
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, including the near-term consequences of the coronavirus pandemic and the longer-term effects of program spending on the federal budget and the program's financial sustainability.
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2023 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health agency, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- as mandated by the Congress, report on Bipartisan Budget Act (BBA) of 2018 changes to the low-volume hospital payment adjustment.
- as mandated by the Congress, report on the impact of changes to the home health payment system required by the BBA of 2018.
- review the status of the MA program (Medicare Part C), through which beneficiaries can join private plans in lieu of traditional FFS Medicare.
- as mandated by the Congress, report on the performance of specialized MA plans that serve beneficiaries who are dually eligible for Medicare and Medicaid.
- review the status of the Medicare program that provides prescription drug coverage (Medicare Part D).
- as mandated by the Congress in the Consolidated Appropriations Act, 2021, report on a prototype value-based payment program under a unified prospective payment system (PPS) for post-acute care (PAC) services and analyze the impacts of the prototype's design.

In this report, we recommend payment rate updates for nine FFS payment systems for 2023. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2020. Starting in 2020, the ongoing coronavirus pandemic has had catastrophic consequences for many Medicare beneficiaries and affected health care delivery for all. In this report, we discuss some of the effects of the pandemic and pandemic-related policies on beneficiaries and providers, and we have considered the effects of the coronavirus PHE on our indicators in 2020 and beyond. To the extent that the effects of the PHE are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than a permanent change to payment rates in 2023 and future years.

The goal of Medicare payment policy is to obtain good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Payment system incentives that promote the efficient delivery of care serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums.

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

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

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

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

Context for Medicare payment policy

This year, both the short-term and long-term context for the Medicare program is sobering. In the short term, the nation and the Medicare program are in the midst of the historic coronavirus pandemic. Medicare beneficiaries have been disproportionately impacted by COVID-19, with the elderly constituting 12 percent of COVID-19 cases but 76 percent of COVID-19 deaths by the end of 2021. Health care providers have faced extreme stress during the pandemic—risking their lives to treat patients. Providers have also faced major financial disruptions to their operations. In response, the Congress and CMS have extended federal grants to providers and temporarily altered certain Medicare payment policies. At least in part, those actions have offset the short-term financial effects of the coronavirus public health emergency (PHE) for many providers.

Considering the context, beneficiaries have maintained relatively good access to care during the pandemic. Although some nonurgent routine appointments were canceled in the early months of the pandemic, beneficiaries continued to obtain urgent and emergency care and used telehealth to access clinicians by interactive video and audio-only phone calls. Importantly, the share of Medicare beneficiaries completely forgoing a service that they thought they needed in the past year (as opposed to delaying it) has not increased during the pandemic relative to prior years, according to the Commission's annual telephone surveys.

Although the pandemic is not expected to have a long-term impact on Medicare, the program's finances nevertheless need urgent attention. Medicare's Trustees expect that the program's Hospital Insurance Trust Fund (which funds Medicare Part A services) will become insolvent by 2026, and the Congressional Budget Office (CBO) expects the fund to reach insolvency in 2027, due to the declining ratio of workers to Medicare beneficiaries (since payroll taxes are the primary source of funding for the trust fund). To extend the solvency of the trust fund for an additional 25 years, Medicare's Trustees have estimated that the Medicare payroll tax would need to be raised from 2.9 percent to 3.7 percent, or Medicare Part A spending would need to immediately be reduced by 18 percent (about \$70 billion in 2022); alternatively, a smaller tax rate increase could be combined with a smaller spending reduction to achieve a comparable effect.

Medicare's Trustees estimate that total Medicare spending will nearly double between 2020 and 2030—driven by growth in the volume and intensity of services provided to beneficiaries and by the number of beneficiaries in the program (which is projected to increase from 62 million to 77 million over this period).

Medicare spending has been consuming a growing share of the federal budget and strains beneficiaries' household budgets. In 2021, Medicare premiums and cost sharing were estimated to consume 23 percent of the average Social Security benefit, up from 14 percent 20 years earlier. The Medicare Trustees estimate that in another 20 years, these costs will consume 34 percent of the average Social Security benefit.

One of the most powerful ways Medicare can control spending growth is by setting prices. Over the last 10 years, spending per Medicare beneficiary has grown much more slowly than spending per privately insured enrollee. Increasing prices were the main cause of spending growth for the privately insured, which was in turn driven by high levels of provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over private insurers in negotiating higher payment rates. From 2010 to 2020, that consolidation contributed to a 2.8 percent average annual per enrollee growth in spending on private health insurance. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent per year—nearly the same as the general inflation rate of 1.8 percent over this period. This difference suggests that private plans’ greater ability to constrain volume has less of an effect on spending than the Medicare program’s greater ability to constrain prices under its administered pricing system.

The Commission makes recommendations about appropriate payment levels for various Medicare payment systems in our March report each year. These recommendations are based on our review of the latest available data and attempt to balance the need to pay high enough prices to ensure beneficiaries’ access to high-quality care with the need to be a responsible steward of fiscal resources.

Given Medicare’s financing challenges, many believe that restraining price growth will not be enough to ensure Medicare’s financial sustainability and that the quantity and/or mix of health care services must also be changed. Medicare has piloted several alternative payment models that give providers incentives to more closely manage and coordinate beneficiaries’ care to keep them healthy and reduce unnecessary utilization. One of the main goals of these payment models is to save Medicare money by financially rewarding providers for efficiently furnishing health care services while maintaining or improving the quality of care. Service utilization rates and payments to providers can also be influenced through other means. The Commission has made numerous recommendations that, if implemented, could address challenges with Medicare’s payment systems and improve payment accuracy and equity. Some key recommendations from prior years are summarized at the end of Chapter 1.

Medicare’s fiscal challenges must be met in a manner that improves quality and reduces inequities in access to care across the Medicare population. Although quality of care appears stable, there is room for improvement. The Commission is also dedicated to understanding and reducing disparities in access to care. As Medicare consumes growing shares of the federal budget and beneficiaries’ incomes, the Commission will continue to identify changes that could improve Medicare payment policy.

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 Medicare’s traditional FFS payment systems. 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 explained in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (here, 2022) by considering beneficiaries’ access to care, the quality of care, providers’ access to capital, and how Medicare payments compare with providers’ costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Next, we assess how those providers’ costs are likely to change in the year the update will take effect (the policy year; here, 2023). Finally, we make a judgment about what, if any, update is needed for the policy year in question.

Providers’ financial status and the pattern of Medicare spending in 2020 varied substantially from historical patterns. In the spring of 2020, many health care sectors experienced large reductions in demand for services, resulting in temporary financial distress for some providers. In response, the Congress and CMS have extended federal grants to providers and temporarily altered certain Medicare payment policies. At least in part, those actions have offset the short-term financial effects of the coronavirus PHE for many providers. Some providers have returned funds to the federal government because their finances recovered faster than expected. The extension of federal funds, even if not precisely targeted, was a commensurate response to the immediate financial effects of the PHE.

To fulfill our congressional mandate to recommend updates to Medicare’s payment systems, we must confine our focus to effects that we expect will impact payment adequacy in 2023. To the extent that the effects of the pandemic are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Because updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in demand for health care or resulting health care spending. Where we expect effects on providers’ costs to persist into 2023, the policy year for our recommendations, those changes are noted in each sector’s payment adequacy discussion and factor into our estimates of payment adequacy.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospice providers. The Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure its recommendations accurately reflect current conditions. We use the best available data and changes in payment policy to project margins for 2022 and make payment recommendations for 2023, accounting for anticipated changes in Medicare payments and providers’ costs between 2022 and 2023. Because of standard data lags, the most recent complete data we have are generally from 2020. Where possible, we have bolstered our analyses with data from 2021, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may make recommendations that redistribute payments within a payment system to correct any biases that may make treating patients with certain conditions financially undesirable, make certain procedures unusually profitable, or otherwise result in inequity among providers. We may also recommend changes to improve program integrity. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment on the rate in the most efficient setting would in many cases save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher-paid setting.

Our recommendations in this report, if adopted, could significantly change the revenues that providers receive from Medicare. Payment rates set to cover the costs of relatively efficient providers help induce all providers to control their costs. Furthermore, Medicare rates have broader implications for health care spending because they are used in setting payments for private health insurance and for other federal and state government programs. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also help control health care spending across payers.

Hospital inpatient and outpatient services

Short-term acute care hospitals provide acute inpatient and outpatient services, such as treatments for acute medical conditions and injuries. Medicare generally sets FFS payment rates for hospital inpatient and outpatient services under the inpatient prospective payment systems (IPPS) and the outpatient prospective payment system (OPPS). In 2020, about 3,100 short-term acute care hospitals paid under the IPPS provided about 7.5 million inpatient stays to 4.8 million FFS Medicare beneficiaries. That same year, roughly 3,600 hospitals paid under the OPPS provided 78.1 million visits to 18.2 million FFS Medicare beneficiaries. The IPPS and OPPS payments for these services totaled \$172.6 billion, including \$8.3 billion in uncompensated care payments.

As described in Chapter 3, in 2020, some hospital payment adequacy indicators improved while others declined; however, indicators varied substantially across hospitals and largely reflect temporary changes during the PHE rather than changes in the overall adequacy of Medicare payments to hospitals.

Beneficiaries’ access to care—At certain points during the PHE, FFS Medicare beneficiaries’ access to hospital care was disrupted and inpatient capacity was stressed. However, short-term acute care hospitals continued

to have significant excess inpatient capacity in 2020, as indicated by an aggregate occupancy rate of 62 percent. In 2020 and 2021, the number of hospital closures declined substantially from the high in 2019. Inpatient stays and outpatient services per FFS beneficiary declined in 2020, driven by a decrease of over 40 percent in the use of hospital services in the spring of 2020, followed by partial rebounds by the end of the year. IPPS hospitals with excess capacity continued to have financial incentives to provide inpatient and outpatient services to Medicare beneficiaries, as indicated in 2020 by a positive Medicare marginal profit of about 5 percent.

Quality of care—Quality of care in 2020 is difficult to assess. While we report 2020 mortality, readmissions, and patient experience results, we have not used those results to inform our conclusions about trends in the quality of care provided to Medicare beneficiaries. In March 2019, the Commission recommended a redesign of the current hospital quality payment programs, including removing the current penalty-only quality programs and enacting a new hospital value incentive program that balances rewards and penalties and has the potential to drive further improvement in hospital quality.

Providers' access to capital—In 2020, IPPS hospitals' all-payer total margin remained strong but declined to 6.3 percent (a level similar to the average over the past 15 years). For rural hospitals, the all-payer total margin reached a near record high, reflecting targeted federal relief funds. In addition, certain large hospital systems reported that their 2021 all-payer operating margins exceeded 2019 levels, suggesting that hospitals' access to capital strengthened in 2021.

Medicare payments and providers' costs—In 2020, Medicare's payments to hospitals continued to be below hospitals' costs. IPPS payments per stay grew 8.7 percent, faster than in prior years; however, costs per stay grew even faster, rising 12.6 percent. Similarly, OPSS payments per service grew 13.5 percent, faster than in prior years, but costs per service grew even faster at 24.4 percent. For both IPPS stays and OPSS services, the faster growth in costs relative to payments is likely due to a combination of factors unique to the PHE, including spreading fixed costs over lower volume, increased wage rates, and pandemic-related protocols and supplies. Including the Medicare share

of federal PHE-related relief funds intended to help cover lost revenue and payroll costs, IPPS hospitals' Medicare margin was -8.5 percent, slightly above the 2019 margin, indicating that the federal relief funds did their intended job.

The coronavirus PHE made 2020 and 2021 anomalous years in many respects, and it is impossible to predict with certainty the extent to which these effects will continue into 2022 and beyond. Under these circumstances, we project that IPPS hospitals' Medicare margin in 2022 will be close to -10 percent prior to allocating relief funds. We project that IPPS hospitals' Medicare margin including relief funds will be around -9 percent, and the median Medicare margin for relatively efficient hospitals will remain at about 1 percent.

Recommendation—Our payment adequacy indicators are mixed but generally positive, and we anticipate changes caused by the PHE to be temporary (other than potentially increased wage rates, which should be accounted for under the current-law annual updates to the hospital market basket). Given these factors, the Commission recommends that the Congress maintain current-law IPPS and OPSS updates in 2023. The final update for 2023 will not be set until summer 2022, but CMS's third-quarter 2021 projections of the market basket and productivity (and the additional statutory increase to IPPS payments) would result in the IPPS base payment rate increasing by 2.5 percent and the OPSS base payment rate increasing by 2.0 percent. The Commission anticipates that this recommendation will be enough to maintain beneficiaries' access to hospital inpatient and outpatient care and keep IPPS and OPSS payment rates close to the cost of delivering high-quality care efficiently.

Mandated report: Changes to the low-volume hospital payment adjustment

In Chapter 3, we also report on the effects of the modifications to the low-volume hospital (LVH) payment adjustment for fiscal years 2019 through 2022, as mandated by the Bipartisan Budget Act (BBA) of 2018. The BBA of 2018 mandated that hospitals with fewer than 3,800 all-payer inpatient stays be eligible for the LVH adjustment (instead of hospitals with fewer than 1,600 Medicare stays, as mandated by the Affordable Care Act of 2010 (ACA)). However, the BBA of 2018

kept other aspects of the ACA changes to LVH policy, including specifying the exact adjustment (instead of having the Secretary of the Department of Health and Human Services determine an empirically justified adjustment) and the isolation requirement of fewer than 15 miles from the nearest IPPS hospital.

Our analysis found that in 2019, the BBA of 2018 policy change raised the number of LVHs by 5 percent but increased LVH payments by about 19 percent, due to increases in LVHs, the average number of FFS Medicare stays per LVH, and the average LVH adjustment. The BBA of 2018 requirement that LVH eligibility be based on all-payer volume (and not Medicare volume) is consistent with the Commission's prior recommendation, and LVH policy will become more consistent with our prior recommendation beginning in 2023 when CMS's authority to determine an empirically justified LVH adjustment is restored. Still, concerns remain that the policy is not well targeted to isolated hospitals and is duplicative for the majority of LVHs that receive cost-based payments through their designation as a sole-community or Medicare-dependent hospital.

Physician and other health professional services

Physicians, nurse practitioners, and other health professionals deliver a wide range of services in a variety of settings. In 2020, Medicare paid \$64.8 billion for these clinician services, accounting for just under 17 percent of traditional FFS Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule.

In Chapter 4, we recommend a 2023 update to the conversion factor (a fixed dollar amount) used in Medicare's physician fee schedule based on our assessment of beneficiaries' access to care, the quality of their care, and providers' payments and costs.

Beneficiaries' access to care—Overall, beneficiary access to clinician services is comparable to that of privately insured people ages 50 to 64 and comparable to prior years, despite the ongoing PHE. Ninety-three percent of the Medicare beneficiaries ages 65 and over that we surveyed in mid-2021 were satisfied with the quality of the care they received in the past year. Only 10 percent reported forgoing care. Half of beneficiaries reported that during the past year they had accessed clinicians

through telehealth. Over 90 percent of beneficiaries in our survey had a primary care provider and did not need to find a new primary care provider in the past year. Consistent with prior years, among those looking for a new clinician, larger shares reported problems finding a new primary care provider than a new specialist. While the number of clinicians held steady in 2020, the ratio of clinicians to beneficiaries dipped slightly because of enrollment growth. The share of providers billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept physician fee schedule amounts as payment in full—remains very high, and the share of beneficiaries who report encountering a clinician who does not accept Medicare is extremely low.

Quality of care—Quality of care is difficult to assess in 2020 due to the effects of the pandemic on beneficiaries and providers. While we report 2020 results for our quality measures (ambulatory care-sensitive hospitalizations and emergency department visits and patient experience), we have not used those results to inform our conclusions about whether overall quality has improved, worsened, or stayed the same. The 2020 results may reflect temporary changes in the delivery of care and data limitations unique to the PHE rather than trends in the quality of care provided to beneficiaries.

Medicare payments and providers' costs—After growing at an average annual rate of 2 percent from 2015 to 2019, FFS Medicare's allowed charges for clinician services per FFS beneficiary fell by 10.6 percent in 2020 due to care being postponed or forgone during the PHE. Medicare spending on clinician services in 2020 was \$8.7 billion lower than it was in 2019; it is too soon to tell whether clinicians experienced revenue declines in 2021. The Congress has provided clinicians with tens of billions of dollars to offset their pandemic-related revenue losses. This support accelerated the growth of national spending on clinician services, with spending on these services (by all sources, not just Medicare) growing by 5.4 percent in 2020 (up from 4.2 percent growth in 2019).

In 2020, private insurance payment rates for clinician services were 138 percent of Medicare's FFS rates, up from 136 percent in 2019. Despite reduced Medicare spending on clinician services due to the pandemic, median physician compensation from all payers

continued to grow in 2020, rising 1.0 percent. However, median compensation in 2020 remained much lower for primary care physicians than for many specialists—underscoring concerns about the mispricing of physician fee schedule services and its impact on the number of physicians who choose to practice primary care. In 2021, CMS substantially increased the payment rates for E&M office/outpatient visits, which could help reduce the large gap in compensation between primary care physicians and certain specialists.

Recommendations—The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2023 (however, clinicians are eligible for annual performance-based payment adjustments through Medicare’s Merit-based Incentive Payment System, or they can receive an annual bonus worth 5 percent of their Medicare professional services payments if they participate in advanced alternative payment models). The Commission’s analyses suggest that Medicare’s aggregate payments for clinician services are adequate. Although clinicians have experienced declines in their Medicare service volume and revenue due to the pandemic, the Congress has provided tens of billions of dollars in relief funds to clinicians, and we expect volume and revenue to rebound to prepandemic levels (or higher) by 2023. Therefore, the Commission recommends that, for calendar year 2023, the Congress should update the 2022 Medicare base payment rate for physician and other health professional services by the amount determined under current law.

Before the coronavirus PHE, CMS paid for telehealth services under the physician fee schedule only if the services were provided using an interactive telecommunications system that included two-way audio and video communication technology. During the PHE, however, CMS has waived this requirement for certain services. But Medicare claims do not always indicate whether a telehealth service was delivered by an audio-only interaction or an audio-video interaction. Consequently, CMS and others are unable to use claims data to assess the impact of many audio-only telehealth services on access, quality, and cost. Therefore, the Commission recommends that CMS require clinicians to use a claims modifier to identify all audio-only telehealth services, like the agency has done for audio-only telehealth services for mental health conditions and substance use disorders. This

recommendation applies whether Medicare is covering these services temporarily or permanently.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay in a hospital. In 2020, the 5,930 ASCs that were certified by Medicare treated 3.0 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$4.9 billion.

As described in Chapter 5, in 2020, some ASC payment adequacy indicators improved while others diminished. However, the decreasing measures very likely reflect the temporary effects of the PHE rather than the adequacy of Medicare payments to ASCs.

Beneficiaries’ access to care—Our analysis of facility supply and volume of services indicates that beneficiaries’ access to ASC services is adequate. From 2015 to 2019, the number of ASCs increased by an average annual rate of 2.1 percent. In 2020, the number of ASCs increased 2.0 percent. Most new ASCs in 2020 (95 percent) were for-profit facilities. From 2015 through 2019, the volume of services per Part B FFS beneficiary grew by an average annual rate of 1.5 percent. In 2020, volume per beneficiary declined by 13.6 percent, largely due to a substantial drop in the spring of 2020 caused by the PHE. ASC volume rebounded strongly, and volume in December 2020 was 97 percent of the volume in December 2019.

Quality of care—From 2013 through 2017, ASC-reported quality data showed improvement in performance; improvement plateaued from 2017 to 2019. For 2020, CMS collected data on five quality measures; these measures were generally unchanged from 2019 to 2020. However, CMS did not require ASCs to submit quality data for the first six months of 2020. We continue to be concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems® measures, the lack of a value-based purchasing program for the ASC sector, and the lack of claims-based outcome measures that apply to all ASCs.

Providers’ access to capital—Because the number of ASCs—especially for-profit ASCs—has continued to increase and consolidation in the ASC market has maintained a steady pace, access to capital appears to be adequate.

Medicare payments and providers' costs—From 2015 through 2019, Medicare payments for ASC services per FFS beneficiary grew by an average annual rate of 6.7 percent. However, in 2020, payments fell by 3.9 percent, reflecting the effects of the PHE. 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.

Recommendations—Cost data would support more informed decisions about updating ASC payment rates and identifying an appropriate input price index for ASCs. Therefore, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay. Considering the available evidence of payment adequacy, the Commission recommends that, for calendar year 2023, the Congress eliminate the update to the 2022 Medicare conversion factor for ambulatory surgical centers.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2020, nearly 384,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 7,800 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services based on a PPS bundle that includes certain dialysis drugs and ESRD-related clinical laboratory tests that were previously paid separately. In 2020, Medicare expenditures for outpatient dialysis services totaled \$12.3 billion. Six percent of the total consisted of payments for two calcimimetics paid under the ESRD PPS's transitional drug add-on payment adjustment (TDAPA), which pays providers according to the number of units of a drug and the drug's average sales price.

Tragically, patients with ESRD are at increased risk for COVID-19-associated morbidity and mortality. However, as described in Chapter 6, our payment adequacy indicators for dialysis services remain generally positive.

Beneficiaries' access to care—Measures of the capacity and supply of providers, beneficiaries' ability to obtain care, and changes in the volume of services suggest that payments are adequate. Between 2015 and 2019,

the number of in-center treatment stations grew faster than the number of FFS dialysis beneficiaries (but kept pace with demand from all dialysis patients across all types of health coverage). Between 2019 and 2020, capacity continued to grow but at a slower rate than between 2015 and 2019. Between 2019 and 2020, the number of FFS dialysis beneficiaries and the total number of treatments each declined by 3 percent, but these declines are attributable to the coronavirus pandemic, which resulted in slowing the initiation of dialysis by new patients and in excess mortality. Use of ESRD drugs in the payment bundle continued to decline, but at a slower rate than during the initial years of the ESRD PPS. In 2020, dialysis facilities' marginal profit was 20 percent, indicating that dialysis providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—The growing trend under the ESRD PPS toward home dialysis, which is associated with better patient satisfaction, continued in 2020. Between 2019 and 2020, all-cause hospitalizations, emergency department use, and kidney transplantation declined while mortality increased. Each of these changes are likely linked to the pandemic. By contrast, between 2018 and 2019, kidney transplantation increased while the other quality metrics held steady.

Providers' access to capital—Information from investment analysts suggests that access to capital for dialysis providers continues to be strong. The number of facilities, particularly for-profit facilities, continues to increase. Under the ESRD PPS, the two largest dialysis organizations have grown through acquisitions of and mergers with midsize dialysis organizations.

Medicare payments and providers' costs—In 2019, the aggregate Medicare margin for dialysis facilities jumped to 8.4 percent, due to the profitability of calcimimetics paid under the TDAPA policy. In 2020, cost per treatment rose by 4 percent, while Medicare payment per treatment declined by 2 percent, and the aggregate Medicare margin fell to 2.7 percent, similar to the 2018 margin of 2.1 percent. Including federal relief funds, the aggregate Medicare margin was 3.7 percent. While the PHE has made 2020 and 2021 anomalous years in many respects and it is impossible to predict with certainty the extent to which these effects will continue into 2022 and beyond, we project that the 2022 aggregate

Medicare margin will drop to 1.8 percent, in part due to cost changes that will exceed payment updates.

Recommendation—Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.2 percent. Given that most of our indicators of payment adequacy are positive, for 2023, the Commission recommends that the Congress update the calendar year 2023 ESRD PPS base rate by the amount determined under current law.

Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to Medicare beneficiaries after a stay in an acute care hospital. In 2020, about 15,000 SNFs furnished 1.7 million Medicare-covered stays to 1.2 million FFS beneficiaries (3.3 percent of Medicare's FFS beneficiaries). In that year, Medicare FFS spending on SNF services was \$28.1 billion.

In Chapter 7, we examine the adequacy of Medicare's SNF payments. The effects of the coronavirus pandemic on beneficiaries and nursing home staff have been devastating. However, the combination of federal policies and the implementation of Medicare's new case-mix system resulted in considerably improved financial performance for SNFs in 2020. Some of the changes in our payment adequacy indicators in 2020 likely reflect the unusual circumstances of the pandemic rather than the adequacy of Medicare's payments.

Beneficiaries' access to care—The number of SNFs participating in the Medicare program has been fairly stable at about 15,000 for many years. In 2020, 88 percent of beneficiaries lived in a county with three or more SNFs or swing bed facilities. The median occupancy rate declined from 85 percent before the start of the pandemic to 74 percent in September 2021. This decline reflects the impact of the pandemic and is unrelated to the adequacy of Medicare's payments. Between 2019 and 2020, Medicare-covered admissions per 1,000 FFS beneficiaries dropped 7.9 percent, consistent with the lower number of admissions in the early days of the pandemic for hospital stays lasting at least 3 days, which is normally required for Medicare coverage. This requirement has been waived during the PHE. Covered days per 1,000 FFS beneficiaries also declined in 2020. The Medicare marginal profit

averaged 25 percent for freestanding facilities in 2020. This high level indicates that SNFs with available capacity have a strong incentive to admit Medicare beneficiaries.

Quality of care—Between 2019 and 2020, rates of successful discharge to the community fell and the rates of hospitalization rose. Given the effects of the pandemic, we cannot draw conclusions about whether the changes reflect the adequacy of Medicare's payments.

Providers' access to capital—Though lending activity stalled in 2020, transactions picked up in 2021, indicating investor interest in the nursing home sector. In 2020, the all-payer total margin—reflecting all payers and all lines of business—was 3 percent. This improvement is due to the general and targeted funding nursing homes received during the PHE, changes in Medicare payments, and the temporary increases in Medicaid rates made by many states.

Medicare payments and providers' costs—Despite the decline in volume, Medicare's aggregate FFS spending between 2019 and 2020 rose 2.7 percent to \$28.1 billion, reflecting the effects of the new case-mix system and PHE-related policies. On a per day basis, payments increased over 8 percent, while costs grew 2.1 percent. The aggregate Medicare margin for freestanding SNFs was 16.5 percent. If we allocate a portion of the reported federal relief funds to Medicare payments, we estimate that the aggregate Medicare margin was 19.2 percent. Margins varied greatly across facilities, reflecting differences in costs per day, economies of scale, and cost growth.

The level of Medicare's FFS payments remains well above the cost of Medicare-covered stays. Since 2000, the aggregate Medicare margin has been above 10 percent. The 2020 Medicare margin for efficient SNFs was very high (22.8 percent), though we are reluctant to place much weight on this indicator, given the impact of the pandemic on costs and quality measures. Medicare Advantage plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments, which is unlikely to be explained by the differences in patient characteristics.

As required by the Affordable Care Act of 2010, we also report on Medicaid use and spending and non-

Medicare (private-payer and Medicaid) margins. Medicaid finances the majority of long-term care services provided in nursing homes, and some state programs also cover the copayments on SNF care for dual-eligible beneficiaries who stay more than 20 days in a SNF. Between 2020 and 2021, the number of Medicaid-certified facilities declined less than 1 percent, to 14,720. Spending was \$39.8 billion in 2020, 3.8 percent less than in 2019. The average non-Medicare margin (which includes all payers and all lines of business except FFS Medicare SNF services) was -0.3 percent, an improvement from 2019.

Recommendation—Considering our payment adequacy indicators, the Commission recommends that, for fiscal year 2023, the Congress should reduce the 2022 Medicare base payment rates for skilled nursing facilities by 5 percent. While the effects of the pandemic on beneficiaries and nursing home staff have been devastating, the combination of federal policies and the implementation of the new case-mix system resulted in improved financial performance for SNFs under Medicare. The high level of Medicare’s payments indicates that a reduction to payments is needed to more closely align aggregate payments to aggregate costs.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2020, about 3.1 million Medicare FFS beneficiaries received care, and the program spent \$17.1 billion on home health care services. In that year, over 11,456 HHAs participated in Medicare. In January 2020, CMS implemented major changes to the payment system for home health care services, as mandated by the BBA of 2018. The changes included shortening the unit of payment from 60 days to 30 days, eliminating the number of in-person therapy visits provided in a home health episode as a factor in the payment system, and introducing a new case-mix system, the Patient-Driven Groupings Model (PDGM).

As described in Chapter 8, our payment adequacy indicators for home health care services are generally positive.

Beneficiaries’ access to care—In 2020, over 99 percent of beneficiaries lived in a county served by at least one

HHA. Between 2019 and 2020 the number of HHAs fell by 1.0 percent, continuing a slow decline since 2013 but at a lower rate than in prior years. The slower decline in supply of HHAs suggests that neither the coronavirus PHE nor the implementation of the PDGM has had a significant impact on HHA supply. In 2020, the number of beneficiaries receiving home health care fell by 4.7 percent; that decline was concentrated in April and May. This monthly pattern, with the largest drop in volume coinciding with the onset of the PHE, indicates that the decline in services was not attributable to the implementation of the PDGM. The average number of in-person visits per 30-day period also declined (9.4 percent), but some of the decline may have been offset by greater use of virtual visits through telehealth, for which we lack detailed information. Freestanding HHAs’ Medicare marginal profit was 22.9 percent in 2020, suggesting a significant financial incentive for HHAs to serve additional Medicare patients.

Quality of care—Quality of care was difficult to assess in 2020. The number of home health patients who were hospitalized during their spell of home health services fell slightly. However, the share of beneficiaries who were successfully discharged to the community (patients who did not experience an unplanned hospitalization within 30 days of the end of their home health care spell) also fell. Given the various disruptions to the health care delivery system in 2020, these results should be interpreted cautiously.

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.

Medicare payments and providers’ costs—In 2020, Medicare spending for home health care declined by 4.7 percent to \$17.1 billion. Medicare aggregate margins for freestanding agencies averaged 20.2 percent, even as the cost per 30-day period increased by 3.1. Medicare’s payments have always been in excess of cost under prospective payment, with the Medicare margin for HHAs averaging 16.2 percent from 2001 to 2019. The projected margin for 2022 is 17.0 percent.

Recommendations—Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare’s payments for home health services are too high, and these excess payments diminish the service’s value as a substitute for more costly services. Based on these findings, for 2023 the Commission recommends reducing the 2022 home health PPS base payment rate by 5 percent.

The lack of detailed information on the use of telehealth in 2020 impairs our ability to assess the impact of the PDGM and the PHE. As the use of telehealth in home health care grows, the lack of information about telehealth visits could also compromise CMS’s ability to accurately set payments under the home health PPS. The Commission therefore recommends that the Secretary require HHAs to report the provision of telehealth during home health care on Medicare claims, like they already report for in-person visits and other home health care services.

Mandated report: Assessing the impact of the PDGM on home health care in 2020

In Chapter 8, we also report on the effects of the changes to the home health PPS as mandated by the BBA of 2018. The mandated changes included shortening the unit of payment under the PPS from 60 days to 30 days and eliminating the number of in-person therapy visits provided in a home health episode as a factor in the payment system. CMS implemented these changes on January 1, 2020, under a new case-mix system, the PDGM. The Commission is required to assess the impact of the changes on costs, quality, and other behavioral responses by HHAs.

Assessing the initial impact of the PDGM on home health care in 2020 is confounded by the disruptions associated with the coronavirus PHE. The payment adequacy indicators for 2020 point to relative stability for Medicare home health care in the first year of the PDGM. Though the number of 30-day periods and the number of beneficiaries served in 2020 were lower than in 2019, the monthly pattern in home health care volume for 2020 signals that the declines were mostly attributable to the PHE and not the PDGM. In addition, the high payment levels under the PDGM in 2020 suggest that HHAs had adequate reimbursement to provide quality care.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) are hospitals and hospital units that provide intensive rehabilitation services to patients after illness, injury, or surgery. In 2020, Medicare spent \$8.0 billion on IRF care provided to FFS beneficiaries in about 1,110 IRFs nationwide. About 335,000 beneficiaries had 379,000 IRF stays. On average, the FFS Medicare program accounted for about 54 percent of IRF discharges.

As described in Chapter 9, in general, our payment adequacy indicators for IRFs are positive.

Beneficiaries’ access to care—After declining for several years, the number of IRFs increased in 2020. Over time, the number of hospital-based and nonprofit IRFs has fallen, while the number of freestanding and for-profit IRFs has increased. In 2020, the average IRF occupancy rate remained at 67 percent, indicating that capacity is more than adequate to meet demand for IRF services. The number of Medicare cases per 10,000 FFS beneficiaries fell by 5 percent in 2020, but this decline likely reflects the decrease in elective acute care hospital services requiring subsequent IRF care, not the adequacy of Medicare payments. The marginal profit was 19 percent for hospital-based IRFs and 38 percent for freestanding IRFs. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

Quality of care—Quality of care is difficult to assess for 2020. We present average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations during the IRF stay but do not draw conclusions about whether quality has improved, worsened, or stayed the same.

Providers’ access to capital—Despite variation among provider types, in general, the parent institutions of hospital-based IRFs continued to have strong access to capital. The major freestanding IRF chain, accounting for about 31 percent of Medicare IRF discharges in 2020, continued expanding during the PHE and returned all federal relief funds, suggesting good access to capital. In 2020, IRFs’ total margin remained at 10.2 percent for freestanding IRFs.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has remained above 13 percent since 2010, reaching over 14 percent in 2018. From 2019 to 2020, IRF cost growth outpaced payment growth, lowering the Medicare margin in 2020 to 13.5 percent. However, after including an estimate of Medicare's share of federal relief funds, the aggregate Medicare margin in 2020 rose to 14.9 percent. While the coronavirus PHE has made 2020 and 2021 anomalous years in many respects and it is impossible to predict with certainty the extent to which the effects will continue, for 2022, we project an aggregate Medicare margin of 14 percent.

Recommendation—Given our positive payment adequacy indicators, the Commission recommends that for fiscal year 2023, the fiscal year 2022 IRF base payment rate be reduced by 5 percent. The Commission anticipates that this recommendation would provide IRFs with sufficient revenues to maintain beneficiaries' access to IRF care and bring IRF PPS payment rates closer to the cost of delivering high-quality care efficiently.

Long-term care hospital services

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods of time. To qualify as an LTCH, a facility must meet Medicare's conditions of participation for acute care hospitals and have an average length of stay of more than 25 days for certain Medicare patients. In 2020, Medicare spent \$3.4 billion on care provided in LTCHs; about 71,000 FFS Medicare beneficiaries had about 77,600 LTCH stays.

Medicare pays for care in LTCHs under the LTCH PPS for cases that meet the qualifying criteria specified in law. LTCH qualifying cases are those with an immediately preceding acute care hospital stay who spent 3 or more days in an intensive care unit or coronary care unit or who receive mechanical ventilation for at least 96 hours at the LTCH. Under the dual payment-rate system, cases that do not qualify for LTCH-level care may be treated in LTCHs but are paid a lower rate. After a four-year transition period from 2016 through 2019, during which they were paid a blended rate, LTCHs were slated to be paid lower site-neutral rates for cases that do not meet the qualifying criteria starting in 2020. However, site-neutral

payments have not yet been fully implemented because they were temporarily waived during the coronavirus PHE.

As described in Chapter 10, in general, our payment adequacy indicators for LTCHs reflect the transition to the dual payment-rate system and the effects of temporary PHE-related policies that waived certain LTCH payment policies.

Beneficiaries' access to care—Between 2019 and 2020, the decline in the supply of LTCHs slowed compared with the prior three years. Average LTCH occupancy in 2020 was 65 percent. From 2016 through 2019, after controlling for the number of FFS Medicare beneficiaries, total LTCH case volume fell about 10 percent annually, compared with a 12.4 percent decline in case volume in 2020. Medicare marginal profit averaged about 18 percent across LTCHs in 2020. For LTCHs with a high share of qualifying cases, Medicare marginal profit was 20 percent in 2020, an increase over 2019 that reflects temporary PHE-related policies that raised Medicare payments.

Quality of care—In 2020, the aggregate risk-adjusted rate of hospitalizations (6.1 percent) was higher than in prior years, as was the rate of successful discharge to the community (23 percent). Given the effects of the pandemic on these rates, we do not draw conclusions about whether the changes reflect the adequacy of Medicare's payments.

Providers' access to capital—In recent years, impending implementation of site-neutral rates for nonqualifying LTCH cases limited opportunities for growth and reduced the industry's need for capital to expand. In 2020, temporary payment policies to create additional inpatient capacity during the coronavirus PHE raised payments for nonqualifying cases, and LTCHs received relief funds. In 2020, the all-payer LTCH margin with relief funds included was 4 percent; all else equal, the margin was 2.7 percent excluding relief funds.

Medicare payments and providers' costs—Fueled by the suspension of the 2 percent sequestration reduction and temporary waivers of site-neutral payments and other LTCH payment criteria, Medicare aggregate margins in 2020 increased to 6.9 percent, up from 2.9 percent in 2019. We project that LTCHs' Medicare aggregate margin for facilities with a high share of qualifying cases will be 3 percent in 2022.

Recommendation—Based on payment adequacy indicators and in the context of ongoing changes to payment policy, the Commission recommends for fiscal year 2023 that the 2022 Medicare base payment rate for LTCHs be increased by the market basket minus the applicable productivity adjustment. We estimate, based on CMS’s third-quarter 2021 projections of the market basket productivity, that this recommendation would result in the LTCH base payment rate increasing by 2 percent in 2023, but that may change because the final update for 2023 will not be set until summer 2022. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. In 2020, with the onset of the pandemic, deaths among Medicare beneficiaries increased by nearly 18 percent and more than 1.7 million Medicare beneficiaries (including almost half of decedents) received hospice services from 5,058 providers. Medicare hospice expenditures totaled \$22.4 billion.

As described in Chapter 11, our payment adequacy indicators for hospice services are positive.

Beneficiaries’ access to care—In 2020, the number of hospice providers increased by 4.5 percent, due to growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers. The number of beneficiaries using hospice services at the end of life grew 9 percent in 2020, while the share of Medicare decedents using hospice declined between 2019 and 2020 because deaths increased more rapidly than hospice enrollments. Between 2019 and 2020, average lifetime length of stay among decedents grew from 92.5 days to 97.0, and the median length of stay was stable at 18 days. In 2019, Medicare payments to hospice providers exceeded marginal costs by roughly 17 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

Quality of care—Quality of care is difficult to assess for 2020. Due to the pandemic, CMS temporarily suspended collection of the hospice quality data submitted by providers (the Hospice Item Set and the Hospice Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey); these data will become available again in 2022. Based on the most recent data reflecting performance through 2019, hospice quality, as measured by scores on the Hospice CAHPS, was stable. Performance on a measure of visits in the last three days of life improved slightly in 2019. Separate Commission analysis of nurse and social worker visits in the last days of life suggests some decline in in-person visits between 2019 and 2020, which is likely tied to the pandemic and is not necessarily a reflection of quality of care.

Providers’ access to capital—Hospices are not as capital intensive as other provider types because they do not require extensive physical infrastructure. However, continued growth in the number of for-profit providers and reports of strong investor interest in the sector suggest capital is available. 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—Medicare payments are more than sufficient to cover providers’ costs. Between 2018 and 2020, hospice cost growth was generally modest. Average cost per day for routine home care, the level of care that accounts for more than 98 percent of hospice days, increased 0.5 percent between 2018 and 2019 and 1.2 percent between 2019 and 2020. The aggregate 2019 Medicare margin was 13.4 percent, up from 12.4 percent in 2018, and the projected 2022 margin is 13 percent.

In addition to indicators of hospice payment adequacy, Chapter 11 also discusses the hospice aggregate cap, which limits the total payments a hospice provider can receive in a year in aggregate. If a provider’s total payments exceed the number of patients treated multiplied by the cap amount, the provider must repay the excess to the Medicare program. The aggregate cap functions as a mechanism that reduces payments to hospices with long stays and high margins. In 2019, about 19 percent of hospices exceeded the cap; their

aggregate Medicare margin was about 22 percent before and 10 percent after application of the cap.

Recommendations—Based on these payment adequacy indicators and analysis of the hospice aggregate cap, the Commission recommends that hospice payment rates for 2023 be held at their 2022 levels and that the aggregate cap be wage adjusted and reduced by 20 percent.

In response to the PHE, CMS modified the hospice conditions of participation to permit hospice providers to furnish services using telecommunication systems during the PHE, under certain circumstances. However, hospices are unable to report on the use of telehealth services on Medicare claims (with the exception of social worker phone calls, which have historically been reported on claims). This lack of information has impaired our ability to understand the frequency and the role that telehealth has played during the PHE. For this reason, the Commission's recommendation is that CMS should require hospice providers to report telehealth visits on Medicare claims.

The Medicare Advantage program: Status report and mandated report on dual-eligible special needs plans

In Chapter 12, the Commission provides a status report on the Medicare Advantage (MA) program. In 2021, the MA program included 4,778 plan options offered by 186 organizations, enrolled nearly 27 million beneficiaries (46 percent of Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$350 billion (not including Part D drug plan payments).

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 among Medicare coverage options, including the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care management techniques to deliver more efficient care.

For the past two years, the coronavirus pandemic has had a significant and tragic impact on beneficiaries.

Policymakers have been concerned that the disruption in service utilization and plan administrative activities related to the coronavirus pandemic could impact payments in unexpected ways. However, because Medicare payments to MA plans are established before the start of each calendar year based on prior years' data, overall plan revenues in 2020 remained at prepandemic levels while service use declined, resulting in increased profitability for most MA plans. Although utilization remained below prepandemic levels and most publicly traded insurers reported profitability in 2021, some plans are concerned that lower utilization in 2020 limited their ability to document diagnoses, resulting in smaller risk adjustments and lower plan revenues in 2021. The effect of risk adjustments on 2021 revenues is not yet known and likely varies across the industry. In 2022, Medicare payments to MA plans are increased because of the expectation that deferred care will raise utilization above prepandemic levels. We do not anticipate that the pandemic will have a deleterious impact on overall plan revenues.

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and, for the sixth straight year, a historically high level of extra benefits. In 2022, the average Medicare beneficiary has a choice of 36 plans and the average MA plan enrollee has access to nearly \$2,000 in extra benefits annually that Medicare FFS enrollees cannot access without purchasing additional health insurance coverage. Medicare payments for MA extra benefits have increased by 53 percent since 2019. In this way, payments to MA plans have increasingly been used to provide an indirect subsidy to offer expanded benefits for MA enrollees. Medicare spending for these extra benefits (plus plan administrative fees and profit) accounts for 15 percent of payments to MA plans, yet we have no data about their use nor information about their value. In the three years from 2018 to 2021, the share of eligible Medicare beneficiaries enrolled in MA rose by 3 percentage points per year, from 37 percent to 46 percent. If the trend continues, a majority of eligible Medicare beneficiaries will be enrolled in MA by 2023.

MA plans continue to capitalize on their administrative flexibility and reduce their relative growth in health care costs year over year. For 2022, the average plan bid to provide Medicare Part A and Part B benefits was 15 percent less than FFS Medicare would spend for those

enrollees, and nearly all plan bids are below the cost of FFS Medicare.

However, these efficiencies are shared exclusively by the companies sponsoring MA plans and MA enrollees in the form of extra benefits. The taxpayers and Medicare beneficiaries who fund the MA program do not realize any savings from MA plan efficiencies. Instead, Medicare spends 4 percent more on MA than it would spend on FFS Medicare. The MA program has been expected to reduce Medicare spending since its inception: Under the original incorporation of private plans in Medicare in 1985, payments to private plans were set at 95 percent of FFS payments. However, private plans in the aggregate have never produced savings for Medicare, due to policies governing payment rates to MA plans that the Commission has found to be deeply flawed.

In particular, coding intensity inflates payments to MA plans and undermines plan incentives to improve quality and reduce costs; the quality bonus program boosts plan payments for nearly all enrollees but does not meaningfully reflect plan quality, from the perspective of the MA plan enrollee or the Medicare program; and plan benchmarks are set high enough that the government subsidizes substantial and ever higher levels of extra benefits for MA enrollees.

Apart from payments, the Commission finds that the plan-submitted data about beneficiaries' health care encounters are incomplete, preventing policymakers from understanding plan efficiencies or implementing program oversight. These policy flaws diminish the integrity of the program and generate waste from beneficiary premiums and taxpayer funds. A major overhaul of MA policies is therefore urgently needed.

Over the past few years, the Commission has made recommendations to address coding intensity, improve the completeness of encounter data, replace the quality bonus program, and establish more equitable benchmarks. The Commission remains committed to including private plans in the Medicare program. Beneficiaries clearly find MA to be an attractive option through which to receive their Medicare benefits, as evidenced by robust trends in year-over-year enrollment growth. However, this does not mean that Medicare should continue to overpay MA plans; in fact, under current policies, as MA enrollment continues to grow, doing so will further worsen Medicare's fiscal sustainability. It is therefore imperative that the Congress and the Secretary make policy improvements.

To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for providers in the traditional FFS program.

Enrollment—For the third consecutive year, enrollment in MA plans grew by 10 percent. Between July 2020 and July 2021, MA enrollment grew by 2.5 million enrollees—to 26.9 million enrollees. In 2021, about 46 percent of MA-eligible beneficiaries were enrolled in MA plans, up from 43 percent in 2020.

Plan availability—In 2022, access to MA plans remains high, with 99 percent of Medicare beneficiaries having access to at least one plan. The average beneficiary has 36 available plans sponsored by 8 different parent organizations, both increases relative to 2021.

Plan rebates—In 2022, rebates that are used to provide additional benefits to enrollees are at a historic high of \$164 per enrollee per month. The average total rebates are 17 percent higher than in 2020 (\$24 higher per enrollee per month). Plans can devote the rebate to lower cost sharing, lower premiums, or supplemental benefits. In 2022, 43 percent of projected plan rebates was allocated for lower cost sharing, down from 46 percent in 2021.

Plan payments—In 2022, plan payments remain higher than FFS spending levels. Total Medicare payments to MA plans average an estimated 104 percent of FFS spending. The 2022 estimate incorporates about 3.6 percentage points of uncorrected coding intensity. Relative to FFS spending for Part A and Part B benefits, quality bonuses in MA account for 3 percentage points of MA payments. Using plan bid data for 2022 and ignoring the impact of coding intensity, we estimate that MA payments are 100 percent of FFS spending. In addition, MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—continue to be well above FFS spending levels. In 2022, MA benchmarks averaged an estimated 108 percent of FFS spending (including quality bonuses), about the same level as in 2021. Bids fell to 85 percent of FFS, a record low.

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. MA plans have a financial incentive to ensure that their providers record all possible diagnoses: Each diagnosis documented raises an enrollee's risk score, and higher enrollee risk scores result in higher payments to the plan.

A Commission analysis of 2020 data shows that higher diagnosis coding intensity resulted in MA risk scores that were about 9.5 percent higher than scores for similar FFS beneficiaries. By law, CMS makes an across-the-board reduction to MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a larger reduction than the minimum required by law, the agency has never done so. In 2020, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores that were about 3.6 percent higher than they would have been if MA enrollees had been treated in FFS Medicare, translating to \$12 billion in excess payments to MA plans. We continue to find that coding intensity varies significantly across MA plans and that increasing diagnostic coding allows some plans to offer more extra benefits, thereby attracting more enrollees and undermining the goal of plan competition based on improved quality and reduced health care costs.

The Commission previously recommended changes to MA risk adjustment that exclude diagnoses collected from health risk assessments, use two years of diagnostic data, and apply an adjustment to eliminate any residual impact of coding intensity. These changes were intended to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity. Recent reports from the Office of Inspector General highlight the impact of MA plans' use of medical chart reviews (a coding practice that does not exist in FFS Medicare) and of health risk assessments to increase risk scores. We find that nearly two-thirds of MA coding intensity could be due to chart reviews and health risk assessments, and that these two mechanisms are a primary factor driving coding differences among MA plans.

Quality in MA—The current state of quality reporting in MA is such that the Commission can no longer provide an accurate description of the quality of care in MA. With 46 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care that MA enrollees receive and how that quality compares with quality in FFS Medicare is necessary

for beneficiaries and policymakers to have the ability to compare MA and FFS quality and to compare quality among MA plans. In its June 2020 report, the Commission recommended a new value incentive program for MA that would replace the current quality bonus program.

Mandated report: Comparing the performance of D-SNPs and other plans that serve dual-eligible beneficiaries

Dual-eligible special needs plans (D-SNPs) are specialized MA plans that limit their enrollment to beneficiaries who receive both Medicare and Medicaid. The BBA of 2018 permanently authorized D-SNPs and, starting in 2021, requires them to meet new standards for integrating the delivery of Medicare and Medicaid services. The Commission is mandated by the BBA of 2018 to periodically compare the performance of different types of D-SNPs and other plans that serve dual-eligible beneficiaries. Chapter 12 includes our first report under the mandate, which we are required to submit to the Congress by March 15, 2022. We find that the performance data that MA plans report as part of the Healthcare Effectiveness Data and Information Set (HEDIS[®]) provide limited insight on the relative performance of D-SNPs. This finding is consistent with previous Commission analyses that have examined the difficulties of assessing the quality and performance of MA plans.

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

In 2021, Part D paid for outpatient prescription drug coverage on behalf of more than 49 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing to about 13 million individuals with low income and assets. The 2020 and 2021 benefit years were extraordinary due to the coronavirus pandemic and its toll on Medicare beneficiaries and health care providers. However, Medicare beneficiaries experienced comparatively less disruption in access to medicines than in access to other types of health care services.

In 2020, Part D program expenditures totaled \$105.3 billion, accounting for about 11 percent of Medicare

spending. Of that amount, enrollees paid \$13.6 billion in plan premiums for basic benefits. Above and beyond program spending, Part D plan enrollees paid \$17.6 billion in cost sharing plus additional amounts in premiums for enhanced benefits.

Since its inception in 2006, Part D has changed in important ways. Enrollment has moved gradually toward MA-PDs that provide combined medical and drug coverage. In absolute numbers, enrollment in stand-alone prescription drug plans (PDPs) began to decline in 2019; in 2021, Part D enrollees were split evenly between PDPs and MA-PDs. Prescription drug use and spending have also changed dramatically. Part D enrollees have greatly expanded their use of generics, while a relatively small percentage of prescriptions for high-cost biological products and specialty medications accounts for a mounting share of spending. Medicare's payments to Part D plans have changed as well. Whereas fixed-dollar payments per enrollee used to make up most of Part D's subsidies, over time, a growing share has taken the form of cost-based reimbursements to plans through Medicare's reinsurance. The financial risk that plans bear, as well as their incentives to control costs, has declined markedly. In 2020, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies to restore the role of risk-based, capitated payments that was present at the start of the program and provide some drag on drug price increases.

Nearly 300 organizations sponsor Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most large sponsors are vertically integrated with their own pharmacy benefit manager (PBM), and many also operate mail-order and specialty pharmacies. Formularies remain plan sponsors' most important tool for managing drug benefits. Generally, pharmaceutical manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Plan sponsors also use provisions in network contracts with pharmacies that require postsale recoupments or payments for meeting performance metrics. Plan sponsors and PBMs have negotiated rebates and pharmacy fees that have grown as a share of Part D spending.

Enrollment in 2020 and benefit offerings for 2021—

In 2021, about 76 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 2 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. We estimate that the remaining 22 percent of beneficiaries were divided equally between those who had drug coverage from other sources and those with no coverage or coverage less generous than Part D.

Between 2020 and 2021, enrollment in PDPs declined from 25.5 million to 24.0 million, while enrollment in MA-PDs grew from 21.9 million to 24.3 million. As a result, in 2021, just over 50 percent of enrollees were in MA-PDs compared with 30 percent in 2007. The number of enrollees who receive the LIS has grown more slowly than the broader Part D population. In 2021, LIS enrollees made up 27 percent of total enrollment compared with 39 percent in 2007.

For 2022, beneficiaries continue to have a broad choice of plans, with growth in MA-PDs more than offsetting a contraction in the number of PDPs. Compared with 2021, sponsors are offering 7 percent more MA-PDs open to all beneficiaries and 19 percent more MA-PDs tailored to specific populations (special needs plans) but 23 percent fewer PDPs, due primarily to mergers among plan sponsors. In 2022, 2,159 plans are participating in the Center for Medicare and Medicaid Innovation's Part D Senior Savings Model that covers certain insulins at cost sharing of no more than \$35 per one-month supply. Most Part D plans use a five-tier formulary with differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs. For 2022, the base beneficiary premium rose by less than 1 percent over 2021 to \$33.37, reflecting the relatively small increase in the total average estimated cost for basic benefits after taking postsale rebates and discounts into account. However, individual plans' premiums vary substantially. In 2022, 198 premium-free PDPs are available to enrollees who receive the LIS, a 24 percent drop from 2021. All regions have at least four premium-free PDPs for LIS enrollees.

Part D program costs—Between 2007 and 2020, Part D program spending increased from \$46.2 billion to \$91.7 billion (average annual growth of 5.5 percent). Medicare's reinsurance (which covers 80 percent of spending in the catastrophic phase of the benefit after rebates) continues to be both the largest and

fastest-growing component of program spending, at an annual average rate of about 15 percent since 2007. As a result, between 2007 and 2020, the portion of the average basic benefits paid to plans through the capitated direct subsidy plummeted from 54.7 percent to 13.5 percent. In 2020, fewer enrollees reached the benefit's catastrophic phase, due in large part to a statutory increase in the out-of-pocket threshold. High-cost enrollees (those whose spending reaches the benefit's catastrophic phase) accounted for 62 percent of Part D spending, up from about 40 percent before 2011. In 2020, average prices continued to grow more slowly than in prior years, owing to the decline in prices of generic drugs. However, generics' share of prescriptions plateaued at about 90 percent in 2017, and further opportunities for generic substitution may be limited because a significant portion of brand products are protected from competition through longer periods of market exclusivity, extensive patent protection, or both. Inflation in prices for brand-name drugs and biologics will likely continue to drive spending upward. In 2020, over 443,000 enrollees filled a prescription for which a single claim was sufficient to meet the out-of-pocket threshold, up from just 33,000 in 2010.

Beneficiary access and quality in Part D—The quality of prescription drug care requires a balance between beneficiary access and medication management. Data from CMS audits and Part D appeals processes suggest that beneficiaries may be less likely to encounter access issues for most drugs than in previous years. However, among beneficiaries without the LIS, high cost sharing for expensive therapies may be a barrier to access. For 2022, average star ratings for Part D plans increased substantially, but much of that increase reflects changes CMS made in how it calculated the ratings to address the coronavirus pandemic. While average star ratings for MA-PDs continue to exceed those of PDPs, the trend among MA-PD sponsors of consolidating contracts leads us to question the validity of MA-PD ratings.

Mandated report: Designing a value incentive program for post-acute care

The Consolidated Appropriations Act, 2021, requires the Commission to report on a prototype value-based payment program under a unified PPS for PAC services and analyze the impacts of the prototype's design by

March 15, 2022. Building on the Commission's past work, in Chapter 14 we present key design elements for a PAC value incentive program (VIP). For each of the following elements, policymakers will need to make decisions to develop and implement a PAC VIP.

- **Small set of performance measures.** The PAC VIP would adjust payments based on provider performance on a small set of measures tied to clinical outcomes, patient experience, and resource use. Policymakers would need to decide whether all providers should be scored on the same set of measures and which measures should be scored.
- **Strategies to ensure reliable measure results.** The PAC VIP's measure results would reflect true differences in performance and not random variation. Policymakers would need to define the reliability standard for measure results and determine which strategies will ensure reliable results for as many providers as possible.
- **System to distribute rewards with minimal "cliff" effects.** The PAC VIP would use a simple scoring approach that awards points for every level of performance achieved. Policymakers would need to decide whether a provider should meet some minimum performance standard before it earns performance points that translate into a reward.
- **Approach to account for differences in patients' social risk factors using a peer-grouping mechanism, if necessary.** If higher social risk is tied to poorer outcomes, the PAC VIP would stratify providers into peer groups based on the social risk of their patient populations. Under this grouping mechanism, providers in peer groups with patient populations at high social risk would receive larger payment adjustments for attainments in quality compared with other providers. Policymakers would need to decide how to define and measure patient populations' social risk to establish the peer groups, as well as how many peer groups would be needed to meaningfully differentiate providers.
- **Method to distribute the entire provider-funded pool of dollars.** The PAC VIP would redistribute all withheld funds to providers based on their performance. Policymakers would need to determine the size of rewards and penalties needed to motivate providers to improve performance.

For illustrative purposes, we modeled a PAC VIP design that includes these elements and adjusts each provider's payments based on its performance. Approaches taken for four of the elements could be readily incorporated into a design—a starter set of performance measures, the reliability standard, a scoring methodology, and the distribution of incentive payments. However, questions remain about an approach to account for the social risk of a provider's patient population. Although there is a conceptual relationship between the share of fully dual-eligible beneficiaries (beneficiaries eligible for both Medicare and Medicaid, a proxy for low income) a provider treats and its outcomes, we did not find an empirical association in each of the four settings. More work is needed to define a measure of social risk that considers multiple dimensions before concluding whether adjusting performance results for social risk is always needed.

Implementing a PAC VIP would involve many steps and would be a multiyear endeavor. First, a PAC PPS would need to be implemented so that setting-specific practice patterns begin to converge. Concurrently, CMS would need to begin aligning regulatory requirements for PAC providers. Until this process is completed, providers' performance would likely be compared only within each setting because current practice patterns reflect current regulatory

requirements and the payment incentives embedded in the various PPSs. Setting-specific comparisons of performance would be phased out over time, leading up to comparisons of performance.

CMS would need to select a set of performance measures that captures differences across providers. There will be trade-offs between using common measures and using patient population-specific measures. In addition, the measure set should evolve to include accurate measures of the maintenance and improvement in patients' functional status and of patient experience. CMS would need to test a measure of social risk that has both a conceptual relationship and an empirical association with outcomes. CMS should explore the use of geographic area-level measures of social risk and whether they are accurate proxies for the social risk of individual patients.

Finally, CMS would need to design a methodology that scores providers' performance, ensures reliable measure results, distributes rewards with minimal cliff effects, accounts for differences in the social risks of a provider's patient population through peer grouping if necessary, and fully redistributes provider-financed incentive payments to providers. The Commission's PAC VIP model would be a good starting point for CMS's deliberations. ■

