealth benefits beyond those covered under FFS Medicare.

Medicare telehealth use is low but has grown rapidly in recent years. Medicare beneficiaries using telehealth services tend to be under 65, disabled, and dually eligible for Medicare and Medicaid, and they tend to reside in rural areas. Beneficiaries use telehealth services for psychiatric care and basic medical consultations. Outside of the Medicare program, interest in telehealth services has grown also, but the use of these services is not widespread. Commercial insurers and most state Medicaid programs cover some telehealth services to expand convenience and access to primary care. A growing share of large-scale employers provide telehealth services to create convenience for their employees and reduce their health care spending. The Department of Veterans Affairs has also implemented telehealth programs for its patients.

Evidence is mixed regarding the efficacy of telehealth services to expand access and create convenience, improve quality and outcomes, and reduce costs. Evidence that certain telehealth services improve access and create convenience is much stronger compared with that regarding quality improvement or cost reduction. Telehealth for patients with chronic conditions has shown some positive quality and cost results. More targeted research isolating specific telehealth interventions for specific patient populations is needed.

If policymakers consider expanding telehealth services in the Medicare program, they should differentiate among the financial incentives that exist under Medicare’s payment models. In MA, many bundled payment models, and ACOs, the financial risk of providing such services falls to the insurers or providers. By contrast, under traditional FFS Medicare, the additional cost for telehealth services would be borne by the Medicare program, unless such services were substitutes for traditional face-to-face clinical services.

Issues affecting dual-eligible beneficiaries: CMS’s financial alignment demonstration and the Medicare Savings Programs

Policymakers have long been concerned that dual-eligible beneficiaries—those who qualify for both Medicare and Medicaid—may receive fragmented or ineffective care because they are generally in poorer health than other Medicare beneficiaries and must obtain care through two distinct programs. These concerns also reflect the high costs of caring for dual-eligible beneficiaries. In

2011, dual eligibles represented about 20 percent of Medicare beneficiaries but accounted for about 35 percent of Medicare spending. For Medicaid, dual eligibles represented about 14 percent of enrollment and about 33 percent of total spending.

Chapter 9 provides a status report on the “financial alignment” demonstration project, an initiative by CMS and states to test new models of care for dual eligibles in 13 states. About 450,000 dual eligibles are currently enrolled in the demonstrations. Most demonstrations are testing a “capitated” model, which uses health plans known as Medicare–Medicaid Plans, or MMPs, to provide all Medicare and Medicaid benefits to dual eligibles. MMPs are required to provide extensive care coordination for their enrollees. MMPs vary in how they provide this care coordination and are still trying to refine and improve their approaches. Six MMPs have left the demonstration since it began, with some citing inadequate payment rates as one factor. CMS recently increased the payment rate for Part A and Part B services, based on research that the existing risk adjustment model tends to underestimate costs for full-benefit dual eligibles.

Enrollment in the MMPs has been lower than some expected. Under the demonstration, states can “passively” (that is, automatically) enroll dual eligibles in MMPs

to help ensure that the plans have enough enrollment to justify up-front investments in care coordination activities. However, many beneficiaries have opted out because they are satisfied with their existing care or are uncertain about how the demonstration will affect them. Passive enrollment has helped generate sufficient participation for most MMPs, but its use could be improved in the future.

Chapter 9 also examines the potential cost of three illustrative scenarios for expanding the Medicare Savings Programs (MSPs), which are Medicaid programs that provide assistance with Medicare premiums and cost sharing to certain low-income Medicare beneficiaries. We summarize MSP eligibility rules and assistance and examine the potential effects of expanding MSP eligibility under three illustrative scenarios. The scenarios highlight some of the key issues that policymakers would need to consider as part of an MSP expansion, such as the relationship between the eligibility rules for MSPs and those for the Part D low-income subsidy, how much Medicare cost-sharing assistance MSPs should provide (in particular, whether states can continue to limit their payments for cost sharing), and whether MSPs should be federalized in some fashion. ■