Executive summary

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As part of its mandate from the Congress, each June the Commission reports on refinements to Medicare payment systems and issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services. In the 10 chapters of this report we consider:

- ***The effects of the Hospital Readmissions Reduction Program.*** In this mandated report, we conclude that the Hospital Readmissions Reduction Program contributed to a significant decline in readmission rates without causing a material increase in emergency department (ED) visits or observation stays or an adverse effect on mortality rates.
- ***Using payment to ensure appropriate access to and use of hospital emergency department services.*** To reduce the risk of ED services being undersupplied in rural areas and oversupplied in urban areas, we recommend two changes to Medicare payment for ED services.
- ***Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services.*** We describe a budget-neutral approach to rebalance the fee schedule that would increase payment rates for ambulatory evaluation and management services while reducing payment rates for other services.
- ***Paying for sequential stays in a unified prospective payment system for post-acute care.*** We consider refinements to a unified post-acute care (PAC) prospective payment system, focusing on increasing the accuracy of payment for cases that involve a course of PAC care—that is, sequential stays.
- ***Encouraging Medicare beneficiaries to use higher quality post-acute care providers.*** We discuss increasing the use of higher quality PAC providers. At discharge from an inpatient stay, the selection of a provider within a PAC category can be crucial because the quality of care varies widely among providers.
- ***Issues in Medicare's medical device payment policies.*** We explore ways to improve Medicare's payment policies for durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies. We also address how to constrain the risks posed by physician-owned distributors by making them more transparent to beneficiaries, enforcement agencies, and others.
- ***Applying the Commission's principles for measuring quality: Population-based measures and hospital quality incentives.*** We formalize the Commission's quality principles and apply them to two population-based outcome measures that may be used to evaluate quality of care for different populations. We also apply the principles to the design of a new hospital quality incentive program that combines measures of hospital outcomes, patient experience, and Medicare spending per beneficiary.
- ***Medicare accountable care organization models: Recent performance and long-term issues.*** We review the current Medicare accountable care organization (ACO) models and look at ACO performance on cost and quality thus far. Based on this review, we raise six issues that are important for two-sided-risk ACOs in the long term.
- ***Managed care plans for dual-eligible beneficiaries.*** We consider three potential policies to encourage the development of plans that integrate care for individuals who receive both Medicare and Medicaid (known as dual-eligible beneficiaries).
- ***Medicare coverage policy and use of low-value care.*** We find that the fee-for-service coverage process does not prevent the use of low-value services and that the use of such services is prevalent in Medicare. We describe six tools that Medicare could consider to reduce the use of low-value care.

Mandated report: The effects of the Hospital Readmissions Reduction Program

To encourage hospitals to reduce preventable readmissions, CMS began to publicly report hospitals' readmission rates for three conditions in 2009. In 2010, the Congress added a financial incentive to reduce readmission rates when it enacted legislation providing for the Hospital Readmissions Reduction Program (HRRP). At the same time, the Congress funded programs to help hospitals improve care transitions and reduce preventable readmissions. The end goal of reducing hospital readmissions is to relieve Medicare beneficiaries of the burden of returning to the hospital and to relieve taxpayers of the cost of unnecessary readmissions.

In the 21st Century Cures Act of 2016, Congress mandated that the Commission evaluate whether the recent declines in readmission rates were associated with offsetting increases in observation stays and ED visits. In Chapter 1, we first conclude that HRRP did indeed reduce readmission rates. We then consider the question in the mandate and, finally, evaluate whether hospitals that lowered their readmission rates saw an increase in mortality rates.

Hospitals' response to the HRRP has contributed to a large decline in readmissions since 2010, with the greatest declines being in conditions initially covered by the program (acute myocardial infarction (AMI), heart failure, and pneumonia). We measured the change in readmission rates from 2010 to 2016 and found that raw (not risk-adjusted) readmission rates fell by 3.0 percentage points for AMI, 2.2 percentage points for heart failure, and 1.7 percentage points for pneumonia, compared with 0.7 percentage points on average across conditions not covered by the program. Our analyses support the conclusion that the HRRP led to fewer readmissions.

- The rate of decline in *raw* readmission rates for heart failure and pneumonia and in *risk-adjusted* readmission rates for heart failure were faster by a statistically significant amount after HRRP's enactment (2010 to 2016) than in prior years.
- Raw and risk-adjusted readmission rates declined faster, on average, for conditions covered by the program than for other conditions. The difference is statistically significant.

After the reduction in readmission rates, some researchers expressed concerns that the lower rates may have induced an increase in observation stays or ED use. Our analysis found the following:

- Observation stays increased at a slightly faster rate after introduction of the HRRP. However, the increase in observation stays was small and offset only a small share of the reduction in readmissions. Therefore, we conclude that the reduction in readmission rates reflects real changes in practice patterns and not simply a shifting of short-stay admissions into observation stays to avoid readmission penalties. We also found similar rates of increase in observation stays among patients without a recent admission.
- ED visits increased after introduction of the HRRP. However, this increase appears to be due primarily to reasons other than the HRRP.

Some researchers have raised the question of whether efforts to reduce avoidable readmissions have also reduced necessary readmissions, resulting in higher mortality for heart failure patients. We examined readmission and mortality changes from 2010 to 2016. Our measure of mortality includes deaths that occurred during the hospital stay and within 30 days after discharge. We found no evidence to suggest that the readmission policy on net had a negative effect on mortality. To the extent that there was a small effect, our data as a whole suggest the HRRP may have done more to improve than harm mortality rates.

In summary, the HRRP gave hospitals an incentive to reduce inappropriate readmissions. After implementation of the HRRP, readmission rates declined, and our analysis suggests the decline was in part due to the HRRP. Beneficiaries endured fewer readmissions to the hospital, without an increase in risk-adjusted mortality. While the HRRP may have contributed slightly to the secular trend of increasing observation and ED use, the small increases in costs were far outweighed by reduced readmissions costs. (The decline in readmissions across all conditions resulted in net savings to the Medicare program of roughly $1.5 billion per year.)

Using payment to ensure appropriate access to and use of hospital emergency department services

Medicare's payment policies should foster adequate access to care and encourage efficient delivery of services. Maintaining access to ED services can be a challenge in remote rural areas, where a single hospital may be the sole source of ED care. If that hospital closes, access to emergency care can be lost. In contrast, efficiency can be a challenge in urban areas, where EDs can be in oversupply. New urban stand-alone EDs could result in patients being treated at higher cost EDs rather than lower cost urgent care facilities and physician offices. These facilities also could siphon off lower acuity patients from on-campus hospital-based EDs. To reduce the risk of ED services being undersupplied in rural areas and oversupplied in urban areas, in Chapter 2, we recommend two changes to Medicare payment for ED services.

Maintaining access to ED services can be challenging in isolated rural areas with low population densities.

Hospitals in many isolated rural areas have seen the number of inpatient cases fall dramatically; many hospitals now average less than one inpatient admission per day. However, Medicare will pay a facility for emergency services only if it maintains inpatient services. Therefore, small isolated communities that want an ED must maintain a low-occupancy inpatient department in the hospital.

As an alternative to maintaining empty inpatient beds, the Commission recommends a new payment model that would allow Medicare to pay for emergency services at outpatient-only hospitals in isolated rural areas (more than 35 miles from another ED). Isolated rural full-service hospitals that choose to convert to outpatient-only hospitals would receive the same standard prospective payment rates for ED visits as a full-service hospital. In addition, a set annual payment (common across all outpatient-only hospitals) would be made to help cover the facility's fixed costs.

The new payment option would allow rural communities that cannot support a full-service hospital to maintain access to emergency care in their community while retaining the option to convert back to a full-service hospital if circumstances changed. The recommendation would increase Medicare spending by less than $50 million per year.

Conversely, an oversupply of EDs can be a problem in urban areas. Urban hospitals can set up stand-alone EDs that bill Medicare as if they are part of the hospital's main ED as long as those EDs are located within 35 miles of the main hospital campus. We refer to these facilities as off-campus EDs (OCEDs). The number of OCEDs has increased rapidly in recent years, particularly in areas with high household incomes. The number of ED visits and the share of visits with high coded severity levels also have increased. Under Medicare's current payment system, providers have an incentive to add new OCEDs rather than urgent care centers, which are paid less than half the hospital ED rates.

Patients who seek care at OCEDs appear to have less complex care needs than those of patients served at on-campus hospital EDs. Ambulance operators typically take trauma, stroke, and heart attack patients to on-campus hospital EDs, which provide trauma services, operating rooms, and inpatient services. OCEDs do not incur the standby costs of these resource-intensive services. While urban OCEDs may provide some services not available at doctors' offices and urgent care centers, we conclude that Medicare overpays these facilities relative to what is paid to on-campus hospital EDs for more difficult cases.

Medicare currently has two levels of payments for OCEDs. One is for EDs open 24 hours a day, 7 days a week (Type A payment rates), and the other is for EDs open less than 24 hours a day, 7 days a week (Type B payment rates). In 2018, Type B payment rates are roughly 30 percent lower than Type A rates. The Commission recommends that Medicare pay urban OCEDs the Type A payment rates reduced by 30 percent—which would better align payments with costs and make off-campus ED rates similar to Type B rates. An exception would be needed for the one-quarter of urban OCEDs located relatively far (more than six miles) from on-campus EDs and that are more likely to provide unique access to ED services for their local communities (other exceptions could be contemplated when an urban OCED is essential to retain access—for example, if the OCED is the result of its parent hospital closing). Paying these more isolated urban OCEDs the full Type A payment rates would be justified to ensure continued appropriate access to emergency services. This recommendation also would reduce cost sharing for Medicare beneficiaries served at OCEDs close to on-campus EDs. Overall, this policy would reduce the financial incentive to develop new OCEDs and would lower Medicare spending by between $50 million and $250 million annually.

Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services

The Commission is concerned that ambulatory evaluation and management (E&M) services, such as clinician office and hospital outpatient visits, are underpriced in the Medicare fee schedule for physicians and other health professionals ("the fee schedule") relative to other services such as procedures. CMS has made incremental efforts to review potentially mispriced services over the last several years, but there is evidence that certain types of services are still overpriced. CMS's lack of current, accurate, and objective data on clinician work time and practice expenses is a key reason the review process has been inadequate. Under the fee schedule's budget-neutrality rules, the relative prices for ambulatory E&M services are too low because the prices for other services have become artificially high. We call this process "passive devaluation."

In Chapter 3, we describe a budget-neutral approach for rebalancing the fee schedule that would increase payment

rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests). Under this approach, the increased payment rates would apply to ambulatory E&M services provided by all clinicians. For illustration, we modeled the impact of a 10 percent increase in the payment rate for ambulatory E&M services (higher or lower increases could be considered). A 10 percent increase would raise annual spending for ambulatory E&M services by $2.4 billion. To maintain budget neutrality, payment rates for all other fee schedule services would be reduced by 3.8 percent.

Certain specialties would receive a large increase in their total fee schedule payments (on net) as a result of this change. The three specialties that would receive the highest proportional increases in payments are endocrinology, rheumatology, and family practice. Other specialties—including diagnostic radiology, pathology, physical therapy, and occupational therapy—would experience reductions in their fee schedule payments of about 3.8 percent because they provide very few ambulatory E&M services.

This change would be a one-time adjustment to the fee schedule to address several years of passive devaluation of ambulatory E&M services. Even if this approach is adopted, we urge CMS to accelerate its efforts to improve the accuracy of the fee schedule by developing a better mechanism to identify overpriced services and adjust their payment rates. If successful, these efforts would improve the accuracy of prices for ambulatory E&M and other services going forward and could reduce the need for future significant adjustments to the prices of E&M services. Together, these actions will help reduce the risk of beneficiaries experiencing problems accessing these services and will send a more positive signal to medical students and residents contemplating careers in specialties that provide large shares of these services.

Paying for sequential stays in a unified prospective payment system for post-acute care

Medicare uses separate prospective payment systems (PPSs) to pay for stays in each of the four PAC settings—skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). As a result, Medicare's fee-for-service (FFS) payments can differ substantially for similar patients treated in different settings. As mandated by the Congress, in June 2016, the Commission evaluated a prototype design and concluded that it was feasible to design a unified PAC PPS that spans the four settings and bases payments on patient characteristics. In June 2017, the Commission recommended that a unified PAC PPS be implemented beginning in 2021 with a three-year transition and a corresponding alignment of setting-specific regulatory requirements.

In Chapter 4, we consider a refinement to the unified PAC PPS that would increase the accuracy of payment for cases that involve a course of PAC care—that is, sequential stays, which we define as PAC stays within seven days of each other. We evaluate two payment issues related to sequential stays. The first has to do with the way the cost of a stay can vary, depending on where it falls in a sequence of PAC stays. The second involves how to identify, for payment purposes, distinct phases of care for a PAC provider that treats a patient "in place" as care needs evolve rather than refers the patient to another PAC provider. Under the unified PAC PPS, such providers would be financially disadvantaged unless the payment system included a way to trigger payments for different phases of care.

Our analysis of sequential PAC stays found different patterns of costs relative to estimated PAC PPS payments for home health stays and institutional PAC stays. For home health stays, payments under the unified PAC PPS would decrease over the course of a sequence of stays, but the cost of stays would decline more. These results suggest that payments for home health care need a separate downward adjustment for later stays, similar to the adjustment used in the current HHA PPS. By contrast, PAC PPS payments for institutional stays would remain reasonably well aligned with the cost of stays throughout a sequence of care.

However, under its current design, the prototype PAC PPS would not be able to appropriately pay a PAC provider that offered a range of PAC services and was able to treat in place beneficiaries with evolving care needs. For payment purposes, Medicare will need to define when one "stay" or phase of care ends and the next one begins. Otherwise, with only one admission and discharge date, providers would receive only one payment, creating a financial disincentive to treat in place.

Of the approaches we examined, the most promising involves episode-based payments; that is, Medicare would make a single payment for all post-acute care provided

during an episode of PAC. Payment could be made to a hospital, a health system, the PAC provider where the episode starts, an ACO, or a third-party convener that assumes financial risk for the episode. Under this approach, Medicare would not need to define and set payments for subsequent stays because the entity would be paid for the PAC provided during the episode, regardless of how many stays were encompassed.

The Commission will continue to explore episode-based payments over the coming year. Shifting the unit of service from a stay to an episode would change certain incentives (most notably the incentive to initiate subsequent PAC stays), but the most important features of a PAC PPS would remain: correcting the biases of the current PPSs and increasing the equity of payments across all types of stays so that providers have less incentive to selectively admit certain beneficiaries over others. In the meantime, CMS should proceed with implementing a stay-based unified PAC PPS.

Encouraging Medicare beneficiaries to use higher quality post-acute care providers

About 40 percent of Medicare acute inpatient hospital discharges result in use of PAC. Ensuring that the patient is served by the appropriate type of PAC provider is critical, but the selection of a provider within a PAC category can also be crucial because the quality of care varies widely among providers. In Chapter 5, we discuss increasing the use of higher quality PAC providers.

Medicare discharge planning regulations place the responsibility on hospitals for connecting acute hospital inpatients with their options for PAC—including educating beneficiaries about their choices and facilitating access to PAC when necessary. But hospitals are limited in the assistance they can provide. Although they are required to provide beneficiaries who need PAC with a list of nearby SNFs and HHAs, Medicare regulations prohibit hospitals from recommending specific PAC providers.

Beneficiaries report that they value quality of care and that they prefer PAC providers that are close to their home or family. The Improving Medicare Post-Acute Care Transformation Act of 2014 requires hospitals to include quality data when informing beneficiaries about their options, but CMS has yet to finalize the regulations implementing this requirement. Medicare has developed consumer-oriented websites that provide information on the quality of SNFs and HHAs, but many studies have concluded that these efforts have not significantly increased the use of higher quality PAC providers.

Our analysis of referral patterns of Medicare beneficiaries who were sent to SNFs and HHAs indicates that many beneficiaries had another nearby provider that offered better quality, though not all of the higher quality providers may have had available capacity. For example, over 94 percent of beneficiaries who used HHA or SNF services had at least one provider within a 15-mile radius that was of higher quality than the provider that served them.

Helping beneficiaries to identify better quality PAC providers should be a goal in a reformed discharge planning process, and authorizing hospital discharge planners to recommend specific higher quality PAC providers would further this goal. However, several design decisions would need to be resolved. First, a consistent approach to identifying better quality PAC providers would be needed, and quality standards would need to be transparent for PAC providers and beneficiaries. Second, policies would be needed to safeguard against potential conflicts of interest that could ensue from the authority to recommend specific providers.

Regardless of the approach selected to encourage the use of higher quality PAC providers, beneficiaries should retain freedom of choice. Beneficiaries may have important concerns that are not necessarily reflected in standard quality measures, such as language competency or proximity to family members. These preferences may lead them to select a PAC provider that has lower performance on some quality measures, but additional quality information would allow them to better understand the nature of their options and any trade-offs.

Medicare's options for expanding the authority of discharge planners to recommend higher quality PAC providers range from prescriptive approaches that provide specific metrics or definitions that hospitals must use to more flexible approaches that leave key decisions to discharge planners. A hybrid approach could blend these two methods and specify certain selection criteria that hospitals would need to use while granting hospitals discretion in the application of these criteria.

Issues in Medicare's medical device payment policies

In Chapter 6, we explore two distinct topics related to medical devices. First, we look at ways to improve Medicare's payment policies for durable medical equipment, prosthetic devices, prosthetics, orthotics,

and supplies (DMEPOS). Second, we examine ways to constrain the risks posed by physician-owned distributors (PODs) and to make them more transparent to beneficiaries, enforcement agencies, and others.

Medicare beneficiaries rely on DMEPOS products to treat their illness or injury and to allow them to remain in their homes, as opposed to seeking care in an institutional setting. DMEPOS comprises a large array of products that vary in cost and complexity, ranging from complex power wheelchairs to diabetes testing supplies to knee braces.

Pursuant to a statutory requirement, CMS implemented the DMEPOS Competitive Bidding Program (CBP) to use market competition to set payment rates and limit fraud and abuse, while ensuring beneficiaries retain access to needed DMEPOS products. The CBP began in 2011 with some of the highest cost and highest volume DMEPOS products in nine large urban areas. Over time, the CBP has added products and expanded geographically. The CBP has successfully driven down the cost of DMEPOS products for the Medicare program and beneficiaries. Compared with payment rates in the year before the CBP, Medicare's payment rates for some of the highest expenditure DMEPOS products have fallen by an average of roughly 50 percent.

At the same time, Medicare expenditures for DMEPOS products excluded from the CBP have continued to grow. By 2015, nearly half of all Medicare expenditures on DMEPOS products were for products excluded from the CBP. Medicare pays for these products using a fee schedule that is largely based on supplier charges from 1986 to 1987 (updated for inflation) and undiscounted list prices. Medicare's payment rates for the top 10 non-CBP DMEPOS products in 2015 were a third higher, on average, than private-payer rates for comparable products, and some non-CBP DMEPOS products continue to generate high rates of improper payments and utilization growth and to exhibit patterns of potential fraud and abuse.

To address these issues, additional products that are not currently competitively bid could be moved into the CBP. We also observe that the participation and balance billing rules for DMEPOS products and suppliers could be strengthened to better protect beneficiaries and better align those policies with many other Part B services.

PODs are entities that derive revenue from selling, or arranging for the sale of, devices ordered by their physician-owners for use in procedures the physician-owners perform on their own patients. PODs have the ability to distort the supply chain for medical devices—potentially resulting in an increase in the volume of surgeries performed on beneficiaries, higher costs for hospitals and the Medicare program, and inappropriate care.

The Commission questions the value PODs produce for the Medicare program and beneficiaries. We suggest several ways in which Medicare and policymakers can constrain the risks posed by PODs. We discuss two specific options to revise the Stark law (which is intended to prohibit physicians from referring Medicare beneficiaries to certain health care facilities in which they have a financial interest) and several key topics for policymakers to consider if such changes are made. While the options likely would limit the use of PODs, some PODs might continue to operate, even if the Stark law were modified. In addition, the Commission supports increasing the transparency of POD-physician relationships by requiring all PODs to report under the Open Payments program, a program designed to shed light on financial ties between physicians and certain industries.

Applying the Commission's principles for measuring quality: Population-based measures and hospital quality incentives

The Commission has recommended that Medicare link payment to the quality of care to reward accountable entities and providers for offering high-quality care to beneficiaries. In Chapter 7, the Commission formalizes a set of principles for measuring quality in the Medicare program. Overall, quality measurement should be patient oriented, encourage coordination, and promote delivery system change. Medicare quality incentive programs should use a small set of population-based measures (e.g., outcomes, patient experience, value) to assess quality of care for populations served by Medicare Advantage (MA) plans, ACOs, FFS in market areas, hospitals, groups of clinicians, and other providers. Medicare quality incentive programs should score these risk-adjusted, population-based measure results against absolute performance thresholds and then use peer grouping to determine payment adjustments based on the provider's quality performance. In Chapter 7, we first apply the Commission's principles to two population-based outcome measures (potentially preventable admissions and home and community days) that may be used to evaluate quality of care for different populations. Next, we apply the principles to the design of a new hospital quality incentive

program that combines measures of hospital outcomes, patient experience, and Medicare spending per beneficiary.

Potentially preventable admissions (PPAs) constitute an important quality measure because hospitalizations for conditions such as diabetes and pneumonia can potentially be preventable if ambulatory care is provided in a timely and effective manner. We calculated the observed rate of PPAs per 1,000 FFS beneficiaries for both chronic and acute conditions. We found that observed (that is, not risk adjusted) PPA rates varied across population groups and across market areas and hospital service areas. This variation signals opportunities to improve the quality of care within areas and the potential to use the measure to compare quality across local health care markets. However, more development is needed to incorporate risk adjustment based on FFS data in the analysis.

The Commission also tested a prototype home and community days (HCDs) measure to assess how well health care markets and organizations that take responsibility for a population keep people alive and out of health care institutions. The HCD measure is defined as 365 days minus the sum of days a beneficiary spends in certain institutional and ambulatory health care settings coupled with mortality days. However, because of the limited variation in HCDs over market areas and the challenges posed by the need to develop appropriate weights for constructing the composite measure, the Commission questions the immediate utility of the HCD measure in its current form to assess market-level FFS performance.

We also examined the potential to create a single quality-based payment program for hospitals to replace the four current hospital payment incentive programs Medicare uses: the Hospital Inpatient Quality Reporting Program, Hospital Readmissions Reduction Program, Hospital-Acquired Condition Reduction Program, and Hospital Value-based Purchasing. The Commission is concerned that these overlapping hospital quality payment and reporting programs create unneeded complexity in the Medicare program.

Ideally, the Congress could redesign the multiple hospital quality payment programs under a single hospital value incentive program (HVIP) that would be patient oriented, encourage coordination across providers and time, and promote change in the delivery system. It also would account for social risk factors by adjusting payment through peer grouping. Based on these principles, we modeled an HVIP in which quality-based payments are distributed to hospitals organized into 10 peer groups, with awards funded by a payment withhold from all hospitals.

Under our HVIP model, relative to the withhold, about half of hospitals would receive a negative payment adjustment, and about half would receive a positive adjustment. Our peer grouping of hospitals allowed us to examine how hospitals serving large shares of low-income patients perform. We found that, compared with the existing quality payment programs, the HVIP approach makes more equitable payment adjustments among hospitals that serve different populations. Over the next year, the Commission plans to continue to design an HVIP that conforms with our principles for quality measurement. Some topics the Commission will further explore include weighting of measures, withhold values, patient experience measures, and patient safety measures.

Medicare accountable care organization models: Recent performance and long-term issues

Medicare ACOs were created to help moderate the growth in Medicare spending and improve quality of care for beneficiaries by giving providers greater responsibility for costs and quality. In Chapter 8, we first review the current Medicare ACO models and look at their performance on cost and quality. We find that some models—predominantly two-sided models at risk for both savings and losses—are producing small savings relative to the benchmarks set by CMS, and all are maintaining or improving quality. Spending relative to benchmarks is important because it determines which ACOs will receive "shared savings" bonuses. However, some have observed that benchmarks are not necessarily the best measure of what spending would have been in the absence of the ACO and thus may not be a good measure of true program savings. We review the literature on this question and conclude that ACOs may have been saving Medicare 1 percent to 2 percent more than indicated by their performance relative to benchmarks, and that two-sided ACO models appear to save more than one-sided ACO models.

In light of evidence indicating that two-sided ACOs tend to generate greater savings than one-sided ACOs, we consider six issues that need to be resolved if two-sided ACOs are going to be part of the Medicare program in the long term:

- ***Are hospitals viable participants in ACOs?*** We find that, despite the apparent conflict in incentives, hospitals may still want to participate in ACOs because most savings for ACOs to date stem from reduction in the use of post-acute care and not from reductions in inpatient care.
- ***Should asymmetric models be continued?*** Asymmetric models—models with greater opportunities for savings than losses—could be one strategy to help ACOs transition to two-sided risk. The Commission will monitor the current asymmetric ACO models to determine whether aspects of them should be extended.
- ***How should benchmarks be set initially and rebased for subsequent agreement periods?*** The basic ACO model essentially sets benchmarks as a function of historical spending for beneficiaries who would have been attributed to the ACO in the past. In subsequent agreement periods, ACOs must continuously improve over their own past performance to achieve savings, which can create diminishing returns for consistently successful ACOs and potentially discourage long-term participation. We discuss this issue and others related to benchmarking, and then highlight other benchmarking approaches.
- ***Should the 5 percent bonus for clinicians in advanced alternative payment models (A–APMs) be distributed differently to encourage A–APM participation?*** Under current law, clinicians receive a 5 percent bonus on all of their physician fee schedule (PFS) payments if they exceed a threshold level on payments or patients in A–APMs. Moving to a system in which clinicians receive a 5 percent bonus with certainty on their share of PFS payments derived from an A–APM could make the incentive more equitable and encourage participation in two-sided ACOs.
- ***What will be the relationship between specialists and two-sided ACOs?*** We find that currently there are a substantial number of specialists on the participant lists of ACOs. ACOs may include specialists as a way to more effectively coordinate the care of their beneficiaries, and specialists may join ACOs to receive referrals and potentially share in savings.
- ***Are two-sided ACOs a long-term option in the Medicare program?*** Some maintain that ACOs are one way for providers to take greater accountability for a group of patients and then transition toward taking full accountability as an MA plan. We have found in previous work that ACOs can be the low-cost option in some areas of the country, and their advantage of lower administrative costs could make them a long-term option if benchmarks are set equitably.

Managed care plans for dual-eligible beneficiaries

Individuals who receive both Medicare and Medicaid (known as dual-eligible beneficiaries) often have complex health needs but are at risk of receiving fragmented or low-quality care because of the challenges in obtaining care from two distinct programs. Many observers have argued that the two programs could be better integrated by developing managed care plans that provide both Medicare and Medicaid services. Supporters argue that integrated plans would improve quality and reduce federal and state spending because they would have stronger incentives to coordinate care than either program has when acting on its own. However, these plans have been difficult to develop, and only 8 percent of full-benefit dual-eligible beneficiaries are now enrolled in a plan with a high level of Medicare and Medicaid integration. In Chapter 9, we examine the use of integrated plans and consider three potential policies that would encourage the development of highly integrated plans.

Since 2013, CMS and 10 states have tested the use of integrated Medicare–Medicaid Plans (MMPs) as part of the financial alignment demonstration. There are limited data available on the demonstration's effects on quality, service use, and cost because the evaluations of the demonstration are taking longer to complete than expected. However, the information available is generally positive. Although the individual demonstrations often have been difficult to implement, enrollment now appears stable (although participation is lower than many expected), and quality appears to be improving.

The demonstration is part of a broader effort by many states to use Medicaid managed care to provide long-term services and supports (LTSS), such as nursing home care and personal care. Between 2004 and 2018, the number of states with managed LTSS programs grew rapidly from 8 to 24, and more states likely will develop similar programs in the future. The growing use of managed care to provide LTSS—which account for most of Medicaid's spending on dual eligibles—means that, in many states, the development of health plans that provide both Medicare

and Medicaid services is probably the most feasible approach for pursuing closer integration.

Medicare now has four types of plans that serve dual eligibles: the demonstration's MMPs, MA dual-eligible special needs plans (D–SNPs), fully integrated dual-eligible SNPs (FIDE SNPs), and the Program of All-Inclusive Care for the Elderly. There are significant differences among these plans in several key areas, such as their level of integration with Medicaid, ability to use passive enrollment, and payment methodology. In addition, allowing MMPs and D–SNPs to operate in the same market has been problematic in some states because competition between the plans has reduced enrollment in the more highly integrated MMPs. Policy changes to better define the respective roles of each type of plan or consolidate plans in some fashion may be needed.

Three potential policies that would encourage the development of integrated plans are (1) limiting how often dual-eligible beneficiaries can change their coverage, (2) limiting enrollment in D–SNPs to dual eligibles who receive full Medicaid benefits, and (3) expanding the use of passive enrollment, particularly when beneficiaries first qualify for Medicare. Collectively, these policies would improve care coordination and continuity of care, require D–SNPs to focus on the dual eligibles who stand to benefit the most from integrated care, and encourage more dual eligibles to enroll in plans with higher levels of Medicare–Medicaid integration.

Medicare coverage policy and use of low-value care

Some researchers contend that there is substantial use of low-value care—care that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit—in the Medicare program. Many new services disseminate quickly into routine medical care in FFS Medicare with little or no basis for knowing whether they outperform existing treatments.

In Chapter 10, we review the coverage processes used in FFS Medicare and MA plans and by Part D sponsors. Medicare covers many items and services without the need for an explicit coverage policy. When an explicit coverage policy is required, some services do not show that they are better than existing covered services. Coverage policies often are based on little evidence and usually do not include an explicit consideration of a service's cost-effectiveness or value relative to existing treatment options. As a result, the coverage process does not prevent the use of low-value services. MA plans are permitted to use tools that are not widely used in FFS Medicare, such as requiring prior authorization to have a service covered and using variable levels of cost sharing. Part D plan sponsors are responsible for creating and managing formularies, which are lists of drugs their plans cover. By contrast, Medicare FFS lacks the flexibility to use formularies for drugs covered by Part B.

Our review of the literature on low-value care reveals that such care is prevalent across FFS Medicare, Medicaid, and commercial insurance plans. Evidence suggests that the amount of low-value care within a geographic area appears to be more a function of local practice patterns than payer type. We analyzed selected low-value services in FFS Medicare using 31 evidence-based measures developed by a team of researchers. In 2014, there were between 34 and 72 instances of low-value care per 100 beneficiaries—depending on whether we used a narrow or broad version of each measure—and annual Medicare spending for these services ranged from $2.4 billion to $6.5 billion. The spending estimates are conservative because they do not reflect the downstream cost of low-value services. We also conducted three case studies on care of potentially low value in FFS Medicare: the trend in starting dialysis earlier in the course of chronic kidney disease, proton beam therapy, and H.P. Acthar Gel® (a drug covered under Part D).

Last, we identified six tools that Medicare could consider using to address the use of low-value care.

- Expanding prior authorization, which requires providers to obtain approval from a plan or payer before delivering a product or service, could help reduce certain types of low-value care.
- Implementing clinician decision support and provider education could decrease low-value care, and studies show that these tools have reduced inappropriate prescribing of antibiotics.
- Increasing cost sharing for low-value services has the potential to reduce their use. Although Medicare does not currently do so, other health plans and payers have raised cost sharing for targeted low-value services, and an evaluation of one program found that it reduced the use of these services.
- Establishing new payment models that hold providers accountable for the cost and quality of care—such as

ACOs—creates incentives for organizations to reduce low-value services.

- Revisiting coverage determinations on an ongoing basis has the potential to both decrease use of low-value services and result in the development of more rigorous clinical evidence.
- Linking information about the comparative clinical effectiveness and cost-effectiveness of health care services to FFS coverage and payment policies has the potential to improve the value of Medicare spending. Medicare's coverage process considers, but does not require, comparative clinical effectiveness evidence, and the program's rate-setting processes generally do not consider such evidence. For most items and services, Medicare lacks statutory authority to consider evidence on cost-effectiveness in either the coverage or payment processes. ■