
Executive summary

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By law, the Medicare Payment Advisory Commission reports to the Congress each March on the Medicare fee-for-service (FFS) payment systems, the Medicare Advantage (MA) program, and the Medicare prescription drug program (Medicare Part D). In this year's report, we:

- consider the context of the Medicare program in terms of the effects of its spending on the federal budget and its share of national gross domestic product (GDP).
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2018 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health care, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- consider post-acute care as a whole and recommend blending the relative weights of our recommended unified post-acute payment system with those of each post-acute setting to help providers in those settings adjust to the new unified system.
- review the status of the MA plans (Medicare Part C) that beneficiaries can join in lieu of traditional FFS Medicare and recommend a change to how plan quality is assessed when MA contracts are consolidated.
- review the status of the Medicare program that provides prescription drug coverage (Medicare Part D) and recommend a change in applying the coverage gap discount to biosimilar drugs.
- recommend that the Merit-based Incentive Payment System (MIPS) for clinician quality be eliminated and outline a path forward for a new voluntary value program to replace it.
- report on telehealth in Medicare as mandated by the Congress.

The goal of Medicare payment policy is to get good value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the taxpayers and beneficiaries who finance Medicare through their taxes and premiums.

We recognize that managing updates and relative payment rates alone will not solve what have been fundamental problems with Medicare FFS payment systems to date—that providers are paid more when they deliver more services without regard to the value of those additional services and are not routinely rewarded for care coordination. To address these problems directly, two approaches must be pursued. First, payment reforms such as incentives to reduce excessive hospital readmission rates need to be implemented more broadly and coordinated across settings, and efforts such as a unified payment system for post-acute care must be pursued expeditiously. Second, delivery system reforms that have the potential to encourage high-quality care, better care transitions, and more efficient provision of care need to be enhanced and closely monitored, and successful models need to be adopted on a broad scale. Our recommendation to eliminate MIPS addresses both of these goals by moving the definition of clinician quality beyond the uncoordinated individual clinician focus of MIPS to a more population-based concept of quality that encourages clinicians to band together and be evaluated as a group.

In the interim, it is imperative that the current FFS payment systems be managed carefully. Medicare is likely to continue using its current payment systems for some years into the future. This fact alone makes unit prices—their overall level, the relative prices of different services in a sector, and the relative prices of the same service across sectors—an important topic. In addition, constraining unit prices could create pressure on providers to control their own costs and to be more receptive to new payment methods and delivery system reforms.

For each recommendation, we present its rationale, its implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods; unlike official budget estimates for legislation, they do not take into account the complete package of policy recommendations or the interactions among them. They also do not take into account any changes in current law made subsequent to our analysis, such as those in the Bipartisan Budget Act of 2018. Although we recognize budgetary consequences, our recommendations are not driven by any single budget target but instead reflect our assessment of the payment

rate needed to provide adequate access to appropriate care balanced with preserving the fiscal sustainability of the Medicare program.

In Appendix A, we list all recommendations and the Commissioners' votes. The Commission voted on those recommendations at its January 2018 meeting. Subsequently, as this report was being finalized, the Congress passed the Bipartisan Budget Act of 2018, which contained numerous changes to the Medicare program. We have identified those provisions in the Bipartisan Budget Act of 2018 most pertinent to the recommendations in this report, but these are not an exhaustive representation of all the provisions in the legislation.

Context for Medicare payment policy

Part of the Commission's mandate is to consider the effect of its recommendations on the federal budget and to view Medicare in the context of the broader health care system. We do so in Chapter 1. In 2016, total national health care spending was \$3.3 trillion, or 17.9 percent of GDP. Private health insurance spending was \$1.1 trillion, or 6.0 percent of GDP. Medicare spending was \$672.1 billion, or 3.6 percent of GDP.

The rate of change of health care spending has fluctuated recently. For decades—from 1975 to 2009—total health care spending and Medicare spending grew robustly, annually averaging 9.0 percent and 10.6 percent, respectively. Then, from 2009 to 2013, growth in total health care spending and Medicare spending slowed to average annual rates of 3.6 percent and 4.3 percent, respectively. More recently, spending increased from 2013 to 2015 and then slowed somewhat from 2015 to 2016.

The aging of the baby-boom generation will have a profound impact both on the Medicare program and the taxpayers who support it. Over the next 15 years, as Medicare enrollment surges, the number of taxpaying workers per beneficiary is projected to decline. By 2028 (when most boomers will have aged into Medicare), the Medicare Trustees project there will be just 2.4 workers for each Medicare beneficiary, down from 4.6 around the time of the program's inception and 3.0 in 2018. Those demographics create a financing challenge not only for the Medicare program but also for the entire federal budget. By 2039, under federal tax and spending policies specified in current law, Medicare spending combined with spending on other major health care programs, Social Security, and net interest on the national debt will exceed total projected federal revenues and will thus either

increase federal deficits and debt further or crowd out spending on all other national priorities.

The growth in health care spending also affects state budgets and the budgets of individuals and families. States pay for a significant portion of Medicaid spending (funded jointly by states and the federal government for health care services provided to state residents with low incomes). Increases in private insurance premiums have outpaced the growth of individual and family incomes over the past decade, and out-of-pocket costs for Medicare beneficiaries have grown faster than Social Security benefits.

Some health care spending is inefficient. For Medicare, if such spending could be identified and eliminated, the efficiencies achieved could result in improved beneficiary health, greater fiscal sustainability for the program, and reduced federal budget pressures. Certain structural features of the Medicare program pose challenges for targeting inefficient spending; however, the Commission is pursuing efforts to curtail low-value care, move care to more efficient settings, and move beyond FFS to payment policies designed to improve care coordination.

Assessing payment adequacy and updating payments in fee-for-service Medicare

As required by law, the Commission annually makes payment update recommendations for providers paid under FFS Medicare. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. As described in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2018) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and Medicare payments and providers' costs. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year, 2019). As part of the process, we examine payments in relation to the efficient delivery of services consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professionals, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years

using the most recent data available to make sure its recommendations accurately reflect current conditions. We may also consider recommending changes that redistribute payments within a payment system to correct any biases that may make patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we also may make recommendations to improve program integrity.

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

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services across settings. Basing the payment on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the financial incentive to provide services in the higher paid setting. However, putting into practice the principle of paying the same rate for the same service across settings can be complex because it requires that the definition of the services and the characteristics of the beneficiaries across settings be sufficiently similar. In March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments and physicians' offices. In 2014, we extended that recommendation to additional services. In the Bipartisan Budget Act of 2015, the Congress made payment to outpatient departments for certain services equal to the physician fee schedule rates for those same services provided at any new outpatient off-campus location beginning in 2018. In 2016, to make payments across all of the post-acute care (PAC) payment settings comparable, the Commission recommended elements of a single prospective payment system (PPS) for all PAC to replace the four independent PPSs in use today (skilled nursing facility, inpatient rehabilitation facility, long-term care hospital, and home health). In Chapter 7, we recommend blending setting-specific and unified PAC PPS relative weights to help transition to a unified system. The Commission will continue to analyze opportunities for applying this principle to other services and settings.

Hospital inpatient and outpatient services

In 2016, the Medicare FFS program paid 4,700 hospitals \$183 billion for about 10 million Medicare inpatient admissions and 200 million outpatient services, and for \$6 billion of their non-Medicare uncompensated care costs. These sums represent a 2.3 percent increase in hospital spending per FFS beneficiary from 2015 to 2016. On net, inpatient payments increased by about \$4 billion, outpatient payments increased by about \$3 billion, and uncompensated care payments decreased by about \$1 billion. Inpatient payments increased primarily because of an increase in inpatient surgeries. Outpatient payments rose because of rapid growth in Part B drug spending and an increase in physician services billed as hospital outpatient services (which in part reflects hospitals' acquisition of physician practices).

As discussed in Chapter 3, most payment adequacy indicators for hospitals (including access to care, quality of care, and access to capital) are positive. Aggregate Medicare margins continue to be negative, although hospitals with excess capacity still have an incentive to see Medicare beneficiaries because Medicare payment rates remain about 8 percent higher than the variable costs associated with Medicare patients.

Beneficiaries' access to care—The average hospital occupancy rate was 62 percent in 2016, suggesting hospitals have excess inpatient capacity in most markets. Inpatient admissions per beneficiary decreased by 2.8 percent in 2016, and outpatient services per beneficiary increased by 1.1 percent. The 2.8 percent decline per beneficiary in admissions reflects a 5 percent decline in medical admissions per capita and a 4.3 percent increase in surgical admissions per capita. This is the first time in 20 years that inpatient surgical admissions per capita have increased.

Quality of care—Hospital mortality and readmission rates have improved in recent years. Patient satisfaction also has improved somewhat: The share of patients who rated their hospital a 9 or a 10 on a 10-point scale increased from 69 percent in 2011 to 73 percent in 2016.

Providers' access to capital— Access to bond markets is very strong, with hospital bond offerings increasing from \$25 billion in 2015 to \$37 billion in 2016. Much of the increase represented refinancing of older debt. While some hospitals struggle with low occupancy and limited access to capital, most hospitals have good access to capital because of strong all-payer profit margins.

Medicare payments and providers' costs—In 2016, hospitals' aggregate Medicare margin was –9.6 percent. The decline in margins from 2015 was primarily due to a freeze in outpatient rates in 2016 and a decline in uncompensated care payments as the share of insured people increased from 2015 to 2016. While average Medicare payments were lower than average costs, Medicare payments were higher than the variable costs of treating Medicare patients in 2016—resulting in a marginal profit of about 8 percent. Therefore, hospitals with excess capacity still have a financial incentive to serve more Medicare patients.

In light of these findings on payment adequacy, the Commission recommends that, for 2019, the Congress should update the 2018 Medicare base payment rates (inpatient and outpatient) for acute care hospitals by the amount determined under current law.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services, including office visits, surgical procedures, and diagnostic and therapeutic services in a variety of settings. In 2016, Medicare paid \$69.9 billion for physician and other health professional services. About 952,000 clinicians billed Medicare—nearly 589,000 physicians and almost 363,000 nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners. Medicare pays for the services of physicians and other health professionals using a fee schedule. In Chapter 4, we discuss the available indicators of payment adequacy for physicians and other health professionals.

Beneficiaries' access to care—Overall, beneficiary access to physician and other health professional services is comparable with prior years. Most beneficiaries continue to report that they are able to find a new doctor without a problem. A small number of beneficiaries report more difficulty, with a higher share reporting problems obtaining a new primary care doctor than reporting problems obtaining a specialist. The number of physicians per beneficiary declined slightly, the number of advanced practice registered nurses and physician assistants per beneficiary rose, and the share of providers enrolled in Medicare's participating provider program remained high. In 2016, across all services, volume per beneficiary grew by 1.6 percent.

Quality of care—CMS assesses the quality of Medicare-billing physicians and other health professionals based on clinician-reported individual quality measures. Starting in 2019, clinicians' payments will be adjusted through the mechanism mandated in MIPS, which builds on the current quality assessment programs. The Commission does not agree with this approach and recommends eliminating MIPS and taking another direction for rewarding quality (see Chapter 15 for further discussion). In Chapter 4, we report two population-based measures—avoidable hospitalizations for ambulatory care-sensitive conditions and rates of low-value care in Medicare. On these measures, clinicians' performance is mixed.

Medicare payments and providers' costs—CMS currently projects that the increase in 2019 in the Medicare Economic Index will be 1.8 percent. In 2016, Medicare payment rates for physician and other health professional services were 75 percent of commercial rates for preferred provider organizations, compared with 78 percent in 2015. Average compensation in 2016 was much lower for primary care physicians than for physicians in specialty groups such as radiology and nonsurgical procedural specialties, continuing to raise concerns about the relative prices Medicare pays for clinician services.

The evidence suggests that payments for physicians and other health professionals are adequate. Therefore, the Commission recommends that the 2019 payment rates for physician and other health professional services be updated by the amount specified in current law.

Ambulatory surgical center services

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay after the procedure. In 2016, 3.4 million FFS Medicare beneficiaries were treated in the 5,532 ASCs certified to provide services to Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$4.3 billion.

As discussed in Chapter 5, our results indicate that beneficiaries' access to ASC services is adequate. The available indicators of payment adequacy for ASC services are positive.

Beneficiaries' access to care—Beneficiaries' access to ASC services has generally been adequate. From 2011 to 2015, the number of ASCs grew at an average annual rate of 1.3 percent. In 2016, the number of ASCs increased 1.4 percent. Most new ASCs in 2016 (92 percent) were for-

profit facilities. From 2011 through 2015, the volume of services per beneficiary grew by an average annual rate of 0.7 percent. In 2016, volume decreased by 0.5 percent.

Quality of care—The first three years of ASC-reported quality data show improvements in performance but also identify opportunities for improvement in both ASCs' quality of care and the ASC Quality Reporting (ASCQR) Program. Among the 10 quality measures for which data were available in 2015, the 4 adverse event measures reflect consistently low levels of adverse events, and the share of ASCs reporting no adverse events has increased each year since 2013. CMS made improvements to the ASCQR Program for 2018, but the Commission remains concerned about the share of ASCs for which quality data are missing and the lack of claims-based outcomes measures that apply to all ASCs. For example, CMS could add a measure targeting the frequency of ASC patients receiving subsequent hospital care.

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

Medicare payments and providers' costs—Medicare payments per FFS beneficiary increased by an average of 3.6 percent per year from 2011 through 2015 and by 3.5 percent in 2016. ASCs do not submit data on the cost of services they provide to Medicare beneficiaries. Therefore, we cannot calculate a Medicare margin as we do for other provider types to help assess payment adequacy.

Based on these indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services with no update to the payment rates for 2019. In addition, the Commission recommends that the Secretary of Health and Human Services collect cost data from ASCs without further delay.

Outpatient dialysis services

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2016, more than 390,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from more than 6,700 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services using a prospective payment system (PPS) that is based on a bundle of services. In 2016, Medicare expenditures for outpatient dialysis services were \$11.4 billion, a 2 percent increase over 2015 expenditures.

Our payment adequacy indicators for outpatient dialysis services, discussed in Chapter 6, are 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 payments are adequate. Dialysis facilities appear to have the capacity to meet demand. Between 2015 and 2016, growth in the number of dialysis treatment stations was faster than growth in the number of FFS dialysis beneficiaries. Between 2015 and 2016, the number of FFS dialysis beneficiaries grew by 1 percent, while the total number of treatments grew by 3 percent.

Quality of care—From 2011 to 2016, unadjusted mortality, hospitalization, and 30-day readmission rates declined, though emergency department use increased. With regard to anemia management, negative cardiovascular outcomes associated with high use of erythropoiesis-stimulating agents declined, and blood transfusion use, which initially increased under the PPS, has trended down since 2013. Between 2011 and 2016, beneficiaries' use of home dialysis, which is associated with improved patient satisfaction and quality of life, increased from 9 percent to 11 percent of dialysis beneficiaries. Since 2014, a shortage of dialysis solutions needed for the predominant home method, peritoneal dialysis, has slowed this modality's growth.

Providers' access to capital—Access to capital for dialysis providers continues to be adequate. The number of facilities, particularly for-profit facilities, continues to increase. Since 2011, the two largest dialysis organizations have grown through acquisitions of and mergers involving midsized dialysis organizations and other providers, including physician services organizations.

Medicare payments and providers' costs—Our analysis of Medicare payments and costs is based on 2015 and 2016 claims and cost report data submitted to CMS by freestanding dialysis facilities. During this period, cost per treatment decreased by 0.7 percent, while Medicare payment per treatment decreased by about 0.6 percent. We estimate that the aggregate Medicare margin was 0.5 percent in 2016, and the rate of marginal profit—that is, the rate at which Medicare payments exceed providers' marginal costs—was 17.2 percent. The 2018 Medicare margin is projected at 0.4 percent.

The Commission recommends that for 2019, the Congress should update the 2018 dialysis PPS base rate by the amount determined under current law.

Post-acute care: Increasing the equity of Medicare's payments within each setting

PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2016, FFS program spending on PAC services totaled \$60 billion.

Each year, in addition to evaluating the adequacy of Medicare FFS payments, the Commission considers whether revisions to the payment systems are needed to better align program payments with the costs of treating patients with different care needs. For years, the Commission has raised concerns that the PAC PPSs encourage providers to favor treating some types of patients over others (thereby impairing access for some beneficiaries), furnish therapy services unrelated to a patient's condition, engage in certain questionable coding practices, extend the length of stay so that a full payment (rather than short-stay outlier payment) is made, or engage in some combination of these strategies. The Commission has urged CMS to revise the payment systems to correct these shortcomings.

In addition, the Commission has recommended lowering the level of payments for HHAs and IRFs to more closely align them with the cost of care. But concern about the wide variation in financial performance across providers has constrained these recommendations. The Commission's update recommendations this year again signal that Medicare's aggregate payments are too high relative to the costs to treat Medicare beneficiaries receiving PAC.

As explained in Chapter 7, PAC presents particular challenges in establishing accurate and equitable payments because it is not always clear whether the beneficiary requires PAC and, if so, which setting is best suited to the patient's care needs or how much care would yield the best outcome. The lack of uniform assessment tools makes it difficult to compare beneficiaries, cost of services, and outcomes of care across settings on a risk-adjusted basis.

In 2016, in response to a congressional mandate, the Commission recommended design features of a unified payment system to be used in the four PAC settings.

The Commission found that a unified PAC PPS could use readily available data to pay for a stay based on a patient's characteristics, not the site of service or the amount of therapy furnished. The design would correct current distortions in the SNF and HHA PPSs that encourage providers to furnish services of questionable value and advantage providers that avoid medically complex patients. In June 2017, the Commission recommended that the new payment system begin to be implemented in 2021 so that inequities in the current payment systems could start to be corrected as soon as possible.

Before implementing a unified PAC PPS, the Commission recommends that the Congress direct the Secretary to begin blending the relative weights of the setting-specific payment systems and the unified PAC PPS in 2019. Because the resulting payments would be more closely aligned with the cost of care across all conditions, the equity of the program's payments would increase. Under this blend, each PAC setting's total payments would be kept at the recommended level while payments would be redistributed within each setting based on a provider's mix of patients, costs, and therapy practices. Blending unified PAC PPS and setting-specific relative weights before the implementation of a unified payment system would give providers more time to adjust their practices and costs to the incentives of the new system. With closer alignment of payments and costs and the redistribution of payments across providers, policymakers then could consider establishing a level of payment that more accurately reflects the costs of care. When the PAC PPS is fully implemented, the relative weights of that design would be used exclusively in establishing payments for providers in the four PAC settings.

The recommendation to blend the relative weights in no way detracts from the Commission's concurrent recommendations to revise the SNF and HHA payment systems. Because the PAC PPS is on a longer implementation timetable, Medicare must continue to improve its setting-specific payment systems. To address the persistently high level of payments in the PAC settings, the Commission has setting-specific recommendations to lower payments in the case of HHAs and IRFs and to provide no updates to the payments for SNFs and LTCHs. The blending recommendation to redistribute payments within a setting would not interfere with the consideration of the setting's payment level either in the aggregate or for individual PAC settings.

Skilled nursing facility services

SNFs provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2016, about 15,000 SNFs furnished 2.3 million Medicare-covered stays to 1.6 million FFS beneficiaries. Medicare FFS spending on SNF services was \$29.1 billion in 2016, about 1 percent less than in 2015.

The key measures, discussed in Chapter 8, indicate Medicare payments to SNFs are adequate. We also find that 970 relatively efficient SNFs provided relatively high-quality care at relatively low costs, suggesting that opportunities remain for other SNFs to achieve greater efficiencies.

Beneficiaries' access to care—Access to SNF services remains adequate. The number of SNFs participating in the Medicare program has been stable. The vast majority (89 percent) of beneficiaries live in a county with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds), and less than 1 percent live in a county without one. Between 2015 and 2016, the median occupancy declined slightly but remained high (85 percent). Medicare-covered admissions per FFS beneficiary decreased between 2015 and 2016, consistent with decreases in inpatient hospital admissions (a three-day inpatient stay is required for Medicare coverage of SNF services). Lengths of stay also declined. Both trends contributed to fewer covered days in 2016 compared with 2015.

Quality of care—Between 2015 and 2016, SNFs had mixed performance on quality measures. The community discharge rate increased (improved), while the rates of hospital readmissions (during SNF stay and within 30 days after discharge) increased slightly (got worse). However, since 2011, both readmission rates have improved overall. Measures of changes in patients' functional status have remained essentially constant.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Access to capital was adequate in 2017 and is expected to remain so in 2018. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—In 2016, the average Medicare margin for freestanding SNFs (96 percent of SNFs) was 11.4 percent—the 17th year in a row that the average was above 10 percent. Margins

varied greatly across facilities, reflecting differences in costs and shortcomings in the SNF PPS that favor treating rehabilitation patients over medically complex patients. The marginal profit, a measure of the relative attractiveness of treating Medicare beneficiaries, was at least 19.6 percent.

On the basis of these factors, the Commission recommends no update to SNF payment rates for two years (2019 and 2020) and that the Secretary implement a revised SNF PPS in 2019. Then, in 2021, the Secretary would evaluate the need to make further adjustments to payments to bring them in alignment with costs. This recommendation is made in the context of the Commission's recommendation to establish SNF payments using a blend of the unified PAC PPS and current SNF PPS relative weights beginning in fiscal year 2019. A blend of the relative weights would redistribute payments within the SNF setting by increasing payments for medically complex patients and lowering payments for patients who receive rehabilitation therapy unrelated to their care needs.

Medicaid trends

As required by the Patient Protection and Affordable Care Act of 2010, we report on Medicaid use, spending, and non-Medicare (private-payer and Medicaid) margins. Medicaid finances mostly long-term care services provided in nursing homes, but also covers copayments for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF. The number of Medicaid-certified facilities has declined slightly since 2015 but remains close to 15,000. CMS reports total FFS spending on nursing home services declined 3.2 percent between 2015 and 2016 and estimates a smaller decline between 2016 and 2017. In 2016, the average total margin—reflecting all payers and all lines of business—was 0.7 percent. The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was –2.3 percent.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing or therapy services. In 2016, about 3.4 million Medicare beneficiaries received care, and the program spent about \$18.1 billion on home health care services. In that year, over 12,200 agencies participated in Medicare.

The indicators of payment adequacy for home health care, discussed in Chapter 9, are generally positive.

Beneficiaries' access to care—Access to home health care is generally adequate: Over 99 percent of beneficiaries lived in a ZIP code where a Medicare home health agency operated in 2016, and 86 percent lived in a ZIP code with five or more agencies. In 2016, the number of agencies fell slightly by 1.2 percent after increasing by over 60 percent between 2004 to 2015. In 2016, the total number of users increased slightly, the average number of episodes per home health user declined by 0.9 percent, and the volume of 60-day episodes decreased by 0.7 percent. From 2002 to 2015, home health utilization increased substantially, with the number of episodes rising by over 60 percent and the episodes per home health user climbing from 1.6 to 1.9 episodes. Episodes not preceded by a hospitalization accounted for most of the growth in this period, increasing from about half to two-thirds of total episodes since 2001.

Quality of care—In 2016, performance improved on some quality measures. The share of beneficiaries reporting improvement in walking and transferring increased significantly, though this finding may be due to changes in coding practices; the share of beneficiaries hospitalized or using emergency care during their home health stay was unchanged.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for home health care because this sector is less capital intensive than other health care sectors. The major publicly traded for-profit home health companies had sufficient access to capital markets for their credit needs. Several capacity acquisitions and expansion of capacity by publicly traded home health care firms indicate adequate access to capital.

Medicare payments and providers' costs—In 2016, Medicare spending for home health care increased about 0.1 percent. However, between 2002 and 2016, spending increased by over 80 percent. For more than a decade, payments under the home health PPS have consistently and substantially exceeded costs. In 2016, Medicare margins for freestanding agencies (which accounted for 90 percent of episodes in 2016) averaged 15.5 percent. Also in 2016, freestanding HHAs' marginal profit was 17.4 percent. The projected margin for 2018 is 14.4 percent. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by lowering the number of visits provided, and cost growth has been lower than the annual payment updates for home health care.

On the basis of the positive indicators for payment adequacy and freestanding HHAs' high margins, the Commission recommends a 5 percent reduction in the home health PPS base payment rate for 2019 and a two-year rebasing beginning in 2020. These two actions should help to better align payments with actual costs, ensuring better value for beneficiaries and the taxpayer without impeding access.

Our update recommendation is made in the context of the Commission's recommendation (discussed in Chapter 7) to establish HHA payments using a blend of the unified PAC PPS and current HHA PPS relative weights beginning in calendar year 2019. A blend of the relative weights would redistribute payments within the HHA setting by increasing payments for medically complex patients and lowering payments for patients who receive therapy services unrelated to their care needs.

We continue to recommend, as we have for the last six years, that Medicare eliminate the use of the number of therapy visits as a payment factor in the home health PPS. Doing so would base home health payment solely on patient characteristics and would result in a more patient-focused approach to payment. (Subsequent to the Commission's vote on the recommendation, the Bipartisan Budget Act of 2018 eliminated the number of therapy visits as a payment factor in the home health PPS, beginning in 2020.)

Inpatient rehabilitation facility services

IRFs provide intensive rehabilitation services to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupation therapy, rehabilitation nursing, speech-language pathology, and prosthetic and orthotic services. In 2016, Medicare spent \$7.7 billion on FFS IRF care provided in about 1,200 IRFs nationwide. About 350,000 beneficiaries had almost 391,000 IRF stays. On average, Medicare accounts for about 60 percent of IRF discharges.

Our indicators of Medicare payment adequacy for IRFs, discussed in Chapter 10, are positive.

Beneficiaries' access to care—Capacity remains adequate to meet demand. After declining for several years, the total number of IRFs increased in 2014 and continued to grow through 2016. Over time, the number of hospital-based and nonprofit IRFs has declined, while the number of freestanding and for-profit IRFs has increased. In 2016,

the average IRF occupancy rate remained at 65 percent. The number of FFS cases grew 2.4 percent between 2015 and 2016.

Quality of care—The Commission tracks three broad categories of IRF quality indicators: risk-adjusted facility-level change in functional and cognitive status during the IRF stay, rates of discharge to the community and to skilled nursing facilities, and rates of readmission to an acute care hospital. Most measures were steady or improved between 2011 and 2016.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital. The major freestanding IRF chain, which accounted for almost half of all freestanding IRFs in 2016 and about a quarter of all Medicare IRF discharges, also has good access to capital. This assessment is based on the chain's continued expansion.

Medicare payments and providers' costs—After a period of steady growth between 2009 and 2015, the aggregate IRF margin declined in 2016 but remained high at 13.0 percent. The Medicare margin in freestanding IRFs was 25.5 percent. Hospital-based IRF margins were lower, but one-quarter of hospital-based IRFs had Medicare margins greater than 11 percent, indicating that many hospitals can manage their IRF units profitably. Lower margins in hospital-based IRFs were driven largely by higher unit costs. Given the difference in financial performance across IRFs, we examined IRFs' marginal profits to assess whether they have a financial incentive to expand the number of Medicare beneficiaries they serve. We found that Medicare payments exceed marginal costs by a substantial amount—19.3 percent for hospital-based IRFs and 40.9 percent for freestanding IRFs—suggesting that IRFs with available beds have an incentive to admit Medicare patients. We project an aggregate Medicare margin of 11.9 percent for IRFs in 2018.

Considering these factors, the Commission recommends that the IRF payment rate for fiscal year 2019 be reduced by 5 percent. The reduction in the payment rate is made in the context of the Commission's recommendation in Chapter 7 that the Congress direct the Secretary to adjust IRF payments using a blend of the current IRF PPS relative weights and the unified post-acute care PPS weights beginning in 2019. A blend of the relative weights would redistribute payments within the IRF setting by increasing payments for medically complex patients and lowering payments for patients with less complex

conditions. In addition, the Commission reiterates its March 2016 recommendations that the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and that the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding, and reassess the inter-rater reliability of the IRF assessment tool to improve the accuracy of payments and protect program integrity.

Long-term care hospital services

LTCHs provide care to beneficiaries who need hospital-level care for relatively extended periods. To qualify as an LTCH for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals, and certain Medicare patients must have an average length of stay greater than 25 days. In 2016, Medicare spent \$5.1 billion on care provided in LTCHs nationwide. About 111,000 FFS beneficiaries had roughly 126,000 LTCH stays in 407 LTCHs. On average, Medicare FFS beneficiaries account for about two-thirds of LTCHs' discharges. Chapter 11 presents our findings on payment adequacy for LTCHs.

Beneficiaries' access to care—We consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. The number of LTCHs decreased in recent years because of two moratoriums on new facilities and changes to Medicare's LTCH payment policy. The number of LTCHs and LTCH beds decreased annually by an average of 1.1 percent and 2.3 percent, respectively, from 2012 through 2016. We expect these trends to continue because of the implementation of the patient-specific criteria that began in fiscal year 2016. However, the average LTCH occupancy rate was 66 percent in 2016, suggesting that LTCHs have excess capacity in the markets they serve. From 2015 to 2016, the number of LTCH cases decreased by 4.2 percent, continuing a four-year trend that began in 2013. The number of LTCH cases per beneficiary declined during this period (2015 to 2016) by 5.1 percent, similarly continuing a trend of decreasing per capita LTCH use that began in 2012.

Quality of care—Consistent with prior years, we found stable non-risk-adjusted rates of readmission, death in the LTCH, and death within 30 days of discharge across the top 25 LTCH diagnoses.

Providers' access to capital—The new criteria to receive the higher LTCH payment rate specified in the Pathway for SGR Reform Act of 2013, coupled with payment

reductions to annual updates required by statute, have limited opportunities for growth and reduced the industry's need for capital in the near term.

Medicare payments and providers' costs—The aggregate Medicare margin for qualifying cases was 6.8 percent in 2015 and 6.3 percent in 2016. Financial performance in 2016 varied across LTCHs, reflecting differences in cost control and responses to payment incentives. Marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit more Medicare patients, was about 20 percent in 2016. We project that LTCHs' aggregate Medicare margin for discharges that meet the patient-specific criteria and that qualify for the full LTCH payment rate will be 4.7 percent in 2018.

On the basis of these indicators and in the context of recent changes in payment policy, the Commission concludes that LTCHs can continue to provide Medicare beneficiaries with access to safe and effective care and accommodate changes in their costs with no update to LTCH payment rates in fiscal year 2019. This update recommendation applies to the Medicare LTCH PPS base payment rate. That is, it applies to payments for discharges that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and to the portion of the blended payment that reflects the LTCH payment rate for discharges that do not meet the specified criteria.

The recommendation about the level of payments to LTCHs is made in the context of the Commission's recommendation (discussed in Chapter 7) to establish LTCH payments using a blend of the current LTCH PPS relative weights and the unified post-acute care PPS weights beginning in fiscal year 2019. A blend of the relative weights would redistribute payments within the LTCH setting by increasing payments for medically complex patients and lowering payments for patients with less complex conditions.

Hospice services

The Medicare hospice benefit covers palliative care and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. Beneficiaries may elect the Medicare hospice benefit; in so doing, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2016, more than 1.4 million Medicare beneficiaries (including nearly 50 percent of decedents) received hospice services from more

than 4,380 providers, and Medicare hospice expenditures totaled about \$16.8 billion. In Chapter 12, we find the indicators of payment adequacy for hospices are positive.

Beneficiaries' access to care—Hospice use among Medicare beneficiaries has grown substantially in recent years, suggesting greater awareness of and access to hospice services. The number of hospice providers increased by about 4.4 percent in 2016 because of growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers. In 2016, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased slightly. In 2016, 49.7 percent of Medicare beneficiary decedents used hospice, up from 48.6 percent in 2015. In 2016, hospice use increased across all demographic and beneficiary groups examined. However, rates of hospice use remained lower for minority beneficiaries than for White beneficiaries. Between 2015 and 2016, average length of stay among decedents increased from about 87 days to 88 days and median length of stay increased from 17 to 18 days.

Quality of care—Hospices' performance on seven quality measures related to processes of care at hospice admission is generally high and increased between 2015 and 2016. In 2016, most hospices scored high (93 percent or higher) on six of the seven measures, while performance on the pain assessment measure was lower and more varied.

Providers' access to capital—Hospices are not as capital intensive as some other provider types because they do not require extensive physical infrastructure. Continued growth in the number of for-profit providers (a more than 7 percent increase in 2016) suggests capital is available to for-profit providers. Less is known about access to capital for nonprofit freestanding providers. Hospital-based and home health-based hospices have access to capital through their parent organizations.

Medicare payments and providers' costs—The aggregate 2015 Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 10.0 percent, up from 8.2 percent in 2014. The projected 2018 aggregate Medicare margin is 8.7 percent.

On the basis of strong financial performance and other strong positive indicators of payment adequacy, the Commission recommends no update for the 2019 Medicare hospice payment rates.

The Medicare Advantage program: Status report

Each year, the Commission provides a status report on the MA program. In 2017, the MA program included almost 3,300 plan choices, enrolled about 19 million beneficiaries (32 percent of all Medicare beneficiaries), and paid MA plans about \$210 billion (not including Part D drug plan payments). In Chapter 13, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and current quality indicators in MA. As a result of the analyses, we recommend changes for determining eligibility for bonuses under the quality bonus program.

The MA program gives Medicare beneficiaries the option of receiving benefits from private plans rather than from the traditional FFS Medicare program. The Commission strongly supports the inclusion of private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and alternative delivery systems that private plans can provide. Because Medicare pays private plans a per person predetermined rate rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission has recommended that payments be brought down from prior levels, which were generally higher than FFS, and be set so that the payment system is neutral and does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS. As a result, over the past few years, plan bids and payments have come down in relation to FFS spending while MA enrollment continues to grow. The pressure of lower benchmarks has led to improved efficiencies and more competitive bids that enable MA plans to continue to increase enrollment by offering benefits that beneficiaries find attractive.

Enrollment—Between 2016 and 2017, enrollment in MA plans grew by about 8 percent (1.4 million enrollees) to 18.9 million enrollees. About 32 percent of all Medicare beneficiaries were enrolled in MA plans in 2017.

Among plan types, HMOs continued to enroll the most beneficiaries (12.2 million).

Plan availability—Access to MA plans remains high in 2018, with most Medicare beneficiaries having access to many plans. Nearly all Medicare beneficiaries (96 percent) have an HMO or local preferred provider organization plan operating in their county of residence. Overall, 99 percent of Medicare beneficiaries have access to an MA plan. Compared with 2007, MA enrollment in 2017 is more heavily concentrated in large MA organizations. The top 10 MA organizations (ranked by enrollment) had 72 percent of total enrollment in 2017, compared with 61 percent in 2007.

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. Medicare pays most claims in traditional FFS Medicare using procedure codes, which offer little incentive for providers to record more diagnosis codes than necessary to justify ordering a procedure. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan.

Our analysis for 2016 finds that higher diagnosis coding intensity resulted in MA risk scores that were 8 percent higher than scores for similar traditional FFS Medicare beneficiaries. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding. In 2016, the adjustment reduced MA risk scores by 5.41 percent, compared with our estimate of 8 percent. The adjustment for 2018 will be 5.91 percent. The Commission previously recommended that CMS change the way diagnoses are collected for use in risk adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.

Plan payments—Using the 2018 plan bid data, before adjusting fully for coding intensity, we estimate that 2018 MA benchmarks, bids, and payments (including quality bonuses) average 107 percent, 90 percent, and 101 percent of FFS spending, respectively. All these values increase by about 2 percentage points if coding intensity beyond the legislatively mandated downward adjustment is reflected fully; for example, payments for MA plans will average 103 percent of FFS spending. On average, quality

bonuses in 2018 add 4 percent to the average plan's base benchmark and add 3 percent to plan payments.

Quality measures—Plans in MA contracts receive bonus payments if their contract has an overall rating of 4 stars or higher on CMS's 5-star rating system. Plans in a lower rated contract can obtain a bonus payment if their contract is absorbed (consolidated) with a contract that is rated 4 stars or higher. At the end of 2017, 1.4 million enrollees were in a nonbonus contract that was absorbed by another contract with a rating of 4 stars or higher and, thus, will be in bonus status for the 2018 payment year. Since 2013, over 4 million enrollees—over 20 percent of MA enrollees—have been moved by organizations among contracts to secure bonus payments. Thus, while over 70 percent of MA enrollees are classified as being in plans at 4 stars or higher, taking into account the enrollees who are in bonus-status plans because of consolidations, the actual share could be as low as 50 percent. In addition to the unwarranted bonus payments, the wave of contract consolidations has resulted in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area.

The Commission recommends that contract consolidations should not be allowed to affect star ratings and bonus payments when two contracts serving different geographic areas are consolidated. The determination of star ratings for each geographic area of the original contracts and the reporting of quality indicators that are the basis of the star ratings should continue as though the consolidation had not occurred. (Subsequent to the Commission's vote on the recommendation, the Bipartisan Budget Act of 2018 directed the Secretary to address contract consolidations by averaging the star results of contracts that are being combined.) In conjunction with the recommendation addressing consolidations, the Commission restates its recommendation that the geographic unit for quality reporting should be the local health care market area.

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

In 2016, Medicare spending and enrollee premiums for Part D benefits totaled \$91.6 billion. Enrollee premiums made up \$12.7 billion of that total (enrollees also paid cost sharing). In 2017, 42.5 million individuals (72.5 percent of all Medicare beneficiaries) were enrolled in Part D plans. Of those enrolled, 59 percent were in stand-alone prescription drug plans (PDPs) and 41 percent were in Medicare Advantage–Prescription Drug (MA–PD) plans.

In Chapter 14, the Commission provides a status report on the Medicare prescription drug benefit that describes beneficiaries' access to prescription drugs: enrollment levels, plan benefit designs, and the quality of Part D services. The report also analyzes changes in plan bids, premiums, and program costs. In addition, the chapter includes a recommendation related to biosimilars.

For the past two years, the Commission has noted its concern that a growing share of program spending has been for high-cost enrollees—beneficiaries who reach the catastrophic phase of Part D's benefit. The Commission's June 2016 recommendations addressed these concerns. This year's status report provides further evidence that this trend has continued, and we point to factors that contribute to greater catastrophic spending.

Medicare beneficiaries' drug coverage in 2017 and benefit offerings for 2018—Among the 42.5 million beneficiaries enrolled in Part D drug plans in 2017, 12.2 million received the low-income subsidy (LIS). Three percent of all Medicare beneficiaries (1.6 million individuals) received drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 25 percent of Medicare beneficiaries not enrolled in a Part D plan or in an employer plan receiving the retiree drug coverage subsidy were divided about equally between those who had creditable drug coverage (i.e., benefits at least as generous as Part D) from other sources, and those with no coverage or coverage less generous than Part D.

For 2018, plan sponsors are offering 782 PDPs and 2,003 MA–PDs, about 5 percent and 16 percent, respectively, more plans than in 2017. Beneficiaries continue to have broad choice among plans—between 19 and 26 PDPs to choose from, depending on where they live, as well as typically 10 or more MA options. MA–PDs continue to be more likely than PDPs to offer enhanced benefits. For 2018, 216 premium-free PDPs are available to enrollees who receive the LIS, a 6 percent decrease from 2017. With the exception of one region (Florida), all regions continue to have at least 3 and as many as 10 PDPs available at no premium to LIS enrollees.

In 2018, the 10 PDPs with the highest 2017 enrollment continue to use a 5-tier formulary with differential cost sharing. Over time, many plan sponsors have moved from charging fixed-dollar copayments to coinsurance for certain tiers.

Part D program costs—Between 2007 and 2016, Part D program spending on an incurred basis increased from \$46 billion to \$79 billion (an average annual growth rate of about 6 percent). Medicare’s reinsurance subsidy (which covers 80 percent of spending if an enrollee reaches the catastrophic phase of the benefit) became the largest component of program spending in 2014 and has remained the fastest growing component, at an average annual growth rate of nearly 18 percent between 2007 and 2016. Thus, in 2016, a higher share of Medicare payments was retrospective, cost-based reimbursement rather than prospective, risk-based payments—a result not contemplated in the original design of the program. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) have been driving Part D program costs, accounting for 57 percent of gross spending in 2015. Spending on a per enrollee basis for high-cost individuals grew by more than 10 percent, and that growth was accounted for almost entirely by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used). Going forward, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have high prices. The use of high-priced drugs by Part D enrollees will likely grow and put significant upward pressure on Medicare spending for reinsurance and the LIS.

Financial disincentives to use biosimilars in

Part D—Biologics make up a fast-growing segment in the biopharmaceutical sector and will continue to grow in importance. Biosimilars are expected to have lower prices than originator biologics. However, the take-up of biosimilars in Part D may be dampened by certain Part D policies. To rectify financial incentives that disadvantage biosimilars, the Commission recommends applying the same discount that manufacturers of originator biologics and brand-name drugs provide in the coverage gap to biosimilar products. Consistent with the Commission’s 2016 recommendations, discounts on biosimilars would not count as though they were an enrollee’s own out-of-pocket spending for purposes of determining when an enrollee reached Part D’s catastrophic phase. To the extent that the adoption of the Commission’s set of recommendations results in net program savings, the Congress could consider enhancing protections for non-LIS enrollees facing high cost-sharing burdens. (Subsequent to the Commission’s vote on this recommendation, the Bipartisan Budget Act of 2018 directed biosimilar manufacturers to, beginning in 2019,

provide a discount on their products in the coverage gap. However, unlike the Commission’s recommendation, the discount amount would continue to count as though it were the enrollees’ own OOP spending.)

Access to prescription drugs—Giving plans greater flexibility to use management tools could help ensure that prescribed medicines are safe and appropriate for the patient and could potentially reduce overuse or misuse. However, for some beneficiaries, those same tools could also limit access to needed medications. Beneficiary advocates, prescribers, plan sponsors, and CMS have all noted frustrations with Part D coverage determinations, exceptions, and appeals processes. A more efficient approach would be to resolve such issues at the point of prescribing, through e-prescribing and electronic prior authorization, rather than at the pharmacy counter.

Quality in Part D—In 2018, the average star rating among Part D plans increased somewhat for PDPs and remained about the same for MA–PDPs. However, quality measures used currently for Part D may not help beneficiaries make informed choices among plan options. For example, Part D plans are required to implement medication therapy management (MTM) programs to improve quality. However, sponsors of stand-alone PDPs do not have financial incentives to engage in MTM. In 2017, Medicare began testing enhanced MTM programs by providing incentives for selected stand-alone PDPs to conduct medication reviews and tailor drug benefit designs that encourage adherence to appropriate drug therapies.

Moving beyond the Merit-based Incentive Payment System

Recognizing that an enacted public policy is not fulfilling its intended goals and therefore calling for its elimination is complex. For example, the sustainable growth rate (SGR) system, which was intended to limit growth in Medicare fee schedule spending to a formula based on GDP, started in 1999, was repeatedly overridden by the Congress between 2003 to 2014 and was not eliminated until the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Commission supports the elements of MACRA that repealed the SGR and encouraged comprehensive, patient-centered care delivery models such as advanced alternative payment models (A–APMs).

Notwithstanding, the Commission has concluded that one part of MACRA, the Merit-based Incentive Payment System (MIPS), will not fulfill its goals and therefore

should be eliminated. The Commission did not reach this conclusion hastily. We first examined options for improving MIPS as it was implemented, and we provided constructive feedback as CMS established rules for the first two years of the program. However, as we continued to explore the issue in several Commission reports to the Congress, we determined that, from the Commission's perspective, the basic design of MIPS is fundamentally incompatible with the goals of a beneficiary-focused approach to quality measurement.

The basic design principle of MIPS is that quality of care and payment adjustments for quality can and should be determined primarily at the individual clinician level, based on measures that clinicians themselves choose to report. But a system built on this design will be inequitable for two reasons. First, clinicians will be evaluated and compared on dissimilar measures—measures which they will have likely chosen based at least in part on their self-assessment of their own ability to perform well on those measures. Second, many clinicians will not be evaluated at all. As individuals, they will not have a sufficient number of cases for statistically reliable scores. Further, the design is at odds with the fact that quality outcomes for patients—the principal objective of any value-improvement program—are determined primarily through the combined efforts of many providers rather than by the actions of any one clinician.

It is this underlying conception of how best to improve quality that is most essential. The core Commission principle for value-based purchasing programs is that clinical outcomes, patient experience, and cost must be evaluated together and that these measures are dependent on the totality of the delivery system that produces them. It can be difficult to put all these principles in operation given the uncoordinated nature of traditional FFS Medicare payment, but it can be done. However, MIPS, by design, does not meet this principle. In fact, the core of MIPS is based on predecessor Medicare programs that have generally not been successful at improving population outcomes or substantively improving care processes. In addition:

- MIPS imposes a significant reporting burden on clinicians (estimated by CMS as over \$1.3 billion in the first year);
- MIPS scores are not comparable among clinicians because each clinician's composite MIPS score will reflect a mix of different, self-chosen, measures;

- MIPS is complex and inequitable, with different rules for clinicians depending on location, practice size, and other factors, and it exempts more clinicians than will participate; and
- MIPS-based payment adjustments will be small in the first years, providing little incentive, and then arbitrary and possibly very large in the later years, creating significant financial uncertainty for clinicians.

For these reasons, the Commission recommends that the Congress eliminate the current MIPS program as soon as possible. At the same time, the Commission believes that traditional Medicare FFS payment should have a value-based payment component. Thus, we recommend creating a new clinician value-based purchasing program to take its place. This recommendation reflects a conceptual direction for rewarding clinician quality in Medicare FFS according to the core quality principles developed by the Commission. The Commission will engage in a more detailed development of the concept should the Congress choose to pursue these recommendations.

Mandated report: Telehealth services and the Medicare program

The 21st Century Cures Act of 2016 mandated that the Commission provide, by March 15, 2018, information about (1) the extent to which the Medicare FFS program covers telehealth services, (2) the extent to which commercial insurance plans cover telehealth services, and (3) ways in which the telehealth coverage policies of commercial insurance plans might be incorporated into the Medicare FFS program. The Commission fulfills this mandate in Chapter 16.

Medicare coverage of telehealth services—(The Bipartisan Budget Act of 2018 expanded coverage of telehealth services under Medicare related to telestroke care, MA, and accountable care organizations.) Medicare coverage of telehealth services is broad and flexible under payment systems in which providers or payers bear some degree of financial risk, but more limited under the fee schedule for physicians and other health professionals (referred to as the physician fee schedule, or PFS). The PFS covers telehealth services originating at rural medical facilities and offices, as well as certain telehealth services paid for as a part of a bundle of services delivered in both urban and rural areas. Under Medicare's other FFS payment systems (e.g., hospital inpatient and home health), providers receive a fixed payment for patient encounters and are able to use telehealth services that best

serve beneficiaries under the fixed payment. Under the MA program, plans must cover all telehealth and non-telehealth services included in the basic Medicare FFS benefit, but plans also can offer extra telehealth benefits that are supplemental to the basic FFS benefit. MA plans must use rebate dollars or additional premiums to finance extra benefits. Under CMS's Center for Medicare & Medicaid Innovation (CMMI), some entities bearing financial risk (e.g., accountable care organizations (ACOs) in the Next Generation ACO Model) have waivers from PFS rules to use telehealth in urban areas or from a patient's residence.

The use of telehealth services under the PFS has grown rapidly in recent years, but remains low. In 2016, 108,000 beneficiaries (0.3 percent of FFS beneficiaries) accounted for over 300,000 telehealth visits totaling \$27 million. These services were most commonly used for basic physician office and mental health services. Use was concentrated among a small group of clinicians and beneficiaries. Beneficiaries using telehealth services tended to be under age 65, disabled, and dually eligible for Medicare and Medicaid; reside in rural areas; and disproportionately have chronic mental health conditions. In addition, our analysis suggests that some portion of telehealth claims are supplemental to, rather than a substitute for, in-person services.

Commercial insurance plan coverage of telehealth—The coverage of telehealth services by commercial insurance plans in 2017 was variable. In general, most plans we surveyed covered some form of telehealth service, but few covered a comprehensive set of services. The most commonly used telehealth services were basic physician office and mental health services. Several plans covered direct-to-consumer (DTC) virtual visits (i.e., clinical services provided by clinicians other than the patient's primary care provider that are available to patients 24 hours per day, typically routine medical services). Plans consistently covered telehealth in urban and rural areas; only half covered telehealth from the patient's residence. As with Medicare FFS, commercial use was low, less than 1 percent of plan enrollees. Commercial insurers often test telehealth using pilot programs before implementation.

In general, cost reduction does not appear to be a significant consideration in plans' decisions to cover telehealth services. Plan representatives with whom we spoke cited competitive pressures from employers or other insurers rather than cost reduction as the primary rationale for covering telehealth services.

Expanding Medicare coverage of telehealth services—Our analysis found relatively little use of telehealth services among enrollees in commercial plans and a lack of uniformity in how commercial insurers covered telehealth services. We also found that cost is not a significant consideration in commercial insurers' adoption of telehealth services. However, as a public payer, Medicare is obligated to consider costs to the program, beneficiaries, and taxpayers in determining whether to expand coverage of telehealth. Therefore, because we do not see clear examples of commercial payer practices that should be imported into FFS Medicare, this report does not make recommendations about coverage of specific telehealth services. Instead, the Commission recommends that policymakers use a set of principles (cost, access, and quality) to evaluate individual telehealth services separately before adoption into Medicare coverage. The Commission's principle-based approach can be applied to telehealth services commonly used by commercial plans today and for telehealth services developed or considered for coverage in the future.

Several of the most commonly implemented and tested services by commercial insurers include telestroke services, telehealth services for beneficiaries with disability-related treatment-intensive conditions, tele-mental health services, DTC services, telehealth for nursing home residents, and remote patient monitoring. In cases where evidence exists that these services balance the cost, access, and quality principles, policymakers could consider adopting them for Medicare. However, when such evidence is lacking, policymakers should consider pilot testing these services through CMMI, just as testing before implementation is common among commercial insurers. Under the Medicare FFS payment systems other than the PFS, providers maintain adequate flexibility to evaluate and use telehealth services. MA plans and risk-bearing ACOs could be granted greater flexibility to use telehealth services because, in bearing financial risk, they have the financial incentive to assess the value of these services. ■

