
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 2021 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.
- as mandated by the Congress, report on the expansion of the hospital post-acute care transfer policy to hospice.
- review the status of the MA program (Medicare Part C) through which beneficiaries can join private plans in lieu of traditional FFS Medicare.
- review the status of the Medicare program that provides prescription drug coverage (Medicare Part D).
- as requested by the Congress, report on health care provider consolidation and its effects on Medicare, its beneficiaries, and other aspects of the delivery system.

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 best 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 payment systems seldom include incentives for providers to

coordinate services across time and 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 in a sector, and the relative prices of the same service across sectors—of critical importance. Constraining unit price increases can 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, 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 take into account 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 balanced with ensuring the fiscal sustainability of the Medicare program.

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

Context for Medicare payment policy

Sustaining Medicare fiscal solvency is a growing and pressing challenge, as described in Chapter 1. Medicare's Trustees estimate that the program's Hospital Insurance Trust Fund—which is primarily funded through a payroll tax—will be depleted by 2026. One driver of Medicare's

growing fiscal challenge is the declining number of workers per Medicare beneficiary—falling from 4.6 workers around the program’s inception to 3.0 in 2019 and projected to drop to 2.5 in the next 10 years.

Other parts of Medicare are funded through general tax revenues (and federal borrowing) and beneficiary premiums. As this spending grows, it increases deficits and the debt; assuming no other policy or legislative interventions, it also reduces the resources available to make investments that expand future economic output (e.g., investments in education, transportation, and research and development).

Increasing Medicare spending also strains beneficiaries’ household budgets. In 2019, Medicare Part B and Part D premiums and cost sharing consumed 23 percent of the average Social Security benefit, up from 7 percent in 1980.

Over the last 10 years, private health insurance spending per enrollee has grown faster than Medicare spending per enrollee. Per enrollee growth in spending on private health insurance was 4.3 percent annually from 2008 to 2018, despite the tools private plans have to constrain service use. By comparison, over that same period, Medicare spending per enrollee rose by 2.0 percent annually. Increasing prices were largely responsible for the growth in private insurance spending, which occurred despite a decline in service use. One key driver of the private sector’s growth in prices was provider market power (see Chapter 15). Hospitals and physician groups have increasingly consolidated, in part to gain leverage over insurers to negotiate higher payment rates. In contrast, Medicare has been able to control spending growth principally by setting prices.

However, there are limits on Medicare’s ability to set prices (e.g., Medicare does not set prices for drugs, and Medicare spending on drugs has grown more rapidly than other areas of spending). In addition, Medicare enrollment will continue to increase, and Medicare cannot directly control the volume of services. Hence, spending on the program is growing and is projected to constitute a growing share of the country’s GDP—3.6 percent in 2018, expected to grow to 4.7 percent by 2027.

Certain aspects of the Medicare program hamper its ability to achieve fiscal sustainability; however, the Commission has made numerous recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and

equity. These include recommendations to better align Medicare payments with providers’ costs; make payments site neutral; increase payments to primary care providers; reduce incentives to treat certain types of patients and to furnish certain types of services; scrutinize claims more closely; encourage better integration with Medicaid; modify beneficiary cost sharing to incentivize high-value care; collect more complete and accurate MA data; and incentivize improving population-based outcomes, such as by implementing and improving value-based purchasing programs.

As Medicare consumes a growing share of the federal budget, the country’s GDP, and beneficiaries’ incomes, the Commission will continue to identify policy changes that could put Medicare spending on a more sustainable path, including through recommendations contained in this report and future reports to the Congress.

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 rate 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 (2020) by considering beneficiaries’ access to care, the quality of care, providers’ access to capital, and how Medicare payments compare with providers’ costs. Next, we assess how those providers’ costs are likely to change in the year the update will take effect (the policy year, 2021). As part of the process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Finally, we make a judgment about what, if any, update is needed.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health care agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. Each year, the Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure our recommendations accurately reflect current conditions. We may also consider recommending changes

that redistribute payments within a payment system to correct any biases that may make treating patients with certain conditions financially undesirable, make particular procedures unusually profitable, or otherwise result in inequity among providers. Finally, we may also make recommendations to improve program integrity.

Our recommendations, if enacted, could significantly change the revenues providers receive from Medicare. Payment rates that reflect the costs of relatively efficient providers help create fiscal pressure on all providers to control their costs. Furthermore, Medicare rates also have broader implications for health care spending because Medicare rates are used in setting payments for other government programs, states, and private health insurance.

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, generally 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 equitable rates for the same service across settings can be complex because it requires that the definition of the services and the characteristics of the beneficiaries be sufficiently similar across settings. For example, in March 2012, we recommended equalizing rates for evaluation and management office visits provided in hospital outpatient departments and physicians' offices. In 2016, to make payments across all of the post-acute care payment settings comparable, the Commission recommended elements of a single prospective payment system (PPS) for all post-acute care (PAC) to replace the four independent PPSs in use today. Most recently, in 2018, we recommended blending setting-specific and unified post-acute care 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 2018, the Medicare FFS program and its beneficiaries paid 4,700 short-term acute care hospitals \$190 billion for inpatient and outpatient services, consisting of \$121 billion for inpatient stays and \$69 billion for outpatient services. Between 2017 and 2018, Medicare FFS payments to hospitals for inpatient and outpatient services increased by \$6 billion (3.2 percent), even as the number

of Medicare FFS beneficiaries slightly declined. Over this period, payments for inpatient services rose by \$1.3 billion (1.1 percent). Payments for outpatient services rose by \$4.7 billion (7.4 percent), primarily due to rapid growth in Part B drug spending, a continued shift in the site of service billing from physician offices to hospital outpatient departments, and an increase in outpatient payment rates.

As described in Chapter 3, most of our payment adequacy indicators for hospital services are positive.

Beneficiaries' access to care—Our payment adequacy indicators suggest Medicare FFS beneficiaries continue to have adequate access to hospital services. In 2018, the average hospital occupancy rate was 63.3 percent, suggesting that hospitals have excess inpatient capacity in most markets. Although 69 hospitals closed inpatient services in 2018 or 2019, on average the closest hospital was 13 miles away, suggesting most beneficiaries maintained access to emergency and inpatient care. Hospitals' marginal profit on Medicare FFS beneficiaries was over 8 percent in 2018, indicating that hospitals with excess capacity continue to have a financial incentive to serve additional Medicare beneficiaries.

Quality of care—From 2016 to 2018, risk-adjusted hospital mortality and readmission rates improved slightly while patients' overall rating of their experience during a hospital stay remained steady. In March 2019, the Commission recommended that the Congress replace Medicare's current hospital quality programs with a single, outcome-focused quality-based payment program for hospitals—the hospital value incentive program (HVIP)—based on our principles for quality measurement.

Providers' access to capital—On average, hospitals' access to capital remains strong due to several years of high all-payer profit margins. The industry-wide all-payer margin was 6.8 percent in 2018, slightly below the all-time high of 7.1 percent in 2017. As a result, there has been significant hospital construction and strong bond offerings at relatively low interest rates.

Medicare payments and providers' costs—In 2018, inpatient PPS (IPPS) hospitals' aggregate Medicare margin was –9.3 percent, up slightly from –9.9 percent in 2017. The median Medicare margin for relatively efficient providers was about –2 percent. The improvement in the aggregate Medicare margin appears to be due to three factors. CMS overestimated input price inflation, hospitals limited their inpatient cost growth, and outpatient (Part B)

drug spending continued to rise rapidly, which can improve Medicare margins. Specifically, a feature of the 340B Drug Pricing Program can improve hospitals' Medicare margins because hospital discounts on drugs obtained through the 340B program increase if drug prices grow at a faster rate than the consumer price index for urban consumers. Given our expectation of continued growth in reported case mix and increases in spending on Part B drugs (which have high profit margins in part due to the 340B program), we expect the aggregate Medicare margin to improve from -9.3 percent in 2018 to approximately -8 percent in 2020. The exact change in Medicare margins for 2020 will depend on whether cost growth is larger or smaller than hospitals' payment rate growth on a case-mix-adjusted basis.

On the basis of these generally positive payment adequacy indicators, the Commission recommends that the Congress, for 2021, update the 2020 Medicare base payment rates for acute care hospitals by 2 percent and provide hospitals with an amount equal to the difference between the update recommendation and the amount specified in current law (projected to be 2.8 percent) through the Commission's recommended hospital value incentive program (HVIP). Because of the elimination of the inpatient penalties in the current quality programs under HVIP, using current estimates, this recommendation would be expected to raise aggregate Medicare payments for hospitals by 3.3 percent, an amount higher than the projected update under current law.

Congressional request on expanding the post-acute care transfer policy to hospice

In Chapter 3, we also report on our preliminary results concerning the expansion of the post-acute care (PAC) transfer policy in the IPPS to hospice. Under the post-acute care transfer policy, when Medicare FFS beneficiaries with certain conditions and short inpatient stays are transferred to a post-acute care setting, the transferring hospital receives a per diem payment rather than the full IPPS amount. The Bipartisan Budget Act of 2018 expanded the IPPS PAC transfer policy to include hospital transfers to hospice beginning in fiscal year 2019 and mandates that the Commission evaluate and report on the effects of this policy change. Preliminary results from the first six months indicate that the policy change produced small savings without any significant changes in Medicare FFS beneficiaries' timely access to hospice care.

Physician and other health professional services

Physicians and other health professionals deliver a wide range of services in a variety of settings. Medicare pays for clinician services using a fee schedule. In 2018, more than 1.2 million clinicians billed according to the fee schedule—including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners—and Medicare FFS spending on these services was \$70.5 billion.

As described in Chapter 4, our payment adequacy indicators for clinician services are positive.

Beneficiaries' access to care—Overall, beneficiary access to clinician services is stable and comparable with that for privately insured individuals. Consistent with prior years, most beneficiaries continue to report that they are able to find a new doctor without a problem, and the vast majority of beneficiaries report being satisfied with their care, having a usual source of care, and having no trouble accessing timely care. From 2013 to 2018, the number of clinicians billing the fee schedule grew faster than the number of Medicare beneficiaries, with a slight decrease in the number of primary care physicians more than offset by rapid growth in the number of advanced practice registered nurses and physician assistants. The number of clinician encounters per beneficiary increased modestly.

Quality of care—Patient experience scores have remained stable. However, geographic variation in FFS beneficiaries' ambulatory care-sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care.

Medicare payments and providers' costs—Clinicians' Medicare payments and input costs have continued to rise. Between 2017 and 2018, Medicare program and beneficiary spending for clinician services per beneficiary grew 2.3 percent, a higher growth rate than in prior years. In 2018, commercial payment rates for preferred provider organizations were 135 percent of Medicare FFS payment rates for clinician services. Physicians' total compensation from all payers continued to rise, with median compensation increasing 18.6 percent between 2014 and 2018. However, median compensation in 2018 remained much lower for primary care physicians than for physicians in certain other specialties—continuing to raise concerns about the mispricing of fee schedule services and its impact on primary care. CMS projects that clinicians'

input costs—as measured by the Medicare Economic Index—will increase by 2.6 percent in 2021.

Under current law, there is no update to the Medicare fee schedule base payment rate for 2021. However, clinicians are eligible for performance-based payment adjustments ranging from plus or minus 7 percent, or they can receive an incentive payment worth 5 percent of their professional service payments if they participate in an advanced alternative payment model. On the basis of the positive payment adequacy indicators, the Commission recommends that, for 2021, the Congress update Medicare payment rates for physician and other health professional services by the amount determined under 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 2018, over 5,700 ASCs certified by Medicare treated 3.5 million FFS Medicare beneficiaries, and Medicare program and beneficiary spending on FFS ASC services was \$4.9 billion.

As described in Chapter 5, our payment adequacy indicators for ASC services are positive.

Beneficiaries' access to care—Increasing growth in the supply of ASCs and the volume of ASC services indicates that Medicare FFS beneficiaries' access to ASC services has generally been adequate. In 2018, the number of ASCs increased by 2.6 percent, faster than the 1.5 percent average annual growth rate from 2013 through 2017. Similarly, in 2018, the volume of ASC services increased by 2.2 percent, faster than the 1.5 percent average annual growth rate over the prior four years.

Quality of care—The first five years of ASC-reported quality data showed improvement in performance. However, CMS will be making several changes to the ASC Quality Reporting Program for 2019 and beyond. In addition, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems[®] measures and the lack of claims-based outcome measures that apply to all ASCs.

Providers' access to capital—The continued growth in the number of ASCs and the extent to which hospital systems and others have incorporated ASCs into their business strategies indicate that ASCs' access to capital has been adequate.

Medicare payments and providers' costs—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. Medicare FFS spending on ASC services per beneficiary increased by 7.4 percent in 2018, faster than the 4.9 percent average annual rate over the prior four years.

On the basis of these positive payment adequacy indicators, the Commission concludes that ASCs can continue to provide Medicare beneficiaries with access to ASC services and recommends no update to the payment rates for 2021. In addition, because the Commission believes cost data are vital for making informed decisions about updating ASC payment rates and for identifying an appropriate input price index for ASCs, the Commission continues to recommend 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 2018, approximately 7,400 dialysis facilities treated nearly 395,000 Medicare FFS beneficiaries with ESRD, and Medicare FFS spending was \$12.7 billion.

As described in Chapter 6, our payment adequacy indicators for dialysis services are generally positive.

Beneficiaries' access to care—Growth in the capacity of dialysis facilities and their continued financial incentive to treat additional Medicare FFS beneficiaries indicate that Medicare FFS beneficiaries' access to dialysis services has been adequate. Between 2017 and 2018, the number of dialysis treatment stations grew faster than the number of FFS dialysis beneficiaries. Over this same time period, the growth in the number of Medicare FFS beneficiaries receiving dialysis matched the growth in the number of treatments furnished. Consistent with the goal of the ESRD PPS to incentivize providers to be more judicious about their provision of dialysis drugs included in the payment bundle, dialysis drug use continued to decline. In 2018, dialysis facilities' marginal profit on Medicare FFS beneficiaries was 18 percent, indicating providers with excess capacity have an incentive to treat additional Medicare beneficiaries.

Quality of care—Between 2013 and 2018, rates of hospital readmission and mortality among Medicare FFS beneficiaries on dialysis remained steady and hospital rates declined, though the proportion using the emergency department increased. In addition, the share of beneficiaries using home dialysis, which is associated with better patient satisfaction, increased from 10 percent to 12 percent between 2013 and 2018.

Providers' access to capital—Access to capital for dialysis providers continued to be strong. The number of facilities, particularly for-profit facilities, continued to increase. The two largest dialysis organizations have grown through acquisitions and mergers with midsize dialysis organizations.

Medicare payments and providers' costs—Medicare's payments to freestanding dialysis facilities have increased faster than their costs. In 2018, Medicare payment per dialysis treatment increased 11 percent while cost per treatment increased 7 percent. Freestanding dialysis facilities' aggregate Medicare margin was 2.1 percent in 2018 and is projected to be 2.4 percent in 2020.

On the basis of the positive payment adequacy indicators, the Commission recommends that, for 2021, the Congress update the ESRD PPS base payment rate by the amount determined under current law (projected to be 2.0 percent).

Improving Medicare payment for post-acute care

Post-acute care (PAC) providers offer important recuperation and rehabilitation services to Medicare beneficiaries. PAC providers include skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). In 2018, Medicare FFS spending on PAC services was \$58.6 billion.

As discussed in Chapter 7, the Commission has recommended creating a unified PAC PPS that would accurately align payments with the costs of treating patients with different care needs and erase distinctions between settings. In the meantime, the individual settings' PPSs must continue to be improved. As a first step, as the Commission has consistently recommended, payment rates need to be reduced in three of the PAC settings (SNFs, HHAs, and IRFs) to bring payments more in line with costs. As a second step, the relative payments within each payment system need to be

revised to increase the equity of Medicare payments and minimize PAC providers' financial incentives to favor admitting beneficiaries with certain care needs over others. In the 2020 payment year, CMS overhauled the payment systems Medicare uses to pay HHAs and SNFs, consistent with past Commission recommendations. The dual payment-rate structure used to pay LTCHs, which began implementation in 2016, is having its intended effect of reducing the volume of lower acuity stays that could be treated in lower cost settings. These revisions to the setting-specific payment systems are directionally consistent with the changes providers will need to make under an eventual unified payment system for all PAC providers.

The changes made to the SNF and HHA payment systems are an improvement, but the systems continue to rely in part on patients' functional status to adjust payments. The Commission has raised questions about the current state of functional assessment data and whether Medicare should rely on relatively subjective, provider-reported information to establish payments. Because patients of varying functional status have different resource needs and because change in functional status is generally viewed as a key quality metric of PAC, it is important to improve reporting of this information, which will be essential in a unified PAC PPS.

Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2018, approximately 15,000 SNFs furnished 2.2 million Medicare-covered stays to 1.5 million Medicare FFS beneficiaries, and Medicare FFS spending on SNF services was \$28.5 billion.

As described in Chapter 8, most of our payment adequacy indicators for SNF services are positive.

Beneficiaries' access to care—Stability in the supply of SNFs and their continued financial incentive to treat additional Medicare FFS beneficiaries indicate that Medicare FFS beneficiaries' access to SNF services has generally been adequate. The number of SNFs participating in the Medicare program has been stable; the vast majority of Medicare FFS 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. SNFs' median occupancy rate

declined slightly in 2018 but remained high at about 84 percent. Consistent with this slight decline in SNF occupancy, Medicare-covered SNF admissions per FFS beneficiary decreased by 3 percent in 2018, similar to the decrease in the number of hospital stays that lasted at least three days (a prerequisite for Medicare coverage of SNF services). Freestanding SNFs had an average marginal profit on Medicare FFS patients of 18 percent in 2018, indicating that freestanding SNFs with excess capacity have a financial incentive to treat additional Medicare FFS beneficiaries.

Quality of care—SNF quality measures have shown mixed performance since 2012, but rates of both SNF discharges to the community and hospital readmissions improved between 2017 and 2018.

Providers' access to capital—SNFs' access to capital was adequate in 2019 and is expected to remain so in 2020. While total margins for nursing homes—the parent organization of most SNFs—were slightly negative (–0.3) in 2018 for the first year since 2000, investment activities in long-term care remained robust. Any lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare's payments: Medicare remains a preferred payer of SNF services.

Medicare payments and providers' costs—Consistently high average Medicare margins indicate that Medicare FFS payments have continued to substantially exceed freestanding SNFs' average costs. In 2018, freestanding SNFs' Medicare margins averaged 10.3 percent—the 19th year in a row that the average was above 10 percent—and are projected to be 10 percent in 2020. However, widely varying SNF margins illustrate why a revised PPS was needed. In October 2019, CMS substantially revised the SNF PPS, removing therapy as a payment adjuster and adding components and factors that better reflect differences in the clinical care needs of patients. The redesign is estimated to increase payments for medically complex patients and patients with high costs for nontherapy ancillary items (such as drugs). The redesign is consistent with the Commission's previously recommended designs for the SNF PPS and a unified post-acute care PPS. The changes are likely to alter the mix of cases treated in SNFs, providers' cost structures, and the relative costs of different types of stays.

On the basis of these positive payment adequacy indicators and the changes to the PPS, the Commission recommends that the Congress eliminate the update to the fiscal year

2020 Medicare base payment rates for SNFs for 2021. While the level of payments indicates a reduction to payments is needed to more closely align aggregate payments and costs, the SNF industry is likely to undergo considerable changes as it adjusts to the redesigned PPS. Given the impending changes, the Commission will proceed cautiously in recommending reductions to payments. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low.

Medicaid trends

As required by the Affordable Care Act of 2010, we report on trends in Medicaid use of and spending on nursing home services and nursing facilities' non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes and covers the copayments on SNF care for low-income Medicare beneficiaries (known as dual-eligible beneficiaries) who stay more than 20 days in a SNF.

In 2019, there was a small decrease in the supply of Medicaid-certified nursing facilities and in the projected Medicaid FFS spending on nursing home services, though CMS projects spending will increase slightly in 2020. In 2018, there was a small decrease in nursing facilities' average total margin (from 0.6 percent to –0.3 percent) and non-Medicare margin (–2.4 percent to –3.0 percent).

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing or therapy. In 2018, over 11,500 HHAs participating in Medicare treated 3.4 million Medicare FFS beneficiaries, and Medicare FFS spending on home health care services was \$17.9 billion.

As described in Chapter 9, our payment adequacy indicators for home health care services are generally positive.

Beneficiaries' access to care—Medicare FFS beneficiaries' access to home health care services has been adequate. In 2018, over 98 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated, and 83 percent lived in a ZIP code with five or more HHAs. The number of HHAs has decreased 8.3 percent since 2013, including a 2.4 percent decrease in 2018. However, these decreases are small compared with the over 80 percent increase in HHAs that occurred between

2002 and 2013, and the more recent slight decreases in supply have been concentrated in areas that experienced sharp increases in supply in prior years. Similarly, the volume of home health care episodes continued the slight decline that began in 2011, but these decreases were small compared with the 67 percent increase in episodes between 2002 and 2011. While home health care episodes have decreased slightly, freestanding HHAs' marginal profit on Medicare patients in 2018 was 18 percent, indicating that freestanding HHAs have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—The stability in the rate of home health patients who were hospitalized or received treatment in the emergency room between 2018 and prior years indicates that the quality of home health care services has remained stable. Measures of functional status, such as improvement in walking and transferring, increased in 2018; however, these measures should be interpreted cautiously because these measures are based on provider-reported data and could be affected by agency coding practices.

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—Consistently high Medicare margins indicate that payments under the home health PPS have substantially exceeded HHAs' costs for more than a decade. Medicare margins for freestanding HHAs averaged 15.3 percent in 2018 and are projected to increase to 17 percent in 2020. Two factors have contributed to payments exceeding costs: Agencies have reduced episode costs by decreasing the number of visits provided, and cost growth in recent years has been lower than the annual payment updates for home health care. Consistent with the Commission's prior recommendations, in 2020, CMS substantially revised the home health PPS, including removing therapy thresholds. CMS has projected that HHAs' behavioral responses to the new policies will increase payments by 4.36 percent, and the agency has implemented an offsetting reduction. Given the high financial margins of HHAs, as well as the other positive indicators, additional reductions would be appropriate to better align Medicare's payments with actual costs.

On the basis of these positive payment adequacy indicators and how overpayments diminish home health care

service's value as a substitute for more costly services, the Commission recommends a 7 percent reduction in home health payment rates for 2021.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) provide intensive rehabilitation services, such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services to patients after illness, injury, or surgery. In 2018, the 1,170 IRFs that participated in the Medicare program provided 408,000 IRF stays to 364,000 Medicare FFS beneficiaries, and Medicare FFS spending on IRF care was \$8 billion. On average, Medicare FFS beneficiaries accounted for about 59 percent of IRF stays.

As described in Chapter 10, our payment adequacy indicators for IRFs are generally positive.

Beneficiaries' access to care—Relative stability in the supply of IRFs and their continued financial incentive to treat additional Medicare FFS beneficiaries indicate that Medicare FFS beneficiaries' access to IRF services has remained adequate. In 2018, the average IRF occupancy rate remained at 66 percent, indicating that capacity is more than adequate to meet demand for IRF services. In addition, the number of Medicare IRF stays increased by 3.0 percent in 2018. IRFs' marginal profits on Medicare patients also remained very high—averaging 20.1 percent for hospital-based IRFs and 40.8 percent for freestanding IRFs—indicating that IRFs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—Performance on most IRF quality measures was steady or improved between 2012 and 2018. However, IRFs varied widely in their performance on Medicare's quality measures, such as rates of discharge to the community or a SNF.

Providers' access to capital—Hospitals' continued strong access to capital (as discussed in Chapter 3), the continued expansion of the major freestanding IRF chain, and freestanding IRFs' high total margin of 10.7 percent indicate that IRFs generally continue to have good access to capital.

Medicare payments and providers' costs—The aggregate Medicare margin for IRFs has grown steadily since 2010, indicating that Medicare FFS payments to IRFs continue

to exceed their costs. In 2018, the aggregate Medicare margin across all IRFs averaged 14.7 percent, with higher Medicare margins at freestanding IRFs (25.4 percent) than hospital-based IRFs (2.5 percent). Relatively efficient IRFs had higher aggregate Medicare margins than other IRFs: 17.8 percent in 2018. We project that costs will grow faster than payments in 2020 and thus the Medicare margin across all IRFs will decline slightly to 12.7 percent.

On the basis of these indicators, the Commission recommends a 5 percent reduction to the IRF payment rate for fiscal year 2021. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded to further redistribute payments in the IRF payment system and reduce the impact of misalignments between IRF payments and costs and (2) the Secretary conduct focused medical record review of IRFs that have unusual patterns of case mix and coding and conduct other research necessary to improve the accuracy of payments and protect program integrity.

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 for Medicare payment, a facility must meet Medicare's conditions of participation for acute care hospitals and certain Medicare patients in the facility must have an average length of stay more than 25 days. In 2018, nearly 375 LTCHs participated in the Medicare program and provided about 102,000 LTCH stays to 92,000 Medicare FFS beneficiaries. Medicare FFS spending on LTCH services was \$4.2 billion. On average, FFS beneficiaries accounted for about 60 percent of LTCH stays.

In fiscal year 2016, CMS began implementing a dual payment-rate structure for LTCHs that decreased payment rates for certain cases that do not meet criteria specified in the Pathway for SGR Reform Act of 2013. The phase-in of the dual payment-rate structure will be completed after the 2020 LTCH cost-reporting period. The extent to which LTCHs alter admission patterns for cases that meet the criteria and are thus paid the standard LTCH PPS rate will ultimately determine the industry's financial performance under Medicare. We focus some analyses on a cohort of LTCHs with a high share (85 percent or more) of cases meeting the LTCH PPS criteria in 2018, consistent with the goals of the dual payment-rate policy. This cohort included 39 percent of LTCHs with valid cost reports in 2018.

As described in Chapter 11, our payment adequacy indicators for LTCHs are generally positive or reflect expected changes under the new dual payment-rate structure.

Beneficiaries' access to care—In 2018, the number of LTCHs decreased by 5.1 percent, continuing the decline following the implementation of the dual payment-rate structure. However, the average LTCH occupancy rate was 63 percent in 2018, suggesting that LTCHs have adequate capacity in the markets they serve. The number of LTCH cases decreased by about 10 percent. At the same time, LTCH's marginal profit on Medicare patients averaged 16 percent across LTCHs in 2018, indicating that LTCHs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—Rates of non-risk-adjusted readmissions to acute care hospitals directly from LTCHs, death in the LTCH, and death within 30 days of discharge were consistent with prior years, indicating quality of LTCH services remained stable.

Providers' access to capital—LTCHs have been altering their referral patterns in response to the dual payment-rate structure, which reduces payment for cases that do not meet the criteria specified in law. This transition, coupled with payment reductions to annual updates required by statute, have limited opportunities for growth in the near term and reduced the industry's need for capital.

Medicare payments and providers' costs—After the start of the transition to the dual-payment rate structure, average Medicare margins across all LTCHs initially fell to -2.2 percent in 2017 but then increased to -0.5 percent in 2018. However, for a cohort of LTCHs with a high share of cases that met the LTCH PPS criteria in 2018 (and thus admission patterns consistent with the goals of the dual payment-rate structure), the Medicare margin was 4.7 percent in 2018. We expect continued changes in LTCHs in response to the implementation of the dual payment-rate structure and project that average Medicare margins among the cohort of LTCHs with a high share of cases meeting the LTCH PPS criteria will be 3.7 percent in 2020.

On the basis of these payment adequacy indicators and in the context of recent changes in payment policy, the Commission recommends a 2 percent increase in LTCH payment rates for 2021. This update supports LTCHs in their provision of safe and effective care for Medicare

beneficiaries meeting the criteria for payment at the standard LTCH prospective payment system 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. When beneficiaries elect to enroll in the Medicare hospice benefit, they agree to forgo Medicare coverage for conventional treatment of their terminal illness and related conditions. In 2018, the 4,639 hospice providers that participated in the Medicare program treated more than 1.5 million Medicare beneficiaries (including more than half of decedents), and Medicare FFS spending on hospice services was \$19.2 billion.

As described in Chapter 12, our payment adequacy indicators for hospice services are positive.

Beneficiaries' access to care—In 2018, the number of hospice providers increased by 3.4 percent, due largely to growth in the number of for-profit hospices, continuing a more than decade-long trend of substantial market entry by for-profit providers. Hospice use among Medicare beneficiaries has also grown substantially in recent years, suggesting greater awareness of and access to hospice services. In 2018, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased. Use of hospice services increased across almost all demographic and beneficiary groups examined; however, rates of hospice use remained higher for White beneficiaries than for other beneficiaries. In 2017, hospices' marginal profit on Medicare FFS beneficiaries averaged 16 percent, indicating that hospices with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—Hospices' performance on available process measures remained very high, although these measures are limited and are largely topped out. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems® were also stable in 2018. However, an Office of Inspector General analysis of data from state survey agencies and accrediting organizations identified 313 hospice providers as poor performers in 2016 due to at least one occurrence of a serious deficiency or severe and substantiated complaint that year.

Providers' access to capital—Access to capital is a less important indicator of Medicare payment adequacy for hospice services because this sector is less capital intensive than most other health care sectors. However, continued growth in the number of for-profit providers and reports of strong investor interest in the sector indicate capital is available to these providers. Less is known about access to capital for nonprofit freestanding providers, for which capital may be more limited. Hospital-based and home health-based hospices have access to capital through their parent providers.

Medicare payments and providers' costs—Consistently high average Medicare margins indicate that Medicare FFS payments to hospice providers continued to exceed hospices' average costs. Hospices' Medicare margin averaged 12.6 percent in 2017 (up from 10.9 percent in 2016) and is projected to remain stable in 2020.

In addition to indicators of hospice payment adequacy, Chapter 12 also discusses the hospice aggregate cap, which limits the total Medicare payments a hospice provider can receive in a year.

The aggregate cap functions as a mechanism to reduce payments to hospices with long stays and high margins. We estimate that 14 percent of hospices in 2017 exceeded the cap; those hospices had an average Medicare margin of 21 percent before and 13 percent after application of the cap. Those hospices also had high average lengths of stay and high live-discharge rates, and they were disproportionately for profit, freestanding, urban, small, and new entrants to the Medicare program. Because the hospice aggregate cap is not wage adjusted but Medicare payments are, the aggregate cap is more binding in some areas of the country than others. A policy to wage adjust and reduce the hospice aggregate cap would make the cap more equitable across providers and reduce payments for providers with the longest stays and high margins.

On the basis of these payment adequacy indicators and analysis of the hospice aggregate cap, the Commission recommends that the hospice payment rates in 2021 be held at their 2020 levels and that the hospice aggregate cap be wage adjusted and reduced by 20 percent.

The Medicare Advantage program: Status report

In Chapter 13, as we do each year, the Commission provides a status report on the Medicare Advantage

(MA) program. In 2019, the MA program included over 3,000 plan options offered by 184 organizations, enrolled over 22 million beneficiaries (34 percent of all Medicare beneficiaries), and paid MA plans an estimated \$274 billion (not including Part D drug plan payments). To monitor program performance, we examine MA enrollment trends, plan availability for the coming year, and payments for MA plan enrollees relative to spending for FFS Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and quality in MA.

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 the alternative delivery systems that private plans provide. Because Medicare pays private plans a risk-adjusted per enrollee predetermined rate 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.

The Commission has emphasized the importance of imposing fiscal pressure on all providers of care to improve efficiency and reduce Medicare program costs and beneficiary premiums. For MA, the Commission previously recommended that payments be brought down from prior levels, which subsidized MA plans by providing payments above FFS rates, and be set so that the payment system does not favor either MA or the traditional FFS program. Legislation has reduced the inequity in Medicare spending between MA and FFS nationally; nevertheless, plans have received increased payments because of higher risk coding and quality bonus rules. With the legislated MA payment reductions over the past few years, plan bids and payments have fallen in relation to FFS spending while MA enrollment continues to grow. Plans have improved efficiencies, leading to more competitive bids that enable MA plans to continue to increase enrollment by offering extra benefits that beneficiaries find attractive, suggesting that further efficiencies are possible in MA.

Enrollment—Between November 2018 and November 2019, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 22.6 million enrollees. Among plan types, HMOs continued to enroll the most beneficiaries (14 million). About 34 percent of Medicare beneficiaries

were enrolled in MA plans in 2019, up from 33 percent in 2018.

Plan availability—Access to MA plans remains high in 2020, with most Medicare beneficiaries having access to many plans. Overall, 99 percent of Medicare beneficiaries have access to an MA plan. On average, beneficiaries had access to 27 available plans in 2020, an increase from 23 plans in 2019. Compared with 2018, MA enrollment in 2019 was slightly more concentrated. The top 10 MA organizations (ranked by enrollment) had 76 percent of total enrollment in 2019, compared with 74 percent in 2018.

Plan payments—We estimate that 2020 MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—will average 107 percent of FFS spending. (This estimate includes quality bonuses but does not fully adjust for coding intensity.) Benchmarks in 2020 are lower relative to FFS than in earlier years. Lower benchmarks have led to more competitive bids from plans: Bids have dropped from roughly 100 percent of FFS before the Affordable Care Act of 2010 to 88 percent of FFS in 2020. When a plan bids below the benchmark, its payment rate is its bid plus a share of the difference between its bid and the benchmark. We estimate that total Medicare payments to MA plans will average about 100 percent of FFS spending in 2020. Quality bonuses in 2020 will account for 2 percentage points to 3 percentage points of these payments. We estimate that uncorrected coding intensity would add 2 percentage points to 3 percentage points to these payments relative to FFS.

Encounter data—In 2012, CMS began collecting information about each encounter an MA enrollee has with a health care provider. MA plans are required to submit encounter data about all items and services provided to MA enrollees. Complete encounter data would be the best vehicle for learning about how, and how much, care is provided to the one-third of Medicare beneficiaries who receive their benefit through an MA plan.

The Commission has long been interested in using MA encounter data to gather information about MA plan practices and utilization that can then be used to inform Medicare policies. Nonetheless, we continue to find that encounter data lack completeness and accuracy, making them insufficient for most uses. The Commission reiterates the previous recommendation that CMS include

assessments of data completeness in plan performance metrics, implement a payment withhold as a financial incentive for plans to improve data completeness and accuracy, and require submissions of providers' claims directly to Medicare administrative contractors if performance thresholds are not met.

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

Our updated analysis for 2018 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 8 percent higher than scores for similar FFS beneficiaries. By law, CMS makes a minimum across-the-board adjustment to MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a higher adjustment, the agency has never done so. In 2018, the adjustment reduced MA risk scores by 5.91 percent, leaving MA risk scores and payments about 2 percent to 3 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. In 2019 and subsequent years, the minimum adjustment for coding intensity will be 5.9 percent until risk adjustment incorporates MA diagnostic, cost, and use data. The Commission previously recommended that MA risk adjustment exclude diagnoses collected from health risk assessments, use two years of diagnostic data, and apply an adjustment for any residual impact of coding intensity in order to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity.

Quality in MA—The Commission has previously reported its concerns with the MA star rating system and has recommended improvements. 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 one-third of the Medicare population enrolled in MA plans, good information on the quality of care MA enrollees receive and how that

quality compares with quality in FFS Medicare is crucial. The ability to compare MA and FFS quality and to compare quality among MA plans is also important for beneficiaries. Recognizing that the current quality program is not achieving its intended purposes, the Commission continues to work on developing a new value incentive program for MA.

Future direction of MA payment policy—Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits. For the immediate future, the Commission is assessing an alternative model to evaluate MA plan quality at the local level and distribute quality-based bonuses. Over the longer term, the Commission will review benchmark policy to improve equity and efficiency in the MA program. In setting payment policy for FFS Medicare, the Commission consistently applies a level of fiscal pressure on providers to promote the efficient provision of care while maintaining beneficiary access to good quality care. However, given the level of overutilization in FFS and other factors, we cannot conclude that achieving payment parity between MA and FFS Medicare would leverage any efficiency from the MA program. We expect plans to be more efficient than FFS, an expectation consistent with the original incorporation of full-risk private plans in Medicare in 1982, when they were paid 95 percent of FFS payments. Therefore, the principle of equal treatment of the MA and FFS programs should expand to include equal levels of cost and quality pressure in the two programs.

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

In 2019, Part D plans were the primary source of outpatient prescription drug coverage for 45.4 million Medicare beneficiaries. 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 12.7 million individuals with low income and assets. In 2018, Part D expenditures totaled \$97.5 billion, of which enrollees paid \$14.2 billion in plan premiums. In addition, enrollees paid cost sharing of \$16.7 billion when filling their prescriptions.

As discussed in Chapter 14, Part D has been a success in many respects. It has improved beneficiaries' access to prescription drugs. Enrollees' average premiums for basic benefits have remained around \$30 per month for

many years, and generic drugs now account for nearly 90 percent of the prescriptions filled. More than 8 in 10 Part D enrollees report they are satisfied with the program.

However, changes to Part D's coverage gap and manufacturer discounts combined with the expanding role of high-cost medicines have eroded the program's competitive incentives. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based reinsurance subsidies rather than capitated payments for the basic benefit. As of 2019, brand-drug manufacturers provide a 70 percent discount in the coverage gap (an increase from 50 percent provided between 2011 and 2018). This discount effectively makes the relative price of brand-name drugs cheaper than generics and decreases what plan sponsors must cover in benefits, blunting sponsors' incentives to manage spending. A separate concern is that Part D's LIS creates plan and beneficiary incentives that increase program costs. Although policymakers have taken steps to give plan sponsors new flexibility to manage drug spending, measures to increase the financial risk that sponsors bear (such as those recommended by the Commission in 2016) are needed so that plan sponsors have greater incentive to use the new management tools and keep Part D financially sustainable for beneficiaries and taxpayers.

Enrollment in 2019 and benefit offerings for 2020—In 2019, 74.1 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 2.3 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 23.6 percent were divided roughly equally between those who had creditable drug coverage from other sources and those with no coverage or coverage less generous than Part D.

Between 2007 and 2019, enrollment grew faster in Medicare Advantage–prescription drug plans (MA–PDs) compared with stand-alone prescription drug plans (PDPs). In 2019, 44 percent of enrollees were in MA–PDs compared with 30 percent in 2007. Over the same period, the LIS share fell from 39 percent to 28 percent.

For 2020, beneficiaries have a broad choice of plans. Compared with plan offerings in 2019, sponsors are offering 5 percent more PDPs, 16 percent more MA–PDs open to all beneficiaries, and 20 percent more MA–PDs tailored to specific populations (special needs plans). MA–PDs continue to be more likely than PDPs to offer enhanced benefits. For 2020, the total average estimated

cost for basic benefits decreased by 1 percent, as did the base beneficiary premium (to \$32.74). In 2020, 244 premium-free PDPs are available to enrollees who receive the LIS, a 13 percent increase from 2019. All regions except for one have at least four PDPs for LIS enrollees at no premium.

Part D program costs—Between 2007 and 2018, Part D program spending increased from \$46.2 billion to \$83.4 billion—an average annual growth rate of 5.5 percent. Over the same period, Medicare's reinsurance (which covers 80 percent of enrollees' spending in the catastrophic phase of the benefit after rebates) grew at an average annual rate of 16 percent. As a result, the share of overall spending paid through Medicare's reinsurance grew from 25 percent to 60 percent. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) continued to drive Part D spending. In 2017, high-cost enrollees accounted for 59 percent of Part D spending, up from about 40 percent before 2011. In 2017, more than 378,000 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.

Quality in Part D—In 2020, the average star rating among Part D plans increased somewhat for PDPs and remained about the same for MA–PDs. (However, the trend among MA–PD sponsors of consolidating contracts to achieve higher star ratings leads us to question the validity of MA–PD ratings and the comparison between PDPs and MA–PDs.) It is not clear that current quality metrics help beneficiaries to make informed choices among their plan options.

Congressional request on health care provider consolidation

In Chapter 15, we report on the effects of hospital mergers and physician–hospital consolidation as requested in 2018 by the chairman of the House Committee on Energy and Commerce. The topics are important given the long-term trend toward greater hospital consolidation and hospital acquisition of physician practices. By 2017, in most markets, a single hospital system accounted for more than 50 percent of inpatient admissions.

The literature indicates that hospitals with large market shares have the leverage to negotiate relatively high prices from commercial insurers. The rewards of market power alone could drive consolidation, but additional reasons

for hospital mergers could include potential efficiency gains from reducing excess capacity, relief from financial difficulties for hospitals seeking to be acquired, pursuit of greater bargaining leverage with suppliers of drugs and devices, and potential to increase care integration. Consistent with these incentives, hospitals have been consolidating into larger systems over several decades. Changes in federal policies have not materially altered the steady trend toward greater hospital consolidation over the past 30 years.

The effect of consolidation on hospital costs is not clear in theory or from our current analysis. Specifically, we found:

- Greater market power has a statistically significant association with higher profit margins on non-Medicare patients.
- Higher non-Medicare margins have a statistically significant association with higher standardized costs per discharge.
- The direct association between market power and standardized costs per discharge is statistically insignificant.

With respect to patient costs, commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets. By contrast, Medicare patients are initially insulated from the effect of hospital mergers because Medicare sets prices for the hospital services administratively. However, an increasing differential between Medicare and commercial prices may create pressure to increase Medicare prices as well.

Changes in government policies also do not appear to be the main driving force behind consolidation of physician practices. Medicare pays the same rates to large and small physician practices, and other Medicare policies, such as policies to encourage the formation of accountable care organizations, appear to have played at most a small role in consolidation. The primary incentives for physicians to join larger practices appear to be the potential for higher commercial prices and the desire of younger physicians for a flexible lifestyle with fewer managerial and on-call duties.

In contrast, government policies have played a role in encouraging hospital acquisition of physician practices. When hospitals acquire physician practices, it increases Medicare spending and beneficiary cost sharing due to the introduction of hospital facility fees for physician services that are provided in hospital outpatient departments. For some services, taxpayer and beneficiary costs can double when services are shifted to a physician office that is deemed part of a hospital outpatient department. The potential for facility fees from Medicare, combined with potential for higher commercial prices, encourages hospitals to acquire physician practices and physicians to become hospital employees.

The chairman of the House Committee on Energy and Commerce also asked the Commission to examine the incentives in the 340B Drug Pricing Program for hospitals to use more expensive Part B drugs. Due to the confidentiality of 340B prices, we could not directly address the question of whether 340B discounts create incentives for the selection of more-expensive products. Instead, we tested whether higher 340B market share is associated with greater average cancer drug spending in a market area. We specifically focused on cancer drugs because drugs used exclusively or largely for cancer treatment account for nearly three-quarters of Part B drug spending in the hospital outpatient setting.

Overall, we found evidence of an association between 340B market share and higher drug spending for some cancers between 2009 and 2017. Of the five cancer types we examined, our regression analysis for two cancer types (lung and prostate cancers) found that 340B market share had statistically significant effects of just over \$300 per patient per month. Those 340B effects, however, were much smaller than the effects of the general trend in oncology spending. For example, between 2009 and 2017, cancer drug spending per beneficiary per month grew by more than \$2,000 for patients with breast cancer, lung cancer, and leukemia/lymphoma. Given the relative size of the potential 340B effect, the overall effect on beneficiary cost sharing is likely to be modest and vary by beneficiaries' supplemental coverage. ■