

Report to the Congress • March 2020

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. In its March 2020 report to the Congress, MedPAC makes payment policy recommendations for nine provider sectors in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and Medicare's prescription drug benefit (Part D). As requested by the Congress, we report on health care provider consolidation and its effects on Medicare, its beneficiaries, and other aspects of the delivery system. Lastly, pursuant to a statutory mandate, we report on our preliminary analysis of the effects of expanding Medicare's inpatient hospital post-acute care transfer policy to hospice, as required by the Balanced Budget Act of 2018.

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

To meet its legislative mandate, the principal focus of the March report is MedPAC's recommendations for annual payment rate adjustments (or "updates") under Medicare's various FFS payment systems. MedPAC assesses payment adequacy by examining beneficiary access to care (supply of providers, service use, and access surveys); quality of care; providers' access to capital; and provider costs and Medicare payments, where available. MedPAC's recommendations for the 2021 payment year are listed below.

Hospitals: Inpatient and outpatient services

- The Congress should:
 - for fiscal year 2021, update the fiscal year 2020 Medicare base payment rates for acute care hospitals by 2 percent; and
 - provide hospitals with an amount equal to the difference between the update recommendation and the amount specified in current law through the Commission's recommended hospital value incentive program (HVIP).

Physicians and other health professional services

- For calendar year 2021, the Congress should update the calendar year 2020 Medicare payment rates for physician and other health professional services by the amount determined under current law.

Ambulatory surgical center services

- The Secretary should require ambulatory surgical centers to report cost data.
- For calendar year 2021, in the absence of cost report data, the Congress should eliminate the update to the calendar year 2020 Medicare conversion factor for ambulatory surgical centers.

Outpatient dialysis services

- For calendar year 2021, the Congress should update the calendar year 2020 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

Skilled nursing facility services

- For fiscal year 2021, the Congress should eliminate the update to the fiscal year 2020 Medicare base payment rates for skilled nursing facilities.

Home health agency services

- For calendar year 2021, the Congress should reduce the calendar year 2020 Medicare base payment rate for home health agencies by 7 percent.

Inpatient rehabilitation facility services

- For fiscal year 2021, the Congress should reduce the fiscal year 2020 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Long-term care hospital services

- For fiscal year 2021, the Secretary should increase the fiscal year 2020 Medicare base payment rates for long-term care hospitals by 2 percent.

Hospice services

- The Congress should:
 - for fiscal year 2021, eliminate the update to the fiscal year 2020 Medicare base payment rates for hospice and
 - wage adjust and reduce the hospice aggregate cap by 20 percent.

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- Between 2018 and 2019, enrollment in MA plans grew by 10 percent to 22.6 million enrollees. In 2019, about 34 percent of all Medicare beneficiaries were enrolled in MA, and Medicare paid plans about \$274 billion (not including Part D drug plan payments) to manage beneficiaries' care. Among plan types, HMOs continue to enroll the most beneficiaries (about 14 million enrollees).
- In 2020, access to MA plans remains high: 99 percent of Medicare beneficiaries have access to an MA plan. Nearly all Medicare beneficiaries (98 percent) have an HMO or a local preferred provider organization (PPO) plan operating in their county of residence. In 2020, 93 percent of Medicare beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). The average beneficiary in 2020 has 27 plans to choose from, an increase from 23 in 2019.
- Medicare payments to MA plans are enrollee specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical costs and are based on diagnoses that providers code. MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan. For several years, the Commission has observed that risk scores for MA enrollees are higher than the risk scores of similar beneficiaries in FFS. Our updated analysis for 2018 shows that higher diagnosis coding intensity resulted in MA risk scores that were 8 percent higher than scores for similar FFS beneficiaries. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding. In 2018, the adjustment reduced MA risk scores by 5.91 percent. However, in the aggregate, MA risk scores and payments were still about 2 percent to 3 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. The Commission previously recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.
- In 2020, MA benchmarks and bids average 107 percent and 88 percent of FFS spending, respectively. We estimate that total Medicare payments to MA plans will average about 100 percent of FFS spending in 2020. Quality bonuses in 2020 will account for 2 percentage points to 3 percentage points of these payments. We estimate uncorrected coding intensity would add 2 percentage points to 3 percentage points to payments relative to FFS.
- Plans receive bonus payments if their contract has an overall rating of 4 stars or higher on CMS's 5-star rating system. Plans in a lower-performing contract can receive a bonus payment if their contract is

absorbed by a contract that is rated 4 stars or higher. In addition to unwarranted bonus payments, contract consolidations result in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area. The Commission previously recommended curtailing the practice of MA plan consolidation to obtain unwarranted quality bonus payments. This concern was partly addressed in the Bipartisan Budget Act of 2018, which provides that, beginning at the end of 2019, the quality rating for consolidated contracts be based on an enrollment-weighted average of the results of each contract.

- However, the Commission continues to have concerns with the MA star rating system, which serves as the basis for plan quality bonuses and public reporting of plan quality. MA star ratings continue to be determined at the contract level. Because contracts can cover wide (and discontinuous) geographic areas and quality results are often determined based on only a small sample of beneficiary medical records, Medicare and beneficiaries lack important information about the quality of care of MA plans in their market. As a result, the Commission can no longer provide an accurate description of the quality of care in MA. The Commission continues to work on developing a new value incentive program for MA.

STATUS OF THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)

- In 2019, over 74 percent of all Medicare beneficiaries (45.4 million beneficiaries) were enrolled in Part D plans. Among Part D plan enrollees, 12.7 million individuals received the low-income subsidy (LIS). An additional 2.3 percent of all Medicare beneficiaries received drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. The remaining 23.6 percent of Medicare beneficiaries were divided about equally between those who had other sources of coverage at least as generous as Part D and those with no coverage or less generous coverage.
- Of those Medicare beneficiaries enrolled in Part D in 2019, 44 percent were in Medicare Advantage–Prescription Drug plans (MA–PDs). Between 2007 and 2019, enrollment in MA–PDs grew at an average rate of 9 percent annually, while enrollment in stand alone prescription drug plans (PDPs) grew at an average annual rate of 4 percent. This trend in MA–PD enrollment is consistent generally with more rapid growth in MA enrollment than in FFS Medicare. For 2020, beneficiaries continue to have broad choice among plans, ranging from 24 to 32 PDPs depending on where they live. The average beneficiary also has 27 MA plans available to them, most of which offer prescription drug coverage.
- In 2018, Medicare spending for Part D benefits was nearly \$98 billion. Enrollee premiums made up about \$14 billion of that total (enrollees also paid cost sharing). Between 2007 and 2019, Part D spending increased at an average annual rate of 5.5 percent. The relatively small share of enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) continued to drive Part D program costs, accounting for 59 percent of gross spending in 2017. Spending for these high-cost individuals was driven almost entirely by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used). In 2017, more than 378,000 enrollees filled a prescription that was so expensive that their cost sharing for a single fill would have been sufficient to put them into the catastrophic phase of the benefit.
- Part D has improved beneficiaries' access to prescription drugs, generic drugs now account for nearly 90 percent of the prescriptions filled, and enrollees' average premiums for basic benefits have remained steady for many years (around \$30 per month).
- There are three types of payments Medicare makes to plan sponsors: direct subsidy payments (capitated monthly payments to plans that pay for expected benefit costs and reduce premiums for all enrollees), low-income subsidy payments (which pay for most of the premiums and cost sharing for LIS enrollees), and reinsurance payments (which pay for 80 percent of spending in the catastrophic portion of the benefit). Spending on reinsurance became the largest component of program spending in 2014 and has remained the fastest growing component.
- The growth in reinsurance and changes to Part D's benefit design combined with the expanding role of high-cost medicines may be eroding plans' incentives to manage benefit costs. Between 2007 and 2018,

reinsurance payments increased at an average annual rate of 16 percent. Over the same period, Medicare's fixed-dollar direct subsidy payments decreased 2.6 percent per year. As of 2019, brand-drug manufacturers must provide a 70 percent discount in the coverage gap (an increase from 50 percent provided between 2011 and 2018), decreasing plans' financial responsibility. This change further weakens plans' incentives to manage spending.

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

CONGRESSIONALLY REQUESTED REPORT: HEALTH CARE PROVIDER CONSOLIDATION

- In 2018, the Chairman of the House Committee on Energy and Commerce requested that MedPAC report on the effects of hospital mergers and physician–hospital consolidation. The Chairman also asked the Commission to examine the incentives in the 340B Drug Pricing Program for hospitals to use more expensive Part B drugs.
- In responding to this request, the Commission found that hospitals have been consolidating for many years and by 2017, in most markets, a single hospital system had more than a 50 percent share of discharges. An assumed incentive for hospital mergers is to gain efficiencies, but hospital consolidation also permits hospitals to leverage higher prices from commercial payers. Changes in federal policies might influence hospital mergers at any given point in time, but changes in Medicare payment rates, in health information technology incentives, and in overall hospital profitability have all occurred without materially altering the 30-year trend toward greater hospital consolidation.
- We found that greater hospital market power (a result of consolidation) has a statistically significant association with higher profit margins on non-Medicare patients and that higher non-Medicare margins have a statistically significant association with higher standardized costs per discharge. However, we could not conclusively demonstrate a statistically significant relationship between hospital market power and hospitals' cost per discharge.
- Medicare patients are initially insulated from the effect of hospital mergers because Medicare sets prices for the hospital services administratively. However, commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets.
- In contrast to what we observe regarding hospital consolidation, federal (Medicare) payment policies have contributed to encouraging hospital acquisition of physician practices. When hospitals acquire physician practices, it increases Medicare spending and beneficiary financial liability due to the introduction of hospital facility fees for physician services that are provided in hospital outpatient departments.
- The Commission examined whether the 340B Drug Pricing Program is associated with greater average cancer drug spending in a market area. To examine the potential influence of the 340B Drug Pricing Program, we examined Medicare spending for certain cancer drugs which account for the majority of Part B drug spending. We analyzed drugs used to treat five types of cancer and found statistically significant higher costs potentially related to the 340B program for two of those drugs. Those 340B effects, however, were much smaller than the effects of the general trend in oncology spending. Given the relative size of the potential 340B effect, the overall effect on beneficiary cost sharing is likely to be modest and vary by beneficiaries' supplemental coverage.

MANDATED REPORT: EXPANDING MEDICARE'S HOSPITAL POST-ACUTE CARE TRANSFER POLICY TO HOSPICE, PRELIMINARY RESULTS

- The Bipartisan Budget Act (BBA) of 2018 expanded the inpatient prospective payment system (IPPS) post-acute care (PAC) transfer policy, which reduces payments to hospitals for certain cases that are transferred to post-acute care providers, to include transfers to hospice beginning in fiscal year 2019. The BBA of 2018 mandates that the Commission evaluate and report on the effects of this policy change.
- As required by the statute, the Commission conducted a preliminary evaluation of the effects of the expansion of the PAC transfer policy to hospice on:
 - the number of discharges of hospital inpatients to hospice,
 - length of stay of patients in an inpatient hospital setting who are discharged to hospice, and
 - Medicare spending.
- In the first half of fiscal year 2019, the expansion of the PAC transfer policy to hospice resulted in a reduction in payments to IPPS hospitals of under \$200 million. However, we do not observe adverse changes in timely access to hospice care by hospital inpatients. Discharges to hospice among hospital inpatients increased slightly in this period, consistent with historical trends of increasing hospice use.
- Lengths of stay for hospital inpatients discharged to hospice varied quarter-to-quarter before the policy change. In the first two quarters of fiscal year 2019, lengths of stay for inpatients discharged to hospice were within the range observed in prior quarters.
- Preliminary results from the first six months indicate that the policy change produced small savings without any significant changes in Medicare FFS beneficiaries' timely access to hospice care. As with any analysis of early data, caution should be taken in generalizing from these results. Our final evaluation report due in March 2021 will provide an assessment of experience over the first 18 months of the policy.