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 2018 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.
- consider post-acute care as a whole and note that payment levels in several of the payment systems are too high and the payment systems themselves need to be revised.
- review the status of the MA plans (Medicare Part C) that beneficiaries can join in lieu of traditional FFS Medicare and recommend a change to the calculation of MA benchmarks.
- review the status of the plans that provide prescription drug coverage (Medicare Part D).

The goal of Medicare payment policy is to get 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. This report includes a recommendation on MA and provides information on Part D, but most of its content focuses on the Commission's recommendations for the annual payment rate updates under Medicare's various FFS payment systems and on aligning relative payment rates across those systems so that patients receive efficiently delivered, high-quality care.

We recognize that managing updates and relative payment rates alone will not solve what have 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 are not routinely rewarded for care coordination. To address these problems directly, two approaches must be pursued. First, payment reforms such as incentives to reduce excessive hospital readmission rates need to be implemented more broadly and coordinated across settings, and efforts such as a unified payment system for post-acute care must be pursued expeditiously. 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. Medicare is likely to continue using its current 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—an important topic. In addition, constraining unit prices could 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, we present its rationale, its 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, they do not take into account the complete package of policy recommendations or the interactions among them. Although we recognize budgetary consequences, our recommendations are not driven by any single budget target, but instead reflect our assessment of the payment rate needed to provide adequate access to appropriate care.

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 addressing those challenges.

In 2015, total national health care spending was $3.2 trillion, or 17.8 percent of GDP. Private health insurance spending was $1.1 trillion, or 5.9 percent of GDP. Medicare spending was $646.2 billion, or 3.6 percent of GDP.

Health care spending growth shows signs of acceleration after several years of historic lows. From 1975 to 2009, total health care spending and Medicare spending grew, at average annual rates of 9.0 percent and 10.6 percent, respectively. Then from 2009 to 2013, those rates fell to 3.6 percent and 4.1 percent. From 2013 to 2015, Medicare actuaries estimate that spending grew faster: National health care spending grew at an average annual rate of 5.6 percent, and Medicare spending grew 4.6 percent.

The aging of the baby-boom generation will have a profound impact on both the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary will decline. By 2030 (the year all 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 3.3 in 2012. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2040, 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 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. Under the Patient Protection and Affordable Care Act of 2010 (PPACA), the Medicaid population is expanding; however, under current law, the federal government will pay for most of the costs associated with the expansion. 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, eliminating such spending would 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, but the Commission has a framework to address those challenges that focuses on payment accuracy and efficiency, care coordination and quality, information for patients and providers, engaged beneficiaries, and an aligned health care workforce.

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 discussed in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2017) 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 (policy year 2018). 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 our recommendations accurately reflect current conditions. We may also consider recommending changes that redistribute payments among providers 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.

Our recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Rates set to cover the costs of relatively efficient providers help create fiscal pressure on all providers to control their costs. Medicare rates also have broader implications for health care spending. For example, Medicare rates are commonly used to set hospital rates charged to uninsured patients eligible for financial assistance, used by Medicare Advantage plans to set hospital prices, and used by the Department of Veterans Affairs (VA) to pay non-VA providers.

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 rate on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting for financial reasons. However, putting into practice the principle of paying the same rate for the same service across settings can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across settings be sufficiently similar. In March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments and physicians' offices. In 2014, we extended that recommendation to additional services provided in those two settings and recommended consistent payment between acute care hospitals and long-term care hospitals for certain classes of patients. In the Bipartisan Budget Act of 2015, the Congress made payment to outpatient departments for certain services equal to the physician fee schedule rates for those same services provided at any new outpatient off-campus location beginning in 2018. In 2015, we recommended site-neutral payments to inpatient rehabilitation facilities (IRFs) for select conditions treated both in skilled nursing facilities and IRFs. The Commission will continue to analyze opportunities for applying this principle to other services and settings.

Hospital inpatient and outpatient services

In 2015, the Medicare FFS program paid 4,700 hospitals $178 billion for about 10 million Medicare inpatient admissions, 200 million outpatient services, and $8 billion of non-Medicare uncompensated care costs. This sum represents a 3 percent increase in hospital spending from 2014 to 2015. On net, inpatient payments increased by $2 billion and outpatient payments increased by almost $4 billion. Inpatient payments increased because of slight increases in prices, patient severity, and inpatient volume. Outpatient payments rose because of volume increases, price increases, and the continued shift of services from lower cost physician offices to higher cost hospital outpatient settings.

As we discuss 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 more Medicare beneficiaries because Medicare payment rates remain about 9 percent higher than the variable costs associated with Medicare patients. Thus, the Commission recommends that the Congress update the inpatient and outpatient payment rates by the amounts specified in current law.

Beneficiaries' access to care—The average hospital occupancy rate was 62 percent in 2015, suggesting that hospitals have excess inpatient capacity in most markets. Inpatient use per beneficiary increased by 0.4 percent in 2015, and use of outpatient services increased by 2.2 percent. The small increase in inpatient admissions per capita follows years of steady declines.

Quality of care—Hospital mortality and readmission rates have improved in recent years. Patient satisfaction also has improved, with the share of patients rating their hospital a 9 or 10 on a 10-point scale increasing from 69 percent in 2011 to 72 percent in 2015.

Providers' access to capital—Access to bond markets remains strong. While some hospitals struggle with low occupancy and limited access to capital, most hospitals have good access to capital due to strong all-payer profit margins. All-payer operating margins reached a record high in 2015.

Medicare payments and providers' costs—In 2015, hospitals' aggregate Medicare margin was –7.1 percent. Under current law, Medicare margins are projected to decline from 2015 to 2017 to approximately –10 percent. This decline in part reflects the sunsetting of IT subsidies and lower uncompensated care payments. Uncompensated care payments are projected to decline as more individuals enroll in Medicaid or private insurance. While average

Medicare payments were lower than average costs, Medicare payments were higher than the variable costs of treating Medicare patients in 2015—resulting in a marginal profit of about 9 percent. Therefore, hospitals with excess capacity still have a financial incentive to serve more Medicare patients.

As we discuss in Chapter 3, stand-alone emergency departments (EDs) have expanded in recent years. However, CMS is currently unable to track growth in stand-alone ED claims because the claims are not distinguished from hospitals' on-campus ED claims. Therefore, the Commission recommends that the Secretary require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities to allow CMS to track this growing category of providers.

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 2015, Medicare paid $70.3 billion for physician and other health professional services, accounting for 15 percent of FFS Medicare benefit spending. About 919,000 clinicians billed Medicare—over 581,000 physicians and nearly 338,000 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, Medicare's conversion factor for the fee schedule will be updated by 0.5 percent in 2018. The payment adequacy indicators below, which are discussed in Chapter 4, suggest that payments for physicians and other health professionals are adequate. Therefore, the Commission recommends an update for 2018 consistent with current law.

***Beneficiaries' access to care*—**Overall, beneficiary access to physician and other health professional services is comparable with prior years, although our access survey shows a slight decline compared with last year in the share of beneficiaries reporting that they never had to wait longer than wanted for regular, routine, illness, or injury care. 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 problems obtaining a specialist. The number of physicians per beneficiary has remained relatively constant, the number of advanced practice registered nurses and physician assistants per beneficiary has grown slightly, and the share of providers enrolled in Medicare's participating provider program remains high. In 2015, 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. The Commission has raised the following concerns with Medicare's current clinician quality programs: The reporting requirements are confusing and burdensome to providers, the process does not allow for comparability across providers, many measures are not linked to patient outcomes, and few measures assess low-value care. We also report three sets of population-based measures—avoidable hospitalizations and emergency department visits for ambulatory care–sensitive conditions and rates of low-value care in Medicare. Our results show substantial use of low-value care in FFS Medicare.

***Medicare payments and providers' costs*—**In 2015, Medicare payment rates for physician and other health professional services were 78 percent of commercial rates for preferred provider organizations, the same as in 2014. In addition, average annual physician compensation increased by 4 percent in 2015, although average compensation was much lower for primary care physicians than for physicians in specialty groups such as radiology and nonsurgical, procedural specialties—continuing to raise concerns about fee schedule mispricing and its impact on primary care. CMS currently projects that the 2018 increase in the Medicare Economic Index (which measures input prices) will be 2.4 percent.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2015, nearly 5,500 ASCs treated 3.4 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about $4.1 billion.

Our results indicate that beneficiaries' access to ASC services is adequate. Most of the available indicators of payment adequacy for ASC services, discussed in Chapter 5 and 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 2010 to 2014, the number of Medicare-certified ASCs grew at an average annual rate of 1.1 percent. In 2015, the number of ASCs increased 1.4 percent. Most new ASCs in 2015 (96 percent) were for-profit facilities. From 2010 through 2014, the volume of services per beneficiary grew by an average annual rate of 0.5 percent. In 2015, volume increased by 1.8 percent, which is higher than in recent years.

***Quality of care*—**ASCs began submitting data on quality measures to CMS in October 2012. CMS has made data from 2013 and 2014 publicly available for five of these measures. Among the ASCs that submitted data on these measures, quality appears to have improved from 2013 to 2014. However, CMS allowed ASCs to suppress their data on these measures, and some ASCs chose that option. Therefore, the data from the ASCs that submitted data may not necessarily represent the quality performance of the sector in general. For 2014, CMS has released quality data on four other measures. We have concerns about ASCs' performance on some of these measures. Reported quality data and claims analysis suggest possible areas of improvement for certain types of ASCs.

***Providers' access to capital*—**Because the number of ASCs has continued to increase, access to capital appears to be adequate.

***Medicare payments and providers' costs*—**Medicare payments per FFS beneficiary increased by an average of 2.8 percent per year from 2010 through 2014 and by 5.2 percent in 2015. 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.

Based on 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 2018. In addition, the Commission again recommends that CMS 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 2015, nearly 388,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 6,500 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services using a prospective payment system (PPS) based on a bundle of services. The bundle includes certain dialysis drugs and ESRD-related clinical laboratory tests that were previously paid separately. In 2015, Medicare expenditures for outpatient dialysis services were $11.2 billion, a slight decline of 0.1 percent compared with 2014 Medicare dialysis expenditures.

Our payment adequacy indicators for outpatient dialysis services discussed in Chapter 6 and below are generally positive. The Commission recommends that the Congress increase the outpatient dialysis base payment rate by the update specified in current law for calendar year 2018.

***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 2014 and 2015, the number of dialysis treatment stations grew slightly faster than the number of dialysis beneficiaries. Between 2014 and 2015, the number of FFS dialysis beneficiaries grew by 1.0 percent while the total number of treatments grew by 0.4 percent. At the same time, the per treatment use of most dialysis injectable drugs (including erythropoiesis-stimulating agents (ESAs), which are used in anemia management) continued to decline, but at a slower rate than during the initial years of the PPS (2011 and 2012). The dialysis PPS created an incentive for providers to be more judicious about their provision of dialysis drugs.

***Quality of care*—**Between 2011, when the outpatient dialysis PPS was implemented, and 2015, there was a declining trend in unadjusted mortality, hospitalization, and 30-day readmission rates, though emergency department use increased. Negative cardiovascular outcomes associated with high ESA use declined, and blood transfusion use, which initially increased under the PPS, trended down in 2014 and 2015. Beneficiaries' use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 9 percent to 11 percent of dialysis beneficiaries. However, home dialysis growth slowed between 2014 and 2015 because of a shortage of the dialysis solutions needed for the predominant home method, peritoneal dialysis. Another important aspect of quality is the appropriate timing of the initiation of dialysis. A potential concern is that the

proportion of patients with higher levels of residual kidney function upon the initiation of dialysis increased from 13 percent in 1996 to 43 percent in 2010.

Providers' access to capital—Information from investment analysts suggests that access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase. Since 2010, the two largest dialysis organizations have grown through acquisitions and mergers with midsized dialysis organizations and other providers, including physician services organizations.

Medicare payments and providers' costs—From 2014 to 2015, cost per treatment in freestanding dialysis facilities increased by 0.5 percent, while Medicare payment per treatment decreased by about 1.3 percent. We estimate that the aggregate Medicare margin was 0.4 percent in 2015, and the rate of marginal profit was 16.6 percent. We project a 2017 Medicare margin of –1.0 percent, which reflects a CMS accounting change that raises average costs. Without that change, the projected 2017 margin would be about the same as our estimate of the margin for 2015.

Post-acute care: The Congress and CMS must act to implement recommended changes to PAC payments

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2015, FFS program spending on PAC services totaled $60 billion.

As we discuss in Chapter 7, the Commission has two goals in making payment recommendations. The *update* recommendations aim to ensure that payments are adequate so that beneficiary access is preserved while taxpayers and the long-run sustainability of the program are protected. The recommendations to *revise the payment systems* aim to match program payments to the costs of treating patients with different care needs. Such targeting increases the equity of the program's payments so that providers have little financial incentive to treat some beneficiaries over others.

Over more than a decade, the Commission has worked extensively on PAC payment reform, proposing closer alignment of costs and payments, more equitable payments across different types of patients, and tying payment to performance on outcomes-based quality measures. While there has been some progress on the quality and value-based purchasing fronts, there have been few corrections to the known shortcomings of the SNF and HHA PPSs, and payments remain high relative to the costs of treating beneficiaries. As a result, the inequities in payment continue to encourage patient selection and to advantage some providers over others.

The cost to the program of not implementing the Commission's update recommendations is substantial. Across the four PAC settings, if this year's recommendations are implemented, we estimate that FFS program spending will be reduced by more than $30 billion over 10 years, all else being equal. The cost of past inaction is also considerable. Had the 2008 recommendations to eliminate the updates to payments for HHAs and SNFs been implemented, we estimate that FFS spending between 2009 and 2016 would have been $11 billion lower without affecting access. The Commission also recommended that the payment systems for SNFs and HHAs be revised to base payments on patient characteristics, not the amount of service furnished. Implementing these recommendations would have narrowed the differences in financial performance across providers within each setting while preserving the profitability of the SNF and HHA sectors. Because FFS payments are the basis of payments under alternative payment models (such as accountable care organizations and bundled payment initiatives) and are used to establish MA benchmarks, reducing post-acute payment rates would also reduce the level of spending in those models.

Although difficult to quantify, revising the SNF and HHA PPSs would have two other salutary effects. It would encourage practices to focus on the care needs of patients rather than the financial advantage of furnishing certain services and treating certain patients over others. In addition, rebalancing spending toward medically complex care would improve access for those patients who now may be less desirable for providers to treat.

The unnecessarily high level of spending and the inequity of payments across different types of patients has led the Commission to recommend changes to both the level and the designs of the payment systems. Further, given the similarity of some of the patients treated in the four PAC settings but substantial differences in the payments

made by Medicare, in June 2016 the Commission recommended features of a unified payment system. Like the recommended designs of the HHA and SNF PPSs, the unified PAC PPS would base payments on patient characteristics. Transitioning to a PAC PPS could begin as early as 2021; until then, CMS should move forward with revisions to the SNF and HHA PPSs. With consistent incentives, those revised payment systems will give providers valuable experience in managing care under payment systems that tailor payments to the care needs of patients.

Skilled nursing facility services

SNFs provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2015, about 15,000 SNFs furnished 2.4 million Medicare-covered stays to 1.7 million FFS beneficiaries. Medicare FFS spending on SNF services was $29.8 billion in 2015.

We report in Chapter 8 that key measures indicate Medicare payments to SNFs are adequate. We also find that relatively efficient SNFs—facilities identified as providing relatively high-quality care at relatively low costs—had very high Medicare margins, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

Beneficiaries' access to care—Access to SNF services remains adequate for most beneficiaries. The number of SNFs participating in the Medicare program is stable. The vast majority (88 percent) of beneficiaries live in a county with three or more SNFs or swing beds (a rural hospital with beds that can serve as both SNF beds and acute care beds), and less than 1 percent live in a county without one. Between 2014 and 2015, the median occupancy declined slightly but remained high (86 percent), with one-quarter of SNFs having rates at or below 75 percent. Covered admissions per FFS beneficiary increased between 2014 and 2015, consistent with increases in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services). At the same time, length of stay declined, resulting in a net reduction in covered days.

Quality of care—Between 2014 and 2015, the community discharge rate and the rates of hospital readmissions (during SNF stay and within 30 days after discharge) improved. The functional change measures were essentially unchanged.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Access to capital was adequate in 2016 but getting tighter and is expected to remain so in 2017. 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—In 2015, the average Medicare margin was 12.6 percent—the 16th year in a row that the average was above 10 percent. Margins continued to vary greatly across facilities, reflecting differences in costs and shortcomings in the SNF PPS, which favors treating rehabilitation patients over medically complex patients. The marginal profit was at least 20.4 percent. The projected Medicare margin for 2017 is 10.6 percent.

Medicare needs to revise the PPS and rebase payments. Over time, the overpayments for therapy services have gotten larger (giving providers an even greater incentive to furnish therapy services of questionable value), and payments for nontherapy ancillary services (most notably drugs) are even more poorly targeted than in prior years. In addition, Medicare Advantage (managed care) payment rates to SNFs are considerably lower than the program's FFS payments.

The Commission recommends that no update to SNF payment rates be made for two years (2018 and 2019) while the SNF PPS is revised. Then, in 2020, the Secretary should evaluate the need to make further adjustments to payments to bring them into better alignment with costs. This recommendation is consistent with our recommendation from 2016, and it reflects concerns about the SNF PPS that we have expressed for many years. The Commission is increasingly frustrated with the lack of statutory or regulatory action to lower the level of payments and revise the payment system.

As required by PPACA, we report on Medicaid use, spending, and non-Medicare (private-payer and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries who stay more than 20 days in a SNF. The number of Medicaid-certified facilities declined slightly (–0.5 percent) between 2015 and 2016. CMS estimates that total spending on nursing home services increased between 2014 and 2015 and again in 2016. In 2015, the average total margin, reflecting

all payers and all lines of business, was 1.6 percent, down slightly from 2014. The average non-Medicare margin was –2.0 percent, also lower than in 2014 (–1.5 percent).

Home health care services

HHAs provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2015, about 3.5 million Medicare beneficiaries received care, and the program spent about $18.1 billion on home health care services. In that year, over 12,300 agencies participated in Medicare.

The indicators of payment adequacy for home health care described in Chapter 9 and below are generally positive.

Beneficiaries' access to care—Access to home health care is generally adequate: Over 99 percent of beneficiaries lived in a ZIP code where a Medicare home health agency operated in 2015, and 86 percent lived in a ZIP code with five or more agencies. In 2015, the number of agencies fell slightly by 0.9 percent after a long period of growth. (From 2004 to 2014, the number of agencies increased by 63 percent.) The decline in 2015 was concentrated in areas that experienced sharp increases in supply in prior years. In 2015, the volume of services increased by 0.3 percent, reversing a three-year trend of modest decline. The total number of users increased slightly, while the average number of episodes per home health user declined by 0.6 percent. From 2002 to 2015, home health utilization increased substantially, with the number of episodes increasing by over 60 percent and the episodes per home health user increasing from 1.6 to 1.9 episodes. Episodes not preceded by a hospitalization account for most of the growth in this period, and between 2001 and 2015 these episodes increased from about half to two-thirds of total episodes.

Quality of care—In 2015, performance on quality measures improved. The share of beneficiaries reporting improvement in walking and transferring increased; the share of beneficiaries hospitalized during their home health spell decreased from 27.8 percent to 25.4 percent.

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 by large post-acute care companies to expand home health capacity indicate this sector is an attractive market to investors.

Medicare payments and providers' costs—Between 2014 and 2015, Medicare spending increased by 2.3 percent to $18.1 billion. For more than a decade, payments have consistently and substantially exceeded costs in the home health PPS. Medicare margins for freestanding agencies averaged 16.5 percent between 2001 and 2014 and were, on average, 15.6 percent in 2015. (The marginal profit for HHAs in 2015 was 18.1 percent.) The Commission projects that Medicare margins for 2017 will equal 13.7 percent.

The high Medicare margins of home health agencies have led the Commission to recommend a 5 percent reduction in the base rate for 2018 and a two-year rebasing beginning in 2019. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and taxpayers without impeding access to home health care services.

We also are recommending, as we have for the last five years, that Medicare eliminate the use of the number of therapy visits as a payment factor in the home health PPS, beginning in 2019. A review of utilization trends and further research by the Commission and others suggest that this aspect of the PPS creates financial incentives that distract agencies from focusing on patient characteristics when setting plans of care. Eliminating the number of therapy visits as a payment factor would base home health payment solely on patient characteristics, a more patient-focused approach to payment.

Inpatient rehabilitation facility services

IRFs provide intensive rehabilitation services to patients after an illness, injury, or surgery. Rehabilitation programs at IRFs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, and speech–language pathology services, as well as prosthetic and orthotic services. In 2015, Medicare spent $7.4 billion on FFS IRF care provided in about 1,180 IRFs nationwide. About 344,000 beneficiaries had more than 381,000 IRF stays. On average, Medicare accounts for about 60 percent of IRFs' discharges.

Our indicators of Medicare payment adequacy for IRFs discussed in Chapter 10 and below are generally positive.

Beneficiaries' access to care—IRF capacity remains adequate to meet demand. After declining for several years, the total number of IRFs increased between 2013 and 2014 and remained relatively stable in 2015. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number of freestanding and for-profit IRFs has increased. In 2015, the average IRF occupancy rate was 65 percent, indicating that capacity is adequate to meet demand for IRF services. Between 2014 and 2015, the number of FFS cases rose 1.5 percent to 381,000 cases.

Quality of care—Between 2011 and 2015, there were small improvements in rates of readmission to the acute care hospital and discharge to the community, as well as in two measures of functional change.

Providers' access to capital—The major freestanding IRF chain, which accounted for 46 percent of all freestanding IRFs in 2015 and about a quarter of all Medicare IRF discharges, has very good access to capital. In addition, the parent institutions of hospital-based IRFs continue to have good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital.

Medicare payments and providers' costs—Between 2014 and 2015, the aggregate IRF Medicare margin rose from 12.4 percent to 13.9 percent. The aggregate margin has risen steadily since 2009. Medicare margins in freestanding IRFs were especially high. Higher margins in freestanding IRFs were driven largely by unit costs that were considerably lower than those of hospital-based IRFs. Despite their lower margins, Medicare payments to hospital-based IRFs in 2015 exceeded marginal costs by 20.5 percent, indicating that hospital-based IRFs with available beds have a strong incentive to admit Medicare patients. Medicare payments to freestanding IRFs exceeded marginal costs by 41.5 percent. We project that IRFs' aggregate Medicare margin will be 14.3 percent in 2017.

The Commission has recommended that the update to IRF payments be eliminated each year since fiscal year 2009. However, in the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase. Thus, payments have continued to rise. In 2015, margins for freestanding IRFs reached an all-time high of 26.7 percent.

Based on these factors, the Commission recommends that the IRF payment rate for fiscal year 2018 be reduced by 5 percent. The reduction in the payment rate should be coupled with an expansion of the high-cost outlier pool, as previously recommended by the Commission, to redistribute payments within the IRF PPS and reduce the impact of potential misalignments between IRF payments and costs.

Long-term care hospital services

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 certain Medicare patients must have an average length of stay greater than 25 days. In 2015, Medicare spent $5.3 billion on care provided in LTCHs nationwide. About 116,000 FFS beneficiaries had roughly 131,000 LTCH stays in about 426 LTCHs. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs' discharges.

The indicators for payment adequacy are discussed in Chapter 11 and below.

Beneficiaries' access to care—Trends suggest that access to care has been maintained. Growth in the number of LTCHs slowed considerably in recent years because of two moratoriums. The first was in effect through December 28, 2012; the second is effective from April 1, 2014 through September 30, 2017. We estimate that the number of LTCHs and LTCH beds decreased by about 2 percent in 2015. From 2014 to 2015, the number of LTCH cases per beneficiary also declined by 2 percent, continuing a trend of decreasing per capita LTCH use that began in 2012.

Quality of care—LTCHs began submitting quality of care data to CMS starting in fiscal year 2013. CMS began publicly releasing provider-level quality data for two measures beginning in mid-December 2016 and plans to release two additional measures in the spring of 2017. Because quality data only recently became available, we continued to use claims data for our 2015 analysis. We found stable non-risk-adjusted rates of readmission, death in the LTCH, and death within 30 days of discharge across the top 25 LTCH diagnoses.

Providers' access to capital—For the past few years, the availability of capital to LTCHs has not reflected current Medicare payment rates but, rather, uncertainty regarding possible changes to Medicare's regulations and legislation governing LTCHs. The criteria to receive the higher LTCH

payment rate specified in the Pathway for SGR Reform Act of 2013, beginning with cost reporting periods starting in fiscal year 2016, provide more long-term regulatory certainty for the industry compared with recent years. However, payment reductions implemented by CMS and the moratorium on new LTCH beds and facilities through September 2017 continue to limit future opportunities for growth and reduce the industry's need for capital.

Medicare payments and providers' costs—From 2007 until 2012, LTCHs held cost growth below the rate of increase in the market basket index, a measure of inflation in the prices of goods and services LTCHs buy to provide care. Between 2012 and 2015, Medicare payments continued to increase, albeit more slowly than provider costs, resulting in an aggregate 2015 Medicare margin of 4.6 percent. Marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit more Medicare patients, equaled 20 percent in 2015. We expect changes in admission patterns and cost structure will occur in response to the patient-specific criteria implemented beginning in fiscal year 2016. We project that LTCHs' aggregate Medicare margin for these qualifying cases will be 5.4 percent in 2017.

Based on these indicators, the Commission concludes that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in fiscal year 2018.

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. Beneficiaries may choose to elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2015, more than 1.38 million Medicare beneficiaries (including nearly 49 percent of decedents) received hospice services from about 4,200 providers, and Medicare hospice expenditures totaled about $15.9 billion.

The indicators of payment adequacy for hospices, discussed in Chapter 12 and below, are positive.

Beneficiaries' access to care—Hospice use among Medicare beneficiaries has grown substantially in recent years. In 2015, hospice use increased across all demographic and beneficiary groups examined. However, rates of hospice use remained lower for racial and ethnic minorities than for White beneficiaries. The number of hospice providers increased by about 2.6 percent in 2015, due almost entirely 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 2015, the proportion of beneficiaries using hospice services at the end of life continued to grow, while average length of stay among decedents declined slightly. Between 2014 and 2015, average length of stay among decedents declined slightly from 88.2 days to 86.7 days, as a result of a decrease in length of stay among hospice decedents with the longest stays. The median length of stay for hospice decedents was 17 days in 2015 and has remained stable at approximately 17 or 18 days for more than a decade.

Quality of care—The first aggregate data on hospice quality have recently become available, and the quality scores are generally positive for most hospices and most measures. Since July 2014, hospices have been reporting data on seven measures of how frequently hospices perform certain care processes on admission that are considered important aspects of hospice care. Initial aggregate data analyzed by a CMS contractor found that most hospices scored high (greater than 90 percent) on six of the seven measures. Performance on the pain assessment measure was lower and more varied, with half of hospices scoring between 65 percent and 92 percent.

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 (a 5 percent increase in 2015) suggests capital is available to for-profit 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 2014 Medicare margin was 8.2 percent, down slightly from 8.5 percent in 2013. In addition, the rate of marginal profit—that is, the rate at which Medicare payments exceed providers' marginal cost—was roughly 11 percent in 2014. The projected aggregate Medicare margin for 2017 is 7.7 percent.

Because the payment adequacy indicators for which we have data are positive, the Commission recommends eliminating the update to hospice payment rates for fiscal year 2018.

Status report on the Medicare Advantage program

In Chapter 13, the Commission provides a status report on the MA program. In 2016, the MA program included 3,500 plans, enrolled more than 17.5 million beneficiaries (31 percent of all beneficiaries), and paid MA plans about $190 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. As a result of the analyses, we include a recommendation to adjust benchmarks.

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 alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques.

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 previous 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. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while enrollment in MA continues to grow. The pressure of lower benchmarks has led to improved efficiencies that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive.

Enrollment—From 2015 to 2016, enrollment in MA plans grew by about 5 percent to 17.5 million enrollees. MA plans enrolled about 31 percent of all Medicare beneficiaries in 2016, up from 30 percent in 2015. Among plan types, HMOs continued to enroll the most beneficiaries (11.7 million). Enrollment in local preferred provider organizations (PPOs) was 4.2 million, and regional PPO enrollment was 1.3 million. Enrollment in private fee-for-service plans was about 200,000.

Plan availability—Access to MA plans remains high in 2017, with most Medicare beneficiaries having access to a large number of plans. Ninety-five percent of Medicare beneficiaries have an HMO or local PPO plan operating in their county of residence, and on a beneficiary-weighted basis, the average beneficiary can choose from 18 plans in 2017. Overall, 99 percent of all Medicare beneficiaries have access to an MA plan.

MA enrollment is becoming more concentrated. The top 10 MA organizations (ranked by enrollment) had 70 percent of total enrollment in 2016, compared with 61 percent in 2007. Despite this concentration, on average by county, an increasing number of MA organizations are participating; between 2007 and 2015, the per county average number of MA organizations offering coordinated care plans (HMOs or PPOs) rose from 2.6 to 3.2.

Plan benchmarks and payments—For 2017, the base county benchmarks (in nominal dollars and before any quality bonuses are applied) average approximately 3 percent higher than the benchmarks for 2016, as compared with expected per capita FFS spending growth of 4 percent. The lower growth in MA benchmarks is due to the final year of the transition to lower benchmarks established in PPACA. Including quality bonuses and before adjustment for unaddressed coding intensity, we estimate that 2017 MA benchmarks will average 106 percent of FFS spending, bids 90 percent of FFS, and payments 100 percent of FFS. Lower benchmarks have led plans to bid more competitively; bids have decreased from about 100 percent of FFS before PPACA to about 90 percent of FFS in 2017. For 2017, about two-thirds of plans, accounting for about 75 percent of projected enrollment, bid below FFS.

On average, the quality bonuses in 2017 will add 4 percent to the average plan's base benchmark and will add 3 percent to plan payments. Removing quality bonuses from the benchmarks, base benchmarks would average 102 percent of FFS in 2017 and thus approach rough equity with FFS. However, because MA plans code more intensively, we estimate payments are effectively about 104 percent of FFS rather than the nominal 100 percent.

In addition, there are county-level equity issues regarding the calculation of MA benchmarks and payments. When

CMS calculates the county-level FFS spending measure, on which the benchmarks are based, it includes all of a county's FFS beneficiaries, regardless of whether these FFS beneficiaries are enrolled in both Part A and Part B. MA beneficiaries, however, are required to enroll in both Part A and Part B to join an MA plan. To make the calculation equitable across counties, the Commission recommends that the Secretary calculate benchmarks using FFS spending data only for beneficiaries enrolled in both Part A and Part B. Making this change would incur a cost to the Medicare program, which could be offset by implementing our March 2016 recommendation on coding intensity (see below).

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. 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 the procedure. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan. Higher coding intensity has resulted in MA enrollees having risk scores that were about 10 percent higher than scores for similar FFS beneficiaries, an increase over our prior-year estimate. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding. The adjustment for 2017 will be 5.66 percent. Last year, the Commission recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.

Quality measures—MA plans are able to receive bonus payments if the contract they are part of achieves an overall rating of 4 stars or higher in CMS's 5-star rating system. Between 2015 and 2016, the proportion of beneficiaries in MA plans with bonus-level ratings increased, while between 2016 and 2017, the share decreased. On net, about 1.2 million fewer current enrollees are in plans that are in bonus status under the 2017 star ratings. In part, these changes reflect higher thresholds for the attainment of 4-star ratings for some of the MA quality measures.

This year we continue to see the practice of contract cross-walking (consolidations under one contract) that results in unwarranted bonus payments. For example, one company is combining three regional contracts into one contract, resulting in two contracts (rated below 4 stars) with over 380,000 enrollees being absorbed into the company's 4-star contract that has 20,000 enrollees. In Chapter 13, we discuss ways of ensuring that bonus payments are available only for enrollees in high-performing plans when there has been cross-walking of contracts.

The cross-state consolidation of MA contracts over the past several years has eroded the ability to evaluate quality in the program because CMS evaluates quality at the contract, not the plan, level. More importantly, this consolidation also reduces the utility of star ratings as a plan comparison tool for beneficiaries. In many cases, star ratings do not reflect the quality of care in the local market area. The Commission has a long-standing recommendation to report quality measures by market areas and compare them with results for the FFS program in those areas. Currently, about one-third of MA enrollees are in contracts for which a substantial share of the enrollment is in noncontiguous states across the country.

Status report on the Medicare prescription drug program (Part D)

In 2015, Medicare spent $80.1 billion for the Part D benefit, accounting for 12 percent of total Medicare outlays. Enrollees' out-of-pocket spending for premiums and cost sharing totaled $11.5 billion and $15.1 billion, respectively. In 2016, 41 million individuals (72 percent of all Medicare beneficiaries) were enrolled in Part D: Of those enrolled, 60 percent were in stand-alone prescription drug plans (PDPs) and 40 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). In general, Part D has improved Medicare beneficiaries' access to prescription drugs, with plans available to all individuals.

In Chapter 14, the Commission provides a status report on the Medicare prescription drug benefit established under Part D. It describes beneficiaries' access to prescription drugs, enrollment levels, plan benefit designs, and the quality of Part D services. The report also analyzes changes in plan bids, premiums, and program costs.

Last year, we noted that a growing share of Part D program spending has been for high-cost enrollees—beneficiaries who reach the catastrophic phase of Part D's

benefit. This year's status report provides further evidence that this trend has continued, and we point to factors that contribute to greater catastrophic-phase spending. The Commission's June 2016 recommendations would address concerns about Part D's financial sustainability and affordability for its enrollees while maintaining the program's market-based approach.

Medicare beneficiaries' drug coverage in 2016 and benefit offerings for 2017—Among the 41 million Part D enrollees in 2016, 12 million received the low-income subsidy (LIS). Nearly 2 million additional individuals (3 percent of all beneficiaries) received drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. In 2013, the latest year of survey data available, 12 percent of beneficiaries had no drug coverage or coverage less generous than Part D. Our previous analysis showed that beneficiaries with no creditable coverage tended to be healthier, on average.

In 2017, plan sponsors are offering 746 PDPs, a 16 percent decrease from 2016, and 1,734 MA–PDs, a 3 percent increase from 2016. PDP reductions reflect mergers and acquisitions among plan sponsors, as well as consolidation of plan offerings into fewer, more widely differentiated products. Even with these consolidations, beneficiaries have between 18 and 24 PDPs to choose from, depending on where they live, as well as typically 10 or more Medicare Advantage options. MA–PDs continue to be more likely than PDPs to offer enhanced benefits. For 2017, 231 premium-free PDPs are available to enrollees who receive the LIS, a 2 percent increase from 2016. All regions of the country continue to have at least 3, and as many as 10, PDPs available at no premium to LIS enrollees.

In 2016, all of the 10 PDPs with the highest enrollment used a 5-tier formulary with differential cost sharing between preferred and other generics, preferred brand-name drugs, nonpreferred drugs, and a specialty tier for high-cost drugs. Also in 2016, nearly 85 percent of PDPs used tiered pharmacy networks that included preferred pharmacies offering lower cost sharing. These strategies provide financial incentives for enrollees to use lower cost drugs or pharmacies, potentially reducing program costs. However, these approaches likely will not result in lower Medicare spending for LIS enrollees because the LIS covers most or all of these enrollees' cost sharing, and thus they will continue to have little incentive to use preferred generics or pharmacies with preferred cost sharing,

Part D program costs—Between 2007 and 2015, Part D spending on an incurred basis increased from $46 billion to $80 billion (an average annual growth rate of more than 7 percent). Reinsurance has been the largest component of program spending since 2014 and grew at an average annual rate of 20 percent between 2007 and 2015. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) have started to drive Part D program costs, accounting for 53 percent of gross spending in 2015, up from about 40 percent before 2011. Spending for these high-cost individuals grew by more than 9 percent per enrollee, driven primarily by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used). The pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for individual reinsurance and the LIS.

Access to prescription drugs—Giving plans greater flexibility to use management tools could help ensure that prescribed medicines are safe and appropriate for the patient and could potentially reduce overuse or misuse. However, for some beneficiaries, those same tools could also limit access to needed medications. Plan sponsors must strike a balance between providing access to medications while encouraging enrollees to use lower cost therapies through their formulary designs. Medicare requires plan sponsors to establish coverage determination and appeals processes with the goal of ensuring access to needed medications. Beneficiary advocates, prescribers, plan sponsors, and CMS have all noted frustrations with Part D coverage determinations, exceptions, and appeals processes. A more efficient approach would be to resolve such issues at the point of prescribing through e-prescribing and electronic prior authorization rather than at the pharmacy counter.

Quality in Part D—In 2017, the average star rating among Part D plans increased somewhat for PDPs while remaining about the same for MA–PDs. However, the utility of star ratings to measure quality of prescription drug services may be limited because data for quality measures do not account for all clinically relevant factors. An additional concern of the Commission is the effectiveness of plans' medication therapy management

(MTM) programs to improve quality. In 2017, Medicare begins testing enhanced MTM programs by providing incentives for stand-alone PDPs to conduct medication reviews and tailor drug benefit designs that encourage adherence to appropriate drug therapies. Six Part D sponsors operating PDPs in 5 regions of the country, with an estimated 1.6 million enrollees, are participating in CMS's enhanced MTM model. ■