

M A R C H 2 0 2 1

REPORT TO THE CONGRESS

Medicare Payment Policy

MEDPAC Medicare
Payment Advisory
Commission

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Commission

The Medicare Payment Advisory Commission (MedPAC) is an independent congressional agency established by the Balanced Budget Act of 1997 (P.L. 105–33) to advise the U.S. Congress on issues affecting the Medicare program. In addition to advising the Congress on payments to health plans participating in the Medicare Advantage program and providers in Medicare’s traditional fee-for-service program, MedPAC is also tasked with analyzing access to care, quality of care, and other issues affecting Medicare.

The Commission’s 17 members bring diverse expertise in the financing and delivery of health care services. Commissioners are appointed to three-year terms (subject to renewal) by the Comptroller General and serve part time. Appointments are staggered; the terms of five or six Commissioners expire each year. The Commission is supported by an executive director and a staff of analysts, who typically have backgrounds in economics, health policy, and public health.

MedPAC meets publicly to discuss policy issues and formulate its recommendations to the Congress. In the course of these meetings, Commissioners consider the results of staff research, presentations by policy experts, and comments from interested parties. (Meeting transcripts are available at www.medpac.gov.) Commission members and staff also seek input on Medicare issues through frequent meetings with individuals interested in the program, including staff from congressional committees and the Centers for Medicare & Medicaid Services (CMS), health care researchers, health care providers, and beneficiary advocates.

Two reports—issued in March and June each year—are the primary outlets for Commission recommendations. In addition to annual reports and occasional reports on subjects requested by the Congress, MedPAC advises the Congress through other avenues, including comments on reports and proposed regulations issued by the Secretary of the Department of Health and Human Services, testimony, and briefings for congressional staff.

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March 15, 2021

The Honorable Kamala D. Harris
President of the Senate
U.S. Capitol
Washington, DC 20510

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
U.S. Capitol
Room H-232
Washington, DC 20515

Dear Madam President and Madam Speaker:

I am pleased to submit the Medicare Payment Advisory Commission's March 2021 *Report to the Congress: Medicare Payment Policy*. This report fulfills the Commission's legislative mandate to evaluate Medicare payment issues and make recommendations to the Congress.

The report contains 14 chapters:

- a chapter that provides a broader context for the report, including the near-term consequences of the coronavirus pandemic and the longer-term effects of Medicare spending on the federal budget and the program's financial sustainability;
- a chapter that describes the Commission's analytic framework for assessing payment adequacy;
- nine chapters that describe the Commission's recommendations on fee-for-service (FFS) payment rate updates and related issues including, as mandated by the Congress, a report on the expansion of the hospital post-acute care transfer policy to include discharges to hospice;
- a chapter that updates the trends in enrollment, plan offerings, and payments in Medicare Advantage plans;
- a chapter that updates the trends in enrollment and plan offerings for plans that provide prescription drug coverage under Part D; and
- a chapter that presents an option for Medicare's coverage of telehealth services after the coronavirus public health emergency.

In 2020, the global coronavirus pandemic had catastrophic consequences for many Medicare beneficiaries and affected health care delivery for all. In this report, we begin to discuss some of the effects of the pandemic, including those on beneficiary access, mortality, and service use. We also begin to assess the effects on providers that are

considered in this report. A fuller discussion of the pandemic's effects on beneficiaries and providers, including lessons learned, will require analysis of data that are still being collected and is beyond the scope of this report.

In this report, we continue to make recommendations aimed at finding ways to provide high-quality care for Medicare beneficiaries while giving providers incentives to constrain their cost growth and thus help control program spending.

In light of our payment adequacy analyses, we recommend positive payment updates in 2022 for two FFS payment systems (hospital and long-term care hospital); zero updates for five systems (physician, ambulatory surgical center, outpatient dialysis, skilled nursing facility, and hospice); and negative updates for two systems (home health and inpatient rehabilitation facility). For two of these sectors, we include additional recommendations to improve payment accuracy by:

- requiring ambulatory surgical centers to report cost data, and
- wage adjusting the hospice aggregate cap and reducing it by 20 percent.

I hope you find this report useful as the Congress continues to grapple with the difficult task of controlling the growth of Medicare spending while preserving beneficiaries' access to efficiently delivered, high-quality care and providing equitable payment for providers.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a long horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.

Enclosure

Acknowledgments

This report was prepared with the assistance of many people. Their support was key as the Commission considered policy issues and worked toward consensus on its recommendations.

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Executive summary

Executive summary

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

- consider the context of the Medicare program, including the near-term consequences of the coronavirus pandemic and the longer-term effects of program spending on the federal budget and the program's financial sustainability.
- evaluate payment adequacy and make recommendations concerning Medicare FFS payment policy in 2022 for acute care hospital, physician and other health professional, ambulatory surgical center, outpatient dialysis facility, skilled nursing facility, home health agency, inpatient rehabilitation facility, long-term care hospital, and hospice services.
- as mandated by the Congress, report on 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).
- present an option for Medicare's coverage of telehealth services after the coronavirus public health emergency (PHE).

In 2020, the global coronavirus pandemic had catastrophic consequences for many Medicare beneficiaries and affected health care delivery for all. In this report, we begin to discuss some of the effects of the pandemic, including on beneficiary access, mortality, and service use. We also begin to assess the effects on providers that are considered in this report. A fuller discussion of the pandemic's effects on beneficiaries and providers, including lessons learned, will require analysis of data that are still being collected and is beyond the scope of this report.

In this report, we recommend payment rate updates for nine FFS payment systems for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. Where relevant, we have considered the effects of the 2020 coronavirus PHE on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the PHE are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than a permanent change to payment rates in 2022 and future years.

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

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

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

receptive to new payment methods and delivery system reforms.

For each recommendation, the Commission presents its rationale, the implications for beneficiaries and providers, and how spending for each recommendation would compare with expected spending under current law. The spending implications are presented as ranges over one-year and five-year periods. Unlike official budget estimates used to assess the impact of legislation, these estimates do not 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 while promoting the fiscal sustainability of the Medicare program.

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

Context for Medicare payment policy

This year, as discussed in Chapter 1, both the short- and long-term contexts for the Medicare program are sobering. In the short term, the nation is in the midst of a historic coronavirus pandemic. Medicare beneficiaries are at particular risk. Those over 65 are more likely to suffer severe COVID-19 cases and complications and die than those who are younger and have fewer comorbidities. Beneficiaries in nursing facilities have accounted for a disproportionate share of fatalities from COVID-19. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society. Providers are also under stress. The demands put on individual clinicians and other staff have been extreme. The financial stress on providers is unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels.

The longer-term prospects for the program are daunting as well. The financial future of the Medicare program was already problematic, but as a result of job losses, in 2020 the Congressional Budget Office projected that Medicare's Hospital Insurance Trust Fund will become insolvent by 2024—two years earlier than previously expected. (Other, long-range projections in Chapter 1 do not yet reflect

the impact of the pandemic.) Driven by growth in the volume and intensity of services provided to beneficiaries and the number of beneficiaries aging into the program, Medicare's annual spending is projected to double in the 10-year period between 2019 and 2029, from \$782 billion to \$1.5 trillion. During this period, Medicare's share of total federal spending is expected to rise from 14.6 percent to 17.5 percent.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare premiums and cost sharing were estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare Trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

One of the most powerful ways Medicare can control spending growth is by setting prices. Over the last 10 years, Medicare's spending per beneficiary has grown much more slowly than private health insurance spending per enrollee. Increasing prices were the main cause of health care spending growth for the privately insured. Price increases were driven by increases in provider market power as hospitals and physician groups consolidated. From 2009 to 2019, that consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period. This difference suggests that private plans' greater ability to constrain volume has less of an effect on spending than the Medicare program's greater ability to constrain prices under its administered pricing system.

Given Medicare's financing challenges, many believe that restraining price growth will not be enough to ensure Medicare's fiscal sustainability and that growth in the quantity of health care services must also be reduced. Medicare has piloted a number of alternative payment models that give providers incentives to more closely manage and coordinate beneficiaries' care to keep them healthy and reduce unnecessary service use. The ultimate goal of these payment models is to reduce growth in spending while maintaining or improving the quality of care.

Prices and utilization rates can also be influenced through other means. The Commission has identified a number

of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. The Commission has and will continue to make recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity without sacrificing quality or access.

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

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare's traditional FFS payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. As explained in Chapter 2, to determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2021) by considering beneficiaries' access to care, the quality of care, providers' access to capital, and how Medicare payments compare with providers' costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Next, we assess how those providers' costs are likely to change in the year the update will take effect (the policy year; here, 2022). Finally, we make a judgment about what, if any, update is needed for the policy year in question.

To the extent that events create temporary shocks to the Medicare component of providers' finances, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' Medicare payment rates. Because payment updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in demand for health care or resulting health care spending. For example, the coronavirus pandemic changed the demand for and delivery of health care in 2020 and had material effects on providers' patient volume, revenues, and costs. Moreover, these effects have varied, and continue to vary widely, across different geographies, across different types of providers, and among individual providers. Although the effects are persisting in 2021, the Commission expects much of the pandemic's impact on health care will be temporary.

To fulfill our congressional mandate in regard to payment system updates, we must confine our focus to effects that we expect will impact payment adequacy in the given policy year. As noted above, to the extent the pandemic

effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Nonetheless, if there are changes during the PHE that have effects on providers' cost structures that we expect will persist into 2022 (the policy year for our recommendations), those changes are noted in each sector's payment adequacy discussion and will factor into our estimates of payment adequacy. We will monitor the impacts of COVID-19 over time, and any lasting effects will be considered as we evaluate the adequacy of Medicare payments in future years.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. The Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure its recommendations accurately reflect current conditions. We use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022, accounting for anticipated changes in providers' costs between 2021 and 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE has created additional data lags, most notably for cost reports because the deadlines for their submission were extended. Where possible, we have bolstered our analyses with data from 2020, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may also recommend 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. We may also make recommendations to improve program integrity where we deem it necessary. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from

Medicare. Payment rates set to cover the costs of relatively efficient providers help induce all providers to control their costs. Furthermore, Medicare rates also have broader implications for health care spending because they are used in setting payments for other government programs and private health insurance. Thus, while setting prices intended to support efficient provision of care directly benefits the Medicare program, it can also help control health care spending across payers.

The Commission also examines payment rates for services that can be provided in multiple settings. Medicare often pays different amounts for similar services furnished in different settings. Basing the payment amount for these services on the rate paid 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.

Hospital inpatient and outpatient services

Short-term acute care hospitals provide acute inpatient and outpatient services, such as treatments for acute medical conditions and injuries. Medicare's payment rates for inpatient and outpatient services are generally set under the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS). In 2019, payments under these hospital payment systems totaled \$186 billion. About 5.5 million beneficiaries had 8.7 million inpatient stays in the 3,200 acute care hospitals paid under the IPPS in 2019. That same year, 20.6 million beneficiaries made 97.1 million visits to the 3,700 hospitals providing outpatient services under the OPPS.

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 beneficiaries continue to have good access to hospital services. In 2019, the aggregate hospital occupancy rate was 64 percent, suggesting that hospitals have excess inpatient capacity in most markets. This capacity remains adequate despite an increase in hospital closures in 2019 that was partially driven by a decline in admissions per capita. Inpatient stays per capita continued their gradual decline in 2019 (falling 1.9 percent), while outpatient services per capita continued their slow increase (rising 0.7 percent). These trends reflect the continuing shift of care from inpatient to outpatient settings and from physician offices to hospital

outpatient departments (as hospitals acquire physician practices). Hospitals' marginal profit on Medicare FFS beneficiaries was about 8 percent in 2019, indicating that hospitals with excess capacity continue to have a financial incentive to serve additional Medicare beneficiaries.

Quality of care—In 2019, risk-adjusted readmission and mortality rates improved modestly, and patient experience measures remained stable. In March 2019, the Commission recommended a redesign of the current hospital quality payment programs, including removing the current penalty-only quality programs and enacting a new hospital value incentive program (HVIP) that balances rewards and penalties and has the potential to drive further improvement in hospital quality.

Providers' access to capital—Hospitals had record high all-payer operating and total margins, which contributed to strong access to capital in 2019. Furthermore, hospital construction spending held steady, municipal bond interest rates remained low, hospital mergers and acquisitions continued, and hospital employment remained stable.

Medicare payments and providers' costs—Medicare's payments to IPPS hospitals grew faster than hospitals' costs in 2019, resulting in the aggregate Medicare margin increasing slightly from -9.3 to -8.7 percent among all IPPS hospitals, and the median margin increasing from about -2 percent to -1 percent for relatively efficient hospitals. Hospitals' Medicare margins increased primarily because Medicare made an additional \$1.5 billion in payments to hospitals to help cover the costs of charity care and non-Medicare bad debts.

While the coronavirus PHE has made 2020 an anomalous year in many respects and it is impossible to predict with certainty the extent to which these effects will continue into 2021, we expect IPPS hospitals' Medicare margin to increase to about -6 percent in 2021, driven by substantially higher payment rate updates than in 2019 and prior years and by the suspension of Medicare sequestration through the first half of fiscal year 2021. We also expect the efficient providers' Medicare margin will improve in 2021 to become slightly positive. The exact increase in the Medicare margin will depend in large part on the duration and severity of the coronavirus pandemic, volume changes, case-mix changes, and changes in costs relative to input price inflation, as well as any additional payment or other policy changes enacted during the pandemic.

On the basis of generally positive payment adequacy indicators, the Commission recommends that the Congress, for 2022, update the 2021 Medicare base payment rates for acute care hospitals by 2 percent. Together with the statutory additional 0.5 percent increase to inpatient payments and the 0.8 percent increase to inpatient payments from our standing recommendation to replace the current quality program penalties with the HVIP, on net, inpatient payments would increase by 3.3 percent and outpatient payment rates would increase by 2.0 percent. The 2 percent outpatient update (rather than the 2.4 percent estimated under current law) would limit growth in the differential between rates paid for physician office visits on a hospital campus and rates paid for those visits at freestanding physician offices.

Mandated report: Expanding the post-acute care transfer policy to hospice

In Chapter 3, we also report on the effects of expanding the post-acute care transfer policy to hospices, as mandated by the Balanced Budget Act of 2018. Under the post-acute care transfer policy, when Medicare beneficiaries with certain conditions have short inpatient stays and 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 post-acute care transfer policy to include hospital transfers to hospice beginning in fiscal year 2019 and mandated that the Commission evaluate and report on the effects of this policy change. We estimate that the policy change resulted in savings of about \$304 million in fiscal year 2019 and about \$78 million in the first quarter of fiscal year 2020, without any discernable changes in Medicare beneficiaries' timely access to hospice care.

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. Medicare pays for these clinician services using a fee schedule. In 2019, Medicare paid \$73.5 billion for clinician services, accounting for just under 18 percent of traditional FFS Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

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 comparable with prior years, despite the current PHE. Consistent with prior years, most beneficiaries continued to report that they are able to find a new doctor without a problem, and the vast majority of beneficiaries reported being satisfied with their care, having a usual source of care, and having no trouble accessing timely care. From 2014 to 2019, 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 from 2018 to 2019.

Quality of care—Geographic variation in traditional Medicare beneficiaries' ambulatory care-sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care. There is also substantial use of low-value care among Medicare beneficiaries. (Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.) We estimate that, in 2018, between 22 percent and 36 percent of beneficiaries in traditional FFS Medicare received at least one low-value service, and Medicare spending for these services ranged from \$2.4 billion to \$6.9 billion.

Medicare payments and providers' costs—Clinicians' Medicare payments and input costs continue to rise. Between 2018 and 2019, traditional Medicare's allowed charges (i.e., payments to providers, including beneficiary cost sharing) for clinician services per beneficiary grew 3.7 percent, a higher growth rate than in prior years. In 2019, private insurance payment rates for clinician services were 136 percent of traditional FFS Medicare's rates, compared with 135 percent in 2018. From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average. However, median compensation in 2019 remained much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties—underscoring concerns about the mispricing of fee schedule services and its impact on primary care. Effective January 1, 2021, CMS increased payment rates

for evaluation and management office/outpatient visits and reduced rates for many other services, which should help address the compensation gap between primary care physicians and certain specialists. CMS projects that clinician input costs—as measured by the Medicare Economic Index—will increase by 1.6 percent in 2022.

Under current law, there is no update to the Medicare fee schedule base payment rate for 2022. However, clinicians are eligible for performance-based payment adjustments or can receive an incentive payment worth 5 percent of their professional services payments if they participate in an advanced alternative payment model. The Commission's analyses suggest that Medicare's aggregate payments for clinicians are adequate. Therefore, the Commission's recommendation is that the Congress should update the 2022 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. In 2019, the 5,816 ASCs that were certified by Medicare treated 3.5 million FFS Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$5.2 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 beneficiaries' access to ASC services is adequate. From 2014 to 2018, the number of ASCs increased by an average annual rate of 1.7 percent. In 2019, the number of ASCs increased 2.5 percent. Most new ASCs in 2019 (96 percent) were for-profit facilities. From 2014 through 2018, the volume of services per Part B fee-for-service beneficiary increased by an average annual rate of 2.1 percent. In 2019, volume increased by 2.7 percent.

Quality of care—Among the eight quality measures in the ASC Quality Reporting (ASCQR) Program for which data were available for multiple years through 2018, performance among the ASCs that reported data improved for most measures from 2013 through 2017, but from 2017 to 2018 the measures were largely unchanged and decreased for one measure. For 2019 and beyond, CMS has been making several changes to the ASCQR Program.

However, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems[®] measures, the lack of a value-based purchasing program for the ASC sector, and the lack of claims-based outcome measures that apply to all ASCs.

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

Medicare payments and providers' costs—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. From 2014 through 2018, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 5.8 percent. However, in 2019, growth in these payments increased by 8.3 percent.

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 2022. 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 2019, nearly 395,000 beneficiaries with ESRD on dialysis were covered under FFS Medicare and received dialysis from nearly 7,700 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services based on a PPS bundle that includes certain ESRD-related drugs and clinical laboratory tests that were previously paid separately. In 2019, Medicare expenditures for outpatient dialysis services were \$12.9 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 beneficiaries' access to dialysis services has been adequate. Between 2018 and 2019, the number of dialysis treatment stations grew faster than the number of FFS dialysis beneficiaries (but kept pace with demand from all dialysis patients). During this same time period, growth in the number of FFS dialysis beneficiaries matched growth in the total number of treatments. At the same time, use of ESRD drugs in the bundle continued to decline, but at a slower rate than during the initial years of the ESRD PPS (2011 and 2012). In 2019, dialysis facilities' marginal profit was 25 percent, indicating that providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—Between 2014 and 2019, hospitalization, hospital readmission, and mortality rates remained steady, though the proportion of FFS dialysis beneficiaries using the emergency department slightly increased. Between 2014 and 2019, the share of beneficiaries using home dialysis, which is associated with better patient satisfaction, increased.

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

Medicare payments and providers' costs—Medicare's payments to freestanding dialysis facilities have increased faster than their costs. From 2018 to 2019, cost per treatment fell by 4 percent, while Medicare payment per treatment rose by 2 percent, and the aggregate Medicare margin increased from 2.1 percent to 8.4 percent. We project the 2021 Medicare margin will drop to 4 percent, in part due to CMS including calcimimetics in the ESRD PPS bundled payment, which will promote provider efficiency.

Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.5 percent. On the basis of the positive payment adequacy indicators, the Commission recommends that, for 2022, the Congress eliminate the update to the 2021 ESRD PPS base rate.

Skilled nursing facility services

Skilled nursing facilities (SNFs) provide short-term skilled nursing and rehabilitation services to Medicare

beneficiaries after a stay in an acute care hospital. In 2019, about 15,000 SNFs furnished about 2 million Medicare-covered stays to 1.5 million FFS beneficiaries, and Medicare FFS spending on SNF services was \$27.8 billion.

As described in Chapter 7, most of our payment adequacy indicators, which are based on the most recent complete data that we have, are positive. That said, we recognize that nursing homes have been particularly hard hit by the coronavirus pandemic and the associated PHE. As devastating as the pandemic's effects have been, we expect the industry to eventually recover, though its recovery may be sluggish and will vary by provider and market.

Beneficiaries' access to care—Before the PHE, access to SNF services was adequate for most beneficiaries. The number of SNFs participating in the Medicare program has been stable for many years. In 2019, the vast majority (90 percent) of beneficiaries lived 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). Between 2018 and 2019, the median occupancy rate declined slightly but remained high (about 85 percent). During the PHE, occupancy declined more than 10 percentage points, but this decline is unrelated to the adequacy of Medicare's payments. Consistent with the slight decline in SNF occupancy observed in 2019, Medicare-covered admissions per 1,000 FFS beneficiaries decreased 4.8 percent, similar to a decrease in the number of admissions for hospital stays that lasted at least three days (required for Medicare coverage). Freestanding SNFs had an average marginal profit of almost 20 percent in 2019, indicating that freestanding SNFs have a financial incentive to treat additional Medicare FFS beneficiaries.

Quality of care—Since 2015, rates of successful discharge to the community have increased and hospitalizations within a stay have decreased. These positive trends continued from 2018 to 2019.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Before the PHE, access to capital was adequate, and though lending activity has stalled during the PHE, it is expected to be good in 2021. In 2019, the total margin (a measure of the total financial performance across all payers and lines of business for the facility) was 0.6 percent. Any lending wariness reflects broad changes in

post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—Consistently high average Medicare margins indicate that Medicare FFS payments have continued to exceed freestanding SNFs' average costs. In 2019, the average Medicare margin for freestanding SNFs was 11.3 percent. Since 2000, the average Medicare margin has been above 10 percent, and the very high Medicare margin (19.2 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care. MA plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments and are unlikely to be explained by the differences in patient characteristics between SNF users enrolled in MA and those in FFS. In 2021, providers are likely to incur higher costs associated with post-PHE changes in practices (e.g., higher expenditures for personal protective equipment and testing). We also expect Medicare volume to not fully recover to pre-PHE levels, at least in the near term. Providers will also continue to adjust their practices to the new case-mix system that was implemented on October 1, 2019. We project the aggregate Medicare margin to be about 10 percent in 2021.

On the basis of these positive payment adequacy indicators, the Commission recommends that, for fiscal year 2022, the Congress eliminate the update to the fiscal year 2021 Medicare base payment rates for SNFs. While the projected level of payments indicates that payments need to be reduced to more closely align aggregate payments and costs, the lasting impacts of COVID-19 on SNFs and the effects of the new case-mix system are uncertain. Because the SNF industry is likely to undergo considerable changes as it adjusts to both, 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, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins. Medicaid finances most long-term care services provided in nursing homes, but it also 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.

Between 2019 and 2020, the number of Medicaid-certified facilities declined less than 1 percent, to 14,784. Spending was \$39 billion in 2019, about 5 percent less than in 2018.

In 2019, the average total margin—reflecting all payers (including managed care, Medicaid, Medicare, and private insurers) and all lines of business (such as skilled and long-term care, hospice, ancillary services, home health care, and investment income)—was 0.6 percent, an increase from 2018. The average non-Medicare margin (which includes all payers and all lines of business except FFS Medicare SNF services) was –2 percent, also an improvement from 2018.

Home health care services

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2019, about 3.3 million Medicare FFS beneficiaries received care, and the program spent \$17.8 billion on home health care services. In that year, over 11,300 HHAs participated in Medicare.

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

Beneficiaries' access to care—Medicare FFS beneficiaries' access to home health care has been adequate. In 2019, over 99 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated, and 86 percent lived in a ZIP code with five or more HHAs. In 2019, the number of HHAs declined by 1.7 percent, continuing a slow decline since 2013. However, the decline follows a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by over 80 percent. The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years. Similarly, in 2019 the number of 60-day episodes declined by 3.0 percent, continuing a slight decline that began in 2011. While home health care episodes have decreased somewhat, freestanding HHAs' marginal profit on Medicare patients in 2019 was 18 percent, suggesting that HHAs have a significant financial incentive to treat additional Medicare beneficiaries.

Quality of care—In 2019, our outcome measures were mixed. The rate of home health patients who were hospitalized during their spell of home health services increased slightly, but the share who were successfully discharged to the community (patients who did not experience an unplanned hospitalization within 30 days of

the end of their spell of home health care) also increased slightly.

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—For more than a decade, payments under the home health PPS have consistently and substantially exceeded costs. In 2019, Medicare spending for home health care declined by 0.5 percent, but Medicare margins for freestanding agencies averaged 15.8 percent. 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. Though the PHE was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry. The Commission projects that Medicare margins for freestanding HHAs in 2021 will be 14 percent.

Overpayments for home health care services diminish the value of the services as a substitute for more costly ones. Given the positive payment adequacy indicators, for 2022 the Commission recommends a 5 percent reduction in the Medicare home health PPS base payment rate.

Inpatient rehabilitation facility services

Inpatient rehabilitation facilities (IRFs) are hospitals or distinct units of hospitals that provide medical care as well as intensive rehabilitation programs to patients after illness, injury, or surgery. Rehabilitation programs are supervised by rehabilitation physicians and include services such as physical and occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2019, Medicare spent \$8.7 billion on IRF care. About 363,000 beneficiaries had roughly 409,000 IRF stays. On average, the FFS Medicare program accounted for about 58 percent of IRF discharges.

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

Beneficiaries' access to care—In 2019, the number of IRFs decreased slightly from 1,170 to 1,152. Over time, the number of hospital-based and nonprofit IRFs has

fallen, while the number of freestanding and for-profit IRFs has mostly increased. In 2019, the average IRF occupancy rate remained at 67 percent, indicating that capacity is adequate to meet demand for IRF services. In addition, the number of Medicare cases per FFS beneficiary increased by 1.6 percent in 2019. That year, IRFs' average marginal profit was 19.4 percent for hospital-based IRFs and 40.2 percent for freestanding IRFs, indicating that IRFs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—Measures of successful discharge to the community and hospitalizations within the IRF stay were steady or improved between 2015 and 2019.

Providers' access to capital—The parent institutions of hospital-based IRFs continue to have good access to capital (as discussed in Chapter 3). The continued expansion of a major freestanding IRF chain and freestanding IRFs' average total (all-payer) margin of 10.4 percent suggests that IRFs generally have good access to capital.

Medicare payments and providers' costs—Medicare FFS payments to IRFs continue to exceed their costs. In the five-year period between 2015 and 2019, the IRF Medicare margin remained above 13 percent. Although the aggregate Medicare margin decreased slightly in 2019 to 14.3 percent, it remained high. Medicare margins in freestanding and hospital-based IRFs were 24.6 percent and 2.1 percent, respectively. The coronavirus PHE has made 2020 an anomalous year in many respects, and it is impossible to predict with certainty the extent to which these effects will continue into 2021. Nevertheless, we expect the increase in revenue will more than offset cost growth over the period. Therefore, for 2021, we project an aggregate Medicare margin of 16 percent.

On the basis of these indicators, the Commission recommends a 5 percent reduction in the IRF base payment rate for fiscal year 2022. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded and (2) the Secretary conduct focused medical record reviews of IRFs.

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 for Medicare payment as an LTCH, a facility must meet Medicare's conditions

of participation for acute care hospitals and have an average length of stay of more than 25 days for certain Medicare patients. In 2019, Medicare spent \$3.7 billion on care provided in LTCHs. That year, about 82,000 FFS Medicare beneficiaries had about 91,000 LTCH stays, which accounted for about 56 percent of LTCH stays among all users.

CMS began a four-year phase-in of a dual payment-rate system for LTCHs in fiscal year 2016. When fully phased in, LTCHs will be paid the standard LTCH PPS rate for cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and will be paid a lower “site-neutral” rate for cases that do not. While policies effective during the coronavirus PHE have temporarily affected the complete transition to site-neutral rates for all LTCHs in 2021, ultimately, the extent to which LTCHs shift toward cases that qualify for the standard LTCH PPS rate will determine the industry’s financial performance under Medicare’s LTCH PPS. Our payment adequacy analysis must be interpreted in the context of the transition to the dual payment-rate system and its anticipated effects on our payment adequacy metrics. To assess the adequacy of standard payments under the LTCH PPS for cases meeting the LTCH criteria, some of our analyses focus on LTCHs treating a high share (more than 85 percent) of LTCH PPS-qualifying cases, consistent with the goals of the dual payment-rate system.

As described in Chapter 10, our payment adequacy indicators for LTCHs are generally positive or reflect expected changes under the new dual payment-rate system.

Beneficiaries’ access to care—In 2019, the number of LTCH facilities decreased by 3.5 percent, and the number of LTCH beds decreased by 3 percent, continuing the decline following the implementation of the dual payment-rate system. However, the average LTCH occupancy rate was 63 percent in 2019, suggesting that LTCHs have capacity in the markets they serve. From 2016 to 2019, the total number of Medicare cases in all LTCHs decreased by an average of about 10 percent annually. At the same time, LTCHs’ marginal profit averaged about 15 percent in 2019, indicating that LTCHs with excess capacity have a financial incentive to treat additional Medicare beneficiaries.

Quality of care—Aggregate risk-adjusted rates of successful discharge to the community have declined, and all-condition hospitalizations within a stay have been

unchanged during the dual payment-rate phase-in period. Consistent with prior years, non-risk-adjusted mean rates of death in the LTCH and death within 30 days of discharge for all cases were stable.

Providers’ access to capital—LTCHs continued to alter their cost structures and referral patterns in response to the dual payment-rate system. Continued phase-in of site-neutral rates for nonqualifying cases, 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—Aggregate margins for all LTCHs have been variable and negative during the phase-in of the dual payment-rate system because costs grew more than payments in most years between 2016 and 2019. In 2017, the first full year that all LTCHs received the blended site-neutral rates under the transition to the dual payment-rate system, aggregate Medicare margins fell to –2.2 percent and then increased to –0.5 percent in 2018. In 2019, margins fell again to –1.6 percent. As they have since 2017, LTCHs with a high share of cases that met the criteria to be paid the standard LTCH rates had positive margins, 2.9 percent in 2019, which is a reduction of 1.8 percentage points from 2018. We expect continued changes in admission patterns and cost structures of LTCHs in response to the full implementation of the dual payment-rate system in 2020 and 2021, but the waiver of some site-neutral payment rules to create additional inpatient capacity during the PHE has delayed full implementation. We project that LTCHs’ aggregate Medicare margin for facilities with more than 85 percent of Medicare discharges meeting the LTCH PPS criteria will be 2 percent in 2021.

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 2022. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate.

Hospice services

The Medicare hospice benefit covers palliative and support services for beneficiaries who are terminally ill with a life expectancy of six months or less if the illness runs its normal course. 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 2019, more than 1.6 million Medicare beneficiaries (including more than half of decedents) received hospice services from 4,840 providers, and Medicare hospice expenditures totaled \$20.9 billion.

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

Beneficiaries' access to care—In 2019, the number of hospice providers increased by 4.3 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. In the same year, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased. Between 2018 and 2019, the share of Medicare decedents who used hospice rose from 50.6 percent to 51.6 percent, the average length of stay among decedents rose from 90.3 days to 92.6 days, and the median length of stay was stable at 18 days. In 2018, hospices' marginal profit on Medicare FFS beneficiaries averaged roughly 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 (i.e., scores are so high and unvarying that meaningful distinctions in performance can no longer be made). Performance on a measure of visits in the last three days of life improved slightly. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems[®] were stable. 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 it is less capital intensive than most other health care sectors. However, continued growth in the number of for-profit providers (a 6.3 percent increase in 2019) and reports of strong investor interest in the sector suggest 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 have continued to exceed hospices' average costs. The aggregate 2018 Medicare margin was 12.4 percent (similar to 12.5 percent in 2017), and the projected 2021 margin is 13 percent.

In addition to indicators of hospice payment adequacy, Chapter 11 also discusses the hospice aggregate cap, which limits the total payments a hospice provider can receive in a year in aggregate. If a provider's total payments exceed the number of patients treated multiplied by the cap amount, the provider must repay the excess to the Medicare program.

The aggregate cap functions as a mechanism that reduces payments to hospices with long stays and high margins. In 2018, about 16 percent of hospices exceeded the cap; their aggregate Medicare margin was about 22 percent before and 10 percent after application of the cap. These above-cap hospices had high average lengths of stay and high live-discharge rates and were disproportionately for-profit, freestanding, urban, small, and new entrants to the Medicare program. Unlike wage-adjusted Medicare payments, the hospice aggregate cap is not wage adjusted, resulting in an aggregate cap that is stricter in some areas of the country than in others.

On the basis of these payment adequacy indicators and analysis of the hospice aggregate cap, the Commission recommends that hospice payment rates for 2022 be held at their 2021 levels and that the aggregate cap be wage adjusted and reduced by 20 percent.

The Medicare Advantage program: Status report

In Chapter 12, as we do each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2020, the MA program included over 4,000 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$317 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 the current state of quality reporting 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 among Medicare coverage options, including the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate, risk adjusted per enrollee, rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

The Commission has emphasized the importance of encouraging 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 substantially above FFS rates. The phase-in of MA payment policies from the Affordable Care Act (ACA) reduced the difference in Medicare spending between MA and FFS on a national average basis. However, aggregate plan payments under the ACA were similar to FFS levels for only one year before rising above FFS due to higher risk coding, an increasing share of MA enrollees in areas with payments above FFS spending, and quality bonus rules. Notwithstanding, over the past few years, plan bids 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. The clear, strong trend suggests an opportunity for the Medicare program to share in MA efficiencies.

Enrollment—Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent, or 2.1 million enrollees, to 24.4 million enrollees. About 43 percent of Medicare beneficiaries with Part A and Part B coverage were enrolled in MA plans in 2020, up from 40 percent in 2019.

Plan availability—Access to MA plans remains high in 2021, with most Medicare beneficiaries having access to many plans. Overall, 99 percent of Medicare beneficiaries

have access to an MA plan and 98 percent have an HMO or local preferred provider organization plan operating in their county of residence. The average beneficiary in 2021 has 32 available plans sponsored by 7 different parent organizations.

Plan rebates—In 2021, rebates used to provide additional benefits to enrollees are at a historic high of \$140 per enrollee per month. The average total rebates are 14 percent higher than in 2020. Plans can devote the rebate (including plans' allocation of administrative costs and profit) to lower cost sharing, lower premiums, or provide supplemental benefits.

Plan payments—In 2021, total Medicare payments to MA plans average an estimated 104 percent of FFS spending, an increase of 1 to 2 percentage points compared with 2020. The 2021 estimate incorporates about 3 percentage points of uncorrected coding intensity. Relative to FFS spending, quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021. Using plan bid data for 2021, and ignoring the impact of coding intensity, we estimate that MA payments would be 101 percent of FFS spending. Bid data also show that MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—are slightly higher relative to FFS than they were in recent years. MA benchmarks in 2021 averaged an estimated 108 percent of FFS spending (including quality bonuses), compared with 107 percent in 2020. Bids slightly decreased to 87 percent of FFS, a record low.

Risk adjustment and coding intensity—Medicare payments to MA plans are enrollee specific, based on a plan's payment rate and an enrollee's risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. 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 providing a service. In contrast, MA plans have a financial incentive to ensure that their providers record all possible diagnoses: Higher enrollee risk scores result in higher payments to the plan.

Our analysis for 2019 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar FFS beneficiaries. This estimate is higher than the prior year due to faster MA risk score growth relative to FFS risk score growth. By law, CMS must make an across-the-board reduction to

MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a larger reduction than the minimum required by law, the agency has never done so. The minimum adjustment for coding intensity will remain at 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 to improve equity across plans and eliminate the impact of differences between MA and FFS coding intensity. This year, we highlight the impact of MA plans' use of medical chart reviews to increase risk scores (a coding practice that does not exist in FFS). Recent reports from the Office of Inspector General indicate that the majority of MA coding intensity may be due to chart reviews and health risk assessments.

Quality in MA—The Commission has previously reported its concerns with the MA star rating system and 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 43 percent of eligible Medicare beneficiaries 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 necessary for proper evaluation. 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 and is costly to Medicare, in our June 2020 report we recommended a new value incentive program for MA that would replace the current quality bonus program.

Future direction of MA payment policy—Many indicators continue to point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and historically high extra benefits. However, some MA policies are in need of immediate improvement. The Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program.

Despite the relative efficiency of MA plans in providing Part A and Part B benefits, in 2021, aggregate MA payments (including rebates that finance extra benefits) are about 4 percent higher than expected FFS expenditures

for similar beneficiaries, an increase of more than 1 percentage point from last year. In setting payment policy in the FFS sector, the Commission consistently strives to encourage providers to deliver care efficiently while maintaining beneficiary access to good quality care. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS Medicare, which are compounded by Medigap's effect of insulating beneficiaries from true health care costs and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare in 1982, in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient. In the future, Medicare may be able to share in some of those efficiencies.

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

In 2020, the Part D program paid for outpatient prescription drug coverage for more than 47 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing to nearly 13 million individuals with low income and assets. The 2020 benefit year was extraordinary due to the coronavirus pandemic and its toll on Medicare beneficiaries and health care providers. However, Medicare beneficiaries experienced comparatively less disruption of access to medicines than to other types of health care services; only 7 percent had to forgo medications compared with 36 percent for medical services.

In 2019, Part D program expenditures totaled \$102.3 billion. Enrollees paid \$13.9 billion of that amount in plan premiums for basic benefits, plus an additional \$16.7 billion in cost sharing, and additional amounts in premiums for enhanced benefits. Part D has been a success in many respects. It has improved beneficiaries' access to prescription drugs. Generic drugs account for nearly 90 percent of the prescriptions filled. More than 9 in 10 Part D enrollees report they are satisfied with the program.

However, changes to Part D's benefit design combined with trends in drug spending have eroded plans' incentives

for cost control. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based subsidies rather than capitated payments, and the financial risk that plans bear has declined markedly. Last year, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies to restore the role of risk-based, capitated payments that was present at the start of the program and to provide drag on drug price increases. Separately, we are concerned that the LIS has features that limit premium competition among plans that serve low-income beneficiaries.

Nearly 300 organizations sponsor Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most large plan sponsors are vertically integrated with their own pharmacy benefit manager (PBM), and many also operate mail-order and specialty pharmacies. Formularies remain plan sponsors' most important tool for managing drug benefits. Generally, pharmaceutical manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Plan sponsors and PBMs have negotiated rebates that have grown as a share of Part D spending. However, the wide gap between spending before and after rebates raises concerns about the accuracy of Part D's risk adjustment system.

Enrollment in 2020 and benefit offerings for 2021—In 2020, 74.6 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1.9 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 23.5 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 2019 and 2020, enrollment in stand-alone prescription drug plans (PDPs) declined slightly, while enrollment in Medicare Advantage–Prescription Drug plans (MA–PDs) expanded to 47 percent of enrollees.

For 2021, beneficiaries have a broad choice of plans, ranging from 25 PDPs in Alaska to 35 PDPs in Texas, along with many MA–PDs in most areas. Most plans use a five-tier formulary that uses differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs. For 2021, the \$33.06 base beneficiary premium increased by 1 percent, but individual plans' premiums can vary substantially. In 2021, 259

premium-free PDPs are available to the 27 percent of Part D enrollees who receive the LIS, and all regions have at least 5 premium-free PDPs for LIS enrollees.

Part D program costs—Between 2007 and 2019, Part D program spending increased from \$46.2 billion to \$88.4 billion. Medicare's reinsurance (which covers 80 percent of spending in the catastrophic phase of the benefit) continues to be both the largest and fastest growing component of program spending. As a result, between 2007 and 2019, the portion of the average basic benefit paid to plans through the capitated direct subsidy fell from 54.7 percent to 15.3 percent. In 2019, Part D saw the largest increase ever in beneficiaries without the LIS reaching the benefit's catastrophic phase (high-cost enrollees). In 2019, high-cost enrollees accounted for 64 percent of Part D spending, up from about 40 percent before 2011. Overall, our index of Part D prices declined in 2019, owing to increased generic competition. However, in classes dominated by brand-name drugs or biologics, prices continued to rise. In 2019, over 483,000 enrollees (11 percent of high-cost enrollees) filled a prescription for which a single claim was sufficient to meet the out-of-pocket threshold, up from just 33,000 in 2010.

Beneficiary access and quality in Part D—Data from CMS audits and Part D appeals processes suggest that beneficiaries may be less likely to encounter access issues for most drugs than in previous years. However, among beneficiaries without the LIS, high cost sharing for expensive therapies may be a barrier to access. In 2021, the average star rating among Part D plans increased somewhat for PDPs and decreased for MA–PDs. While average star ratings for MA–PDs continue to exceed those of PDPs, the trend among MA–PD sponsors of consolidating contracts leads us to question the validity of MA–PD ratings. It is not clear that current quality metrics help beneficiaries make informed choices among their plan options.

Telehealth in Medicare after the coronavirus public health emergency

During the coronavirus PHE, the Congress and CMS have temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and reduce their risk of exposure to COVID-19. Hospitals, physicians, and other providers have responded by rapidly adopting telehealth to provide continued access to medical care for their patients.

Without legislative action, many of the changes will expire at the end of the PHE.

Although temporary telehealth expansions affect virtually all settings of care, most of the changes affect the services paid under the physician fee schedule (PFS). Before the PHE, Medicare paid for a limited number of telehealth services and only if they were provided to beneficiaries in a clinician’s office or facility in a rural area. In addition, most telehealth services were paid at the lower PFS rate used to pay clinicians providing care in facilities (the facility-based rate), rather than the higher rate used to pay office-based clinicians (the nonfacility rate), because the practice expenses associated with furnishing telehealth services were presumed to be lower. During the PHE:

- Clinicians may bill for telehealth services provided to Medicare beneficiaries in any location, including their homes and in urban as well as rural areas.
- CMS has added over 140 PFS services to the list of services it will pay for when delivered through telehealth. Clinicians can bill for some of these services if they are provided using audio-only interaction, and CMS also added new codes for audio-only evaluation and management visits.
- CMS pays the same rate it would have paid if the service had been provided in person.
- Clinicians may reduce or waive beneficiaries’ cost-sharing obligations for telehealth services.

CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect these telehealth expansions will remain in place throughout the PHE. There is ongoing debate on whether the expansions should be made permanent.

In Chapter 14, a policy option for expanded coverage of Medicare telehealth policy after the PHE is over. Under this policy option, policymakers should temporarily continue the following telehealth expansions for a limited

duration of time (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use that evidence to inform any permanent changes. During this limited period, Medicare should temporarily:

- pay for specified telehealth services provided to all beneficiaries regardless of their location,
- cover certain telehealth services in addition to services covered before the PHE if there is potential for clinical benefit, and
- cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.

After the PHE ends, Medicare should return to paying the fee schedule’s facility rate for telehealth services and collect data on the cost of providing those services. In addition, providers should not be allowed to reduce or waive cost sharing for telehealth services after the PHE. CMS should also implement other safeguards to protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth, including:

- applying additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians,
- requiring clinicians to provide an in-person face-to-face visit before they order high-cost durable medical equipment or high-cost clinical laboratory tests, and
- prohibiting “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly.

Chapter 14 also describes CMS’s existing authority to offer telehealth flexibilities to clinicians participating in advanced alternative payment models, such as accountable care organizations. ■

CHAPTER

1

**Context for Medicare
payment policy**

Context for Medicare payment policy

Chapter summary

This year, both the short- and long-term context for the Medicare program are sobering. In the short term, the nation is in the midst of a historic coronavirus pandemic. Medicare beneficiaries are at particular risk of COVID-19. Those over 65 are more likely to suffer severe cases and complications and die than those who are younger and have fewer comorbidities. Beneficiaries in nursing facilities have accounted for a disproportionate share of fatalities from COVID-19. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society. Providers are also under stress. The demands put upon individual clinicians and other staff have been extreme. The financial stress on providers is unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels.

The longer-term context is also sobering. The financial future of the Medicare program was already problematic, but as a result of pandemic job losses, in 2020 the Congressional Budget Office projected that Medicare's Hospital Insurance Trust Fund will become insolvent two years earlier than previously expected—by 2024. (Aside from this projection, long-range projections in this chapter do not reflect the impact of the pandemic.) Driven by growth in the volume and intensity of services provided to beneficiaries and the number of beneficiaries aging into the program, Medicare's annual spending is projected

In this chapter

- The impact of the coronavirus pandemic on beneficiaries
- National health care spending
- Medicare spending projections
- Medicare's financing challenge
- The affordability of health care for Medicare beneficiaries
- Medicare spending trends
- Trends in Medicare beneficiaries' morbidity and mortality
- Alternative payment models incentivize clinicians to deliver care more efficiently
- The Commission's recommendations for restraining Medicare spending growth

to double in the 10-year period between 2019 and 2029, from \$782 billion to \$1.5 trillion. During this period, Medicare's share of federal spending is expected to rise from 14.6 percent to 17.5 percent.

Increasing Medicare spending also strains beneficiaries' household budgets. In 2020, Medicare Part B and Part D premiums and cost sharing are estimated to consume 24 percent of the average Social Security benefit, up from 14 percent in 2000. The Medicare Trustees estimate that in another 20 years, these costs will consume 31 percent of the average Social Security benefit.

One of the most powerful ways Medicare can control spending growth is by setting prices. Over the last 10 years, Medicare's spending per beneficiary has grown much more slowly than private health insurance spending per enrollee. Increasing prices were the main cause of health care spending growth for the privately insured, which was in turn driven by high levels of provider market power. Hospitals and physician groups have increasingly consolidated, in part to gain leverage over private insurers in negotiating higher payment rates. From 2009 to 2019, that consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period. This difference suggests that private plans' greater ability to constrain volume has less of an effect on costs than the Medicare program's greater ability to constrain prices under its administered pricing system.

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

Given Medicare's financing challenges, many believe that restraining price growth will not be enough to ensure Medicare's fiscal sustainability and that growth in the quantity of health care services must also be reduced. Medicare has piloted a number of alternative payment models that give providers incentives to more closely manage and coordinate beneficiaries' care to keep them healthy and reduce unnecessary utilization. The ultimate goal of these payment models is to save Medicare money by financially rewarding providers for efficiently delivering health care services while maintaining or improving the quality of care.

Prices and utilization rates can also be influenced through other means. The Commission has identified a number of aspects of Medicare payment systems that hamper the program's ability to achieve fiscal sustainability. The Commission has made numerous recommendations that, if implemented, could address these challenges and allow Medicare to improve payment accuracy and equity. Some key recommendations from prior years are summarized at the end of this chapter.

Medicare's fiscal challenges must be met in a manner that improves quality and reduces inequities in access to care across the Medicare population. Although quality of care appears stable, there is room for improvement. The Commission is also dedicated to understanding and reducing disparities in access to care across racial and ethnic groups. As Medicare consumes growing shares of the federal budget and beneficiaries' incomes, the Commission will continue to identify changes that could improve Medicare payment policy, including through recommendations contained in this report and future reports to the Congress. ■

Introduction

Each March, the Commission reports to the Congress on traditional Medicare’s various fee-for-service (FFS) payment systems, the Medicare Advantage program, and the Medicare prescription drug program. To place the information presented in those chapters in some context, this chapter highlights key national trends in health care spending for the country as a whole and for the Medicare program in particular. We also review the factors that contribute to Medicare spending growth—including trends in demographics and the price of health care services—and discuss how Medicare’s payment policies can either moderate or exacerbate program spending. Through the graphs and statistics that follow, we show that sustaining Medicare fiscal solvency is a growing and pressing challenge. For example, in 2020 the Congressional Budget Office (CBO) estimated that Medicare’s Hospital Insurance Trust Fund will become insolvent by 2024. (Aside from this projection, long-range projections in this chapter do not yet reflect the impact of the pandemic.)

This year, in addition to the long-term financial context for the Medicare program, we also consider the short-term context: the coronavirus pandemic. Medicare beneficiaries are at particular risk from COVID-19. Providers are also under stress. The demands put upon individual clinicians and other staff have been extreme. In addition, the financial stress on providers has been unpredictable, although it has been alleviated to some extent by government assistance and rebounding service utilization levels. We discuss the financial effects on providers, to the extent they are germane to our payment adequacy analyses, in each update chapter. We look at some of the effects of the pandemic on beneficiary mortality and access to care in the section below.

The impact of the coronavirus pandemic on beneficiaries

The coronavirus pandemic has proven especially tragic for older adults. People ages 65 and over are more likely than younger populations to suffer severe cases of COVID-19, develop complications, and die. Beneficiaries in long-term care and assisted living facilities are particularly at risk and have accounted for a disproportionate share of fatalities nationwide. In addition, non-White Medicare beneficiaries have faced disproportionately high rates of mortality due

to COVID-19, reflecting, in part, longstanding inequalities in the health care system and society.

Beneficiaries and clinicians have had to adjust to new care delivery approaches and priorities during the pandemic—at times switching from in-person appointments to telehealth appointments and delaying elective procedures to avoid potential exposure to the coronavirus and preserve clinicians’ supplies of personal protective equipment.

Increased mortality during the pandemic

In 2020, COVID-19 was the third leading cause of death in the U.S., and in the spring and winter, it overtook heart disease and cancer to become the leading cause of death in the country (Cox and Amin 2021, Woolf et al. 2020a). Medicare beneficiaries face disproportionately high mortality rates compared with younger age groups. As of late September 2020, adults 65 and older accounted for 79 percent of the deaths attributed to COVID-19 in the U.S. (Kamp and Evans 2020, National Center for Health Statistics 2021).¹ As of mid-January 2021, 38 percent of COVID-19 deaths occurred among long-term care and assisted living facility residents and staff (Kaiser Family Foundation 2021).²

Beyond mortality directly attributed to COVID-19, some studies have found that the number of excess deaths (that is, deaths beyond what would have been expected in a typical year) are even greater (Weinberger et al. 2020, Woolf et al. 2020b). From late January 2020 through early December, there were an estimated 475,000 excess deaths (National Center for Health Statistics 2021, Overberg et al. 2021). One study observed that only about two-thirds of excess deaths were caused by COVID-19; it noted that deaths from noninfectious causes increased during COVID-19 surges, which could reflect unrecognized or undocumented coronavirus infections or deaths from uninfected patients that resulted from care disruptions produced by the pandemic (Woolf et al. 2020b).

The pandemic has had a disproportionate effect on non-White individuals. According to age-adjusted COVID-19 mortality data, White Americans have the lowest COVID-19 mortality rate by a significant margin. Mortality rates for Black, Hispanic, and Native American people are at least double the rates for White Americans (APM Research Lab 2021). The rates of excess deaths also reflect these disparities. Comparing actual deaths in 2020 with deaths that would have been expected based on 2015 to 2019 experience, White Americans’ deaths

were 12 percent higher, Native Americans' deaths were 29 percent higher, Black Americans' deaths were 33 percent higher, Asian Americans' deaths were 37 percent higher, and Hispanic Americans' deaths were 54 percent higher (Rossen et al. 2020).

Numerous factors could contribute to racial and ethnic differences in COVID-19 mortality rates, including employment, multigenerational housing arrangements, income, preexisting conditions, and access to health care. For example, non-White workers are disproportionately represented in frontline industries, such as public transit, health care, and building cleaning services (Rho et al. 2020). Those workers are at higher risk for contracting the disease due to their close contact with others and their inability to work from home, as well as not having sufficient access to paid time off (Gould and Wilson 2020). One study found that among Hispanic adults at high risk of severe COVID-19 illness (of any age), 64.5 percent lived with a worker who was unable to work from home, and the same was true of 56.5 percent of Black high-risk adults, compared with 46.6 percent of White high-risk adults (Selden and Berdahl 2020). Non-White individuals are also more likely to delay or avoid urgent or emergency care during the pandemic: A Centers for Disease Control and Prevention (CDC) survey found that 25 percent of Hispanics and 23 percent of Blacks (of any age) reported having avoided care, compared with 7 percent of Whites (Czeisler et al. 2020).

Medicare beneficiaries' access to care was largely maintained during the pandemic, although many beneficiaries temporarily delayed care

A number of surveys have tried to assess how many Medicare beneficiaries (and others) have delayed or forgone care because of the pandemic. These surveys have found that widely varying shares of respondents have forgone or delayed care, depending on how the question was asked, when the survey was fielded, and what time period was referenced. For example, a large national survey by the Census Bureau, fielded in mid-July, found that among respondents age 60 and over, 34 percent had delayed care and 26 percent had forgone care *in the past month* (Census Bureau 2020). In contrast, the Commission's 2020 survey, fielded from April to October, asked about forgone care *in the past year*, and found that only 10 percent of elderly Medicare beneficiaries had forgone care they thought they should have gotten. Since our survey is fielded annually, we are able to observe trends over time, unlike many surveys that were fielded only during the pandemic. We

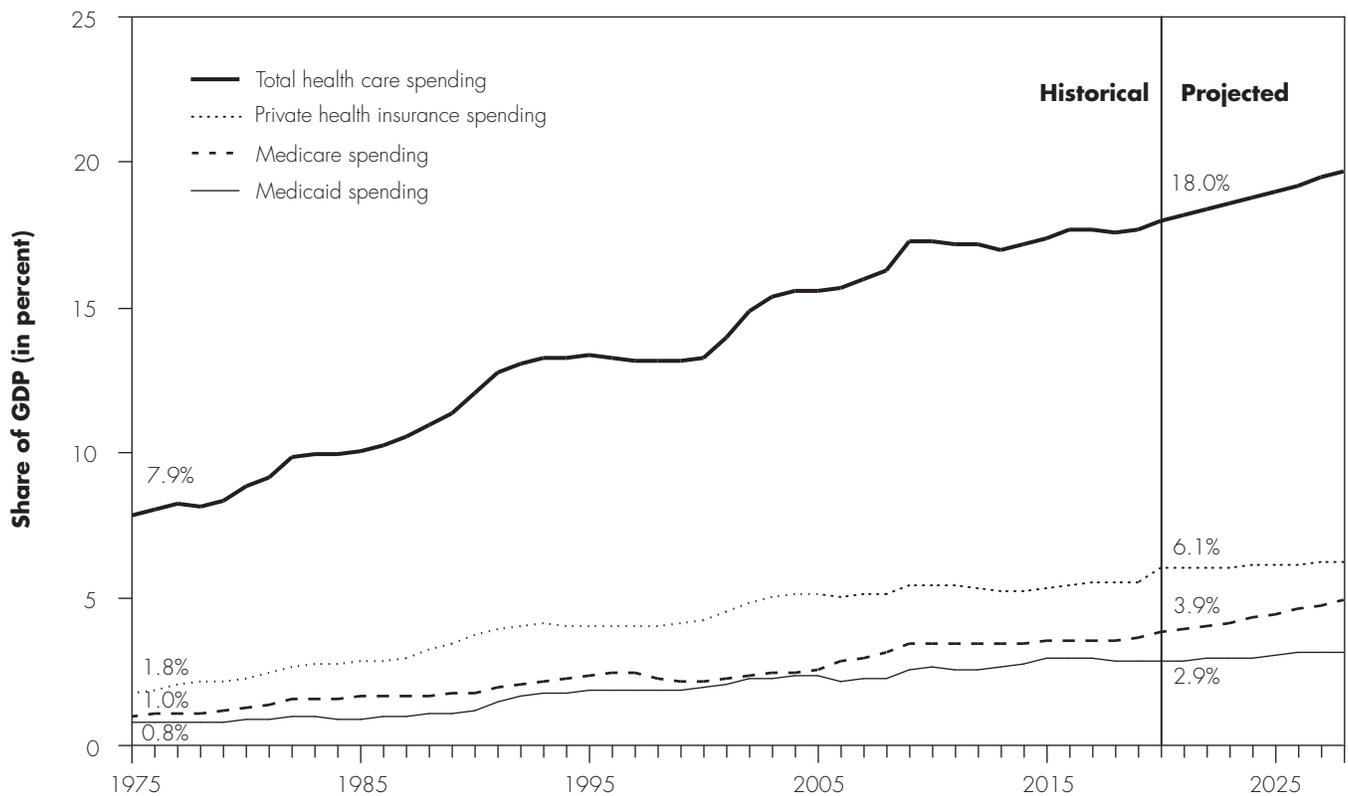
found that the share of beneficiaries who reported forgoing care in 2020 was not statistically significantly different from prior years—although many respondents in 2020 cited the pandemic as the reason they had forgone care instead of other reasons commonly cited in prior years. When beneficiaries do forgo or delay medical care, a CDC survey found that they were far more likely to delay or avoid routine care (which 30 percent of elderly respondents reported doing during the pandemic) than they were to delay or avoid urgent or emergency care (which only 4 percent reported doing) (Czeisler et al. 2020). In some cases, beneficiaries may have put off care because providers and facilities ceased to provide in-person services. In other cases, beneficiaries may have been unwilling to seek in-person care because of the risk of COVID-19 infection.

Many of the findings above are reinforced by what we heard from beneficiaries and clinicians in focus groups held virtually during the summer of 2020 in three cities in different regions of the country. Many of the beneficiaries in each of the groups expressed their reluctance to seek in-person care because of fear of infection from COVID-19, especially during the first two months of the pandemic. Telehealth visits replaced many in-person visits; however, beneficiaries and clinicians noted that many procedures (e.g., colonoscopies) and tests (e.g., blood work) were canceled or delayed. Both beneficiaries and clinicians reported that the number of in-person visits and procedures had been increasing throughout the summer, but some beneficiaries continued to be reluctant to seek in-person care. We will continue to monitor trends in the use of telehealth and health care more generally.

The remainder of this chapter discusses Medicare's longer-term financial outlook. As a note of caution, most of the data sources used in this chapter do not yet reflect the impact of the pandemic in their projections of future-year health care utilization or spending.

National health care spending

For decades, health care spending in the U.S. has grown as a share of the nation's gross domestic product (GDP) (Figure 1-1). From 1975 to 2020, health care spending as a share of GDP more than doubled, from 7.9 percent to 18.0 percent. Private health insurance spending as a share of GDP more than tripled, from 1.8 percent to 6.1 percent. And Medicare spending as a share of GDP nearly quadrupled, from 1.0 percent to 3.9 percent.

**FIGURE
1-1****Health care spending has grown as a share of the country's GDP**

Note: GDP (gross domestic product). First projected year is 2020. Percentages labeled on graph are for 1975 and 2020. Beginning in 2014, private health insurance spending includes federal subsidies for both premiums and cost sharing for the health insurance marketplaces created by the Affordable Care Act. Health care spending also includes the following expenditures (not shown): out-of-pocket spending; spending by other health insurance programs (the Children's Health Insurance Program, the Department of Veterans Affairs, and the Department of Defense); and other third-party payers and programs and public health activity (including Indian Health Service; Substance Abuse and Mental Health Services Administration; maternal and child health; school health; workers' compensation; worksite health care; vocational rehabilitation; and other federal, state, and local programs). The potential effects of the coronavirus pandemic are not reflected in these projections.

Source: MedPAC analysis of CMS's National Health Expenditure Accounts, historical data released December 2020 and projections released March 2020.

Actuaries expect national health care spending to increase at an average annual rate of 5.4 percent from 2019 to 2028, when total health care spending is projected to constitute 19.7 percent of GDP. The largest driver of personal health care spending increases is rising prices, which account for 43 percent of projected growth; for the 2019 to 2028 period, actuaries expect prices to grow at an average annual rate of 2.4 percent, compared with 1.2 percent for the 2014 to 2018 period. The accelerated growth in health care prices is partly a result of an expected acceleration in economy-wide inflation, which will increase input prices for medical providers. The second-largest driver of national spending growth is growth in the use and intensity of services per patient, which accounts for about a third of the projected growth in spending between 2019 and

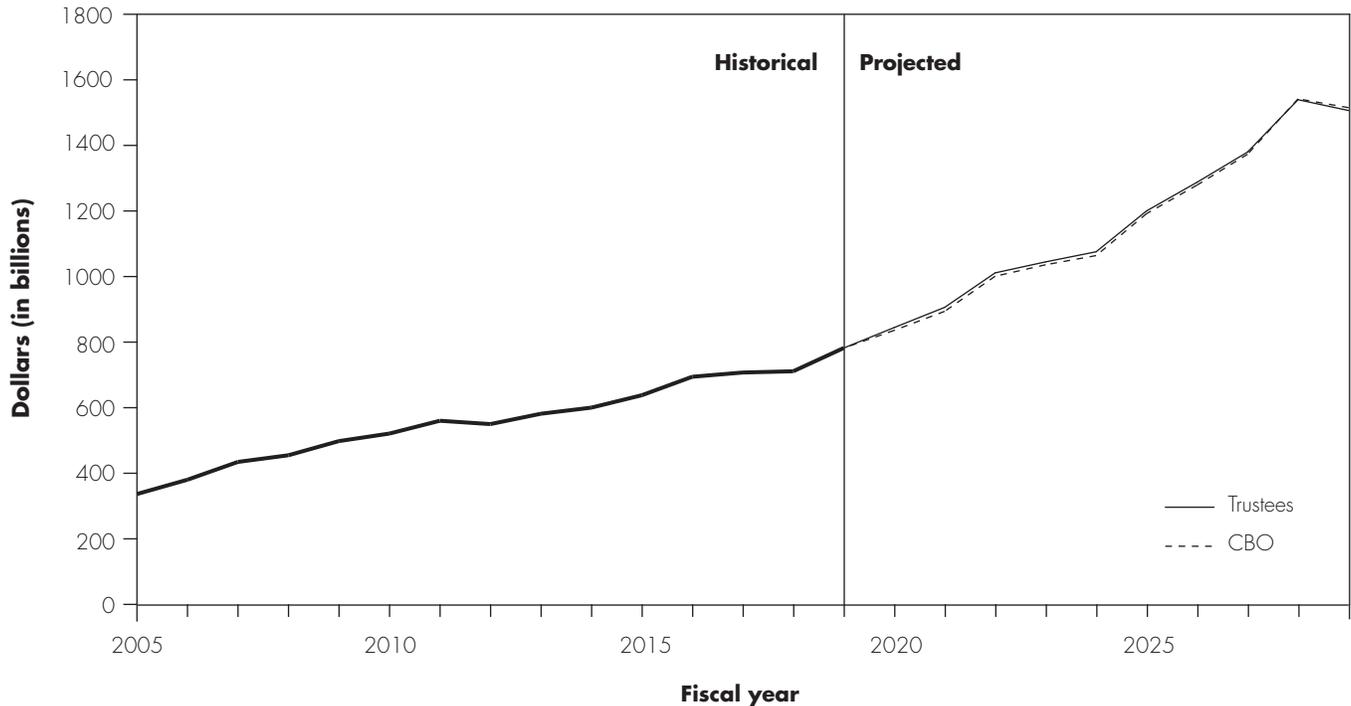
2028. Only about a tenth of the projected growth in health care spending is explained by the aging of the population (Keehan et al. 2020). Retail spending for prescription drugs is projected to grow only slightly faster than overall national health expenditures. However, over the past few decades, drugs' share of spending has expanded significantly (see text box, p. 11).

Medicare spending projections

Similar to national health care spending trends, Medicare is also projected to see increases in spending over the 10 years between 2019 and 2029—rising from \$782 billion

**FIGURE
1-2**

Medicare Trustees and CBO project Medicare spending to nearly double over the next decade



Note: CBO (Congressional Budget Office). Figure shows spending per fiscal year (as opposed to calendar year). The potential effects of the coronavirus pandemic are not reflected in these projections. At the time these projections were developed, a statutorily required sequestration was scheduled to increase in size in 2029 (growing from the current 2 percent reduction to benefit payments to a 4 percent reduction for the period from April 1, 2029, through September 30, 2029). Subsequent legislation delayed the 4 percent sequester past 2029 (not reflected above).

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds and CBO's March 2020 Medicare baseline.

to \$1.5 trillion (Figure 1-2) (Boards of Trustees 2020, Congressional Budget Office 2020a).

Unlike in the private health care sector, price growth is not expected to drive Medicare's increasing spending over the next 10 years (Table 1-1, p. 12) because Medicare is able to unilaterally set prices for health care providers. Medicare's ability to set prices is becoming an increasingly valuable tool as more and more providers consolidate into ever larger organizations able to command increasingly high prices from private payers (see text box, pp. 13–15, on price growth in the private sector). In contrast, Medicare's projected spending in the next 10 years is driven by the increasing number of beneficiaries (which is set to grow a little more than 2 percent per

year) and the increasing volume and intensity of services delivered per beneficiary (which is expected to grow by 2.6 percent per year) (Table 1-1, p. 12). Because enrollment growth is largely outside of the program's control, the most promising avenue for slowing the growth in Medicare spending is likely to be to reduce the quantity (and mix) of services used by beneficiaries, such as through efforts to reduce consumption of low-value care—defined as services with little or no clinical benefit or that have more risk of harm than potential benefit. Consumption of low-value care varies by geography, reflecting different practice patterns—with previous Commission analyses finding high amounts of low-value care delivered in parts of Florida, for example. CMS has tested a number of alternative payment models that

Prescription drug spending has increased significantly

Spending on prescription drugs has increased significantly compared with other sectors over the past few decades—doubling as a share of personal health care spending between 1979 and 2019, from 6 percent to 12 percent (Centers for Medicare & Medicaid Services 2020).

CMS actuaries project that national spending on retail prescription drugs will grow between 2019 and 2028 at an average annual rate of 5.5 percent (Keehan et al. 2020). This projection is driven by accelerating growth in drug prices in coming years and greater use and intensity of prescription drugs, caused in part by new drugs coming on the market. The American Academy of Actuaries has also attributed prescription drug spending growth in the U.S. to “delays in introducing generics, higher cost inflation in the United States for pharmaceuticals relative to other nations, and the compensation of numerous stakeholders throughout the pharmacy supply chain” (Hanna and Uccello 2018).

In 2018, across all payers, retail drug spending made up 9 percent of national health expenditures, compared with 14 percent of Medicare expenditures (Keehan et al. 2020). (Both percentages are net of manufacturers’ rebates.)

Spending for prescription drugs that are administered during a physician visit or a hospital or nursing home stay are not included in measures of retail drug spending. The Commission has previously estimated that in 2016 total drug and pharmacy services (including retail and nonretail spending) accounted for 23 percent of Medicare spending (excluding beneficiary cost sharing)—up from 20 percent in 2007. Over this period, the amount spent by facilities to buy drugs and operate pharmacies increased much more quickly for hospital outpatient facilities than for inpatient facilities. Between 2007 and 2016, drug and pharmacy costs for hospital outpatient departments grew at an annual average rate of about 14 percent, while estimates of comparable costs for inpatient hospitals increased at an average of less than 2 percent annually. ■

incentivize more efficient use of services, but savings for Medicare have been only modest and concentrated in population-based payment models and certain episode-based payment models. The Commission has asserted that it may therefore be time to give accountable entities stronger incentives to control costs and improve quality (Medicare Payment Advisory Commission 2020b).

Medicare’s financing challenge

The aging of the baby-boom generation will have an impact on both the Medicare program and the taxpayers who support it. Workers finance the bulk of Medicare Part A through payroll taxes that are deposited into the Hospital Insurance (HI) Trust Fund; workers also help

finance Part B and Part D through income taxes and other contributions that are deposited into the general fund of the Treasury.³ The ratio of workers per Medicare beneficiary has already declined from about 4.6 workers per beneficiary around the time of the program’s inception to 3.0 workers per beneficiary in 2019 (Figure 1-4b, p. 16). Over the next decade, as Medicare enrollment continues to grow, the number of workers per beneficiary is projected to decline further: by 2029, the Medicare Trustees project just 2.5 workers per beneficiary.

By 2030, the entire baby-boom generation will be eligible for Medicare. That year, Medicare is projected to have nearly 80 million beneficiaries—up from 61 million beneficiaries in 2019 (Figure 1-4a, p. 16) (Boards of Trustees 2020).⁴ Baby boomers aging into Medicare will lower the average beneficiary age over the next 10

**TABLE
1-1**

Factors contributing to Medicare’s projected spending growth from 2020 to 2029 (not including general economy-wide inflation)

Average annual percent change in:

Medicare Part	Medicare prices	Number of beneficiaries	Beneficiary demographic mix	Volume and intensity of services used	Medicare’s projected spending
Part A	0.2%	2.3%	0.1%	1.2%	3.8%
Part B	-0.7	2.3	0.0	4.0	5.7
Part D	-0.4	2.6	-0.1	1.8	3.9
Total	-0.3	N/A*	0.0	2.6	4.7

Note: N/A (not available). Includes Medicare Advantage enrollees. Price increases reflect Medicare’s annual updates to payment rates (not including inflation, as measured by the consumer price index), multifactor productivity reductions, and any other reductions required by law or regulation (including a statutorily required 2 percent sequester to Medicare benefit payments, which was scheduled to increase to 4 percent for a six-month period in 2029 at the time these projections were developed, but has since been delayed). Part A prices are expected to rise faster than economy-wide inflation in the 2020s in part due to statutorily required increases. Specifically, in each of fiscal year 2020 through 2023, there is a statutory 0.5 percent increase in inpatient operating payments due to unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers’ documentation and coding. Volume and intensity together are the residual after the other three factors shown in the table (Medicare price increases, the increase in the number of beneficiaries, and changes in beneficiary demographic mix) are removed. Much of the 1.2 percent projected increase in Part A volume and intensity may be due to increased coding of hospital severity of illness, which may reflect real changes in patients’ needs and/or coding changes; we do not expect the 1.2 percent to reflect increases in volume per capita given that the number of discharges per beneficiary has declined for several decades and fell by 6.1 percent from 2015 to 2019. The “Medicare’s projected spending” column is the product of the other columns in the table. The “Total” row is the sum of the other rows of the table, each weighted by their Part’s share of total Medicare spending in 2019 (as measured by shares of gross domestic product). Any potential effects of the coronavirus pandemic are not reflected in these projections.

*We are unable to calculate the total contribution of the increasing number of beneficiaries to projected spending growth because there is beneficiary overlap in enrollment in Part A, Part B, and Part D.

Source: MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

years. Then, around 2030, the share of the Medicare population ages 85 and older is projected to grow as baby boomers continue to age (Boards of Trustees 2020). This aging will have cost implications for the Medicare program because spending per beneficiary for individuals ages 85 and older is much higher than that for younger elderly beneficiaries (Figure 1-5, p. 16). The changing age structure of the Medicare population will thus exert somewhat less pressure on spending in the near term, then exert increasing pressure over the longer term.

These demographics create a financing challenge for the Medicare program. Payroll tax revenues are not growing as fast as Part A spending, and Medicare already spends more on Part A services each year than it collects through HI Trust Fund revenues—creating annual deficits. (Part A pays for services such as inpatient hospital stays.) Leftover surpluses from prior years have been used in recent years to pay for this deficit spending. As a result,

the Trust Fund’s reserves have been dwindling; before the coronavirus pandemic, the Medicare Trustees estimated that by 2026 the Trust Fund’s prior surpluses would be depleted—meaning the HI Trust Fund would be unable to fully cover its obligations each year (Boards of Trustees 2020). In light of job losses caused by the pandemic, CBO estimated in 2020 that a drop in payroll tax revenues will cause the Trust Fund to become insolvent two years sooner—by 2024 (Congressional Budget Office 2020b).

According to Medicare’s Trustees, if Medicare’s HI Trust Fund is depleted, “Medicare could pay health plans and providers of Part A services only to the extent allowed by ongoing tax revenues—and these revenues would be inadequate to fully cover costs,” which they warn could rapidly curtail beneficiary access to care. However, the Trustees note that lawmakers have never allowed the assets of the HI Trust Fund to become depleted (Boards of Trustees 2020).

Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care

Over the recent decade between 2008 and 2018, spending per enrollee on health care in the private sector has grown faster than spending per enrollee in the Medicare program (Centers for Medicare & Medicaid Services 2020). Increased prices were largely responsible for this faster spending growth, which occurred at a time of low growth in private sector health care utilization (Health Care Cost Institute 2020a). Our analysis of payer data and a review of the literature suggests that, although there is wide variation geographically and by service, private insurers generally pay rates about twice as high as Medicare for hospital services and about one and a half times Medicare rates for physician services (Chernew et al. 2020, Kaiser Family Foundation 2020, Medicare Payment Advisory Commission 2017).

One key driver of the private sector's higher prices is provider market power (Baker et al. 2014a, Baker et al. 2014b, Cooper et al. 2018, Gaynor and Town 2012, Medicare Payment Advisory Commission 2020c, Medicare Payment Advisory Commission 2017, Robinson and Miller 2014, Scheffler et al. 2018). Hospitals and physician groups have increasingly consolidated, in part to gain leverage in negotiating higher payment rates with private insurers (which, themselves, have become more concentrated). Between 2009 and 2019, consolidation contributed to average annual per enrollee growth in spending on private health insurance of 3.6 percent. By comparison, over that same period, Medicare spending per enrollee increased an average of 1.9 percent annually—nearly the same as the general inflation rate of 1.8 percent over this period (Bureau of Labor Statistics 2020, Centers for Medicare & Medicaid Services 2020).

The difference between private sector spending growth and Medicare spending growth becomes more stark once patient cost sharing is taken into account. Between 2014 and 2018, total health care spending per capita (including cost sharing) grew 24 percent for the privately insured, compared with 10 percent for beneficiaries in traditional fee-for-service Medicare (Figure 1-3, p. 14). (These figures do not

include retail spending on prescription drugs.) Actual spending amounts are lower for the privately insured, who tend to be younger and healthier than Medicare beneficiaries. Between 2014 and 2018, annual spending per capita on services for the privately insured rose from \$4,106 to \$5,104. Over the same period, spending per beneficiary in traditional Medicare increased from \$10,406 to \$11,262. (These amounts do not include the cost of premiums.)

Health care prices have been influenced by hospital consolidation since hospital systems with larger market shares are in a stronger bargaining position to negotiate higher prices (Abelson 2018, Department of Justice and the Federal Trade Commission 1996, Federal Trade Commission 2016a, Federal Trade Commission 2016b). One summary of the literature stated:

Overall, ... studies consistently show that when hospital consolidation is between close competitors, it raises prices by substantial amounts. Consolidated hospitals that are able to charge higher prices due to reduced competition are able to do so on an ongoing basis, making this a permanent rather than a transitory problem. (Gaynor 2020)

While most of the literature suggests hospital systems with larger market shares are in a stronger bargaining position to negotiate higher prices, the hospital industry generally disputes the assertion that market power causes an increase in prices (American Hospital Association 2019, Noether and May 2017). Also, while the American Hospital Association asserts that readmission and mortality rates improve following mergers, a more recent study suggests that mortality and readmission rates do not improve and patient satisfaction declines slightly after mergers (Beaulieu et al. 2020). Another study of commercial hospital prices and consolidation finds that prices tend to increase faster in markets where consolidation increases (Health Care Cost Institute 2020b). A third study finds higher prices for hospital services in California markets with higher levels of concentration (California Healthcare Foundation 2019). Taken together, the preponderance

(continued next page)

Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care (cont.)

of evidence suggests that hospital consolidation leads to higher prices (Medicare Payment Advisory Commission 2020c).

From 2003 to 2017, the share of hospital markets that were “super” concentrated increased from 47 percent to 57 percent.⁵ Super-concentrated markets have a single dominant system that accounts for a majority of hospital discharges.

Consolidation of clinician practices has also increased. A study of available data found a steady increase between 2014 and 2018 in the number of mergers

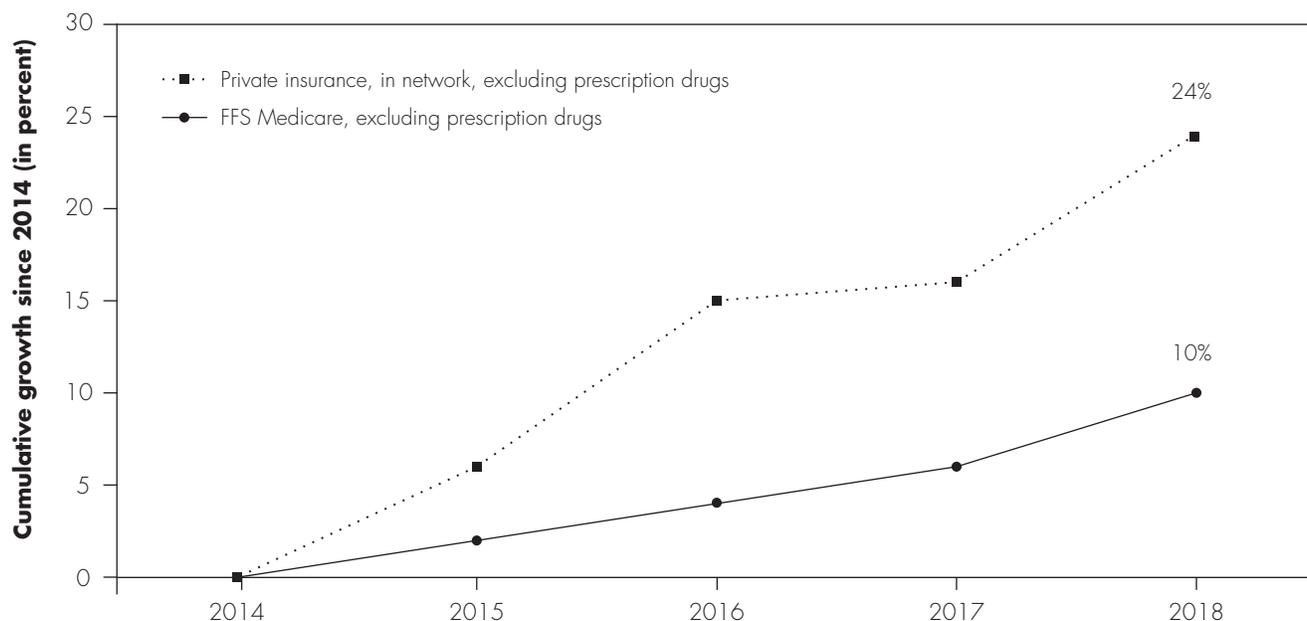
and acquisitions involving physician medical groups (62 such deals vs. 252 deals, respectively) (Irving Levin Associates Inc. 2019). The American Medical Association’s survey of physicians indicates that, over time, physicians have shifted from solo and small practices to larger practices (Kane 2015).

The number of physicians in “vertically consolidated” practices—hospital-acquired physician practices, physicians hired as salaried employees, or both—nearly doubled between 2007 and 2013 (Government Accountability Office 2015). And according to one

(continued next page)

FIGURE 1-3

Health care spending per enrollee has grown faster for the privately insured than for beneficiaries in traditional FFS Medicare, 2014–2018



Note: FFS (fee-for-service). The figure shows cumulative growth since 2014. It reflects payments to providers from health insurers and patients (i.e., cost sharing) but not payments from other sources (e.g., worker’s compensation or auto insurance). Spending on retail prescription drugs is not available for the privately insured, so it is excluded from both lines in this graph. Spending on out-of-network services for the privately insured is not available for that group and thus is not included in this graph. The figure reflects spending for individuals with full-year insurance coverage (including individuals with \$0 of health care spending). “Private insurance” reflects spending for individuals ages 18 to 64 in fully insured and self-insured plans (i.e., employer self-funded plans) contributed by national and regional plans and third-party administrators nationwide; it includes claims from individual and group plans as well as marketplace plans and Medicare Advantage plans for non-elderly disabled individuals.

Source: MedPAC analysis of Medicare’s Master Beneficiary Summary File; FAIR Health analysis of its National Private Insurance Claims database (which reflects 150 million covered lives) for the subset of enrollees ages 18 to 64.

Rapid price growth in the private sector has not affected Medicare beneficiaries' access to care (cont.)

recent study, by 2018, more than half of physicians and 72 percent of hospitals were affiliated with one of 637 vertically integrated health systems, with particularly fast growth in physician affiliations (Furukawa et al. 2020). The Federal Trade Commission observed that “providers increasingly pursue alternatives to traditional mergers such as affiliation arrangements, joint ventures, and partnerships, all of which could also have significant implications for competition” (Federal Trade Commission 2016b). After controlling for the level of horizontal concentration of physician services, three recent studies found that hospital–physician integration led to commercial price increases of 3 percent to 14 percent (Capps et al. 2018, Medicare Payment Advisory Commission 2017, Neprash et al. 2015).

The Commission is concerned that market concentration effects will lead to higher Medicare spending if commercial prices are “imported” into Medicare. The Commission has tried to counteract these effects by recommending restrained payment updates and site-neutral payments (paying the same for a service regardless of the setting of care). But over time, private sector trends may influence Medicare trends. If the private sector is unable to constrain price growth, the profitability of caring for commercially insured patients will increase relative to the profitability of caring for Medicare beneficiaries. Eventually, the difference between commercial rates

and Medicare rates could grow so large that hospitals have an incentive to focus primarily on patients with commercial insurance, which could create pressure to increase Medicare’s payment rates. It is also possible that higher private prices enabled by consolidation could prompt providers to increase their costs; if Medicare payment rates do not keep pace with these higher costs, then Medicare beneficiaries’ access to care could become threatened. Thus, in the long term, Medicare beneficiaries’ access to care may in part depend on commercial payers restraining rates paid to hospitals (Medicare Payment Advisory Commission 2009, Stensland et al. 2010, White and Wu 2014).

Notwithstanding the higher payment rates often available from commercial insurers, the vast majority of clinicians continue to participate in the Medicare program. The number of clinicians who have opted out of Medicare (26,000 clinicians as of October 2020) is overwhelmingly outweighed by the number still in the program (almost 1.3 million clinicians in 2019). The majority of opted-out clinicians are behavioral health providers and dentists. In addition, although nonparticipating clinicians are permitted to balance-bill beneficiaries for higher copayments than Medicare’s usual payment rates, it is extremely rare for clinicians to do so. The Commission closely monitors the numbers of clinicians who have opted out of the program or become nonparticipants each year, and it will continue to do so in the future. ■

To keep the HI Trust Fund solvent over the next 25 years, the Trustees estimate that either the payroll tax would need to be increased immediately from its current rate of 2.9 percent to 3.7 percent or Part A spending would need to be permanently reduced by 17 percent (Table 1-2, p. 17), which is equivalent to about \$62 billion in 2021, and comparable amounts in subsequent years (Boards of Trustees 2020).⁶ The Commission regularly makes recommendations to the Congress that would change Medicare’s spending trajectory, but these recommendations typically achieve much smaller savings.

For example, the recommendations in the Commission’s March and June 2020 reports would decrease Medicare spending by a total of between \$7 billion and \$12.5 billion in their first year of implementation.⁷

The HI Trust Fund is a major financing mechanism for the Medicare program, but it covers less than half of Medicare spending (41 percent in 2019), and that share is declining (Figure 1-6, p. 17).

The rest of Medicare benefit spending, under Part B and Part D, is covered by the Supplementary Medical

FIGURE 1-4

Medicare enrollment is rising while number of workers per beneficiary is declining

Figure 1-4a. Medicare enrollment

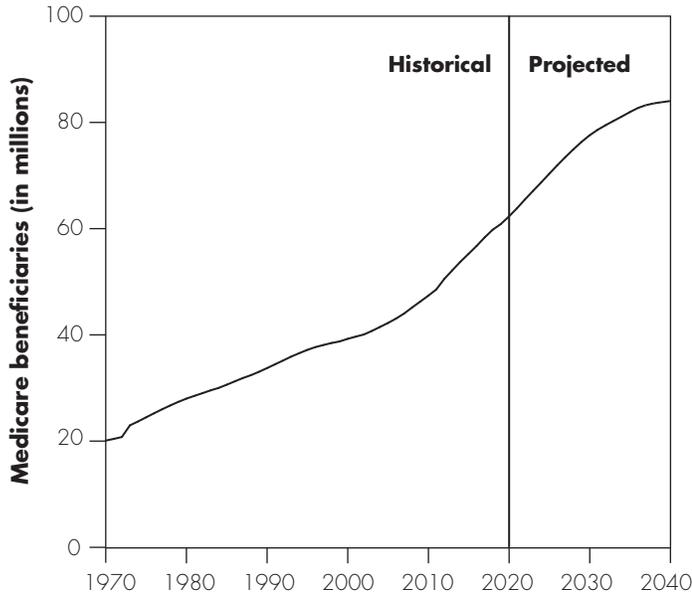
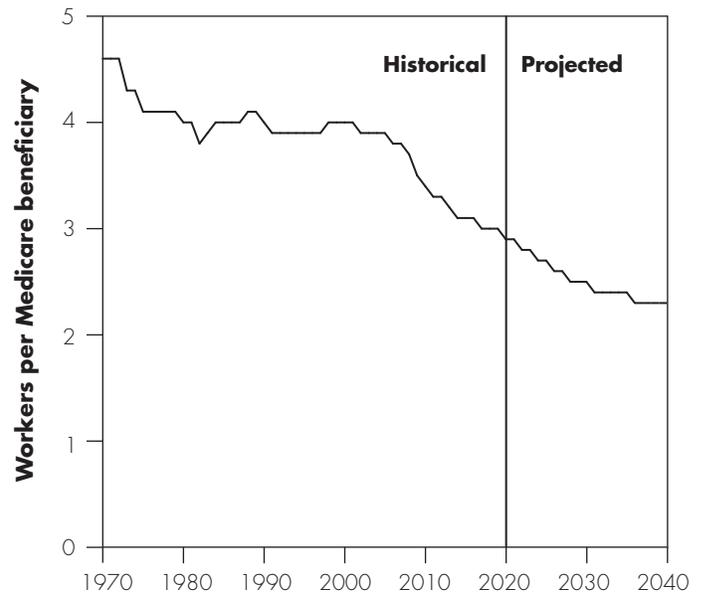


Figure 1-4b. Workers per beneficiary

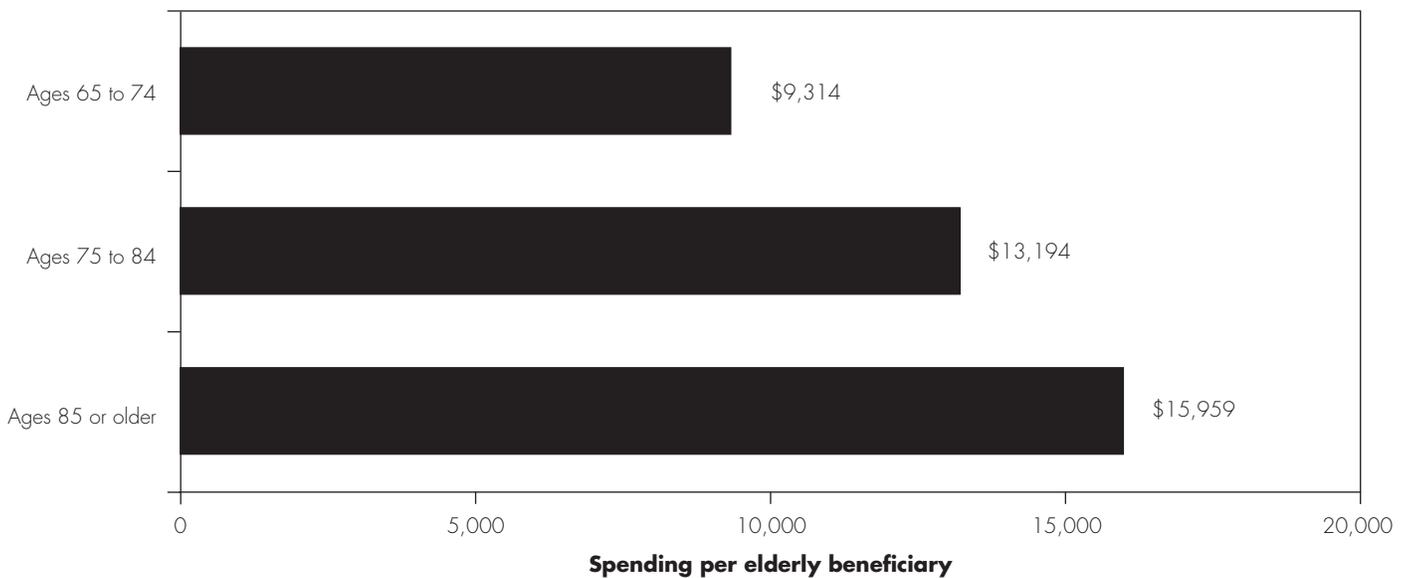


Note: “Beneficiaries” referenced in these graphs are beneficiaries enrolled in Medicare Part A (including beneficiaries in Medicare Advantage). Part A is financed by Medicare’s Hospital Insurance Trust Fund. The potential effects of the coronavirus pandemic are not included in these projections.

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

FIGURE 1-5

Spending per elderly beneficiary varied by age, 2017



Note: Includes beneficiaries in traditional Medicare and Medicare Advantage dwelling in the community and in institutions. Spending per beneficiary for non-elderly enrollees (who are eligible for Medicare due to end-stage renal disease or disability) was \$15,879 (not shown above).

Source: MedPAC analysis of the Medicare Current Beneficiary Survey, Cost Supplement file, 2017.

**TABLE
1-2**

Increases to payroll tax or decreases in Part A spending needed to maintain HI Trust Fund solvency for certain time periods

To maintain HI Trust Fund solvency for:	Increase 2.9% payroll tax to:	Or decrease Part A spending by:
25 years (2020–2044)	3.67%	17.1%
50 years (2020–2069)	3.71	17.3
75 years (2020–2094)	3.66	16.0

Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A. The potential effects of the coronavirus pandemic are not included in these projections.

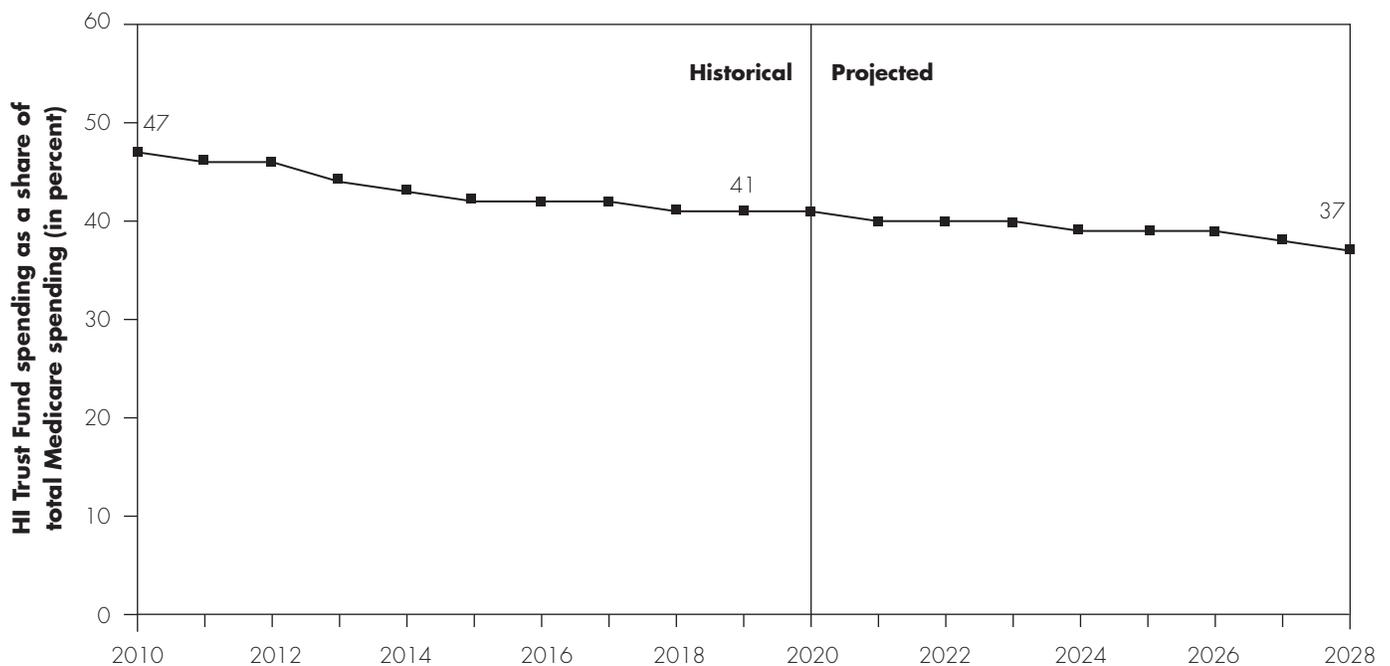
Source: MedPAC calculations based on Table III.B8 in the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

Insurance (SMI) Trust Fund. The SMI Trust Fund is not funded through dedicated taxes like the HI Trust Fund, but by premiums paid by beneficiaries and transfers from the general fund of the Treasury.⁸ Since premiums and transfers are set to grow at the same rate as Part B

and Part D spending, the SMI Trust Fund automatically remains solvent. However, as Part B and Part D spending rises, so do premiums and transfers from the Treasury—increasing deficits, the debt, and the strain on household budgets both of workers and retirees (Figure 1-7, p. 18).

**FIGURE
1-6**

The HI Trust Fund covers a declining share of total Medicare spending

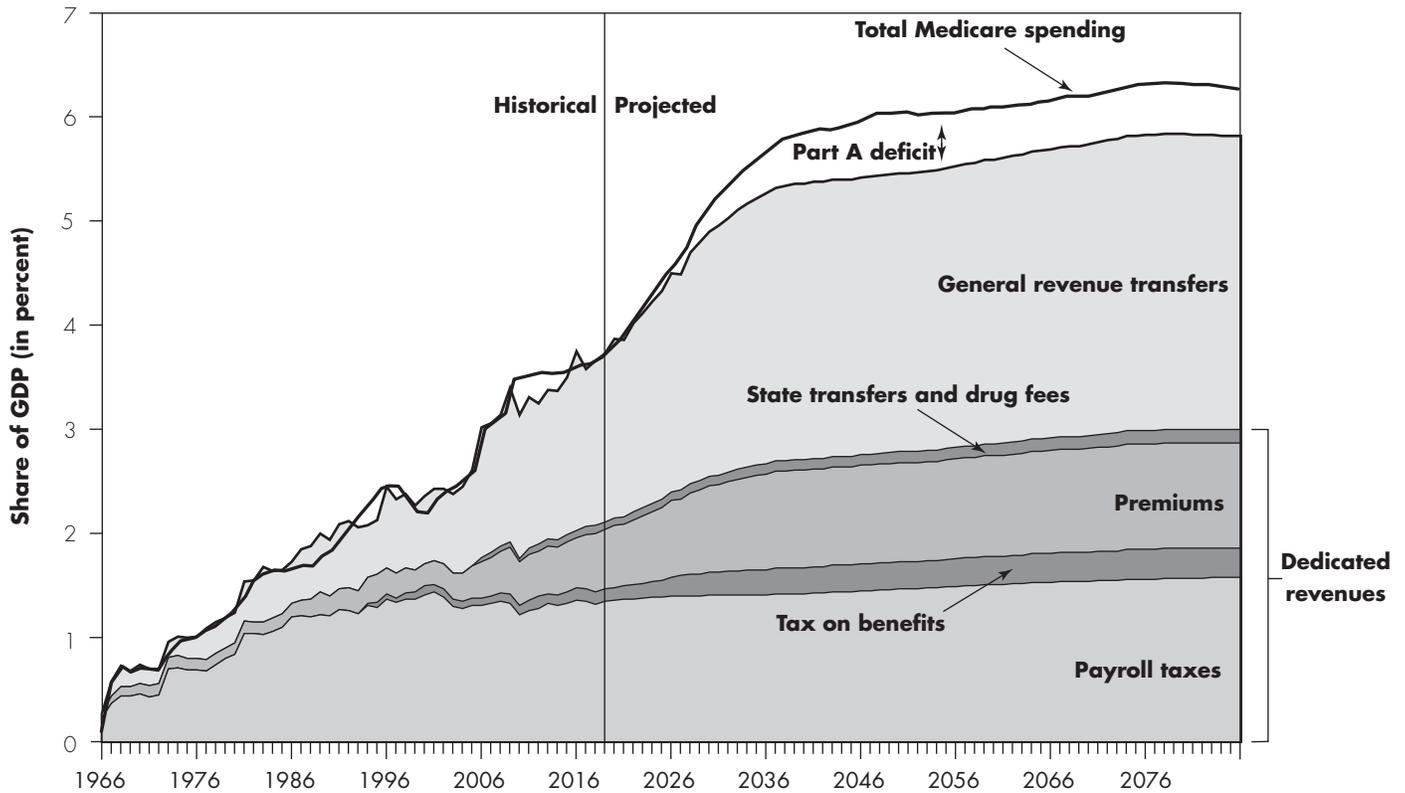


Note: HI (Hospital Insurance). Under intermediate assumptions. HI is also known as Medicare Part A. The rest of Medicare spending (Part B and Part D) is paid for through the Supplementary Medical Insurance Trust Fund. The potential effects of the coronavirus pandemic are not included in these projections.

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

**FIGURE
1-7**

**General revenues have overtaken Medicare payroll taxes
as the largest source of Medicare funding**



Note: GDP (gross domestic product). These projections are based on the Trustees' intermediate set of assumptions and do not reflect the potential effects of the coronavirus pandemic. "Tax on benefits" refers to the portion of income taxes that higher income individuals pay on Social Security benefits, which is designated for Medicare. "State transfers" (often called the Part D "clawback") refers to payments from the states to Medicare, required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, for assuming primary responsibility for prescription drug spending. "Drug fees" refers to the fee imposed by the Affordable Care Act on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance Trust Fund.

Source: 2020 annual report of the Boards of Trustees of the Medicare trust funds.

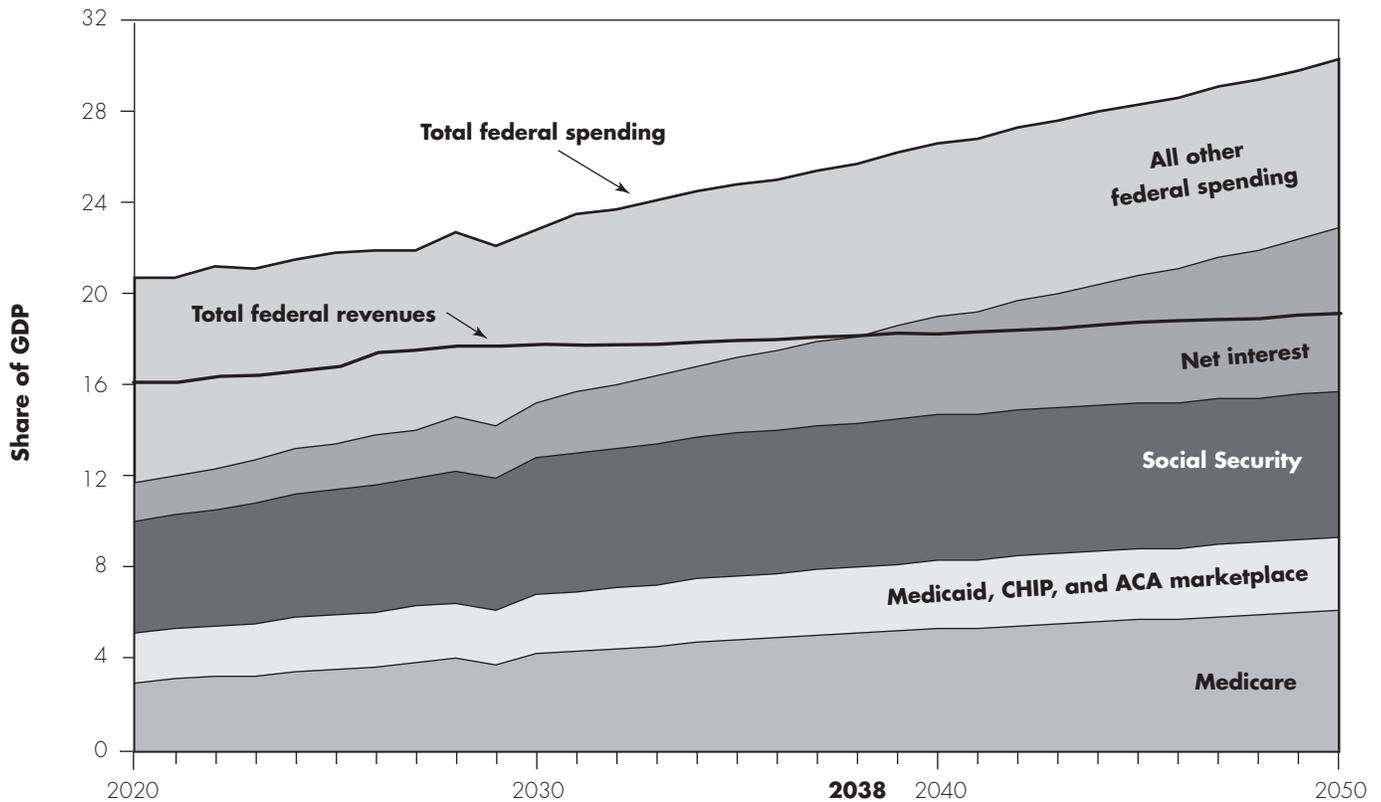
The large and growing share of Medicare spending funded through general revenues is a financing challenge. In 2019, general revenues accounted for 43 percent of Medicare funding and, under current law, are projected to grow to 47 percent by 2029. In this context, general revenues include both general tax revenue as well as federal borrowing. As the amount of general revenues needed to finance Medicare increases, it reduces resources available for other priorities, including making investments that expand future

economic output (e.g., federal investments in education, transportation, and research and development).

The increasing expenditure of general revenues is a looming problem because the federal government already spends more than it collects in revenues each year. The line at the top of Figure 1-8 represents total federal spending as a share of GDP; the line below spending represents total federal revenues (all estimated before the effects of the coronavirus pandemic). The difference between these two

FIGURE 1-8

Spending on Medicare, other major health programs, Social Security, and net interest is projected to exceed total federal revenues by 2038



Note: GDP (gross domestic product), CHIP (Children’s Health Insurance Program), ACA (Affordable Care Act). The potential effects of the coronavirus pandemic are not included in these projections.

Source: Congressional Budget Office’s *Long-Term Budget Projections* (published January 2020).

lines represents the budget deficit, which must be covered by federal borrowing. The layers below the top line in Figure 1-8 depict federal spending by program. Assuming no other policy or legislative interventions, spending on Medicare, the other mandatory programs shown in the figure, and net interest payments are projected to reach 18.3 percent of the nation’s GDP by 2038 and, by themselves, will exceed total federal revenues.⁹ In other words, by 2038, every dollar spent on programs funded through annual discretionary appropriations—such as the military, the national highway system, and air traffic control, just to name a few—would need to be financed through federal borrowing. That date may change (likely

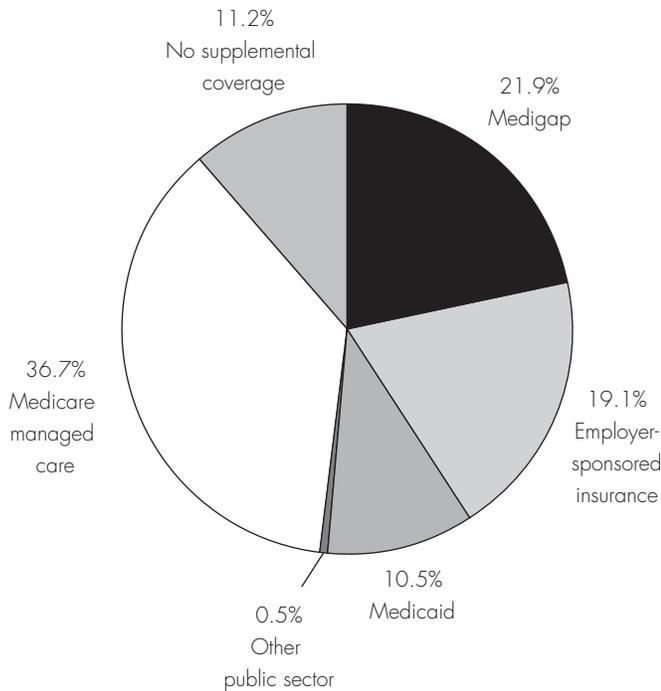
becoming sooner) once the impact of pandemic-related spending and revenue declines are included.

The affordability of health care for Medicare beneficiaries

As Medicare spending increases, it affects beneficiaries’ ability to afford health care—by increasing their premiums (and to a lesser extent, their cost sharing, which many beneficiaries are shielded from). Beneficiaries typically do not pay premiums for Part A (hospital insurance)

FIGURE 1-9

Most Medicare beneficiaries had supplemental coverage or were enrolled in a Medicare Advantage plan that reduced their cost sharing, 2017



Note: Beneficiaries were assigned to the supplemental coverage category they were in for the most time in 2017; they could have had coverage in other categories during 2017. Analysis does not include beneficiaries living in institutions such as nursing homes. It excludes beneficiaries who were not in both Part A and Part B throughout their enrollment in 2017 or who had Medicare as a secondary payer. Figure represents 47.4 million beneficiaries. Components may not sum to 100 percent due to rounding.

Source: MedPAC analysis of Medicare Current Beneficiary Survey, survey file 2017.

coverage, but the annual cost of Part B (supplementary medical insurance) premiums is \$1,735 in 2020, and the average annual cost of Part D (drug plan) premiums is \$456 (Medicare Payment Advisory Commission 2020a). In addition, in 2018, cost sharing for beneficiaries in traditional Medicare averaged \$415 for Part A services, \$1,513 for Part B services, and \$432 for beneficiaries with Part D coverage (although supplemental plans can cover beneficiaries' cost sharing). Taken together, beneficiary spending on Medicare premiums and cost sharing consumed 24 percent of the average Social Security benefit in 2020, up from 14 percent in 2000

(Boards of Trustees 2020). (These percentages do not include beneficiary spending on premiums for Medicare supplemental insurance.) The Medicare Trustees estimate that in another 20 years, premiums and cost sharing will consume 31 percent of the average Social Security benefit. (As a point of reference, Social Security benefits account for more than 60 percent of income for seniors, on average, and for 100 percent of income for more than a fifth of seniors (Social Security Administration 2016).)

Medicare uses beneficiary cost sharing, in part, to deter overuse of services. However, the effectiveness of this mechanism for discouraging unnecessary care is blunted by the fact that most beneficiaries have supplemental coverage that pays some or all of their cost sharing (Figure 1-9). Specifically, 22 percent of beneficiaries have traditional Medicare plus supplemental insurance that they purchase from private companies (Medigap plans).¹⁰ About 37 percent of beneficiaries enroll in private MA plans or some other Medicare managed care plan.¹¹ Another 19 percent are insured through employer-sponsored retiree health plans that are subsidized by Medicare. And 10.5 percent of Medicare beneficiaries are dually enrolled in both Medicare and Medicaid due to low income and resources. Only 11 percent of Medicare beneficiaries are in traditional Medicare without any other type of coverage.

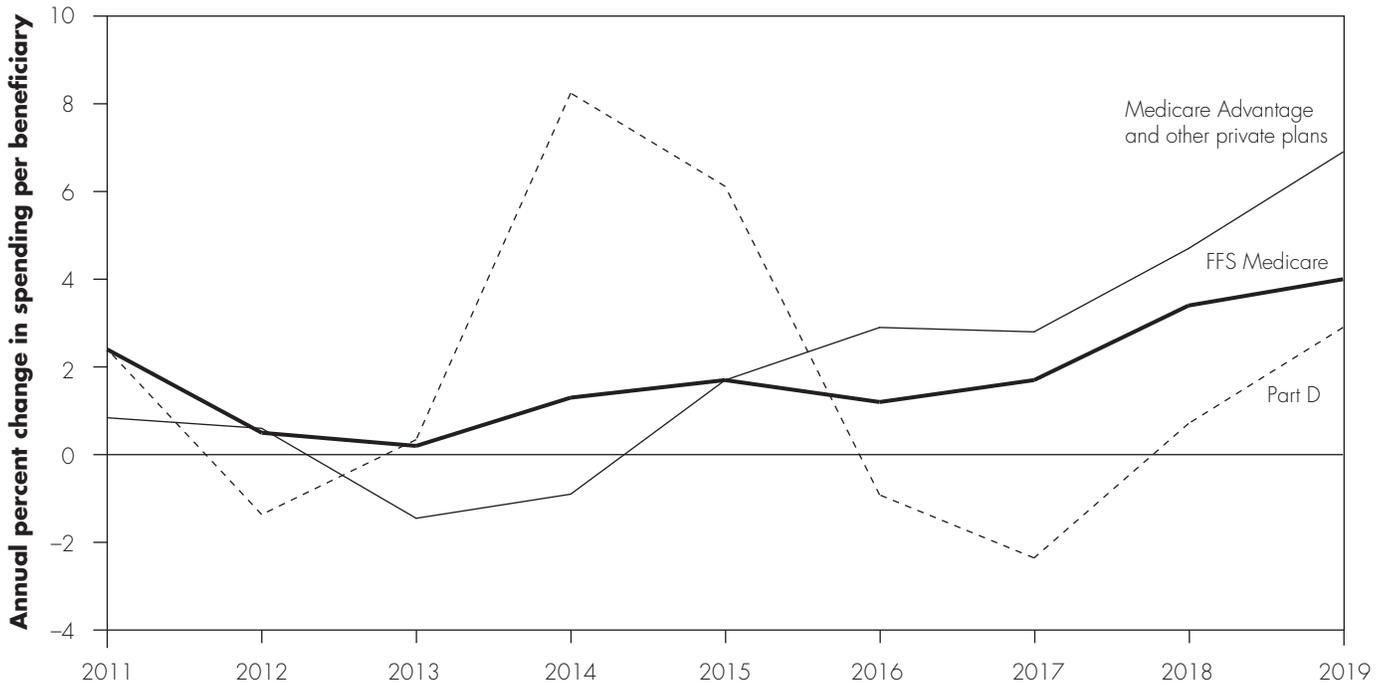
Medicare spending trends

Medicare spending can be divided into three program components: traditional Medicare, Medicare Advantage (MA), and Medicare Part D prescription drug coverage.

- **Traditional Medicare.** In the traditional fee-for-service (FFS) Medicare program, Medicare pays health care providers directly for health care goods and services furnished to Medicare beneficiaries at prices set through legislation and regulation. In 2019, about 38 million beneficiaries had coverage through traditional Medicare, at a cost of \$414 billion (Boards of Trustees 2020).¹²
- **MA and other types of private plans.** Beneficiaries can choose, as an alternative to traditional Medicare, to enroll in MA, which consists of private health plans that receive capitated payments per enrollee to provide Part A and Part B coverage. MA plans pay health care providers for health care goods and services furnished

**FIGURE
1-10**

Since 2016, spending per beneficiary on Medicare Advantage and other private plans has grown faster than other Medicare components



Note: FFS (fee-for-service), Medicare Advantage (MA). Percent change is calculated using annual spending on an incurred basis that is not risk standardized. Private plans include Medicare Advantage plans, Medicare–Medicaid Plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. Spending per beneficiary on Medicare Advantage and other private plans is calculated by summing Part A spending on private health plans and Part B spending on private health plans, then dividing that by the number of enrollees in private health plans. FFS Medicare spending per beneficiary is calculated by summing (1) Part A FFS spending divided by Part A FFS enrollees and (2) Part B FFS spending divided by Part B FFS enrollees. Part D is calculated by taking total Part D spending, subtracting premiums (mostly paid by enrollees), then dividing that by the number of enrollees in Part D.

Source: MedPAC analysis of data from the 2020 annual report of the Boards of Trustees of the Medicare trust funds.

to their enrollees at prices negotiated between the plans and providers, using FFS payment approaches or other payment models such as partial capitation. MA is funded through a combination of the Hospital Insurance (Part A) Trust Fund and the Supplementary Medical Insurance (Part B) Trust Fund, just like traditional Medicare. In addition to MA, there are other types of private health plans available to Medicare beneficiaries: Medicare–Medicaid Plans, Program of All-Inclusive Care for the Elderly (PACE) plans, and cost-based (as opposed to capitated) plans. Only about 6 percent of the beneficiaries in private plans are in non-MA plans. In 2019, Medicare spent \$271 billion on MA and other types of private plans

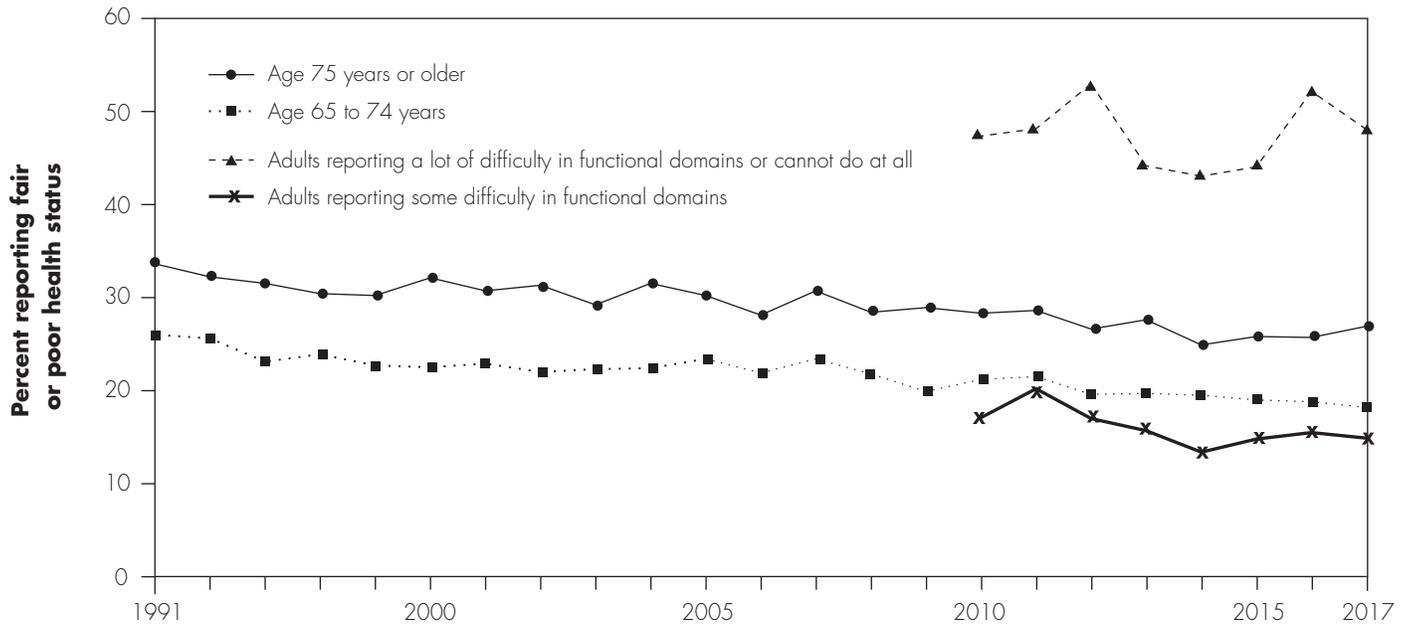
for about 23 million beneficiaries (Boards of Trustees 2020).¹³

- **Medicare Part D prescription drug coverage.** Through Part D, beneficiaries can obtain subsidized prescription drug coverage from private insurers by purchasing a stand-alone drug plan or by enrolling in an MA plan that includes prescription drug coverage. In 2019, Medicare spent \$88 billion on Part D coverage for 47 million beneficiaries (Boards of Trustees 2020).

Growth in spending per beneficiary differs across the three program components (Figure 1-10).¹⁴ Since 2016, spending per beneficiary (not risk standardized)

**FIGURE
1-11**

The share of Medicare eligibles reporting fair or poor health status has changed over time, available years 1991-2017



Note: “Adults reporting a lot of difficulty in functional domains or cannot do at all” and “Adults reporting some difficulty in functional domains” include people 18 years and older who report one or more of the following six functional limitations: seeing (even if wearing glasses), hearing (even if wearing hearing aids), mobility (walking or climbing stairs), communication (understanding or being understood by others), cognition (remembering or concentrating), and self-care (such as washing all over or dressing). These measures of functional limitations among adults 18 years and older did not begin being reported until 2010.

Source: National Center for Health Statistics, National Health Interview Survey.

in MA and other private plans has grown faster than in traditional FFS Medicare and Part D. From 2018 to 2019 alone, Medicare private plan spending per beneficiary increased by 6.9 percent, compared with 4.0 percent in FFS Medicare and 2.9 percent in Part D. The relatively faster growth in private plan spending per beneficiary in recent years at least partially reflects MA demographic changes, the increasing number of MA plans receiving higher payments due to their quality bonus status, growth in the risk scores MA plans report for their enrollees, and Medicare enrollment growth in areas of the country where MA payment benchmarks are set at 115 percent of FFS Medicare’s spending per beneficiary (Medicare Payment Advisory Commission 2020b, Medicare Payment Advisory Commission 2020c, Medicare Payment Advisory Commission 2018).

Trends in Medicare beneficiaries’ morbidity and mortality

In recent decades, a declining share of Medicare eligibles report being in poor health. Between 1991 and 2017, the share of people ages 65 to 74 reporting fair or poor health status declined from 26 percent to 18 percent (Figure 1-11). The share of people ages 75 and older reporting fair or poor health status also declined, from 34 percent to 27 percent. Among adults of any age who report “some” difficulty in functional domains (and thus may serve as a proxy for beneficiaries who qualify for Medicare due to disability or end-stage renal disease), the share reporting fair or poor health status has declined modestly from 2010 to 2017 (declining from 17 percent to 15 percent). Among adults who report “a lot” of difficulty in functional

**TABLE
1-3**

Leading causes of death at ages 65 and older, 1980 and 2017

Table 1-3a. Leading causes of death at ages 65 and older, 1980

Cause of death	Share of deaths
1. Heart disease	44.4%
2. Cancer	19.3
3. Stroke	10.9
4. Pneumonia and influenza	3.4
5. Chronic lower respiratory diseases	3.2
6. Atherosclerosis	2.1
7. Diabetes mellitus	1.9
8. Unintentional injuries	1.9
9. Nephritis, nephrotic syndrome, and nephrosis	1.0
10. Chronic liver disease and cirrhosis	0.7

Table 1-3b. Leading causes of death at ages 65 and older, 2017

Cause of death	Share of deaths
1. Heart disease	25.1%
2. Cancer	20.7
3. Chronic lower respiratory diseases	6.6
4. Stroke	6.1
5. Alzheimer’s disease	5.8
6. Diabetes mellitus	2.9
7. Unintentional injuries	2.7
8. Pneumonia and influenza	2.3
9. Nephritis, nephrotic syndrome, and nephrosis	2.0
10. Sepsis	1.5

Note: “Chronic lower respiratory diseases” was formerly known as “chronic obstructive pulmonary diseases.” Starting with 1999 data, the rules for selecting “chronic lower respiratory diseases” and “pneumonia” as the underlying cause of death changed, resulting in an increase in the number of deaths for chronic lower respiratory diseases and a decrease in the number of deaths for pneumonia. Therefore, trend data for these two causes of death should be interpreted with caution. Also, starting with 2011 data, the rules for selecting renal failure as the underlying cause of death were changed, affecting the number of deaths in the “nephritis, nephrotic syndrome, and nephrosis” and “diabetes mellitus” categories. The result is a decrease in the number of deaths attributed to nephritis, nephrotic syndrome, and nephrosis, and an increase in the number of deaths attributed to diabetes mellitus. Therefore, trend data for these two causes of death should also be interpreted with caution.

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System. <https://www.cdc.gov/nchs/hus/contents2018.htm>.

domains or not being able to perform them at all, 48 percent reported fair or poor health both in 2010 and 2017.

Declines in the share of people reporting fair or poor health occurred despite rising shares of people ages 65 and older having chronic conditions such as diabetes, hypertension, and high cholesterol—perhaps because these increases have coincided with increases in the share of people who have such conditions under control (Federal Interagency Forum on Aging-Related Statistics 2016, National Center for Health Statistics 2015). (Comparable information for the Medicare population under age 65 is not readily available.)

Leading causes of death

Over the past few decades, there has been little change in the leading causes of death in the U.S., with heart disease and cancer remaining the first and second leading causes of death (Table 1-3)—except in the spring and winter of 2020, when COVID-19 overtook them (Cox and Amin 2021, Hoyert 2012, National Center for Health Statistics 2018, Woolf et al. 2020a).

Some of the leading causes of death are also the most prevalent and most expensive chronic conditions among beneficiaries in traditional Medicare (Table 1-4, p. 24)—for example, heart disease (which can lead to heart failure).

Disparities among Medicare beneficiaries

Race and ethnicity are associated with variations in life expectancy. Among individuals who live to age 65, Black individuals can expect to live an additional 18 years, while White individuals can expect an additional 19 years, and Hispanic individuals can expect another 21 years (Table 1-5, p. 25).

Race and ethnicity are also associated with differences in access to care. In the Commission’s 2020 telephone survey, smaller shares of Black beneficiaries reported looking for a new specialist in the past year (9 percent) compared with White beneficiaries (15 percent), and markedly higher shares of Black beneficiaries reported experiencing “a small problem” finding a new specialist compared with White beneficiaries (22 percent vs.

**TABLE
1-4**

The most prevalent and costly chronic conditions in traditional FFS Medicare, 2018

Chronic condition	Prevalence among beneficiaries in traditional Medicare	Spending per beneficiary for those with the specified condition
Five chronic conditions most prevalent among beneficiaries in traditional Medicare:		
Hypertension	58.8%	\$15,514
Hyperlipidemia	49.1	14,970
Rheumatoid arthritis / osteoarthritis	34.7	16,890
Diabetes	27.7	17,380
Ischemic heart disease	27.7	21,138
Five chronic conditions with highest spending per beneficiary in traditional Medicare:		
Stroke / transient ischemic attack	3.9	34,627
Heart failure	14.5	30,940
Hepatitis (chronic viral B and C)	N/A	28,015
Chronic obstructive pulmonary disease	11.9	27,255
Atrial fibrillation	8.7	27,124

Note: FFS (fee-for-service), N/A (not available). Beneficiaries may be counted in more than one chronic condition category. The information should not be used to attribute utilization or payments strictly to the specific condition selected because beneficiaries with any of the specific conditions presented could have other health conditions that contribute to their Medicare utilization and spending amounts. Spending per beneficiary is actual spending, as opposed to standardized spending.

Source: Centers for Medicare & Medicaid Services' Chronic Condition Data Warehouse. <https://www2.ccwdata.org/documents/10280/19096644/ccw-website-table-b2a.pdf>; https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/CC_Main.

8 percent). Among those beneficiaries seeking an appointment for routine care, higher shares of Hispanic beneficiaries reported waiting longer than they wanted to get such appointments (35 percent) compared with White beneficiaries (27 percent). Similarly, among those beneficiaries seeking an appointment for an illness or injury, 24 percent of Hispanic beneficiaries reported waiting longer than they wanted for such appointments, compared to only 18 percent of White beneficiaries. Given these trends, it is perhaps not surprising that lower shares of Hispanic beneficiaries reported being satisfied with their health care, compared with White beneficiaries (83 percent vs. 89 percent). All of these trends were also observed among privately insured individuals age 50 to 64, who were also included in this survey.

Differences by race and ethnicity in the level of care coordination have also been found. One study found that

fewer non-White beneficiaries reported that their doctor helped manage their care and had up-to-date information on care they had received from specialists compared with White beneficiaries. The study also found that higher shares of non-White beneficiaries reported difficulty getting timely follow-up on test results (Martino et al. 2016).

Alternative payment models incentivize clinicians to deliver care more efficiently

One way traditional FFS Medicare has attempted to slow the growth in its spending is through alternative payment models (APMs). APMs are intended to give providers financial incentives to deliver care efficiently, to counteract FFS payment systems' incentives to maximize the volume

**TABLE
1-5**

Years of life expectancy at age 65, by race/ethnicity and sex, 2008 to 2017

	2008	2016	2017	Change 2008-2017 (in years)	Change 2016-2017 (in years)
All races and ethnicities, both sexes	18.8	19.4	19.4	0.6	0
White, not Hispanic, both sexes	18.8	19.4	19.3	0.5	-0.1
Black, not Hispanic, both sexes	17.4	18.1	18.1	0.7	0
Hispanic, both sexes	20.4	21.5	21.4	1.0	-0.1
All races and ethnicities, female	20.0	20.6	20.6	0.6	0
White, not Hispanic, female	20.0	20.5	20.5	0.5	0
Black, not Hispanic, female	18.8	19.5	19.5	0.7	0
Hispanic, female	21.6	22.7	22.7	1.1	0
All races and ethnicities, male	17.4	18.1	18.1	0.7	0
White, not Hispanic, male	17.4	18.0	18.0	0.6	0
Black, not Hispanic, male	15.4	16.2	16.2	0.8	0
Hispanic, male	18.7	19.8	19.7	1.0	-0.1

Source: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

of services provided. APMs are often layered on top of traditional Medicare’s FFS payment systems and are intended to give participating providers incentives to avoid low-value services, select more efficient sites of care, and possibly invest in closer management and coordination of their Medicare beneficiaries’ care to reduce their need for costly types of services (e.g., hospital care). Other payers besides FFS Medicare are also experimenting with APMs to pay the providers in their networks.

The most prominent types of APMs are population-based payment models (e.g., accountable care organizations), episode-based payment models, and advanced primary care models. In population-based payment models and episode-based payment models, CMS offers participating providers bonuses (and in some models, collects financial penalties) based on the degree to which providers can keep beneficiaries’ spending below a target while maintaining care quality. Advanced primary care models typically offer primary care providers supplemental monthly payments per beneficiary to expand the breadth and depth of services they offer and pay bonuses based on performance on quality measures (e.g., beneficiaries’ rates of hospital utilization).

Most APMs are piloted in different parts of the country for three to six years at a time. Models are evaluated by researchers, and CMS uses findings from these evaluations to develop successor APMs that build on lessons learned. CMS is allowed to make permanent any APMs that save Medicare money while maintaining quality or that improve quality without increasing spending. Evidence analyzing the impact of APMs is still emerging, and APM impacts, even when positive, have been modest. Some types of APMs (population-based models and episode-based payment models for some conditions) have performed better than others. Despite modest effects to date, the Commission believes APMs hold great promise and is currently exploring potential improvements to APMs that could increase their success rate.

The Commission’s recommendations for restraining Medicare spending growth

Several aspects of Medicare’s payment systems hamper the program’s ability to maximize efficiencies. The Commission highlights some of Medicare’s key payment

policy challenges and recommends ways to address them below.

MEDICARE CHALLENGE: Medicare pays higher prices in some care settings than in others—for the same service. Because of the different payment systems used for different care settings, Medicare in some cases has different payment rates for the same or similar services. Under these circumstances, providers have an incentive to shift care to the more profitable setting, which leads to increased program spending and higher beneficiary cost sharing, often without any corresponding increase in quality.

- **COMMISSION RECOMMENDATIONS: Make payments site neutral.** The Commission supports equalizing payments when the same services are delivered in different care settings. In this regard, the Commission has made these recommendations:
 - **March 2012 and March 2014**—Medicare should reduce or eliminate differences between hospital outpatient departments (HOPDs) and physician offices in payment rates for evaluation and management office visits and selected other services. (This recommendation was partially implemented: The Congress required CMS to reduce payment rates for HOPD services provided at off-campus HOPDs that began billing Medicare on or after November 2, 2015.)
 - **March 2014**—Medicare should set long-term care hospital base payment rates for non-chronically critically ill cases equal to those of acute care hospitals and redistribute the savings to create additional inpatient outlier payments for chronically critically ill cases treated in inpatient prospective payment system hospitals. (In 2013, the Congress directed CMS to pay the standard long-term care hospital payment rate for certain beneficiaries and lower payments for beneficiaries with lower severity illnesses; this policy was phased in starting in 2016 and will be fully in effect after the coronavirus public health emergency ends.)
 - **March 2015**—Medicare should eliminate the differences in payment rates between inpatient rehabilitation facilities and skilled nursing facilities for selected conditions.

MEDICARE CHALLENGE: Medicare undervalues primary care and overvalues specialty care. In the process of setting rates for thousands of physician fee schedule services, certain services are undervalued relative to others, which creates financial incentives to provide some services more than others. For example, the Commission has long raised concerns that the fee schedule overpays for services provided by clinicians in procedural specialties and underpays for services provided by clinicians in primary care specialties (Medicare Payment Advisory Commission 2011). This imbalance leads to significantly higher incomes for clinicians in procedural specialties relative to those in primary care specialties, which contributes to a corresponding imbalance in the clinician supply. Starting in 2021, fee schedule payment rates will rise for evaluation and management office and outpatient visits (commonly provided by primary care clinicians), which will begin to address this imbalance. However, more can be done to improve the accuracy of the fee schedule and further rebalance the fee schedule toward primary care.

- **COMMISSION RECOMMENDATIONS: Improve the accuracy of payments and increase payments to primary care providers.** In this regard, the Commission has made these recommendations:
 - **October 2011**—Regularly collect data from a cohort of efficient practices to establish more accurate relative value units (RVUs) for physician fee schedule services. Use this information to identify overpriced services and reduce their RVUs. The Congress should also specify an annual numeric goal for RVU reductions. (This recommendation was partially implemented: The Congress specified an annual numeric target for reductions to the RVUs of overpriced services, which expired at the end of 2018.)
 - **March 2015**—Establish a prospective payment per beneficiary for primary care practitioners, funded by reducing fees for non-primary care services in the fee schedule.

MEDICARE CHALLENGE: Providers have financial incentives to selectively treat some patients over others and furnish certain types of services, regardless of clinical value. Another consequence of Medicare’s payment structure is its vulnerability to providers admitting patients with certain care needs

because they are more profitable to treat than others. For example, until the skilled nursing facility and home health agency payment systems were revised, it was financially advantageous for providers to admit patients with rehabilitation care needs (and to furnish more, rather than less, therapy) and avoid medically complex patients.

- **COMMISSION RECOMMENDATIONS: Reduce incentives to treat certain types of patients and to furnish certain types of services.** In this regard, the Commission has made these recommendations:
 - *March 2008 (and subsequent years)*—Revise the prospective payment system for skilled nursing facilities to reduce incentives to treat rehabilitation patients over medically complex patients. (This recommendation has been implemented.)
 - *March 2011 (and subsequent years)*—Revise the prospective payment system for home health agencies to eliminate the use of the number of therapy visits as a factor in payment determination. (This recommendation has been implemented.)
 - *March 2016*—Expand the inpatient rehabilitation facility outlier pool to redistribute payments more equitably, to ease the financial burden for facilities that have a relatively high share of costly cases.
 - *June 2016*—Implement a unified prospective payment system for post-acute care (in place of the separate payment systems for skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) that would base payments on patient characteristics, not the setting of care or the amount of therapy furnished to patients.

MEDICARE CHALLENGE: Spending on drugs is growing rapidly. Hospitals that participate in the 340B Drug Pricing Program qualify for deeply discounted prices from drug manufacturers, while historically, Medicare payments for Part B drugs have substantially exceeded 340B hospitals’ drug acquisition costs. The Commission is also concerned about the overall price Medicare Part B pays for drugs that are administered by infusion or injection in physicians’ offices and hospital outpatient departments and the lack of price competition among drugs with similar health effects. In addition, over time, changes to Medicare Part D’s benefit design combined

with trends in prescription drug pricing and spending have eroded plan sponsors’ incentives to control costs.

- **COMMISSION RECOMMENDATIONS: Strengthen Medicare’s payment systems to address rising drug prices and costs.** In this regard, the Commission has made these recommendations:
 - *March 2016*—Medicare should reduce payment rates for 340B hospitals’ separately payable 340B drugs by 10 percent of the average sales price (ASP) and direct these program savings to hospitals with high uncompensated care costs. (In 2018, CMS reduced payment rates for some Part B drugs furnished by 340B hospitals.)
 - *June 2017*—Medicare should improve Part B drug payment in the short term by spurring competition, protecting Medicare beneficiaries and taxpayers from substantial price increases over time for individual drug products, and improving the accuracy of CMS’s drug prices. Specifically, the Commission recommended that CMS:
 - Require manufacturers of Part B drugs to report ASP data and impose civil monetary penalties for failure to report. (Noting the Commission’s concerns about manufacturers not reporting ASP data for Part B drugs, as of 2020, CMS conditioned the payment of a transitional drug add-on payment under the Part B end-stage renal disease prospective payment system on the availability of ASP data for the drug in question.)
 - Implement an ASP inflation rebate as protection against the potential for rapid price increases by manufacturers.
 - Use consolidated billing codes to pay for Part B products with a reference biologic and its associated biosimilars to spur price competition.
 - *June 2017*—Medicare should improve Part B drug payment in the long term by creating a voluntary market-based alternative to the current average sales price payment system: the Part B Drug Value Program (DVP). The DVP’s intent is to obtain lower prices for Part B drugs by permitting private vendors to negotiate prices

with manufacturers and by improving incentives for provider efficiency through shared savings opportunities. Specifically, the Commission recommended that:

- Medicare contract with a small number of private vendors to negotiate prices for Part B drugs and biologicals.
- Vendors use tools including a formulary and, for products meeting selected criteria, binding arbitration.
- Providers purchase all DVP products at the price negotiated by their selected DVP vendor.
- Medicare pay providers the DVP-negotiated price and pay vendors an administrative fee, with opportunities for shared savings.
- Medicare payments under the DVP not exceed 100 percent of average sales price.
- **June 2020**—Medicare should restructure Part D’s benefit and its subsidies to restore the role of risk-based, capitated payments and improve pricing incentives faced by biopharmaceutical manufacturers. Specifically, the Commission recommended changes that would create a standard benefit for all enrollees, with plans responsible for substantially more insurance risk than they bear today. Instead of the coverage-gap discount, manufacturers would become responsible for at least 30 percent of catastrophic spending.

MEDICARE CHALLENGE: Medicare is required to pay providers’ claims, regardless of clinical appropriateness. In traditional Medicare, providers can augment their revenue by increasing the volume of services they provide. The program’s lack of utilization management can lead to overuse of services because the program pays claims for care that is “reasonable and necessary” even if that care might be considered inappropriate for a given patient. Under traditional Medicare’s statute, the program generally covers services delivered by any provider who is willing to meet Medicare’s participation requirements. As a result, traditional Medicare does not have the authority to develop provider networks or to credential providers—tools that

private payers (including MA plans) can use to reduce the potential for overutilization as well as fraud and abuse. In some cases, the traditional Medicare program even has difficulty removing providers or suppliers whose claims histories clearly demonstrate aberrant patterns of billing, care, or both.

- **COMMISSION RECOMMENDATIONS: Scrutinize claims more closely.** In this regard, the Commission has made these recommendations:

- **March 2010**—Review home health agencies that exhibit unusual billing patterns and implement new safeguards—such as a moratorium on new providers, prior authorization, and suspension of prompt payment requirements—in areas that appear to be high risk.
- **June 2011**—Establish a prior authorization program for practitioners who order a substantially greater number of advanced imaging services than their peers.
- **June 2013**—Develop national guidelines for physical, occupational, and speech therapy services and implement payment edits based on these guidelines to target implausible amounts of therapy. Also use existing authorities to target high-use geographic areas and aberrant providers.
- **June 2013**—Promulgate national guidelines to more precisely define medical necessity requirements for ground ambulance transports and develop national edits for claims processors based on those guidelines. Identify geographic areas and ambulance suppliers and providers that display aberrant patterns of use and address clinically inappropriate use of ground transports that are nonemergency and require only basic life support.
- **March 2016**—Conduct focused medical record review of inpatient rehabilitation facilities that have unusual patterns of case mix and coding.
- **June 2019**—Develop and implement national guidelines for coding hospital emergency department visits, instead of allowing hospitals to use their own internal guidelines, which would give CMS a firmer foundation for assessing and auditing hospitals’ coding behavior.

MEDICARE CHALLENGE: Medicare coverage interacts with beneficiaries' other coverage, sometimes resulting in fragmented care.

While Medicare is the single largest payer in the health care sector, the policy signals from multiple payers can interact in ways that sometimes result in unintended consequences. For example, if a dual-eligible nursing home resident is hospitalized for three days, he or she would potentially qualify for a Medicare-covered skilled nursing facility stay, shifting responsibility from the Medicaid program to the Medicare program. Other care for beneficiaries who are dually eligible for Medicare and Medicaid can also be fragmented.

- **COMMISSION RECOMMENDATIONS: Encourage better integration with Medicaid.** In this regard, the Commission has made this recommendation:
 - *March 2013*—Require MA dual-eligible special needs plans to assume clinical and financial responsibility for Medicare and Medicaid benefits.

MEDICARE CHALLENGE: Medicare's benefit package does not protect against high out-of-pocket (OOP) costs, and many beneficiaries have limited incentives to use care efficiently.

Beneficiaries face differential cost sharing by service (for example, coinsurance for physician services is 20 percent, while home health has no coinsurance). In addition, the cost-sharing amounts, percentages, and deductibles vary by setting, and some services are not covered (for example, Medicare does not generally cover long-term care). Traditional Medicare lacks a cap on OOP costs (a feature that exists in MA plans and nearly all private insurance policies). In response, many beneficiaries purchase supplemental coverage that includes an OOP maximum. Most supplemental policies also substantially reduce or eliminate most of the beneficiary liability for coinsurance and deductibles, thereby blunting the effect of cost sharing. As a result, there is little incentive for many beneficiaries to be cost conscious—that is, to select only those services that are necessary and to choose providers who practice efficiently (Medicare Payment Advisory Commission 2012). Separately, Part D also lacks an OOP maximum on cost sharing.

- **COMMISSION RECOMMENDATIONS: Modify beneficiary cost sharing to incentivize high-value care.** In this regard, the Commission has made these recommendations:

- *June 2012*—Replace the current Part A and Part B benefit design in traditional Medicare with one that would include an OOP maximum, deductibles for Part A and Part B services, and copayments that could vary by type of service and provider or be eliminated for high-value services. The Commission also recommended discouraging the purchase of Medigap plans through an additional charge on supplemental insurance.
- *June 2020*—Modify the structure of the Part D benefit to include an annual OOP maximum.
- *March 2012, June 2016, June 2020*—Modify the Part D low-income subsidy copayments to encourage the use of generic drugs, preferred multisource drugs, and biosimilars.

MEDICARE CHALLENGE: MA data limitations prevent study of utilization and program effectiveness.

Having complete, detailed encounter data for Medicare beneficiaries enrolled in MA plans could inform improvements to MA payment policy, provide a useful comparator with the traditional Medicare program, and generate new policy ideas that could be applied more broadly to the Medicare program. However, given the data errors and omissions that the Commission found in a recent analysis, we cannot use MA encounter data for such purposes at present.

- **COMMISSION RECOMMENDATIONS: Collect more complete and accurate MA data.** In this regard, the Commission has made this recommendation:
 - *June 2019*—Give robust feedback to MA plans on the completeness and accuracy of their encounter data; withhold some payments from MA plans and allow plans to earn back those payments if their encounter data meet thresholds for completeness and accuracy; and, if necessary, require providers to submit MA encounter data to Medicare administrative contractors as a means of ensuring more accurate encounter data submissions.

MEDICARE CHALLENGE: Traditional Medicare lacks strong incentives to improve population-based outcomes and the coordination of care. Some key challenges for the traditional Medicare program are that providers are usually paid more for providing more

services and lack strong incentives to improve population-based outcomes or the coordination of their patients' care.

- **COMMISSION RECOMMENDATIONS: Incentivize improving population-based outcomes.** The Commission has recommended holding providers accountable for hospital readmissions, which could in turn incentivize stronger coordination of care, and has recommended new payments to encourage care coordination. In this regard, the Commission has made these recommendations:
 - **June 2008**—Reduce payments to hospitals with relatively high readmission rates for select conditions and allow gainsharing between hospitals and physicians.
 - **March 2012**—Reduce payments to skilled nursing facilities with relatively high rates of rehospitalization.
 - **March 2014**—Reduce payments to home health agencies with relatively high rates of hospital readmission.
 - **March 2015**—Establish a prospective payment per beneficiary for primary care practitioners, funded by reducing fees for non-primary care services in the fee schedule.

The Commission has also recommended adopting value-based payment programs based on meaningful measures. In this regard, the Commission has made these recommendations:

- **March 2012**—Implement a value-based purchasing program for ambulatory surgical center services.

- **March 2018**—Eliminate the current Merit-based Incentive Payment System for clinicians in traditional Medicare and replace it with a new voluntary value program in which clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures.
- **March 2019**—Replace Medicare's current hospital quality programs with a new hospital value incentive program that:
 - includes a small set of population-based outcome, patient experience, and value measures;
 - scores all hospitals based on the same absolute and prospectively set performance targets; and
 - accounts for differences in patients' social risk factors by distributing payment adjustments through peer grouping.

Beyond these recommended changes to Medicare's payment systems, the Commission also seeks to influence payment rates in each of Medicare's payment systems through the annual recommendations we include in our March reports. These recommendations are based on our review of the latest available data and are aimed at obtaining good value for the program's expenditures—which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. ■

Endnotes

- 1 To put these numbers into some perspective, the over-65 age category accounted for 75 percent of total deaths in the first week of February 2020, which had no reported COVID-19 deaths (National Center for Health Statistics 2020).
- 2 The Kaiser Family Foundation’s analysis of long-term care and assisted living facilities includes nursing facilities, assisted living facilities, adult care centers, intermediate care facilities, and/or other long-term care facilities.
- 3 The HI Trust Fund’s income derives from several sources, including payroll taxes, taxation of Social Security benefits (7 percent of the Trust Fund’s income in 2019), interest earned on Trust Fund investments (3 percent in 2019), and premiums collected from voluntary participants (1 percent in 2019). The Supplemental Medical Insurance Trust Fund is discussed later in this section of the chapter.
- 4 Baby boomers are people born between the years 1946 and 1964.
- 5 The most concentrated markets have a Herfindahl–Hirschman Index above 5,000, meaning in a market with two systems, one of the systems has more than a 50 percent market share; these have been referred to as “super-concentrated” markets (Fulton et al. 2018).
- 6 Workers and their employers split the cost of the payroll tax (workers pay 1.45 percent and employers pay the remaining 1.45 percent). Meanwhile, self-employed people pay both the worker’s and the employer’s share of this tax, totaling 2.9 percent of their net earnings. High-income workers pay an additional 0.9 percent of their earnings above \$200,000 for single workers or \$250,000 for married couples filing joint income tax returns.
- 7 The Congressional Budget Office provides a range of the expected change in Medicare spending for each of the Commission’s recommendations separately, without taking into account interactions between the recommendations and without formal legislative language.
- 8 For Part B, the beneficiary premium equals 25 percent of projected program spending. For Part D, the beneficiary premium share is based on 25.5 percent of the average cost of the basic benefit.
- 9 Other major health programs include Medicaid, the Children’s Health Insurance Program, and federal subsidies for the federal and state exchanges created under the Affordable Care Act. These programs are considered “mandatory” programs; their spending levels are determined by the number of people entitled by law to enroll in such programs and are not subject to the spending limits that apply to “discretionary” programs funded through the annual appropriations process.
- 10 Some Medigap plans nearly eliminate cost sharing and any disincentive to overuse services, while others maintain higher levels of cost sharing.
- 11 Medicare managed care includes Medicare Advantage, health care prepayment, and cost plans.
- 12 The Trustees’ estimates of spending in the traditional Medicare program include, but do not break out, spending on accountable care organizations, which have grown to represent a significant share of program spending.
- 13 The amount of spending on MA in 2019 that we identify in this chapter slightly differs from the amount reported in the MA chapter of the Commission’s March 2020 report. Our March 2020 MA chapter presents a preliminary estimate from CBO, whereas this chapter presents a subsequent estimate released by the Medicare Trustees.
- 14 Spending per beneficiary on MA and other private plans is calculated by summing Part A spending on private health plans and Part B spending on private health plans, then dividing that by the number of enrollees in private health plans. FFS Medicare spending per beneficiary is calculated by summing (1) Part A FFS spending divided by Part A FFS enrollees and (2) Part B FFS spending divided by Part B FFS enrollees. Part D is calculated by taking total Part D spending, subtracting premiums (mostly paid by enrollees), then dividing that by the number of enrollees in Part D.

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CHAPTER

2

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

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

Chapter summary

As required by law, the Commission annually makes payment update recommendations for providers paid under Medicare’s traditional fee-for-service (FFS) payment systems. An update is the amount (usually expressed as a percentage change) by which the base payment for all providers in a payment system is changed relative to the prior year. To determine an update, we first assess the adequacy of Medicare payments for providers in the current year (2021) by considering beneficiaries’ access to care, the quality of care, providers’ access to capital, and how Medicare payments compare with providers’ costs. As part of that process, we examine whether payments will support the efficient delivery of services, consistent with our statutory mandate. Next, we assess how those providers’ costs are likely to change in the year the update will take effect (the policy year; here, 2022). Finally, we make a judgment about what, if any, update is needed for the policy year in question. (The Commission also assesses Medicare payment systems for Part C (Medicare Advantage) and Part D (outpatient prescription drug coverage) in this report and makes recommendations as appropriate. But because they are not FFS payment systems, they are not discussed in this chapter.)

To the extent that events create temporary shocks to the Medicare component of providers’ finances, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers’ Medicare

In this chapter

- Are Medicare payments adequate in 2021?
.....
- What cost changes are expected in 2022?
.....
- How should Medicare payments change in 2022?
.....
- Payment adequacy in context
.....

payment rates. Because updates are cumulative—that is, they compound each year—they are not the preferred policy response to abrupt but temporary changes in demand for health care or resulting health care spending.

The coronavirus pandemic had tragic effects on beneficiaries' health in 2020 and changed the demand for and delivery of health care. In turn, there were material effects on providers' patient volume, revenues, and costs. Moreover, these effects have varied and continue to vary widely across different geographies, across different types of providers, and among individual providers. Although the effects are persisting in 2021, the Commission expects much of the pandemic's impact on health care will be temporary.

Providers' financial status and the pattern of Medicare spending in 2020 have varied substantially from historical patterns. In particular, in the spring of 2020, many sectors of the health care system experienced large reductions in demand for services, resulting in financial distress for some providers. In response, the Congress and CMS extended federal grants to providers and temporarily altered certain Medicare payment policies. At least in part, those actions offset the short-term financial effects of the coronavirus public health emergency (PHE) for many providers. Some providers eventually returned funds to the federal government because their finances recovered faster than expected. Those temporary actions, even if not precisely targeted, were appropriate to a transient problem. Additional temporary relief may be necessary for some providers as the PHE continues.

To fulfill our congressional mandate in regard to payment system updates, we must confine our focus to effects that we expect will impact payment adequacy in the given policy year. As noted above, to the extent the pandemic effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies. Nonetheless, if there are changes during the PHE that have effects on providers' cost structures that we expect will persist into 2022 (the policy year for our recommendations), those changes are noted in each sector's payment adequacy discussion and factor into our estimates of payment adequacy. We will monitor the impacts of COVID-19 over time and any lasting effects will be considered as we evaluate the adequacy of Medicare payments in future years.

This year, we consider recommendations in nine FFS sectors: acute care hospitals, physicians and other health professional services, ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, long-term care hospitals, and hospices. The

Commission looks at all available indicators of payment adequacy and reevaluates any assumptions from prior years, using the most recent data available to make sure its recommendations accurately reflect current conditions. We use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022, accounting for anticipated changes in providers' costs between 2021 and 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE has created additional data lags, most notably for cost reports because the deadlines for their submission were extended. These data lags have affected some health care sectors more than others. Where possible, we have bolstered our data analyses with data from 2020, including interim claims data, information on facility closures, and beneficiary survey data.

In considering updates to payment rates, we may also recommend 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. We may also make recommendations to improve program integrity where we deem it necessary. Our goal is to apply consistent criteria across settings, but because conditions at baseline and anticipated changes between baseline and the policy year may vary, the recommended updates may vary across sectors.

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

Our recommendations in this report, if adopted, could significantly change the revenues providers receive from Medicare. Payment rates set to cover the costs of relatively efficient providers help induce all providers to control their costs. Furthermore, Medicare rates also have broader implications for health care spending because they are used in setting payments for other government programs, states, and private health insurance. For example, most Medicare Advantage plans pay hospitals using rates that are comparable with, or based on, Medicare FFS rates (Berenson et al. 2015, Maeda and Nelson 2017); the Department of Veterans Affairs (VA) has been setting payment rates not to exceed FFS rates for most care provided in non-VA settings (Department of Veterans Affairs 2019); the Medicaid program

uses Medicare rates when setting maximum supplemental “upper payment limit” Medicaid FFS payments to hospitals (Medicaid and CHIP Payment and Access Commission 2019, Medicaid and CHIP Payment and Access Commission 2016); and most recently, Montana’s state employee health plan fixed its inpatient and outpatient hospital payment rates to 234 percent of Medicare (Appleby 2018), and Washington limits rates to 160 percent of Medicare for insurers in its new “public option,” which started in January 2021 (Kliff 2019).¹ Thus, while maintaining fiscal pressure on health care providers through payment-rate updates directly benefits the Medicare program, it can also help control health care spending across payers. ■

Background

The goal of Medicare payment policy should be to obtain 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. Steps toward this goal involve:

- setting the base payment rate (i.e., the payment for services of average complexity) at the right level;
- developing payment adjustments that accurately reflect market, service, and patient cost differences beyond providers' control;
- adjusting payments to encourage high-quality care; and
- considering the need for annual payment updates and other policy changes.

To help determine the appropriate base payment rate for a given payment system in 2022, we first consider whether payments are adequate for relatively efficient providers in 2021. To inform the Commission's judgment, we examine the most recent available data on beneficiaries' access to care, the quality of care, and providers' access to capital, as well as projected Medicare payments and providers' costs for 2021. We then consider how providers' costs are likely to change in 2022. Taking these factors into account, we recommend how Medicare payments for the sector in aggregate should change for 2022.

Within any given level of funding for a sector, we may also consider changes in payment policy to improve relative payment accuracy across patients and procedures. Such changes are intended to improve equity among providers or access to care for beneficiaries and may also affect the distribution of payments among providers in a sector. For example, in 2018, the Commission recommended that CMS use a blend of the setting-specific relative weights and the unified post-acute care (PAC) prospective payment system (PPS) relative weights for each of the four PAC settings to redistribute payments within each setting toward medically complex patients (Medicare Payment Advisory Commission 2018b).

We also make recommendations to improve program integrity when needed. In some cases, our data analysis

reveals problematic variation in service utilization across geographic regions or providers. For example, in 2016, we recommended the Secretary closely examine the coding practices of certain inpatient rehabilitation facilities that appeared to result in very high Medicare margins (Medicare Payment Advisory Commission 2016b).

We compare our recommendations for updates and other policy changes for 2022 with the base payment rates specified in law to understand the implications for beneficiaries, providers, and the Medicare program. As has been the Commission's policy in the past, we consider our recommendations each year in light of the most current data and, in general, recommend updates for a single year.

Are Medicare payments adequate in 2021?

The first part of the Commission's approach to developing payment updates is to assess the adequacy of current Medicare payments. For each sector, we make a judgment by examining information on the following: beneficiaries' access to care, quality of care, providers' access to capital, and Medicare payments and providers' costs for 2021.

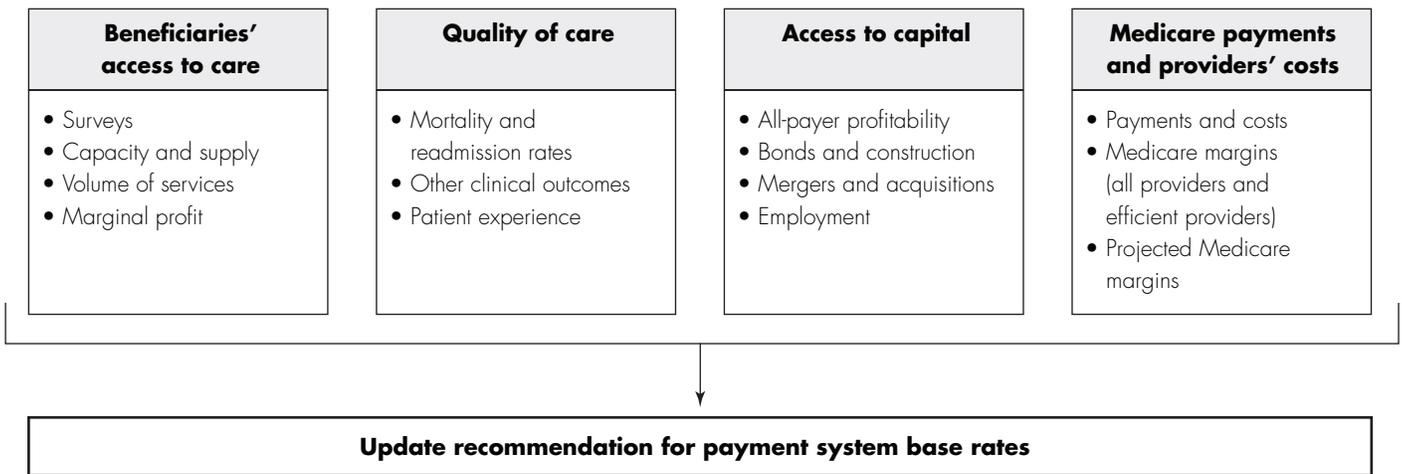
Some measures focus on beneficiaries (e.g., access to care) and some focus on providers (e.g., the relationship between payments and providers' costs). The direct relevance, availability, and quality of each type of information vary among sectors, and no single measure provides all the information needed for the Commission to judge payment adequacy. For example, to inform our assessment of payments for physicians and other health professionals, we conduct a survey of beneficiary access. Ultimately, the Commission makes its recommendations considering as many of these factors as are available. Figure 2-1 (p. 42) shows our payment adequacy framework and an example of the kind of factors used (when they are available) for a sector.

Beneficiaries' access to care

Access to care is an important indicator of the willingness of providers to serve Medicare beneficiaries and the adequacy of Medicare payments. For example, poor access could indicate that Medicare payments are too low. However, factors unrelated to Medicare's payment policies may also affect access to care. These factors include coverage policies, changes in the delivery of health

**FIGURE
2-1**

Payment adequacy framework



Note: $\text{Marginal profit} = (\text{Medicare payment} - (\text{total Medicare cost} - \text{fixed building and equipment cost})) / \text{Medicare payment}$
 $\text{Medicare margin} = (\text{Medicare payments} - \text{Medicare allowable costs}) / \text{Medicare payments}$

Source: MedPAC.

care services, beneficiaries' preferences, local market conditions, supplemental insurance, and other external factors. In March and April of 2020, for example, access was profoundly influenced by the coronavirus pandemic. Many elective procedures were delayed or canceled, and many beneficiaries chose not to visit providers' offices and health care facilities because of the risk of contracting COVID-19 (Czeisler et al. 2020).

The measures we use to assess beneficiaries' access to care depend on the availability and relevance of information in each sector. We use results from several surveys to assess the willingness of physicians and other health professionals to serve beneficiaries and beneficiaries' opinions about their access to physician and other health professional services. For home health services, we examine data on whether communities are served by providers. To the extent that access continues to be affected by the pandemic, we will take that factor into account as well.

Access: Capacity and supply of providers

Rapid growth in the capacity of providers to furnish care may increase beneficiaries' access and indicate that

payments are more than adequate to cover providers' costs. Changes in technology and practice patterns may also affect providers' capacity. For example, as a surgical procedure becomes less invasive, it might be more frequently performed in outpatient settings, freeing up some inpatient hospital capacity. Likewise, as the prices of certain pieces of equipment fall, they can be more easily purchased by providers, increasing the capacity to provide certain services.

Rapid entry of providers into a sector, particularly by for-profit entities, may suggest that Medicare's payments are more than adequate and could raise concerns about the value of the services being furnished. However, if Medicare is not the dominant payer for a given provider type (such as ambulatory surgical centers), changes in the number of providers may be influenced more by other payers and their demand for services and thus may be difficult to relate to Medicare payments. When the number of providers declines due to closure of facilities, we try to distinguish between closures that have serious implications for access to care and those that may have resulted from excess capacity. For example, in 2016, Medicare's payment rates for certain cases in long-term

care hospitals (LTCHs) decreased significantly, and since the dual payment-rate system began, 78 LTCHs have closed, representing over 15 percent of facilities and beds. However, the closures occurred primarily in market areas with multiple LTCHs. We note that a temporary reduction in capacity resulting from the pandemic is not an indicator of inadequate Medicare payment rates. However, any permanent changes in capacity may have implications for beneficiary access going forward.

Access: Volume of services

The volume of services furnished by health care providers can be an indirect indicator of beneficiary access to services. An increase in volume shows that beneficiaries are receiving more services and suggests sufficient access in aggregate, although it does not necessarily demonstrate that the services are necessary or appropriate. Volume is also an indicator of payment adequacy; an increase in volume beyond what would be expected relative to the increase in the number of beneficiaries could suggest that Medicare's payment rates are too high. Very rapid increases in the volume of a service might even raise questions about program integrity or whether the definition of the corresponding benefit is too vague. By contrast, reductions in the volume of services can sometimes be a signal that revenues are inadequate for providers to continue operating or to provide the same level of service. Finally, rapid changes in volume between sectors whose services can be substituted for one another may suggest distortions in payment and raise questions about provider equity. For example, over the last several years, the volume of evaluation and management (E&M) office visits provided in hospital outpatient departments (HOPDs) has increased while the volume of E&M visits in physicians' offices has decreased; this shift in site of service is likely driven by much higher payment rates for E&M visits in HOPDs than in physicians' offices.

However, changes in the volume of services are not direct indicators of access; increases and decreases can be explained by other factors such as population changes, changes in disease prevalence among beneficiaries, dissemination of new and improved medical knowledge and technology, deliberate policy interventions, and beneficiaries' preferences. For example, the number of beneficiaries in traditional fee-for-service (FFS) Medicare varies from year to year; therefore, we look at the volume of services per FFS beneficiary as well as the total volume of services. Explicit policy decisions can also influence

volume. For example, during fiscal year 2016, LTCHs—as expected—changed their admitting practices largely in response to the implementation of the dual payment-rate system, and the number of LTCH admissions decreased markedly.

Changes in the volume of physician services must be interpreted particularly cautiously. Evidence suggests that when payment rates for discretionary services are reduced, providers may attempt to make up for lost revenue by increasing volume—the so-called “volume offset” (Codespote et al. 1998, Congressional Budget Office 2007). Whether a volume offset phenomenon exists within other sectors depends on how discretionary the services are and what the ability of providers is to influence beneficiaries' demand for them.

During the early months of the 2020 coronavirus pandemic, the volume of services provided in many sectors decreased rapidly. In the physician sector, this decline was accompanied by a rapid rise in the volume of telehealth services. By June, the number of office visits and telehealth visits combined was close to the volume experienced for office visits in previous years. (In previous years, the volume of telehealth visits was minimal.) In most other sectors, there was a return in volume to expected levels by late June or July. However, the volume of skilled nursing facility (SNF) services did not fully rebound. Toward the end of 2020, there was an increase in the incidence of COVID-19 and a rise in associated hospitalizations. This trend could affect the volume of services across many sectors that we will monitor throughout the next year.

Access: Marginal profit

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (e.g., the Medicare payment) with its marginal costs—that is, the costs that vary with volume in the short term. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries. We note, however, that in instances in which a sector does not have substantial excess capacity

or in which Medicare composes a dominant share of a sector's patients, marginal profit may be a less useful indicator of access to care.

Quality of care

The relationship between quality of care and the adequacy of Medicare payment is not direct. Simply increasing payments through an update for all providers in a sector is unlikely to influence the overall quality of care beneficiaries receive because there is no imperative for providers to devote the additional revenue to actions that are known to improve quality. Indeed, historically, Medicare payment systems had created little or no incentive for providers to spend additional resources on improving quality.

The Medicare program has in more recent years implemented quality-based payment policies in a number of sectors; however, some issues have arisen. First, it is very difficult to differentiate quality performance among providers when the number of cases per provider is relatively low. This issue has been particularly vexing in measuring quality performance for individual clinicians. Second, the Commission has been concerned that Medicare's approach to quality measurement is flawed because it scores too many measures focused on process as opposed to patient outcomes (Medicare Payment Advisory Commission 2018a). Many current process measures are weakly correlated with outcomes of interest such as mortality and readmissions, and most process measures focus on addressing the underuse of services, while the Commission believes that overuse and inappropriate use are also of concern. Third, reliance on provider-reported measures can create a burden on providers and can lead to biased reporting in response to strong financial incentives.

In our June 2018 report to the Congress, we formalized a set of principles for designing Medicare quality incentive programs, which address these issues. In 2019, we applied these principles to recommend a hospital value incentive program that scores a small set of outcome, patient experience, and cost measures, and in 2020, we recommended changing the quality incentive program for Medicare Advantage to better evaluate quality and reward high-quality plans (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019).

Providers' access to capital

Providers must have access to capital to maintain and modernize their facilities and to improve their capability to deliver patient care. Widespread ability to access capital throughout a sector may reflect the adequacy of Medicare payments. Some sectors such as hospitals require large capital investments, and access to capital can be a useful indicator. Other sectors such as home health care do not need large capital investments, so access to capital is a more limited indicator. In some cases, a broader measure such as changes in employment may be a useful indicator of financial health within a sector. Similarly, in sectors where providers derive most of their payments from other payers (such as ambulatory surgical centers) or other lines of business, or when conditions in the credit markets are extreme, access to capital may be a limited indicator of the adequacy of Medicare payments.

One indicator of a sector's access to capital is its all-payer profitability, reflecting income from all sources. We refer to this amount as the sector's total margin, which is calculated as aggregate income, minus costs, divided by income. Total margins can inform our assessment of a sector's overall financial condition and hence its access to capital.

Medicare payments and providers' costs for 2021

For most payment sectors, we estimate Medicare payments and providers' costs for 2021 to inform our update recommendations for 2022. To maintain Medicare beneficiaries' access to high-quality care while keeping financial pressure on providers to make better use of taxpayers' and beneficiaries' resources, we investigate whether payments are adequate to cover the costs of relatively efficient providers, where available data permit such providers to be defined.

Relatively efficient providers use fewer inputs to produce quality outputs. Efficiency is higher if the same inputs are used to produce a higher quality output or if fewer inputs are used to produce the same quality output. The Commission's approach is to develop a set of criteria and then examine how many providers meet those criteria. It does not establish a set share of providers to be considered efficient and then define criteria to meet that pool size.

For providers that submit cost reports to CMS—acute care hospitals, SNFs, home health agencies, outpatient dialysis

facilities, inpatient rehabilitation facilities (IRFs), LTCHs, and hospices—we estimate total Medicare-allowable costs and assess the relationship between Medicare’s payments and those costs. We typically express the relationship between payments and costs as a payment margin, which is calculated as aggregate Medicare payments for a sector, minus costs, divided by payments. By this measure, if costs increase faster than payments, margins will decrease.

In general, to estimate payments, we first apply the annual payment updates specified in law for 2020 and 2021 to our base data (2019 for most sectors). We then model the effects of other policy changes that will affect the level of payments in 2021. Estimated Medicare payments reflect current law and expected volume. To estimate 2021 costs, we consider the rate of input price inflation or historical cost growth, and, as appropriate, we adjust for changes in the unit of service (such as fewer visits per episode of home health care) and trends in key indicators (such as changes in the distribution of cost growth among providers).²

Use of margins

The adequacy of Medicare payments is assessed relative to the costs of treating Medicare beneficiaries, and the Commission’s recommendations address a sector’s Medicare payments, not total payments. We calculate a sector’s Medicare margin to determine whether total Medicare payments cover average providers’ costs for treating Medicare patients and to inform our judgment about payment adequacy.³ Margins will always be distributed around the average, and a judgment of payment adequacy does not mean that every provider has a positive Medicare margin. To assess whether changes are needed in the distribution of payments, we calculate Medicare margins for certain subgroups of providers with unique roles in the health care system. For example, because location and teaching status enter into the payment formula, we calculate Medicare margins based on where hospitals are located (in urban or rural areas) and their teaching status (major teaching, other teaching, or nonteaching).

In accordance with our authorizing statute, the Commission also, when feasible, computes a Medicare margin for efficient providers.⁴ The Commission follows two principles when identifying a set of efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to

be consistent, meaning that the provider cannot have poor performance on any metric over the past three years. For example, in the hospital sector, the variables we use to identify relatively efficient hospitals are risk-adjusted all-condition mortality, risk-adjusted potentially preventable readmissions, and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms, but rather, relative to a comparison group—in this example, other inpatient prospective payment system hospitals. (We also make such assessments for the SNF, home health, and IRF sectors.) These assessments of efficient providers in a sector help us identify what may be a reasonable level of costs in a sector and hence the relationship between payments and costs that are needed to support Medicare beneficiaries’ access to relatively high-quality care in that sector.

Multiple factors can contribute to changes in the Medicare margin, including changes in the efficiency of providers, changes in coding that may change case-mix adjustment, and other changes in the product (e.g., reduced lengths of stay at inpatient hospitals). Knowing whether these factors have contributed to margin changes may inform decisions about whether and how much to change payments.

In sectors where the data are available, the Commission makes a judgment when assessing the adequacy of payments relative to costs. No single standard governs this relationship for all sectors, and margins are only one indicator for determining payment adequacy. Moreover, although payments can be ascertained with some accuracy, there may be no “true” value for reported costs, which reflect accounting choices made by providers (such as allocations of costs to different services) and the relationship of service volume to capacity in a given year. Further, even if costs are accurately reported, they reflect strategic investment decisions of individual providers, and Medicare—as a prudent payer—may choose not to recognize some of these costs or may exert financial pressure on providers to encourage them to reduce their costs.

Appropriateness of current costs

Our assessment of the relationship between Medicare’s payments and providers’ costs is complicated by differences in providers’ efficiency, responses to changes in payment systems, product changes, and cost reporting accuracy. Measuring the appropriateness of costs is particularly difficult in new payment systems because

changes in response to the incentives in the new system are to be expected. In other systems, coding may change. As an example, the hospital inpatient PPS introduced a new patient classification system in 2008 to improve payment accuracy. However, for a number of years after its implementation, it resulted in higher payments because provider coding became more detailed, making patient complexity appear higher—although the underlying patient complexity was largely unchanged. Any kind of rapid change in policy, technology, or product can make it difficult to measure costs per unit.

To assess whether reported costs reflect the efficient provision of service, we examine recent trends in the average cost per unit, variation in standardized costs and cost growth, and evidence of change in the product. Our goal is to pay enough to provide access to high-quality care for Medicare patients. We do not seek to adjust Medicare payments if other payers under- or overpay. For example, one issue Medicare faces is the extent to which private payers exert pressure on providers to constrain costs. If private payers do not exert pressure, providers' costs may increase and, all other things being equal, margins on Medicare patients would decrease. Providers that are under pressure to constrain costs generally have managed to slow their growth in costs more than those who face less pressure (Medicare Payment Advisory Commission 2011, Robinson 2011, White and Wu 2014). Some have suggested that, in the hospital sector, costs are largely outside the control of hospitals and that hospitals shift costs onto private insurers to offset Medicare losses. This belief assumes that costs are immutable and not influenced by whether the hospital is under financial pressure. We find that costs do vary in response to financial pressure and that low margins on Medicare patients can result from a high cost structure that has developed in reaction to high private-payer rates. In other words, when providers (particularly not-for-profit providers) receive high payment rates from insurers, they face less pressure to keep their costs low, and so, all other things being equal, their Medicare margins are low because their costs are high. (For-profit providers may prefer to keep costs low to maximize returns to stockholders and, indeed, often have higher Medicare margins than similar nonprofit providers.) Lack of pressure is more common in markets where a few providers dominate and have negotiating leverage over payers. This situation is becoming more common as providers continue to consolidate. We do not lower payments because of generous payments from private

plans or raise them if other payers (for example, Medicaid) pay less. That said, we do recognize that access to care for Medicare beneficiaries will be affected by the payment policies outside of Medicare. Moreover, we recognize that in some sectors, Medicare itself can, and should, exert greater pressure on providers to reduce costs.

Variation in cost growth among a sector's providers can give us insight into the range of performance that facilities can achieve. For example, if some providers' costs grow more rapidly than others in a given sector, we might question whether those rapid increases are appropriate. Changes in product can also significantly affect unit costs. For example, in home health care services, one would expect that substantial reductions in the number of visits per 30-day home health care episode would reduce costs per episode. If costs per period instead were to increase while the number of visits were to decrease, one would question the appropriateness of the cost growth and not increase Medicare payments in response.

In summary, Medicare payment policy should not be designed simply to accommodate whatever level of cost growth a sector demonstrates. Cost growth can oscillate from year to year depending on factors such as economic conditions and relative market power. Payment policy should accommodate cost growth only after taking into account a broad set of payment adequacy indicators, including the current level of Medicare payments.

What cost changes are expected in 2022?

The second part of the Commission's approach to developing payment update recommendations is to consider anticipated policy and cost changes in the next payment year. For each sector, we review evidence about the factors that are expected to affect providers' costs. One factor is the change in input prices, as measured by the price index that CMS uses for that sector. (These indexes are estimated quarterly; we use the most recent estimate available when we do our analyses.) Forecasts for those price indexes could be uncertain because of the possible volatility of costs in 2020 and 2021. For example, if labor costs for nurses spike in 2021, those costs may then go down in 2022. Estimates of price indexes that include nursing labor costs may be volatile as a result. For facility providers, we start with the forecasted increase in an industry-specific index of national input prices, called a

“market basket index.” For physician services, we start with a CMS-derived weighted average of price changes for inputs used to provide physician services. Forecasts of these indexes approximate how much providers’ costs would change in the coming year if the quality and mix of inputs they use to furnish care remained constant—that is, if there were no change in efficiency. Other factors may include the trend in actual cost growth, which could be used to inform our estimate if it differs significantly from the projected market basket.

This year, to the extent that we anticipate that changes in costs from the pandemic are likely to persist into 2022, those changes are considered in our analyses. For example, we would consider whether facilities are required going forward to make patient rooms single occupancy or negative air pressure.

How should Medicare payments change in 2022?

The Commission’s judgments about payment adequacy, forthcoming policy changes, and expected cost changes result in an update recommendation for each payment system. 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. In considering updates, the Commission makes its recommendations for 2022 relative to the 2021 base payment as defined in Medicare’s authorizing statute—Title XVIII of the Social Security Act. The Commission’s recommendations may call for an increase, a decrease, or no change from the 2021 base payment. For example, if the statutory base payment for a sector were \$100 in 2021, an update recommendation of a 1 percent increase for a sector means that we are recommending that the base payment in 2022 for that sector be 1 percent greater, or \$101. In the event that the Congress or the Secretary does not adopt the Commission’s recommendation for a payment update, current law will continue to apply unless other actions are taken.

When our recommendations differ from current law or regulation, as they often do, the Congress and the Secretary of Health and Human Services would have to take action and change law or regulation to put them into effect. Each year, we look at all available indicators of payment adequacy and reevaluate prior-year assumptions using the most recent data available. The

Commission does not start with any presumption that an update is needed or that any increase in costs should be automatically offset by a payment update. Instead, an update (which may be positive, zero, or negative) is warranted only if it is supported by the empirical data, in the judgment of the Commission.

In conjunction with the update recommendations, we may also make recommendations to improve payment accuracy that might in turn affect the distribution of payments among providers. These distributional changes are sometimes, but not always, budget neutral. Our recommendation to shift payment weights from therapy to medically complex PAC cases is one example of a distributional change that would affect providers differentially based on their patients’ characteristics (Medicare Payment Advisory Commission 2016a).

The Commission, as it makes its update recommendations, may in some cases take into consideration payment differentials across sectors and make sure the relative update recommendations for the sectors do not exacerbate existing incentives to choose a site of care based on payment considerations. The difficulty of harmonizing payments across sectors to remove inappropriate incentives illustrates one weakness of FFS payment systems specific to each provider type and highlights the importance of moving beyond FFS to more global and patient-centric payment systems. As we continue to support moving Medicare payment systems toward those approaches, we will also continue to look for opportunities to rationalize payments for specific services across sectors to approximate paying the costs of the most efficient sector and lessen financial incentives that reward one sector over another.

Consistent payment for the same service across settings

A beneficiary can sometimes receive a similar service in different settings. Depending on which setting the beneficiary or the treating clinician chooses, Medicare and the beneficiary may pay different amounts. For example, when leaving the hospital, patients with joint replacements requiring physical therapy might be discharged with home health care or outpatient therapy, or they might be discharged to a SNF or IRF, and Medicare payments (and beneficiary cost sharing) would differ widely as a result.

A core principle guiding the Commission is that Medicare should pay the same amount for the same service, even when it is provided in different settings. Putting this

principle into practice requires that the definition of services in the settings and the characteristics of the patients be sufficiently similar. Where these conditions are not met, offsetting adjustments would have to be made to ensure comparability. Because Medicare's payment systems were developed independently and have had different update trajectories, payments for similar services can vary widely. Such differences create opportunities for Medicare and beneficiary savings if payment is set at the level applicable to the lowest priced setting in which the service can be safely performed. For example, under the current payment systems, a beneficiary can receive the same physician visit service in a hospital outpatient clinic or in a physician's office. In fact, the same physician could see the same patient and provide the same service but, depending on whether the service is provided in an outpatient clinic or in a physician's office, Medicare's payment and the beneficiary's coinsurance can differ by 80 percent or more.

In 2012, the Commission recommended that payments for E&M office visits in the outpatient and physician office sectors be made equal, recognizing that those services are comparable across the two settings. Specifically, we recommended setting payment rates for E&M office visits both in the outpatient department and physician office sectors equal to those in the physician fee schedule, lowering both program spending and beneficiary liability (Medicare Payment Advisory Commission 2012). In 2014, we extended that principle to additional services for which payment rates in the outpatient PPS should be lowered to better match payment rates in the physician office setting (Medicare Payment Advisory Commission 2014). In the Bipartisan Budget Act of 2015, the Congress made payment for outpatient departments for the same services equal to the physician fee schedule rates for those services at any new outpatient off-campus clinic beginning in 2018. We also recommended consistent payment between acute care hospitals and long-term care hospitals for certain categories of patients, and the Congress enacted a similar reform in the Pathway to SGR Reform Act of 2013 (Medicare Payment Advisory Commission 2014). In 2016, we recommended elements of a unified PAC PPS that would make payments based on patients' needs and characteristics, generally irrespective of the PAC entity that provides their care (Medicare Payment Advisory Commission 2016a). The Commission will continue to study other services that are provided in multiple sites of care to find additional services for which the principle of the same payment for the same service can be applied.

Budgetary consequences

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Commission to consider the budgetary consequences of our recommendations. Therefore, this report documents how spending for each recommendation would compare with expected spending under current law. We also assess the effects of our recommendations on beneficiaries and providers. Although we recognize budgetary consequences, our recommendations are not driven by any specific budget target, but instead reflect our assessment of the level of payment that efficient providers would need to ensure adequate beneficiary access to appropriate care.

Payment adequacy in context

As discussed in Chapter 1, it is essential to look at payment adequacy not only within the context of individual payment systems but also in terms of Medicare as a whole. The Commission is concerned by any increase in Medicare spending per beneficiary without a commensurate increase in value such as higher quality of care or improved health status. Growth in spending per beneficiary, combined with the aging of the baby boomers, will result in the Medicare program absorbing increasing shares of the gross domestic product and federal spending. Medicare's rising costs are projected to exhaust the Hospital Insurance Trust Fund (which funds Medicare Part A) and significantly burden taxpayers. Therefore, moderating growth trends in Medicare spending per beneficiary is necessary and will require vigilance to be achieved. The financial future of Medicare prompts us to look at payment policy and ask what can be done to develop, implement, and refine payment systems to reward quality and efficient use of resources while improving payment equity.

In many past reports, the Commission has stated that Medicare should institute policies that improve the program's value to beneficiaries and taxpayers. CMS is beginning to take such steps, and we discuss them in the sector-specific chapters that follow. Ultimately, increasing Medicare's value to beneficiaries and taxpayers requires knowledge about the costs and health outcomes of services. Until more information about the comparative effectiveness of new and existing health care treatments and technologies is available, patients, providers, and the

program will have difficulty determining what constitutes high-quality care and effective use of resources.

As we examine each of the payment systems, we also look for opportunities to develop policies that create incentives for providing high-quality care efficiently across providers and over time. Some of the current payment systems create strong incentives for increasing volume, and very few of these systems encourage providers to work together toward common goals. Alternative payment models are meant to stimulate delivery system reform toward more integrated and

value-oriented health care systems and may address these issues. In the near term, the Commission will continue to closely examine a broad set of indicators, make sure there is consistent pressure on providers to control their costs, and set a demanding standard for determining which sectors qualify for a payment update each year. In the longer term, pressure on providers may cause them to increase their participation in alternative payment models. We will continue to contribute to the development of those models and to increase their efficacy. ■

Endnotes

- 1 According to the draft affordability standards: “Participating Cascade Care public option carriers are required to cap reimbursement of providers and facilities for all covered benefits in the statewide aggregate, excluding pharmacy benefits, to one hundred sixty percent (160%) of the total amount Medicare would have reimbursed provider and facilities for the same or similar services” (<http://cascade-care-quality-value-and-affordability-standards.pdf> (wa.gov) (Washington State Health Care Authority 2020)).
- 2 The pandemic had major effects on service use and, in some cases, providers’ costs in 2020. To the extent that those effects continue into 2021, we attempt to factor them into our estimates of 2021 margins.
- 3 In most cases, we assess Medicare margins for the services furnished in a single sector and covered by a specific payment system (e.g., SNF or home health care services). However, in the case of hospitals, which often provide services that are paid for by multiple Medicare payment systems, our measures of payments and costs for an individual sector could become distorted because of the allocation of overhead costs or the presence of complementary services. For example, having a hospital-based SNF or IRF may allow a hospital to achieve shorter lengths of stay in its acute care units, thereby decreasing costs and increasing inpatient margins. For hospitals, we assess the adequacy of payments for the whole range of Medicare services they furnish—inpatient and outpatient (which together account for about 90 percent of Medicare payments to hospitals), SNF, home health care, psychiatric, and rehabilitation services—and compute an overall Medicare hospital margin encompassing costs and payments for all the sectors. The hospital update recommendation in Chapter 3 applies to hospital inpatient and outpatient payments; the updates for other distinct units of the hospital, such as SNFs, are covered in separate chapters.
- 4 Section 1805[11] of the Social Security Act [42 U.S.C. 1395b–6]

“Specifically, the Commission shall review payment policies under parts A and B, including—

(i) the factors affecting expenditures for the efficient provision of services in different sectors, including the process for updating hospital, skilled nursing facility, physician, and other fees, (ii) payment methodologies, and (iii) their relationship to access and quality of care for Medicare beneficiaries.”

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CHAPTER

3

**Hospital inpatient and
outpatient services**

R E C O M M E N D A T I O N

- 3** For fiscal year 2022, the Congress should update the 2021 Medicare base payment rates for acute care hospitals by 2 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Hospital inpatient and outpatient services

Chapter summary

Short-term acute care hospitals provide acute inpatient and outpatient services, such as treatments for acute medical conditions and injuries. Medicare's payment rates for inpatient and outpatient services are generally set under the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS). In 2019, payments under these hospital payment systems totaled \$186 billion. About 5.5 million beneficiaries had 8.7 million inpatient stays in the 3,200 acute care hospitals paid under the IPPS in 2019. That same year, 20.6 million beneficiaries made 97.1 million visits to the 3,700 hospitals providing outpatient services under the OPPS.

In this chapter, we make a recommendation on a payment rate update for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for most payment adequacy indicators. Where relevant, we have considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary changes or vary significantly across individual hospitals, they are best addressed through targeted temporary funding policies rather than a permanent change to all hospitals' payment rates in 2022 and future years. Based on information available at the time of publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to hospital payments in 2022. Instead, to the extent that the PHE continues, any

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payment rates change in 2022?

needed additional financial support should be targeted to affected hospitals that are necessary for access.

Assessment of payment adequacy

In 2019, most hospital payment adequacy indicators either remained positive or improved. Medicare beneficiaries continued to have good access to hospital care, the quality of hospital care improved, and hospitals maintained strong access to capital markets. The Medicare margin at IPPS hospitals remained negative but increased in 2019, and Medicare payments roughly matched relatively efficient hospitals' costs.

Beneficiaries' access to care—Medicare beneficiaries continued to have good access to hospital services in 2019.

- **Capacity and supply of providers**—Short-term acute care hospitals continued to have significant excess inpatient capacity in 2019, as indicated by an aggregate occupancy rate of 64 percent. This capacity remains adequate despite an increase in hospital closures in 2019 caused in part by declining admissions per capita. In 2020, the number of hospital closures decreased, but continued to exceed the number of openings.
- **Volume of services**—Inpatient stays per capita continued their gradual decline in 2019 (–1.9 percent), while outpatient services per capita continued their slow increase (0.7 percent). These trends reflect the continuing shift of care from inpatient to outpatient settings and from physician offices to hospital outpatient departments (as hospitals acquire physician practices). While the decline in inpatient use has been gradual, over time the results have been dramatic, with inpatient stays per capita falling by 31 percent since 1983.
- **Marginal profit**—IPPS hospitals with excess capacity continued to have financial incentives to provide inpatient and outpatient services to Medicare beneficiaries, as indicated by a marginal profit of about 8 percent in 2019.

Quality of care—In 2019, risk-adjusted readmission and mortality rates improved modestly, and patient experience measures remained stable. The Commission recommended in March 2019 a redesign of the current hospital quality payment programs, including removing the current penalty-only quality programs and enacting a new hospital value incentive program (HVIP) that balances rewards and penalties and has the potential to drive further improvement in hospital quality.

Providers' access to capital—Hospitals had record high all-payer operating and total margins, which contributed to strong access to capital in 2019. Furthermore, hospital construction spending held steady, municipal bond interest rates remained

low, hospital mergers and acquisitions continued, and hospital employment remained stable.

Medicare payments and providers' costs—Medicare's payments to IPPS hospitals grew faster than hospitals' costs in 2019, resulting in the aggregate Medicare margin increasing slightly from –9.3 to –8.7 percent among all IPPS hospitals and the median margin increasing from about –2 percent to –1 percent for relatively efficient hospitals. This increase in hospitals' Medicare margin was in part because IPPS payments per inpatient stay grew faster than hospitals' costs per stay, reflecting payment rates that included an overestimate of input price inflation. But the increase in hospitals' Medicare margin occurred primarily because Medicare made additional payments to hospitals to help cover the costs of charity care and non-Medicare bad debts. Medicare's uncompensated care payments, which are added on to the payments Medicare makes for each inpatient stay, are designed to increase when the rate of uninsured individuals increases and hospitals provide more uncompensated care. In 2019, CMS projected the national uninsured rate would increase 16 percent. This projection was the primary reason Medicare paid an additional \$1.5 billion in uncompensated care payments in 2019 (a 22 percent increase from 2018).

While the coronavirus PHE has made 2020 an anomalous year in many respects and it is impossible to predict with certainty the extent to which these effects will continue into 2021, we expect IPPS hospitals' Medicare margin to increase to about –6 percent in 2021, driven by substantially higher payment rate updates than in 2019 and prior years and the suspension of Medicare sequestration through the first half of fiscal year 2021. We also expect the efficient providers' Medicare margin will improve in 2021 to become slightly positive. The exact increase in the Medicare margin will depend in large part on the duration and severity of the coronavirus pandemic, volume changes, case-mix changes, and changes in costs relative to input price inflation, as well as any additional payment or other policy changes enacted in response to the pandemic.

How should payment rates change in 2022?

Under current law, fee-for-service Medicare hospital base payment rates are projected to increase by about 2.4 percent in 2022, substantially higher than in 2019 and prior years, due to the expiration of statutory reductions in hospital updates required by the Affordable Care Act for each year from 2010 through 2019 and to lower productivity offsets. In addition, inpatient payments will increase by 0.5 percent, caused by unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers' documentation and coding. This change will result in an estimated 2.9 percent increase in inpatient payment rates and 2.4 percent increase in outpatient payment rates.

Given our positive payment adequacy indicators, a payment update of 2 percent in 2022—plus the statutory additional 0.5 percent increase to inpatient payments and the 0.8 percent increase to inpatient payments from our standing recommendation to replace the current quality program penalties with the HVIP—would be enough to maintain beneficiaries’ access to care and keep payment rates close to the cost of delivering high-quality care efficiently. On net, inpatient payments would increase by 3.3 percent and outpatient payment rates would increase by 2.0 percent. The 2.0 percent outpatient update (rather than the 2.4 percent estimated current law) would limit growth in the differential between rates paid for physician office visits on a hospital campus and rates paid for these visits at freestanding physician offices.

Mandated report: Expanding the post-acute care transfer policy to hospice

Under the post-acute care transfer policy, when Medicare beneficiaries with certain conditions have short inpatient stays and 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 post-acute care transfer policy to include hospital transfers to hospice beginning in fiscal year 2019 and mandated that the Commission evaluate and report on the effects of this policy change.

We estimate that the policy change resulted in savings of about \$304 million in fiscal year 2019 and about \$78 million in the first quarter of fiscal year 2020, without any discernable changes in Medicare beneficiaries’ timely access to hospice care. ■

Background

Short-term acute care hospitals provide acute inpatient and outpatient services, such as treatments for acute medical conditions and injuries.¹ Fee-for-service (FFS) Medicare payment rates for inpatient and outpatient services are generally set by the inpatient prospective payment system (IPPS) and outpatient prospective payment system (OPPS).² In 2019, payments under these hospital payment systems totaled \$185.7 billion (Table 3-1).³

- **IPPS:** Medicare pays about 3,200 of the 4,700 short-term acute hospitals that participate in the Medicare program for inpatient services under the IPPS. In fiscal year 2019, these hospitals received \$111.3 billion in IPPS payments from the Medicare program and its beneficiaries for 8.7 million inpatient stays by 5.5 million FFS Medicare beneficiaries. Approximately 2,700 of these hospitals received an additional \$8.1 billion from the Medicare program for uncompensated care (charity care and non-Medicare bad debts).
- **OPPS:** Medicare pays some 3,700 short-term and other hospitals for outpatient services under the OPPS.⁴ In calendar year 2019, these hospitals received \$66.2 billion from the Medicare program and its beneficiaries for 97.1 million outpatient visits by 20.6 million FFS Medicare beneficiaries.

The nearly \$186 billion in IPPS and OPPS payments in 2019 was slightly higher than in 2018 (\$181 billion). Medicare’s payments to hospitals rose because increases in payment rates, payments for uncompensated care and Part B drugs, and outpatient services per capita more than offset declines in inpatient stays per capita and declines in the number of FFS beneficiaries.

How Medicare sets hospital payment rates

Under the IPPS and OPPS, CMS sets FFS Medicare payment rates for inpatient and outpatient services prospectively. CMS adjusts IPPS and OPPS payment rates for factors outside hospitals’ control, such as regional wage rates or patient characteristics. One rationale for paying hospitals on a prospective basis is to increase hospitals’ incentive to control their costs. Indeed, as we have reported in previous years’ March reports, hospitals with higher costs are often those under less pressure to constrain costs.

FFS Medicare hospital payment rates affect not only the Medicare program but also an increasing number of other payers that use FFS Medicare rates as benchmarks (see text box on payment rates to hospitals, p. 60).

Inpatient prospective payment system

The IPPS primarily pays hospitals a predetermined amount per inpatient stay. The IPPS per stay payments are derived through adjustments applied to separate, annually updated operating and capital base payment rates. Adjustments to base rates include those for geographic factors, case mix

**TABLE
3-1**

Medicare payments under IPPS and OPPS, 2019

Medicare payment system	Number of hospitals (in thousands)	Payments (in billions)
IPPS—Inpatient services	3.2	\$111.3
IPPS—Uncompensated care	2.7	8.1
OPPS—Outpatient services	3.7	66.2
Total		185.7

Note: IPPS (inpatient prospective payment system), OPPS (outpatient prospective payment system). Payments include any applicable beneficiary cost-sharing responsibilities. The year refers to fiscal year for inpatient services and calendar year for outpatient services. Components do not sum to total because of rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data, IPPS final rule, and outpatient claims.

Fee-for-service Medicare payment rates to hospitals are benchmarks for Medicare Advantage plans and other payers

Increasingly, fee-for-service (FFS) Medicare hospital payment rates are used as rate-setting benchmarks by Medicare Advantage (MA) plans and other payers. As such, any update to these FFS Medicare payment rates will have broader effects, including:

- **MA plan hospital payment rates.** Most MA plans pay hospitals using rates that are equal to rates under FFS Medicare (Berenson et al. 2015, Maeda and Nelson 2017).
- **Department of Veterans Affairs payment rates to community hospitals and other providers.** Since 2011, the Department of Veterans Affairs (VA) has been setting payment rates for most care—including hospital care—provided in non-VA settings not to exceed FFS Medicare rates, citing Medicare as the federal health care industry standard (Department of Veterans Affairs 2019).⁵
- **Upper limit on hospital rates for Medicaid beneficiaries and low-income uninsured.** The Medicaid program uses FFS Medicare rates when setting maximum supplemental “upper payment limit” FFS Medicaid payments to hospitals. States can make supplemental payments to hospitals to make up the difference between the Medicaid payments and the Medicare limit; states reported \$13 billion in such payments in 2017 (Medicaid and CHIP Payment and Access Commission 2019). The rates that uninsured individuals pay are also often benchmarked to Medicare, a result of limits on rates charged to low-income uninsured individuals that were enacted in the Affordable Care Act.
- **State health plans.** Some states’ employee health plans set their hospital payment rates based on a percentage of FFS Medicare rates, and other states have made proposals to do so.⁶ ■

(the expected relative costliness of inpatient treatment for patients with similar clinical conditions), and certain hospital characteristics (such as teaching hospitals or disproportionate share hospitals (DSHs) serving a disproportionate share of low-income patients). The IPPS has additional payment adjustments for new technologies, extraordinarily high-cost cases, certain rural hospitals, and quality incentives and penalties.

Beginning in 2014, each DSH receives a reduced IPPS adjustment but also receives its share of a predetermined pool of payments for uncompensated care (charity care and non-Medicare bad debts). The uncompensated care pool is based on estimates of what DSH payments would have been under prior law and on the national uninsured rate relative to 2013.⁷

Outpatient prospective payment system

The unit of payment in the OPSS consists of a primary service and ancillary items that are packaged with

the primary service. Examples of primary services include emergency department visits, computed tomography scans, and surgical procedures. The OPSS pays a predetermined amount for each primary service. CMS classifies the services into ambulatory payment classifications (APCs) based on clinical and cost similarity. For each APC, CMS determines a base payment rate using the geometric mean cost that hospitals incur when providing the services in the APC. CMS adjusts the base payment rate for each service provided for geographic differences in input prices. The OPSS also has special payments for new technologies, designed for situations in which individual services cost the hospital much more than the base payment, and for certain hospital types (such as cancer, children’s, and rural sole community hospitals). The OPSS also pays separately for drugs that have costs exceeding a threshold, corneal tissue acquisition, and blood and blood products.⁸

The coronavirus public health emergency and the Commission's payment adequacy framework

Since early 2020, the coronavirus public health emergency (PHE) has had tragic effects on beneficiaries' health.⁹ It also has had material effects on providers' patient volume, revenues, and costs. In March and April of 2020, COVID-19 admissions spiked in some parts of the country. Concerns about hospital capacity and patient safety led to a dramatic drop in elective surgeries and hospitals' overall revenue. For many hospitals, April revenue fell by roughly half before largely rebounding by June 2020. For some hospitals, federal coronavirus relief grants and cost reductions offset lost revenue, allowing them to remain profitable during the first three quarters of 2020, but other hospitals experienced losses. In the fourth quarter of 2020, COVID-19 admissions spiked again in many parts of the country. Uncertainty remains about the extent to which the pandemic will affect patient care patterns, hospital volume, and hospital financial performance in 2021 and 2022.

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for most payment adequacy indicators. We use available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the effects of the coronavirus PHE are temporary changes or vary significantly across individual hospitals, they are best addressed through targeted temporary funding policies rather than a permanent change to all hospitals' payment rates in 2022 and future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of the coronavirus PHE on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare base payment rates. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2.) ■

Are Medicare payments adequate in 2021?

To assess whether FFS Medicare payments in 2021 are adequate for relatively efficient hospitals, we examined payment adequacy indicators in four categories:

- beneficiaries' access to hospital inpatient and outpatient care;
- quality of hospital care;
- hospitals' access to capital; and
- the relationship between FFS Medicare payments and hospitals' costs, both across all IPPS hospitals and limited to relatively efficient hospitals.¹⁰

Most of our payment adequacy indicators for hospitals were positive in 2019—the most recent year in which we have data for most indicators—with relatively efficient

IPPS hospitals improving their overall Medicare margin slightly from –2 percent in 2018 to –1 percent in 2019. (For a description of how the coronavirus pandemic has been incorporated into our payment adequacy framework, see text box.)

While it is impossible to precisely predict the future given the evolving coronavirus pandemic, we anticipate most hospital payment adequacy indicators will remain positive in 2020 and 2021 and that IPPS hospitals' aggregate Medicare margin will increase to –6 percent in 2021, resulting from substantially higher payment rate updates in 2020 and 2021 relative to 2019 and prior years, and the suspension of Medicare sequestration for at least the first half of fiscal year 2021.

Beneficiaries continued to have good access to hospital inpatient and outpatient services

FFS Medicare beneficiaries continued to have good access to hospital inpatient and outpatient services in 2019, as

hospitals continued to have excess inpatient capacity and a financial incentive to serve FFS Medicare beneficiaries.

The coronavirus public health emergency (PHE) affected hospitals' inpatient capacity and FFS Medicare beneficiaries' use of hospital services during parts of 2020; however, volume largely returned by the end of fiscal year 2020, and fewer hospitals closed in 2020 than in 2019. While there will continue to be variable effects in fiscal year 2021, we anticipate that in aggregate—across all hospitals and the entirety of the year—indicators of beneficiaries' access to care will remain positive in 2021.

Hospitals continued to have significant excess inpatient capacity in 2019

Short-term acute care hospitals continued to have significant excess inpatient capacity in aggregate, with approximately two-thirds (64 percent) of all bed-days occupied during 2019. Hospitals' aggregate occupancy rate has slowly increased over the last five years as the number of inpatient, swing, or observation days slightly increased and the number of available beds slightly decreased. Nevertheless, hospitals have continued to maintain excess inpatient capacity despite population growth and some hospital closures because of continued declines in inpatient stays per capita.

The occupancy rate also continued to vary across different types of hospitals. In particular:

- ***Rural hospitals continued to have a lower occupancy rate.*** Small rural hospitals designated as critical access hospitals had an occupancy rate of 36 percent, indicating that about one-third of their beds—including observation and post-acute patients in swing beds—were occupied, on average. IPPS hospitals in rural nonmicropolitan counties had a similarly low occupancy rate (34 percent), while those in micropolitan areas had a slightly higher occupancy rate (47 percent). In contrast, IPPS hospitals in metropolitan areas had an occupancy rate of 68 percent.
- ***Teaching hospitals and those that treated a disproportionate share of low-income patients continued to have a higher occupancy rate.*** IPPS hospitals that were both teaching hospitals and DSHs had a substantially higher occupancy rate (72 percent) than nonteaching hospitals and non-DSHs (52 percent).

Hospital occupancy rates varied substantially across hospitals and time periods in 2020, attributable to the coronavirus PHE, including some geographic areas exceeding their hospital capacity as COVID-19 cases peaked. However, limited data to date suggest that hospitals' aggregate occupancy rate across the entirety of fiscal year 2020 dipped, attributable to a decline in all-payer inpatient stays and temporary increases in beds to provide surge capacity.

Fewer hospital closures in 2020 after a peak in 2019

While hospital closures are still relatively rare events, there was an increase from fiscal year 2018 to 2019, when closures rose from 19 to 46.¹¹ The number of closures then decreased to 25 in fiscal year 2020.

The majority of the 71 hospitals that closed in 2019 and 2020 were small (52 had 100 or fewer beds) and located in urban metropolitan areas (39). In comparison, 30 hospitals opened in 2019 and 2020 combined, slightly more than the 17 that opened over the prior two years. The hospitals that opened were small (all had 100 or fewer beds) and all but 3 were in urban areas.

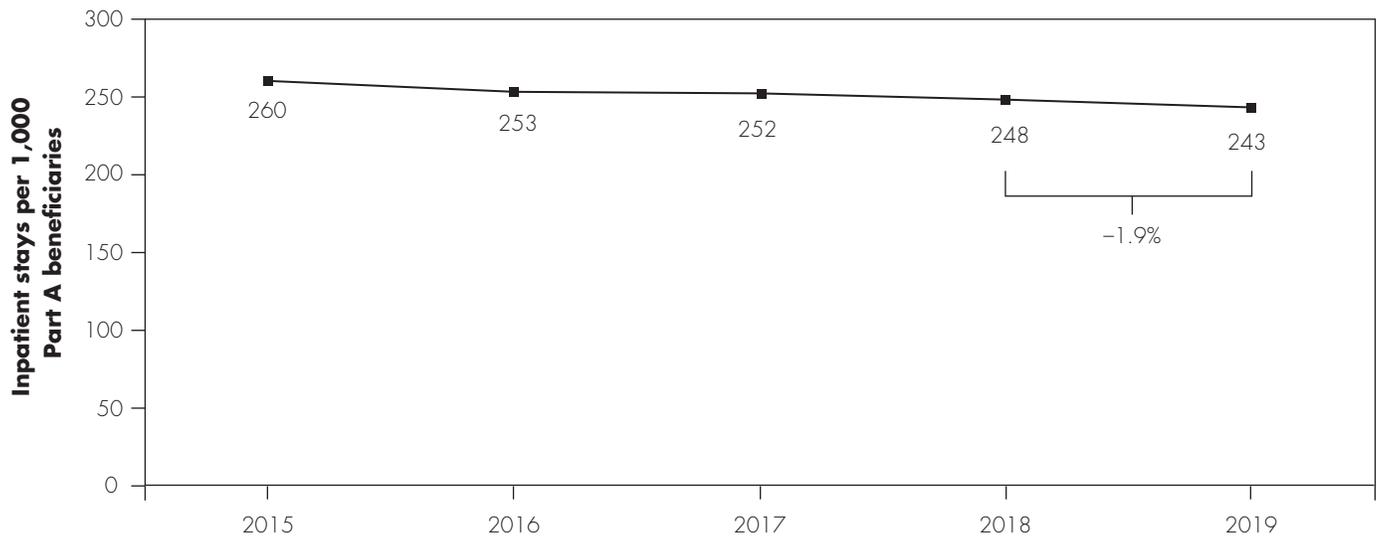
A majority of the hospitals that closed in 2019 and 2020 cited financial reasons as a driving factor for closure. The closed hospitals had comparatively low inpatient occupancy rates (29 percent, on average) and poor profitability (all-payer margin of –11 percent, on average, in the year before closure). The 11 critical access hospitals that closed averaged a slightly positive Medicare margin but an all-payer margin of –13 percent caused by losses on their non-Medicare patients. Several of the hospitals that closed during the two-year period filed for bankruptcy before their closure. Nonfinancial reasons for closures included consolidation, environmental factors (e.g., destruction attributable to the Camp Fire in California), and failure to meet Medicare conditions of participation.

Rural hospitals often face the greatest challenges with declining admissions, in part resulting from rural beneficiaries increasingly bypassing their local hospitals to seek care at urban hospitals. In 2010, 40 percent of rural beneficiaries' hospital admissions were in urban hospitals; by 2018, this share grew to 48 percent of their admissions.

The effect of recent hospital closures on beneficiaries' access varied. The average distance from the 29 hospitals that closed in 2020 to the nearest hospital was about 12

**FIGURE
3-1**

FFS Medicare beneficiaries' inpatient stays per capita continued gradual decline in 2019



Note: FFS (fee-for-service). Analysis includes FFS Medicare beneficiaries' inpatient stays across all short-term acute care hospitals in the U.S. per 1,000 FFS Medicare Part A beneficiaries. Percentage change was calculated prior to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review data and enrollment data from the Medicare Trustees report.

miles, and nearly half of the closures were within 5 miles of the nearest hospital. None of the closures involved hospitals more than 35 miles away from the next nearest hospital, suggesting most beneficiaries continued to have access to inpatient services in their region. In addition, some of the former hospital locations still offered some services, such as urgent care or clinic services, while others were actively working to reopen.

The Commission is especially concerned with rural beneficiaries' access to care as the number of rural hospital closures increases without a comparable increase in rural hospital openings. The Commission recommended in June 2018 that Medicare help preserve access to emergency services in cases where a full-service hospital is not viable by allowing isolated, rural stand-alone emergency departments (Medicare Payment Advisory Commission 2018).

The coronavirus PHE has made 2020 an anomalous year in many respects; for example, hospitals received targeted funding that may have prevented some closures.

It is unclear the extent to which the downward trend will continue in 2021.

Inpatient stays per capita continued their gradual decline in 2019

In 2019, FFS Medicare beneficiaries' inpatient stays per capita declined 1.9 percent (Figure 3-1), reflecting a continued shift of care to outpatient settings. For example, inpatient major hip and knee replacements per capita declined 8 percent (data not shown). The decline in inpatient stays per capita was a continuation of the historical trend—among both FFS Medicare beneficiaries and those who are commercially insured. For example, from 2015 to 2018, Medicare inpatient stays per capita fell 4.7 percent; among the commercially insured population, they fell 3.5 percent (Health Care Cost Institute 2020). While the decline in inpatient use has been gradual, over time the results have been dramatic: Since the IPPS started in 1983, inpatient stays per capita have declined by 31 percent and inpatient days per capita declined even faster,

dropping 63 percent (Centers for Medicare & Medicaid Services 2020, Health Care Financing Administration 1995).

Differential trends in inpatient stays also continued in 2019, resulting in continued shifts in the share of FFS Medicare beneficiaries' inpatient stays at certain types of hospitals and in the share of certain types of inpatient stays. In particular:

- ***Share of inpatient stays at rural hospitals continued to decline.*** The share of FFS Medicare beneficiaries' inpatient stays at hospitals in rural nonmicropolitan counties was 4.8 percent in 2019, down from 5.0 percent in 2018 and 5.4 percent in 2015. The share of inpatient stays at hospitals in rural micropolitan counties has also been decreasing, but to a smaller extent (to 8.5 percent from 8.9 percent in 2015). An analysis of claims data finds that the continued shift of inpatient stays from rural hospitals to urban hospitals reflects primarily beneficiaries bypassing their local rural hospital for inpatient care.
- ***Share of one-day inpatient stays continued to increase.*** The share of FFS Medicare beneficiaries' inpatient stays that were only one day was 14.1 percent in 2019, up from 13.4 percent in 2018 and 11.6 percent in 2014. As the Commission has previously noted, growth in the number of one-day stays could be attributable to the reduced likelihood in recent years that CMS's recovery audit contractors (RACs) will deny payment for one-day stays. In 2015, CMS ceased patient status reviews (which previously resulted in challenges to one-day stay claims). As a result, from 2014 to 2015, the number of claims that were challenged by the RACs as overpayments fell by 91 percent (Centers for Medicare & Medicaid Services 2015).
- ***Share of inpatient stays discharged to home health care and hospice continued to increase.*** The share of FFS Medicare beneficiaries' inpatient stays that resulted in a discharge to home with home health care was 18.4 percent in 2019, up from 18.1 percent in 2018 and 16.9 percent in 2015. At the same time, the share of inpatient stays discharged to skilled nursing facilities decreased slightly. This phenomenon, in conjunction with the increase in the share of one-day inpatient stays, could reflect a growing trend in hospitals discharging Medicare beneficiaries to home with home health care in lieu of monitoring them in

the hospital or a skilled nursing facility. In addition, the share of discharges to hospice increased to 3.4 percent, up slightly from 2018. (For the results of our analysis in support of the mandated report on the expansion of the IPPS transfer policy to hospice, see the text box, pp. 83–87.)

As a result of the coronavirus PHE, hospitals in aggregate experienced substantial declines in FFS Medicare and total inpatient volume in late March and April 2020. The extent of the declines and subsequent rebounds varied across types of inpatient stays, with smaller declines and faster returns to near-normal volumes among less discretionary stays. For example, Medicare beneficiaries' inpatient stays with heart attacks declined in April to 70 percent of prior-year levels and fully rebounded by mid-June, staying near prior-year levels through December 2020. Similarly, non-COVID-19 emergency visits that resulted in an inpatient stay initially declined in April to 50 percent of prior-year levels, partially rebounded to 80 percent of prior-year levels by June, and remained near that level through December. By contrast, more discretionary services had much larger initial declines, with total knee replacements dipping in April to 5 percent of prior-year levels. Total knee replacements then rebounded to 75 percent of prior-year levels by June but began declining as the third wave of COVID-19 cases began in late fall.

While the duration and severity of the coronavirus PHE is unclear, based on information available at the time of this publication, we do not anticipate that it will cause any long-term deviations from the historical trend of slow declines in FFS Medicare beneficiaries' inpatient stays per capita as care continues to shift to outpatient settings.

Outpatient hospital services per capita continued slight increase in 2019

Outpatient services to FFS Medicare beneficiaries per capita increased 0.7 percent in 2019—the same as in 2018. Consistent with prior years, this growth reflects two trends:

- ***Complex surgical procedures continued to shift from inpatient to outpatient settings.*** Growth in relatively complex services—such as knee replacement; endovascular procedures; and removal, replacement, or insertion of defibrillator systems or pulse generators—suggests that some of the growth in OPSS volume and payments is from services migrating from the (relatively higher cost) inpatient to the (relatively lower cost) outpatient setting. For example, in 2019,

**TABLE
3-2**

FFS Medicare beneficiaries' outpatient services per capita increased in HOPDs and decreased in physician offices

Outpatient services per 1,000 Part B beneficiaries

Service	HOPD			Physician office		
	2013	2019	Percent change	2013	2019	Percent change
Clinic or physician office visit	780	972	25%	6,765	6,448	-4.7%
Chemotherapy administration	99	144	45	158	139	-12.4

Note: FFS (fee-for-service), HOPD (hospital outpatient department). HOPDs include all hospitals in the U.S. paid under the outpatient prospective payment system.

Source: MedPAC analysis of outpatient claims and enrollment data from the Medicare Trustees report.

the volume of outpatient services in the Healthcare Common Procedure Coding System (HCPCS) 93656 (a test of electrical activity of the heart) increased 15.8 percent (138 per 100,000 beneficiaries in 2019 versus 116 per 100,000 beneficiaries in 2018). OPSS payments for this service also increased, by 19.1 percent.

- Clinic visits, drug administration, and other services continued to shift from physician offices to hospital outpatient departments as hospitals have acquired physician practices.** A large source of growth in hospital outpatient department (HOPD) volume and OPSS payments for hospital outpatient services has been attributable to a shift from (relatively lower cost) physician offices to (relatively higher cost) HOPDs. From 2013 to 2019, the volume of clinic visits and drug administration (especially for chemotherapy drugs) rose substantially in the hospital outpatient setting, while the volume of these services fell in freestanding physician offices (Table 3-2). However, from 2018 to 2019, the growth in clinic visits in HOPDs slowed, increasing by only 1.6 percent. The relatively slow growth in clinic visits and a small decrease in other evaluation and management services, such as emergency department (ED) visits, is a main reason why overall volume growth in HOPDs from 2018 to 2019 moderated. Despite this moderation, the fact that outpatient volume has grown for over 10 consecutive years suggests FFS Medicare beneficiaries have adequate access to outpatient care.

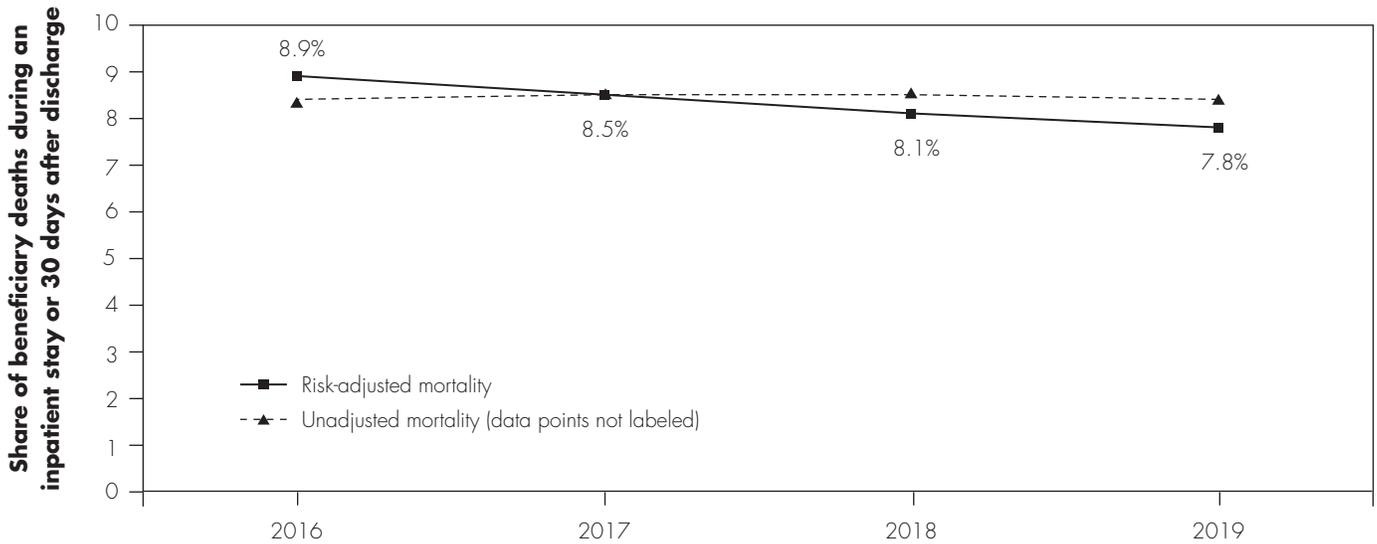
The coronavirus PHE undoubtedly depressed HOPD volume among Medicare beneficiaries in 2020, but data limitations prevent us from providing a precise estimate of the effect at this time. In Medicare, ED visits and clinic visits are two of the most commonly billed services under the OPSS. As for ED visits, we found that the volume in April 2020 was 51 percent of volume in January 2020; as for HOPD clinic visits, volume in April 2020 was 30 percent of volume in January 2020. The volume of these two services rebounded quickly. By June 2020, the volume of ED visits and clinic visits rebounded to about 75 percent of their January 2020 levels.

Hospitals with excess capacity continued to have a financial incentive to serve Medicare beneficiaries in 2019

Hospitals with excess capacity continued to have financial incentives to provide inpatient and outpatient PPS services to FFS Medicare beneficiaries: Their marginal profit on these services remained over 8 percent in 2019. We calculate hospitals' Medicare marginal profit by comparing Medicare's IPSS and OPSS payments with the variable cost of treating an additional FFS Medicare patient. To make a conservative estimate of hospitals' Medicare marginal profit, we use a broad definition of variable costs that is consistent with our prior estimates of the share of costs that varied over a one-year time period. We find that roughly 80 percent of costs are variable; to the extent that a higher share of costs is fixed, the marginal profit would be higher.

**FIGURE
3-2**

FFS Medicare beneficiaries' risk-adjusted, all-condition mortality rates have declined



Note: FFS (fee-for-service). Analysis includes FFS Medicare beneficiaries ages 65 and older. The 2016 to 2018 risk-adjusted values differ from what was presented in the March 2020 report to the Congress because of an update to the baseline years used to calculate expected values (using 2016–2018 instead of 2010–2012 data) and use of an updated version of the 3M™ all-patient refined–diagnosis related group software.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

The rapid response to the coronavirus pandemic has demonstrated that at least some hospitals can substantially decrease their costs over a matter of months. For example, the largest hospital systems were able to substantially reduce costs from the first quarter of 2020 to the second quarter of 2020, despite the expectation that the reduction in volume would be temporary (Medicare Payment Advisory Commission 2020a). We expect that hospitals will have an even greater ability to adjust costs when they have a longer time period to adapt to environmental changes and resulting anticipated long-term changes in volume.

Quality of care improved modestly or remained stable

Two key indicators of the quality of hospital inpatient services provided to FFS Medicare beneficiaries—risk-adjusted mortality rates and readmission rates—improved modestly in 2019, and patient-reported experience measures remained high.

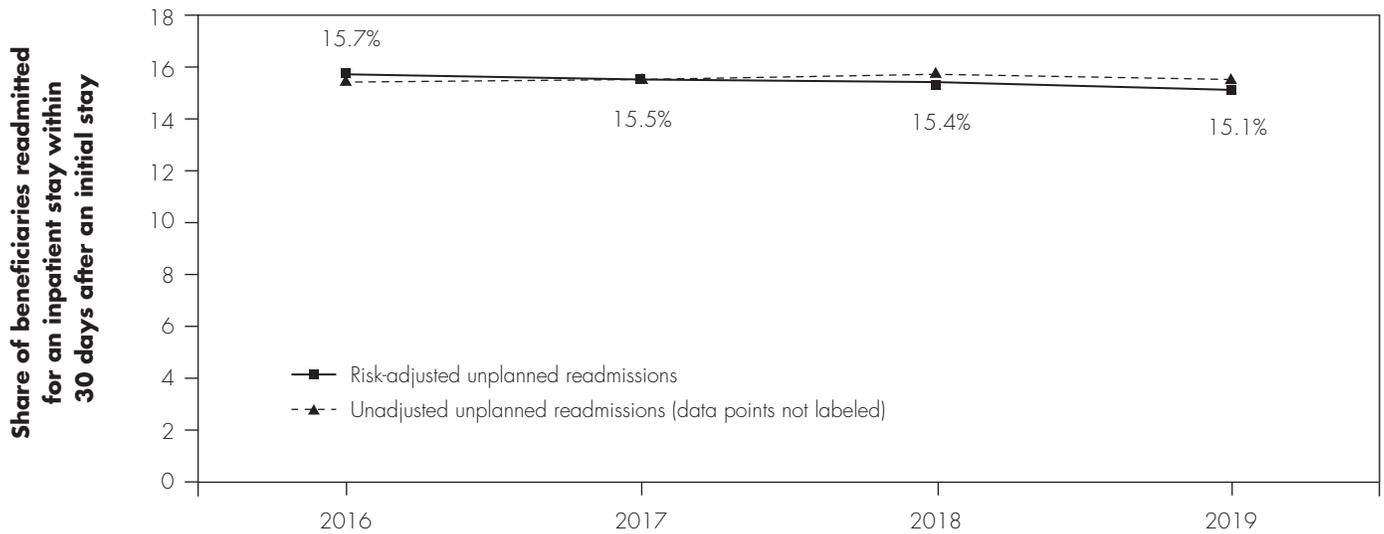
The quality of hospital care in 2020 will be difficult to assess and compare because of the coronavirus PHE. It is likely that information on quality performance during the PHE will be incomplete for at least some portion of 2020 performance and will reflect the pandemic’s tremendous impact on mortality. CMS’s guidance on reporting requirements and how the PHE will affect quality payment programs is evolving. To date, CMS has stated it will exclude at least some of the 2020 experience from the calculation of results for quality payment programs.

Risk-adjusted mortality rate improved in 2019

From 2016 to 2019, FFS Medicare beneficiaries’ risk-adjusted mortality rate declined (that is, improved) by 1.1 percentage points, including a 0.3 percentage point decline in 2019 (Figure 3-2). Over the four-year period, unadjusted mortality rates were relatively stable, but expected mortality increased because beneficiaries admitted to hospitals in recent years tended to have more

**FIGURE
3-3**

FFS Medicare beneficiaries' risk-adjusted, all-condition readmission rates have declined



Note: FFS (fee-for-service). Analysis includes FFS Medicare beneficiaries ages 65 and older. The 2016 to 2018 unadjusted readmission results differ from what was presented in the March 2020 report to the Congress because we used CMS's updated definition of unplanned admissions published in their 2019 measure specifications. The 2016 to 2018 risk-adjusted values differ from what was presented in the March 2020 report to the Congress because of an update to the baseline years used to calculate expected values (using 2016–2018 instead of 2010–2012 data), use of an updated version of the 3M™ all-patient refined–diagnosis related group software, and use of CMS's updated unplanned admissions definition.

Source: MedPAC analysis of Medicare Provider Analysis and Review data.

comorbidities and thus a higher risk of mortality. Other studies have found similar improvements for condition-specific mortality and overall readmissions in earlier years (Hines 2015, Krumholz 2015, Medicare Payment Advisory Commission 2018).

Risk-adjusted readmission rates improved in 2019

The Congress enacted the Hospital Readmission Reduction Program (HRRP) in 2010, and since that time, FFS Medicare beneficiaries' readmission rates have fallen. Our recent analysis of the HRRP found that the program gave hospitals an incentive to reduce unplanned readmissions (Medicare Payment Advisory Commission 2018). Our updated analysis of readmission rates across all conditions for beneficiaries over age 65 found that between 2016 and 2019, the raw unplanned readmission rate increased slightly by 0.1 percentage point, from 15.4 percent to 15.5 percent

(Figure 3-3). Once risk adjusted, these rates declined from 15.7 percent to 15.1 percent.

Patient experience measures remained stable in 2019

Patient-reported experiences regarding their care during inpatient stays remained stable from 2016 to 2019. Hospitals collect Hospital Consumer Assessment of Healthcare Providers and Systems® (H-CAHPS®) surveys from a sample of admitted patients, which CMS uses to calculate results for 10 measures of patient experience.¹² The H-CAHPS measures key components of quality by assessing whether something that should happen during a hospital stay (such as clear communication) actually happened or how often it happened. In 2019, communication with nurses, communication with doctors, and receipt of discharge information had the highest scores, with over 80 percent of surveyed patients answering with the most positive response. From 2016

The Commission's standing recommendation to replace current hospital quality programs with a new hospital value incentive program

The Commission asserts that quality measurement should be patient oriented, encourage coordination, and promote delivery system change. In March 2019, the Commission recommended that the Congress replace fee-for-service 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 (Medicare Payment Advisory Commission 2019). Consistent with the Commission's principles, the HVIP links payment to quality of care to reward hospitals for providing high-quality care to beneficiaries while maintaining low episode costs.

Initially, the HVIP can incorporate existing quality measure domains such as readmissions, mortality, spending, patient experience, and hospital-acquired conditions (or infection rates). By using existing measures on which hospitals are already evaluated, assuming equal weighting of the measure domains, the HVIP raises the weight of mortality and patient experience and lowers the weight of readmissions and infection rates compared with current quality programs. In line with the Commission's principles, the HVIP uses clear, prospectively set performance standards to translate hospital performance on these quality measures to a reward or a penalty.

According to the Commission's principles, adjusting measure results for social risk factors is important

because these factors can mask disparities in clinical performance. Accordingly, the HVIP accounts for differences in providers' patient populations by incorporating a peer-grouping methodology in which quality-based payments are distributed to hospitals separated into 10 peer groups, defined by the share of treated beneficiaries with full dual eligibility for Medicare and Medicaid (as a proxy for income). The HVIP redistributes pools of dollars to hospitals in the peer groups based on their quality performance. The pools of dollars are funded by a payment withhold from all hospitals in the peer group (e.g., 5 percent).

Under the Commission's HVIP model, the grouping of hospitals into peer groups that serve similar populations makes payment adjustments more equitable than existing quality payment programs. As a result, we expect that under the HVIP, large urban hospitals and major teaching hospitals would, on average, receive rewards rather than the penalties they receive under current programs. Rural and nonteaching hospitals, on average, would receive higher rewards than large urban and major teaching hospitals. Relatively efficient providers also would receive more of a reward from the HVIP compared with other hospitals. All groups receive higher payments on average as a result of removing penalties in the current program. In addition, all hospitals would benefit from the streamlined reporting and the HVIP's lower burden of data collection. ■

to 2019, the share of patients rating their overall hospital experience a 9 or 10 on a 10-point scale remained stable at 73 percent. In 2019, the care transitions measure result remained low, with only 54 percent of surveyed patients responding with "Strongly Agree" that they understood their care plan when they left the hospital.

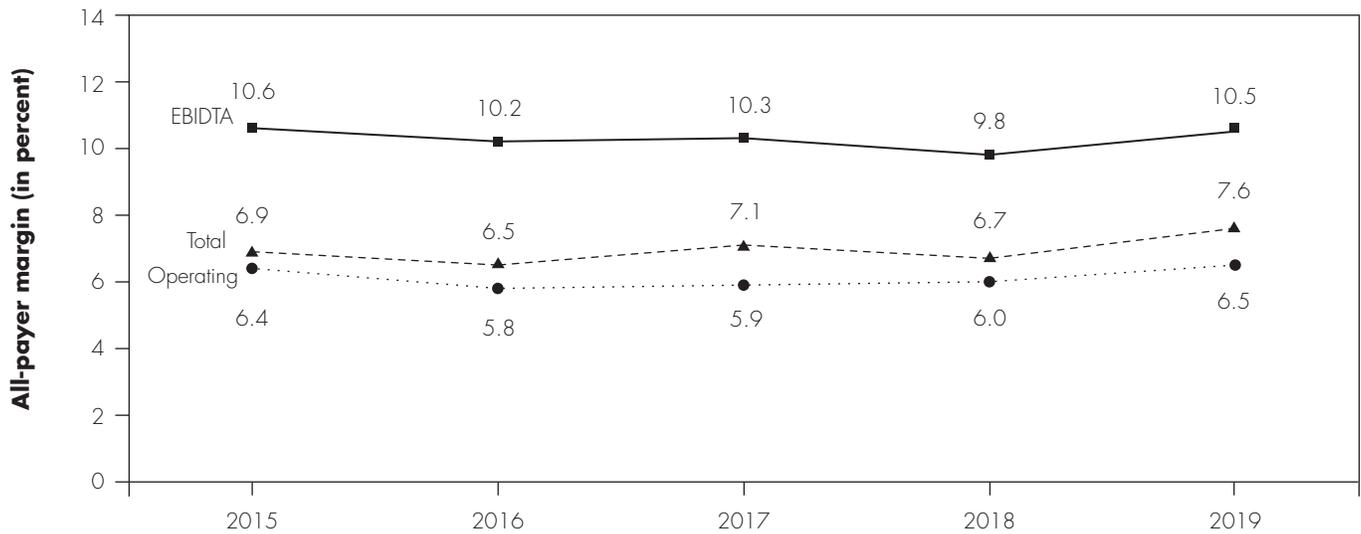
Need for a redesign of hospital quality payment programs

At least part of the improvement in quality appears to be attributable to financial incentives from three Medicare

quality incentive programs added to the IPPS in 2013 and 2015: the HRRP (which can reduce payments up to 3.0 percent), the Hospital Value-Based Purchasing (VBP) Program (which can raise a hospital's payment by as much as 3.0 percent or lower it by up to 1.5 percent), and the Hospital-Acquired Condition Reduction Program (which can reduce a hospital's payments by 1 percent for 25 percent of hospitals). In 2019, hospitals' performance on the combined quality programs had the potential to increase a hospital's IPPS payment rates by as much as

**FIGURE
3-4**

IPPS hospitals' all-payer financial performance has been strong, with total and operating margins reaching record highs in 2019



Note: IPPS (inpatient prospective payment system), EBITDA (earnings before interest, taxes, depreciation, and amortization). Analysis includes short-term acute care hospitals in the U.S. paid under the IPPS with complete and nonoutlier cost report data. A margin is calculated as aggregate payments minus aggregate allowable costs, divided by aggregate payments.

Source: MedPAC analysis of hospital cost reports.

about 3 percent and lower payments by as much as about 5.5 percent. Under the combined effect of the program in 2019, almost a quarter of hospitals saw a net increase in IPPS payments (averaging about 0.5 percent in IPPS payments), and about 70 percent of hospitals saw a net decrease of payments (averaging about 1 percent of IPPS payments). Together, the payments from the two quality penalty programs decreased inpatient payments by about \$0.9 billion in 2019, equivalent to 0.8 percent of IPPS operating payments (including uncompensated care).

In March 2019, the Commission recommended that the Congress replace Medicare's current hospital quality programs (including the penalty-only programs) with a single, outcome-focused quality-based payment program for hospitals—that is, the hospital value incentive program (HVIP)—which balances rewards and penalties and has the potential to drive further improvement in hospital quality (see text box).

Hospitals' access to capital remained strong

Hospitals had record high all-payer operating and total margins, which contributed to strong access to capital in 2019.

In 2020, the coronavirus PHE affected hospitals' access to capital, with different effects on different groups of hospitals. However, in aggregate, the additional federal support hospitals received—as well as advanced Medicare payments—helped maintain hospitals' aggregate access to capital in 2020 near the record highs in 2019. Through November 2020, we saw no increase in rates lenders required from hospitals.

All-payer financial performance reached record highs in 2019

In aggregate, IPPS hospitals' all-payer financial performance was very strong in 2019, with key measures of hospitals' financial performance reaching record highs (Figure 3-4).

- IPPS hospitals' all-payer operating margin—a measure of how hospitals' patient care revenue compares with their operating costs—increased to 6.5 percent, slightly above the prior all-time high of 6.4 percent in 2015.
- IPPS hospitals' all-payer total margin—which includes nonpatient care revenue, such as investment income—increased to 7.6 percent, above the prior all-time high of 7.1 percent in 2017.
- IPPS hospitals' cash flow—as measured by earnings before interest, taxes, depreciation, and amortization—increased to 10.5 percent, the highest level since 2015.

(These all-payer margins calculated from hospitals' cost reports are similar to those calculated from other data sources, such as data collected by the American Hospital Association, with minor differences resulting from differences in the set of included hospitals.)

Within these aggregate results, there continued to be substantial variation in hospitals' financial performance. For example, in 2019, for-profit IPPS hospitals' all-payer operating margin was 12.3 percent, more than double that of nonprofit IPPS hospitals. In contrast, the all-payer operating margin at rural nonmicropolitan IPPS hospitals was only 0.6 percent in 2019 (data not shown).

While the coronavirus pandemic has been a human tragedy, the Congress has supported hospitals with over \$70 billion in supplemental funds as they rise to the pandemic challenge. We find no evidence of widespread financial struggles at hospitals in aggregate. In fact, some large hospital systems returned some relief funds they received because the funds exceeded their pandemic-related losses. Therefore, while the effect of the coronavirus pandemic on hospitals' finances varied substantially across hospitals, we have no evidence that it has had a dramatic effect on hospitals' long-term access to the capital markets.

Construction spending held steady in 2019, and bond issuances remained strong

Hospital construction spending was \$26 billion in 2019, similar to prior years. Hospital construction spending has been relatively stable since 2014 when the health care industry began to see a decrease in spending on inpatient hospital capacity (Census Bureau 2019). This trend is in

part attributable to health systems focusing on lower cost outpatient facilities and renovations to existing facilities (Conn 2017).

Hospitals also issued \$23 billion in bonds in calendar year 2019, including \$16 billion in new financing and \$7 billion in refinancing (Thomson Reuters 2019). This level of bond funding was a decline from 2018, corresponding with an increase in interest rates, but similar to the level in 2016 and higher than bond issuances in 2015. Between January 2018 and January 2019, the average interest rate for double-A tax-exempt 30-year nonprofit hospital bonds increased from 3.3 percent to 3.6 percent (Cain Brothers 2018).

Mergers and acquisitions continued in 2019

Hospital mergers and acquisitions continued in calendar year 2019, with 71 transactions—a number similar to prior years. However, the number of hospitals and beds involved in these transactions declined substantially, reflecting a shift to acquisitions of single hospitals and those with fewer beds. As a result, from 2018 to 2019 the average number of beds per transaction decreased from 372 to 179 (Irving Levin Associates Inc. 2019).

In the first quarter of 2020, hospital mergers and acquisitions were in line with previous years but dipped sharply after mid-March as a result of the coronavirus pandemic. Several large consolidations were called off, including at least one that specifically cited financial issues exposed by the pandemic as a reason for the consolidation's failure (HealthLeaders 2020). According to HealthLeaders, the impact of the coronavirus PHE could slow the pace of hospital mergers and acquisitions. However, according to Moody's, concerns about COVID-19 could accelerate patient preference for outpatient care, which could provide health systems incentives to continue to increase their development and acquisition of outpatient facilities (Moody's Investors Service 2020).

Hospital employment remained stable in 2019

Between the start of fiscal year 2015 and the PHE in March 2020, the number of individuals employed by hospitals grew steadily from 5.7 million to 6.3 million.¹³ Over this same time period, hospital employees' weekly hours grew from 36.6 to 37.6 (2.7 percent), while their weekly earnings grew from \$1,100 to \$1,290 (16.9 percent).

However, hospital employment decreased in April and May 2020 to 6.1 million (2.6 percent below March) as the effects of the PHE set in. While employment varied significantly by region, national hospital employment increased after May, but as of October 2020 (the most recent available month of data) remained 1.6 percent below March. Hospital employees' weekly hours during the PHE also decreased between March and April by 3.7 percent but have subsequently rebounded to above prior-year levels. Weekly earnings followed a similar trajectory, decreasing 2.7 percent between March and April, but rebounding by October 2020 to 2.7 percent higher than the same time in 2019. The drop in hospital employment during the PHE was less than the drop in employment in both the health care sector as a whole and the overall economy. The federal government provided hospitals with many financial resources throughout the public health emergency that other industries did not receive.

Medicare payments for hospital services nearly matched relatively efficient hospitals' costs in 2019

In 2019, driven by the increase in uncompensated care payments and the increased profitability from inpatient services, hospitals' FFS Medicare margin improved to -8.7 percent among all IPPS hospitals and to near break-even among relatively efficient hospitals and those under fiscal pressure.

Projecting hospitals' Medicare margin in 2021 involves substantial uncertainty, but we project IPPS hospitals' Medicare margin will increase to -6 percent, driven by higher than historic payment rate increases with the expiration of statutory reductions enacted in the Affordable Care Act, lower than historic productivity offsets, and the suspension of Medicare sequestration through the first half of fiscal year 2021. We also expect the efficient providers' Medicare margin will improve in 2021 to become slightly positive.

Payments per inpatient stay grew faster than costs per stay in 2019

In 2019, IPPS payments per stay and per capita continued to increase. IPPS payments per stay rose 3.3 percent to about \$12,800, while payments per capita grew 1.4 percent to about \$2,940 per beneficiary (Figure 3-5, p. 72). Nevertheless, because both the number of FFS beneficiaries and the number of inpatient stays per capita

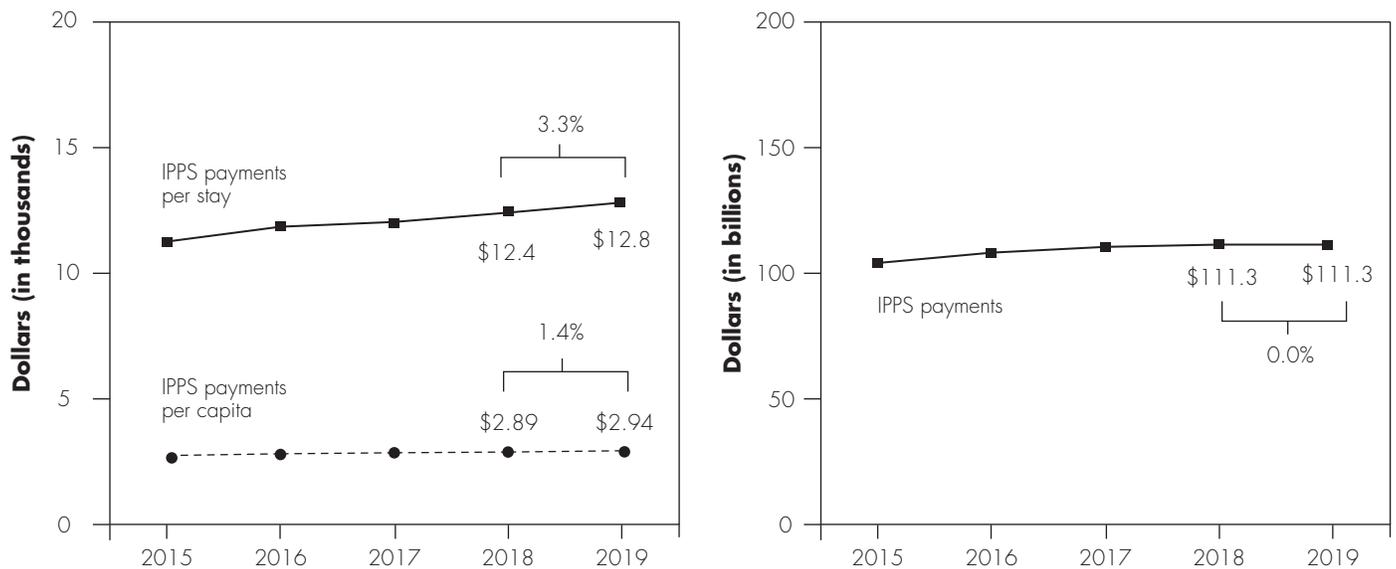
have fallen (by 1.8 percent and 1.4 percent, respectively), Medicare's payments to hospitals for IPPS-covered stays held steady in 2019 at \$111.3 billion. In sum, the increase in payments per inpatient stay—which reflect increases in prices, patient severity, and coding practices—were offset by declines in inpatient stays per capita and enrollment in 2019. (See text box on growth in inpatient payments, p. 73.)

The 3.3 percent growth in IPPS payments per stay in 2019 was faster than the 2.7 percent average over the prior four years (Table 3-3, p. 74). The growth in 2019 resulted from:

- a 1.4 percent annual update to IPPS operating base rates (a combination of the estimated increase in the inpatient market basket, the estimated productivity offset, and a statutory budgetary reduction);
- a 0.5 percent statutory increase in inpatient payment rates resulting from unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers' documentation and coding;
- a 0.8 percent increase in reported patient severity, referred to as inpatient case mix; and
- a 0.6 percent increase from all other factors, including larger than expected outlier payments and a shift in geographic mix toward hospitals with higher wage indexes.

The 2019 increases in the annual update to IPPS operating rates (1.4 percent) and net case mix (0.8 percent) were both lower than their averages over the prior four years. The faster growth in IPPS payments per stay in 2019 was therefore due primarily to the 0.5 percent update required by statute. The Congress mandated that payment rates in 2014 through 2017 be reduced to recoup past overpayments resulting from documentation and coding changes that did not reflect real changes in case mix, then later phased out this reduction.¹⁴ Accordingly, CMS increased payment rates in 2019 by 0.5 percent to make up for the earlier reductions to payment.

We estimate hospitals' IPPS costs per stay grew 3.2 percent in 2019, above the average over the prior four years (Table 3-4, p. 74). This increase in IPPS costs per stay in 2019 resulted from a 2.4 percent growth in input prices and an imputed 0.7 percent increase in costs per

**FIGURE
3-5****IPPS payments per stay and per capita continued to increase in 2019 while aggregate IPPS payments held steady**

Note: IPPS (inpatient prospective payment system). Analysis includes fee-for-service Medicare beneficiaries' inpatient stays across all IPPS hospitals in the U.S. IPPS payments exclude uncompensated care payments and include both Medicare program spending and beneficiary cost-sharing responsibilities.

Source: MedPAC analysis of Medicare Provider Analysis and Review claims and enrollment data from the Medicare Trustees report.

stay from all other factors. We cannot directly measure the extent to which hospitals improved their productivity or coded patients more extensively. However, hospitals' ability to constrain their cost growth to 0.7 percentage point above the growth in input prices—despite a reported 0.8 percent growth in inpatient case mix and higher than expected outlier costs in 2019—indicates that hospitals improved their productivity, coded patients more extensively, or both. As in past years, reported case-mix growth represents a combination of increased severity and increases in coding practices, and we cannot isolate the subset of case-mix growth that represents increased coding.

The faster growth in IPPS payments per stay relative to costs per stay was in part a result of CMS's overestimation of input price growth in 2019. The 2.9 percent estimate of input prices used to prospectively set rates was 0.5 percentage point above actual input price inflation of 2.4 percent (Table 3-3, p. 74, and Table 3-4, p. 74). The market basket forecast is primarily a function of projected

labor cost growth, and overestimates of labor cost growth can result in updates exceeding input price growth. This forecast error was not unique to 2019; hospitals' actual input price inflation was lower than CMS's forecast in every year from 2015 through 2018. Using input price forecasts allows prices to be known at the start of the year but does result in overpayments in some years and underpayments in other years.

Change in uncompensated care payments

In addition to IPPS payments for FFS Medicare beneficiaries' inpatient stays, the Medicare program also makes uncompensated care payments to IPPS hospitals to help cover their costs of treating the uninsured. Pursuant to a provision in the Affordable Care Act, beginning in 2014, each eligible hospital receives (1) a reduced operating DSH payment and (2) an uncompensated care payment. Under the revised operating DSH payment equation, hospitals receive 25 percent of the DSH funds they would have received under prior law. Second, each

Growth in FFS Medicare inpatient payments driven by growth in payments per stay, not volume

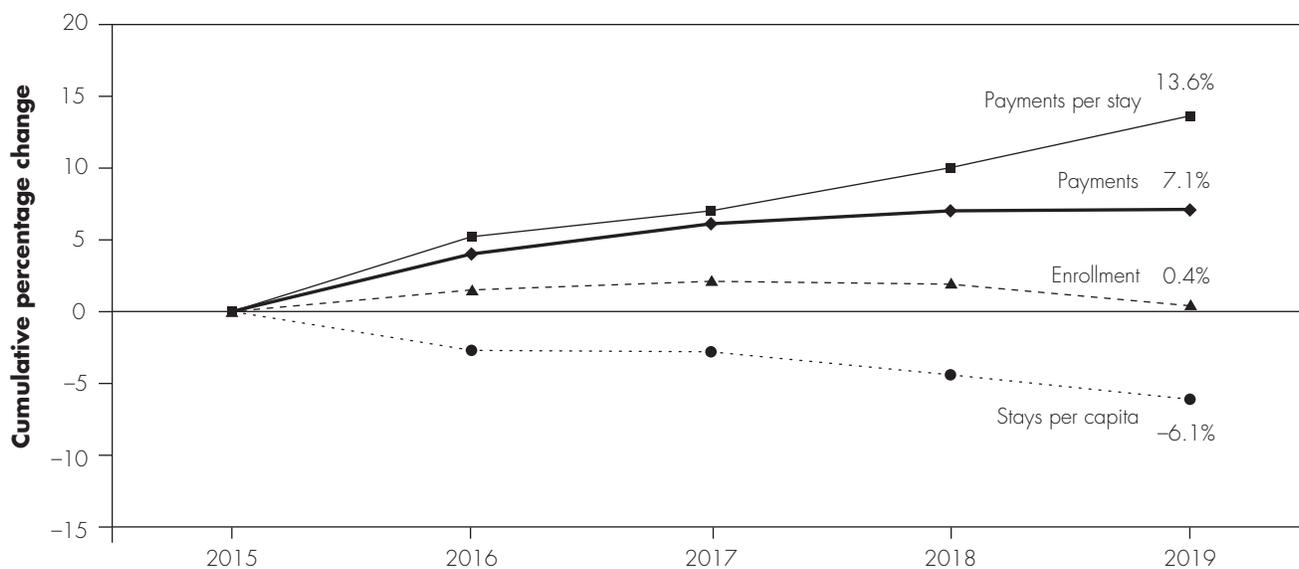
The growth in aggregate inpatient prospective payment system (IPPS) payments for fee-for-service (FFS) Medicare beneficiaries' inpatient stays has been driven by growth in IPPS payments per stay—which reflect increases in prices, patient severity, and coding practices. From 2015 to 2019, payments per stay increased 13.6 percent. By contrast, Medicare Part A enrollment increased just 0.4 percent over the period, with enrollment growth actually slowing from 2018 to 2019 (Figure 3-6).

Increases in payments per stay as the driver behind growth in inpatient payments is not unique to the

FFS Medicare population. For example, despite differences in payment methodologies and in mix of services among commercially insured patients, from 2015 to 2018, inpatient stays per capita declined by slightly less among the commercial population than the Medicare FFS populations (3.5 percent vs. 4.4 percent) while payments per stay increased among the commercial population more than twice as much as Medicare FFS payments (14 percent vs. 6.1 percent) (Health Care Cost Institute 2020 and MedPAC analysis). ■

FIGURE 3-6

Growth in IPPS payments driven by growth in payments per stay



Note: IPPS (inpatient prospective payment system). Analysis includes fee-for-service Medicare beneficiaries' inpatient stays across all IPPS hospitals in the U.S. IPPS payments exclude uncompensated care payments and include both Medicare program spending and beneficiary cost-sharing responsibilities.

Source: MedPAC analysis of Medicare Provider Analysis and Review claims and enrollment data from the Medicare Trustees report.

hospital receives uncompensated care payments equal to its share of a fixed pool of dollars, defined as 75 percent of estimated aggregated operating DSH payments under the prior-law DSH formula multiplied by the national

uninsured rate as a percentage of the uninsured rate in 2013. This amount is referred to as the “uncompensated care pool.”¹⁵

**TABLE
3-3****IPPS payments per stay grew 3.3 percent from 2018 to 2019, faster than in the prior four years**

	Annual change 2019	Average of annual changes, 2015 to 2018
IPPS payments per stay	3.3%	2.7%
Annual update to IPPS operating rates	1.4	1.7
Estimated inpatient market basket	2.9	2.7
Estimated multifactor productivity offset	-0.8	-0.5
Budgetary reduction	-0.8	-0.5
Other non-budget-neutral updates	0.5	-0.6
Inpatient case mix (net)	0.8	1.5
All other factors	0.6	0.1

Note: IPPS (inpatient prospective payment system). Analysis includes fee-for-service Medicare beneficiaries' inpatient stays at IPPS hospitals in the U.S. IPPS payments per stay exclude uncompensated care payments. "Annual update to IPPS operating base rates" includes estimates as of the time of the final rule. Budgetary reduction was required by the Affordable Care Act in each of 2010 to 2019. "Other non-budget-neutral updates" includes statutory adjustments for coding and documentation improvements and the 2017 and 2018 two-midnight policy adjustments. "Inpatient case mix (net)" reflects the change in case mix, net of change anticipated and accounted for through budget-neutrality factors. "All other factors" includes changes in outlier payments, geographic mix, and capital PPS payments. Components may not sum to stated totals as a result of rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review claims and IPPS final rules.

In 2019, uncompensated care payments increased 22 percent to \$8.1 billion dollars (Figure 3-7). The 22 percent increase in the uncompensated care pool in 2019 was the result of a projected 5 percent increase in the estimate of what DSH payments would have been under prior law and a projected 16 percent increase in the national uninsured

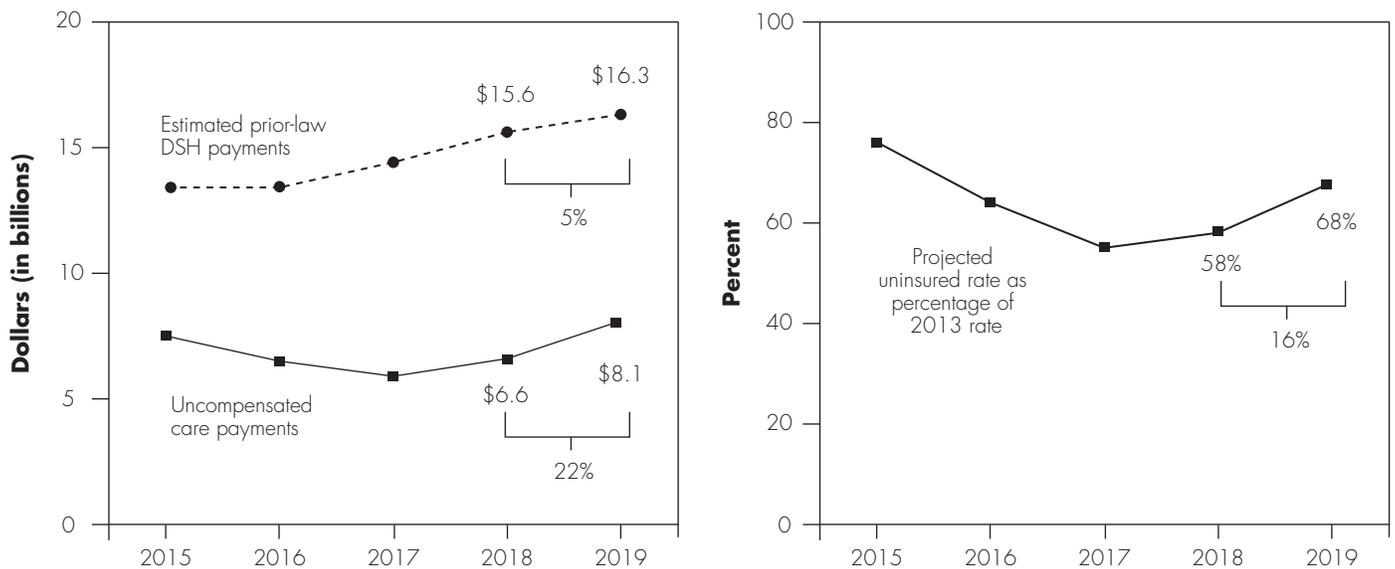
rate (from 58 percent of the 2013 rate up to 68 percent of the 2013 uninsured rate). When the rate of uninsured individuals increases and hospitals have greater losses on uncompensated care, CMS gives hospitals higher uncompensated care add-on payments to their IPPS rates.

**TABLE
3-4****IPPS costs per stay grew 3.2 percent in 2019, faster than in the prior four years, driven mostly by growth in input prices**

	Annual change 2019	Average of annual changes, 2015 to 2018
IPPS costs per stay	3.2%	2.7%
Input prices	2.4	2.1
Imputed change in costs from all other factors, including increases in productivity and coding	0.7	0.6

Note: IPPS (inpatient prospective payment system). Analysis includes fee-for-service Medicare beneficiaries' inpatient stays at IPPS hospitals in the U.S. with complete and nonoutlier cost report data. Actual inpatient input prices are from CMS market basket data as of the 2020 third quarter. Product of components may not equal stated totals as a result of rounding.

Source: MedPAC analysis of hospital cost reports and CMS market basket data.

**FIGURE
3-7****Medicare's uncompensated care payments to IPPS hospitals increased 22 percent in 2019, driven by an increase in the projected uninsured rate**

Note: IPPS (inpatient prospective payment system), DSH (disproportionate share hospital). CMS estimated that from 2018 to 2019, the uninsured rate increased from about 8.2 percent (58 percent of the 2013 uninsured rate of 14 percent) to 9.5 percent (68 percent of the 2013 uninsured rate).

Source: MedPAC analysis of hospital cost reports.

Outpatient payments grew more slowly than costs in 2019 despite continued profitability on Part B drugs

In fiscal year 2019, OPSS payments grew more slowly than costs. OPSS payments at IPPS hospitals increased 5.0 percent, driven primarily by growth in Part B drug payments, which climbed 12 percent. At the same time, costs grew by 5.4 percent.

The growth in both OPSS payments and costs were slower in 2019 relative to prior years, when payments grew at an average annual rate of 6.6 percent from 2015 through 2019 and costs grew by 6.9 percent over the same time period. Three factors contributed to the relatively low growth in 2019. First, hospitals converted fewer acquired ambulatory surgical centers (ASCs) to provider-based departments (maintaining them as ASCs instead), which caused the number of procedures done in HOPDs to be nearly unchanged from 2018 to 2019. Second, the number of evaluation and management services (such as office visits and emergency department visits) increased more slowly from 2018 to 2019, likely due to a slowdown

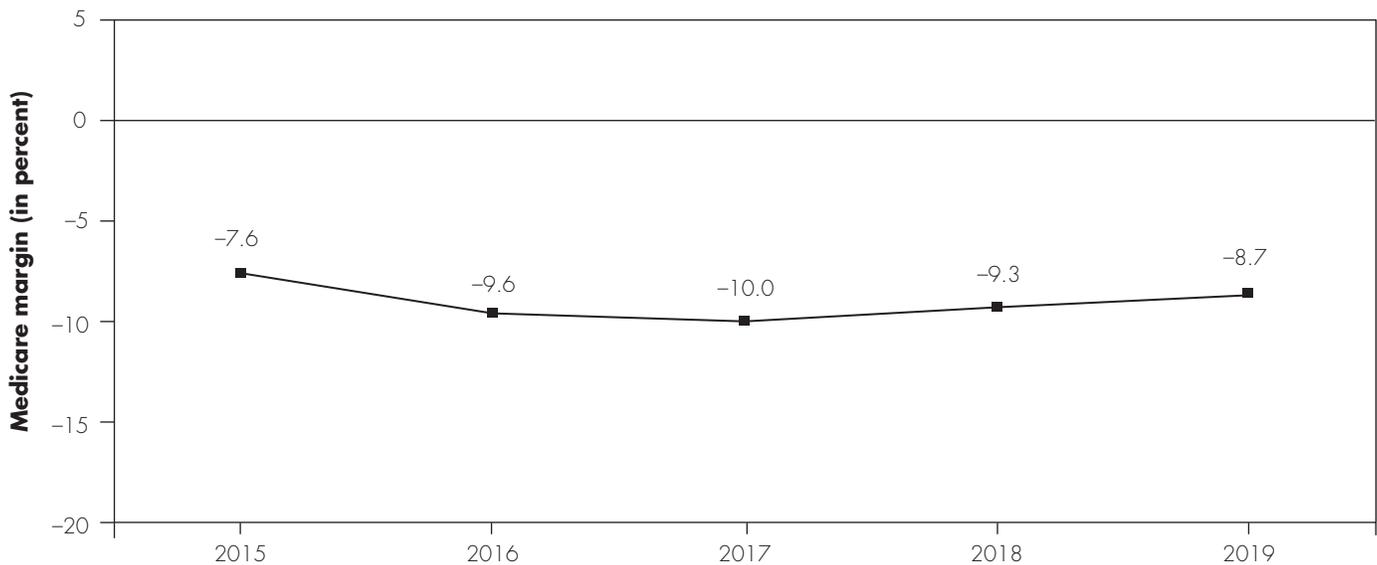
in hospital acquisition of physician practices. Third, in 2019, CMS changed the OPSS payment status of an unusually high number of drugs from pass-through status to separately payable non-pass-through status. Under the OPSS, statute requires that all pass-through drugs be paid at a rate of the drug's average sales price (ASP) plus 6 percent. Also, CMS has established a policy that sets the payment rates for separately payable non-pass-through drugs that hospitals obtain through the 340B Drug Pricing Program at a rate of ASP minus 22.5 percent. Therefore, as the drugs that had pass-through status in 2018 transitioned to separately payable non-pass-through status in 2019, payments to 340B hospitals for these drugs declined substantially.

Overall Medicare margin remained negative in aggregate, but increased in 2019 and was near zero among hospitals under fiscal pressure and for-profit hospitals

In aggregate, IPPS hospitals' overall Medicare margin remained negative in 2019 but increased to -8.7 percent, the highest level since 2015 (Figure 3-8, p. 76).

**FIGURE
3-8**

IPPS hospitals' overall Medicare margin remained negative, but increased in 2019



Note: IPPS (inpatient prospective payment system). Analysis includes IPPS hospitals in the U.S. with complete and nonoutlier cost report data. Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as direct graduate medical education and uncompensated care payments.

Source: MedPAC analysis of hospital cost reports.

As discussed earlier, the increase in hospitals' Medicare margin in 2019 was primarily because Medicare made additional payments to hospitals to help cover the costs of charity care and non-Medicare bad debts. In addition, IPPS payments per inpatient stay grew faster than hospitals' costs per stay, in part attributable to payment rates that included an overestimate of input price inflation.

While IPPS hospitals' overall margin remained negative in aggregate, two groups of IPPS hospitals' margins increased to about zero in 2019:

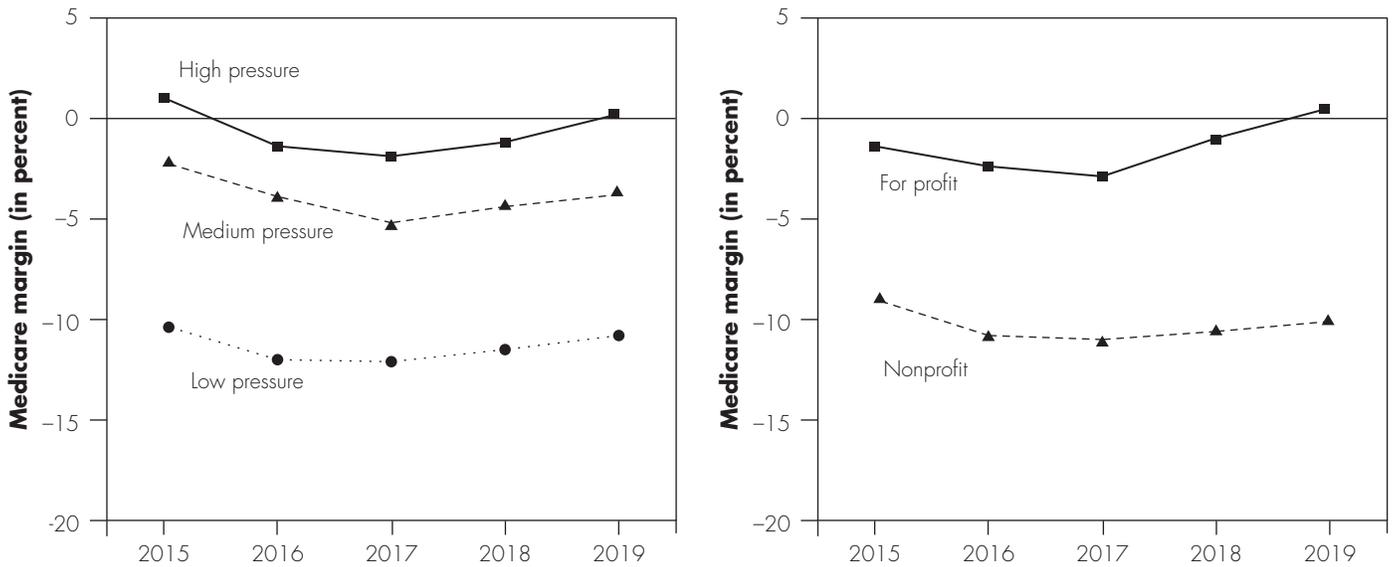
- **Hospitals under fiscal pressure have lower costs and therefore a higher Medicare margin.** Hospitals under fiscal pressure—defined as hospitals with a median non-Medicare margin of less than 1 percent over five years—continued to have lower Medicare inpatient costs and a higher overall Medicare margin.¹⁶ We estimate the quarter of IPPS hospitals under high fiscal pressure in 2019 had a Medicare margin of about 0 percent, while the two-thirds under low fiscal pressure

had a Medicare margin near -11 percent (Figure 3-9). The remaining hospitals with medium pressure had performance in the middle. The higher margin among hospitals under high fiscal pressure was driven by these hospitals' lower standardized inpatient costs per case, which were 9 percent below the hospitals under low pressure to constrain costs (data not shown). Hospitals under high fiscal pressure tended to have slightly higher shares of inpatients paying at government rates (43 percent of inpatient days were attributed to Medicare and Medicaid FFS patients, on average). Hospitals under high fiscal pressure also had better margins on Medicare outpatient services than hospitals under low pressure, but the differences were less than for inpatient services.

These findings are consistent with those of other researchers who generally have found that increases in Medicare payments result in increases in costs. For example, White and Wu found that hospitals that

FIGURE
3-9

IPPS hospitals' overall Medicare margin neared zero in 2019 among hospitals under high fiscal pressure and among for-profit hospitals



Note: IPPS (inpatient prospective payment system). Analysis includes IPPS hospitals in the U.S. with complete and nonoutlier cost report data. Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as direct graduate medical education and uncompensated care payments.

Source: MedPAC analysis of hospital cost reports.

received higher Medicare payment increases resulting from policy changes tended to have higher cost growth (White and Wu 2014). They also found that lower Medicare price growth did not cause hospitals to increase prices negotiated with commercial insurers, contrary to "cost-shift" theory. Instead, White found lower Medicare prices led to lower cost growth (White 2013). Similar findings have been reported by others (Clemens and Gottlieb 2017, Frakt 2015). A different study examined how hospitals responded when they received a large increase in their wage index through Section 508 of the Medicare Modernization Act. The study found that the hospitals that received higher Medicare payments through the 508 program "treated more patients, increased payroll, hired nurses, added new technology, raised CEO pay, and ultimately increased their spending by over \$100 million annually" (Cooper et al. 2017). One exception to the literature is a recent working paper that finds

faster commercial price growth at hospitals that were penalized under the HRRP; however, the authors caution it is not definitive evidence of cost shifting (Darden et al. 2019). The implication of these studies is that constraining Medicare prices should help constrain hospital costs.

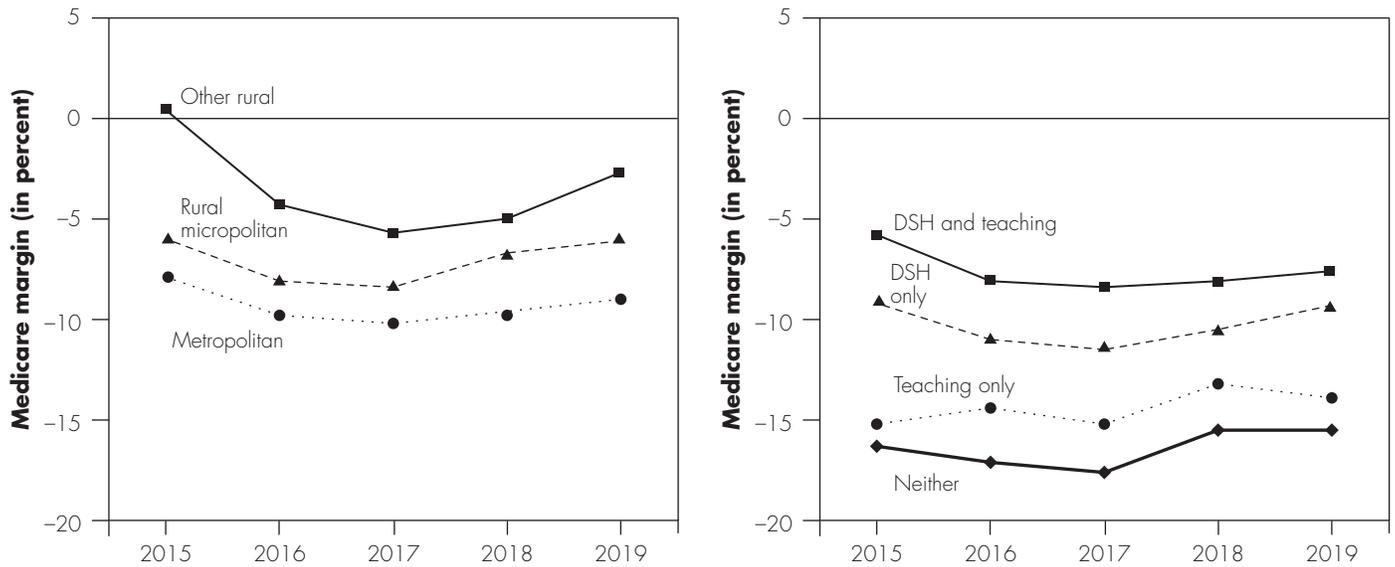
- **For-profit hospitals have a higher Medicare margin.** Similar to hospitals under fiscal pressure, we estimate that in 2019, the Medicare margin for for-profit IPPS hospitals was roughly 0 percent, well above the Medicare margin at nonprofit hospitals (Figure 3-9).

Consistent with historical trends, in 2019 the Medicare margin continued to vary substantially across other hospital characteristics. In particular:

- **Rural hospitals continued to have a higher Medicare margin than urban hospitals.** IPPS hospitals outside of metropolitan and micropolitan areas continued to have a higher Medicare margin than those in less rural

**FIGURE
3-10**

IPPS hospitals' overall Medicare margin was higher among hospitals in rural areas and those that treat a high share of low-income patients



Note: IPPS (inpatient prospective payment system), DSH (disproportionate share hospital). Analysis includes IPPS hospitals in the U.S. with complete and nonoutlier cost report data. Hospitals' Medicare margin is calculated as aggregate Medicare payments minus aggregate allowable Medicare costs, divided by aggregate Medicare payments. "Overall Medicare margin" refers to the aggregate margin across multiple hospital service lines (including inpatient, outpatient, swing bed, skilled nursing, rehabilitation, psychiatric, and home health services), as well as direct graduate medical education and uncompensated care payments. Metropolitan (urban) counties contain an urban cluster of 50,000 or more people, and rural micropolitan counties contain a cluster of 10,000 to 50,000 people.

Source: MedPAC analysis of hospital cost reports.

areas in 2019 (Figure 3-10). The higher margin at IPPS rural hospitals is in large part attributable to the additional IPPS payments many rural hospitals receive, such as through the sole community hospital (SCH), Medicare-dependent hospital (MDH), and low-volume hospital (LVH) designations. Critical access hospitals' Medicare margin held steady in 2019 at near -2 percent (data not shown).¹⁷ Over 95 percent of rural hospitals receive some type of increase in their inpatient payment rates as a result of SCH, MDH, LVH, or critical access hospital special payments.

- **DSHs and teaching hospitals continued to have a higher Medicare margin than other hospitals.** Hospitals receiving two large IPPS adjustments—those that treated a disproportionate share of low-income patients (DSHs) and teaching hospitals—continued to have a higher Medicare margin than other hospitals (Figure 3-10).

Relatively efficient hospitals The Commission follows two principles when identifying a set of efficient providers. First, the providers must do relatively well on cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric over the past three years. In the hospital sector, the variables we use to identify relatively efficient hospitals are hospital-level mortality rates (3MTM risk-adjusted all-condition mortality), readmission rates (3M potentially preventable readmissions), and standardized inpatient Medicare costs per case. Our assessment of efficiency is not in absolute terms, but rather, relative to a comparison group of other IPPS hospitals.¹⁸

Categorizing hospitals as relatively efficient We assigned hospitals to the relatively efficient group or the control group according to each hospital's performance relative to the national median on a set of risk-adjusted cost and quality metrics over the 2016 to 2018 period. We then

examined the performance of the two hospital groups in fiscal year 2019.

Hospitals were identified as relatively efficient if they met four criteria in each year from 2016 to 2018:

- Risk-adjusted mortality rates were among the best two-thirds of all hospitals.
- Risk-adjusted readmission rates were among the best two-thirds of all hospitals.
- Standardized costs per discharge were among the best two-thirds of all hospitals.
- Risk-adjusted mortality or standardized costs per discharge were among the best one-third of all hospitals.

The objective was to identify a sample of hospitals that consistently performed at an above-average level on at least one measure (cost or quality) and that always performed reasonably well on all measures. Because we screen out hospitals that have few Medicaid patients or have poor performance in a single year, our methodology does not seek to identify all efficient hospitals, only a subsample of relatively efficient hospitals. The rationale for this methodology and the details of computing the various measures are discussed in our March 2011 report (Medicare Payment Advisory Commission 2011). As a secondary check on hospital quality, we also require that at least 60 percent of the hospital's patients rated the hospital a 9 or 10 on a 10-point scale (in the year before the performance period).¹⁹

Examining performance of relatively efficient and other hospitals from 2016 to 2018 Of the 1,473 hospitals with available data that met our screening criteria during the 2016 to 2018 period, 224 (15 percent) were found to be relatively efficient.²⁰ We examined the performance of relatively efficient hospitals on three measures by reporting the group's median performance divided by the median for the set of hospitals in our analysis (Table 3-5, p. 80). The median efficient hospital's relative risk-adjusted 30-day mortality rate for the 3-year historical performance period was 90 percent of the national median, meaning that the 30-day mortality rate for the efficient group was 10 percent below (that is, better than) the national median. The median readmission rate for the efficient group was 8 percent below the national median. The standardized Medicare cost per discharge for the efficient group was 9 percent lower than the national median.

Characteristics of relatively efficient hospitals The sample of relatively efficient hospitals represented 15 percent of all hospitals; were spread across the country; and represented diverse categories of hospitals, including teaching, nonteaching, rural, urban, for profit, and nonprofit, as well as hospitals serving large numbers of low-income patients. While most types of hospitals were represented in the efficient group, a disproportionate share of efficient hospitals had relatively high volumes of admissions. Volume primarily affects our efficiency measures through two metrics. First, higher volume hospitals tended to have lower risk-adjusted mortality. Second, we require some consistency of results over three years and remove any hospital that performed in the bottom third on any metric in a single year from the efficient group.²¹ Thus, random variation in smaller hospitals may make them more likely to be excluded from our efficient sample. The effect of higher volume could explain why 19 percent of teaching hospitals were deemed relatively efficient by our criteria and only 13 percent of nonteaching hospitals met our criteria (data not shown). Similarly, 9 percent of rural hospitals were deemed relatively efficient compared with 17 percent of urban hospitals (which had more than double the volume of rural hospitals on average). For-profit and nonprofit hospitals were both deemed relatively efficient 15 percent of the time. While for-profit hospitals had lower costs (Figure 3-9, p. 77), nonprofit hospitals tended to perform slightly better on our quality metrics. The efficient group had a share of Medicaid patients similar to the share at other hospitals.²²

Lower costs allowed the relatively efficient hospitals to generate better Medicare margins. In 2019, the median hospital in the efficient group had a -1 percent margin on Medicare while the median hospital in the comparison group had a Medicare margin of -7 percent (Table 3-5, p. 80). The relatively efficient group also continued to perform better on quality metrics during the 2019 performance period, with risk-adjusted mortality equal to 92 percent of the national median and risk-adjusted readmissions equal to 95 percent of the national median (Table 3-5).

Projected Medicare margin for 2021

We project IPPS hospitals' Medicare margins in 2021 based on payments and costs from the most recent year of available data (2019) and policy and environmental changes that took place in 2020 and are anticipated in 2021. While the coronavirus PHE has made 2020 an anomalous year in many respects and it is impossible to predict with certainty the extent to which these effects

**TABLE
3-5****Performance of relatively efficient hospitals**

Relative performance measure	Type of hospital	
	Relatively efficient, 2016-2018	Other hospitals
Number of hospitals	224	1,249
Share of hospitals in our study sample	15%	85%
Historical performance, 2016-2018 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (3M™)	90%	101%
Readmission rates (3M)	92	101
Standardized Medicare costs per discharge	91	103
Performance metrics, 2019 (percent of national median)		
Risk-adjusted:		
Composite 30-day mortality (3M)	92%	101%
Composite 30-day readmission (3M)	95	101
Standardized Medicare costs per discharge	91	103
Share of patients rating the hospital a 9 or 10 (out of 10)	73	71
Median:		
Overall Medicare margin, 2019	-1%	-7%
Non-Medicare margin, 2019	9	9
Total (all-payer) margin, 2019	7	6
Share of patients where Medicaid is the primary payer	6	7

Note: Relative values are the median for the group as a percent of the median of all hospitals that met inclusion criteria for our study sample. Per case costs are standardized for area wage rates, case-mix severity, prevalence of outlier and transfer cases, interest expense, low-income shares, and teaching intensity. Composite mortality was computed using the 3M methodology to compute risk-adjusted mortality for all conditions. We removed hospitals with a low share of Medicaid patients (the bottom 10 percent of hospitals) and hospitals in markets with high service use (top 10 percent of hospitals) in response to concerns that socioeconomic conditions and aggressive treatment patterns can influence unit costs and risk-adjusted quality metrics.

Source: MedPAC analysis of Medicare cost report and claims-based quality data.

will continue into 2021, our best estimate is that IPPS hospitals' Medicare margin in 2021 will increase relative to 2019, driven by substantially higher payment-rate updates in 2020 and 2021 than in 2019 and prior years, and the suspension of Medicare sequestration through the first half of fiscal year 2021.

The annual update to the IPPS operating and OPFS base rates was 2.6 percent in 2020 and 2.4 percent in 2021 (Table 3-6). This cumulative 5.1 percent increase is substantially higher than in prior years, attributable to the expiration of statutory reductions in hospital updates required by the Affordable Care Act in each of

2010 through 2019 and lower productivity offsets. IPPS operating rates will also increase in 2020 and 2021 from the 0.5 percent statutory increase (due to unwinding a temporary reduction in payments that was put in place to recoup past overpayments resulting from changes in providers' documentation and coding); as a result, IPPS operating base rates will increase 6.1 percent from 2019 to 2021 (exclusive of budget-neutrality adjustments). Uncompensated care payments in 2021 will be approximately the same as in 2019 (data not shown).

The Congress and CMS also made temporary increases to FFS Medicare payments in 2020 and 2021 in response to

**TABLE
3-6**

Current-law updates to IPPS and OPSS payment rates

	2019	2020	2021	2022
Annual update (IPPS and OPSS)	1.35%	2.6%	2.4%	2.4%*
Estimated inpatient market basket	2.9	3.0	2.4	2.7*
Estimated multifactor productivity offset	-0.8	-0.4	0.0	-0.3*
Budgetary reduction	-0.75	0.0	0.0	0.0
Additional statutory increase (IPPS only)	0.5	0.5	0.5	0.5

Note: IPPS (inpatient prospective payment system), OPSS (outpatient prospective payment system). Budgetary reduction was required by the Affordable Care Act in each of 2010 to 2019. The other statutory adjustments are the unwinding of prior adjustments for documentation and coding required in the Medicare Access and CHIP Reauthorization Act of 2015. Separate updates to inpatient capital base rates are not shown.

*Based on forecasts as of third quarter of 2020; forecast used to set actual update will be revised to use most recent economic data at the time the final rule for fiscal year 2022 is published in late summer 2021.

Source: MedPAC analysis of IPPS final rules and CMS market basket data.

the coronavirus PHE. The Congress increased Medicare payments to hospitals and other sectors by suspending the 2 percent Medicare sequestration from May 2020 through March 2021. In addition, for the duration of the PHE, COVID-19 inpatient stays receive a 20 percent increase in IPPS payments, and hospitals will receive additional payments to cover the higher costs of any new COVID-19 treatments authorized for emergency use.

An area of greater uncertainty is hospitals’ cost growth. However, we anticipate it will continue to be less than the combined growth in input prices and case mix, consistent with historical trends (Medicare Payment Advisory Commission 2020b). While hospitals will continue to have COVID-19 cases in 2021 and incur associated costs, these cases will also increase hospitals’ case mix. Given the small share of hospital inpatient stays that are for COVID-19 and the additional payments for these cases (a 20 percent increase in base payments and additional payments for COVID-19 treatments), we do not anticipate that COVID-19 cases will have a material effect on hospitals’ Medicare margin.

Considering these factors, we expect IPPS hospitals’ aggregate Medicare margin in 2021 to improve to approximately -6 percent under current law. We also expect the efficient providers’ Medicare margin will improve in 2021 to become slightly positive. The exact

increase in hospitals’ Medicare margin will depend in large part on the duration and severity of the coronavirus pandemic, volume changes, case-mix changes, and changes in costs relative to input price inflation, as well as any congressional response to the pandemic.

How should Medicare payment rates change in 2022?

The update recommendation for hospital payment rates in 2022 is based on indicators of beneficiaries’ access to care, quality of care, hospitals’ access to capital, and the relationship between FFS Medicare payments and hospital costs.

RECOMMENDATION 3

For fiscal year 2022, the Congress should update the 2021 Medicare base payment rates for acute care hospitals by 2 percent.

RATIONALE 3

Our payment adequacy indicators show that FFS Medicare beneficiaries continued to have good access to inpatient and outpatient acute hospital care, hospital quality improved, and hospitals maintained strong access to

capital markets, despite a negative Medicare margin. In addition, a 1.35 percent annual update (together with other statutory changes and increases in uncompensated care) was sufficient to improve hospitals' Medicare margin in 2019 and for Medicare payments to almost cover the costs of relatively efficient hospitals.

The recommendation of a 2 percent update to hospital payment rates balances several imperatives:

- maintain payments high enough to ensure beneficiaries' access to hospital care,
- maintain payments close to hospitals' cost of efficiently providing high-quality care,
- maintain fiscal pressure on hospitals to constrain costs and improve the long-term sustainability of the Medicare program, and
- minimize differences in payment rates for similar services across sites of care.

We estimate that an update to hospital payment rates of 2 percent in 2022—together with the additional statutory 0.5 percent increase to inpatient payments and a 0.8 percent increase to inpatient payments from our standing recommendation to replace the current penalty-only quality payment programs with an HVIP that balances reward and penalties—would be high enough to maintain beneficiaries' access to care and exceed the cost of delivering high-quality care efficiently. The net 3.3 percent increase in inpatient payments and 2 percent increase in outpatient payments would also continue to keep some fiscal pressure on hospitals to constrain costs and would limit (relative to current law) growth in the differential

between rates paid for physician office visits on a hospital campus and rates paid for office visits at freestanding physician offices.

The coronavirus PHE affected hospital payment adequacy indicators; however, based on information available at the time of this publication, we do not anticipate any long-term changes persisting past the end of the PHE that would warrant an additional increase in the annual update to hospital payments in 2022. Instead, to the extent that the PHE continues, any needed additional financial support should be targeted to affected hospitals that are necessary for access.

IMPLICATIONS 3

Spending

- Current law is expected to increase hospital payment rates by 2.4 percent (a 2.7 percent market basket less a 0.3 percent productivity adjustment). The recommended update of 2.0 percent—together with the additional statutory 0.5 percent increase to inpatient payments and 0.8 percent increase from our standing HVIP recommendation—would increase combined spending on hospital inpatient and outpatient services relative to current law. On net, the recommendation would increase Medicare spending by between \$750 million and \$2 billion in 2022 and by \$5 billion to \$10 billion over five years.

Beneficiary and provider

- We do not expect the recommendation, relative to current law, to materially affect beneficiaries' access to care or providers' willingness to treat Medicare beneficiaries. ■

Mandated report: Expanding the post-acute care transfer policy to hospice

The Bipartisan Budget Act (BBA) of 2018 expanded the inpatient prospective payment system (IPPS) post-acute care (PAC) transfer policy to include hospital transfers to hospice beginning fiscal year 2019. The BBA of 2018 mandated that the Commission evaluate and report on the effects of this policy change. The Commission provided preliminary results in our March 2020 report to the Congress. The Commission is required to submit its final report to the Congress by March 15, 2021. The analysis herein constitutes the Commission’s final report and is based on the first five quarters of experience under the new policy (from October 2018 through December 2019). We find no evidence of adverse effects of the transfer policy on beneficiaries’ access to hospice care.

The PAC transfer policy

The PAC transfer policy applies to discharges from IPPS hospitals to long-term care hospitals, children’s hospitals, cancer hospitals, inpatient psychiatric facilities, inpatient rehabilitation facilities, skilled nursing facilities, and home health agencies. As of October 2018, it also applies to discharges to hospice.

Under the PAC transfer policy, some short inpatient stays that are discharged to a PAC setting receive a reduced payment. Short stays are defined as lengths of stay that are more than one day below the geometric mean length of stay for a given diagnosis under Medicare’s classification system—Medicare severity–diagnosis related groups (MS–DRGs). Short stays for certain DRGs that are discharged to a PAC setting receive a reduced payment. The PAC transfer policy applies to a subset of MS–DRGs that have a relatively high prevalence of short stays followed by discharge to PAC. In fiscal year 2019, the PAC transfer policy applied to 279 of 761 MS–DRGs.

For short stays by patients classified in eligible MS–DRGs that are followed by PAC, payment for IPPS hospitals is calculated by dividing the full MS–DRG payment amount by the geometric mean length of stay for the MS–DRG. The IPPS hospital generally receives

a payment that is double the per diem rate for the first day of the stay plus a per diem payment for each additional day of the stay, with the total payment not to exceed the full MS–DRG payment amount. A special payment formula exists—with a higher first-day payment amount—for a small subset of MS–DRGs that have disproportionately high first-day costs.

Mandated report

The BBA of 2018 requires that the Commission evaluate the effects of the expansion of the PAC transfer policy to hospice on:

- the number of discharges of hospital inpatients to hospice,
- the length of stays of patients in an inpatient hospital setting who are discharged to hospice,
- Medicare spending, and
- any other areas determined appropriate by the Commission.

In conducting the evaluation, the Commission was directed to consider factors such as whether the timely access to hospice care by patients admitted to a hospital has been affected by changes to hospital policies or behaviors made as a result of this policy.

Results of evaluation: No discernable changes in timely access to hospice care

The expansion of the PAC transfer policy to hospice resulted in savings of about \$304 million in fiscal year 2019 and about \$78 million in the first quarter of fiscal year 2020.

In the first five quarters of experience under the new policy, we do not observe discernable changes in timely access to hospice care by hospital inpatients. The share of discharges to hospice among hospital inpatients appears to have increased slightly in this period, consistent with historical trends of increasing hospice use. Lengths of stay for hospital inpatients

(continued next page)

Mandated report: Expanding the post-acute care transfer policy to hospice (cont.)

discharged to hospice oscillated before the policy change, making it difficult to interpret quarter-to-quarter changes in lengths of stay. In the first five quarters of the new policy, lengths of stay for inpatients discharged to hospice were within the range observed in prior quarters. An examination of hospice referral trends and inpatient length of stay for the 10 MS-DRGs with the greatest number of discharges to hospice also suggests that the expansion of the transfer policy has not adversely affected beneficiaries' timely access to hospice care.

Number of discharges of hospital inpatients to hospice

The share of fee-for-service (FFS) Medicare hospital inpatients discharged to hospice has increased or remained stable in the first five quarters of the policy (through the first quarter of fiscal year 2020), consistent

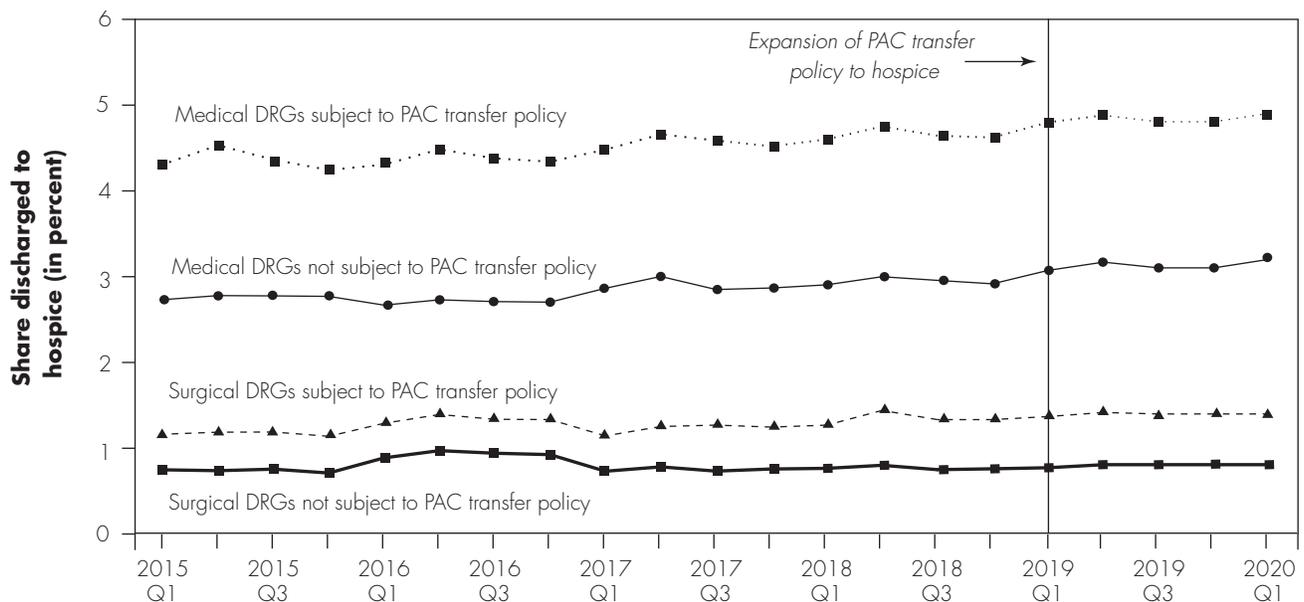
with historical trends (Figure 3-11). Among inpatients in medical MS-DRGs, discharges to hospice appear to have increased slightly in the first five quarters under the new policy, both for those MS-DRGs that are subject to the transfer policy and for those that are not.

For surgical DRGs, the share of patients discharged to hospice has remained stable both for MS-DRGs that are and are not subject to the transfer policy. An examination of hospice referral trends for the 10 MS-DRGs with the greatest number of discharges to hospice also suggests that the PAC transfer policy has not adversely affected hospice referral rates. For each of these MS-DRGs, the share of inpatients discharged to hospice increased or changed little between first quarter 2018 and first quarter 2020 (Table 3-7, p. 87).

(continued next page)

FIGURE 3-11

Share of FFS Medicare inpatients discharged to hospice by type of DRG and whether the DRG is subject to the PAC transfer policy, 2015 to 2020



Note: FFS (fee-for-service), DRG (diagnosis related group), PAC (post-acute care), Q (quarter). Data displayed by fiscal year and quarter. Analysis includes FFS Medicare beneficiaries' inpatient stays across inpatient prospective payment system hospitals in the U.S.

Source: MedPAC analysis of Medicare claims data.

Mandated report: Expanding the post-acute care transfer policy to hospice (cont.)

Hospital length of stay The mandate directs the Commission to examine hospital length of stay for FFS Medicare patients discharged to hospice to determine whether it has changed in response to the transfer policy. Under the PAC transfer policy, when patients are discharged to a setting subject to the policy, the hospital receives a reduced payment only if the patient’s hospital length of stay is equal to or less than the short-stay threshold (defined as one day less than the geometric mean length of stay for the MS–DRG). One way a hospital could theoretically avoid the reduced payment for a patient transferred to hospice would be to keep the patient in the hospital until the length of stay exceeds the short-stay threshold. However, it is also possible that the PAC transfer policy does not play a significant role in discharge decisions for hospice patients. The

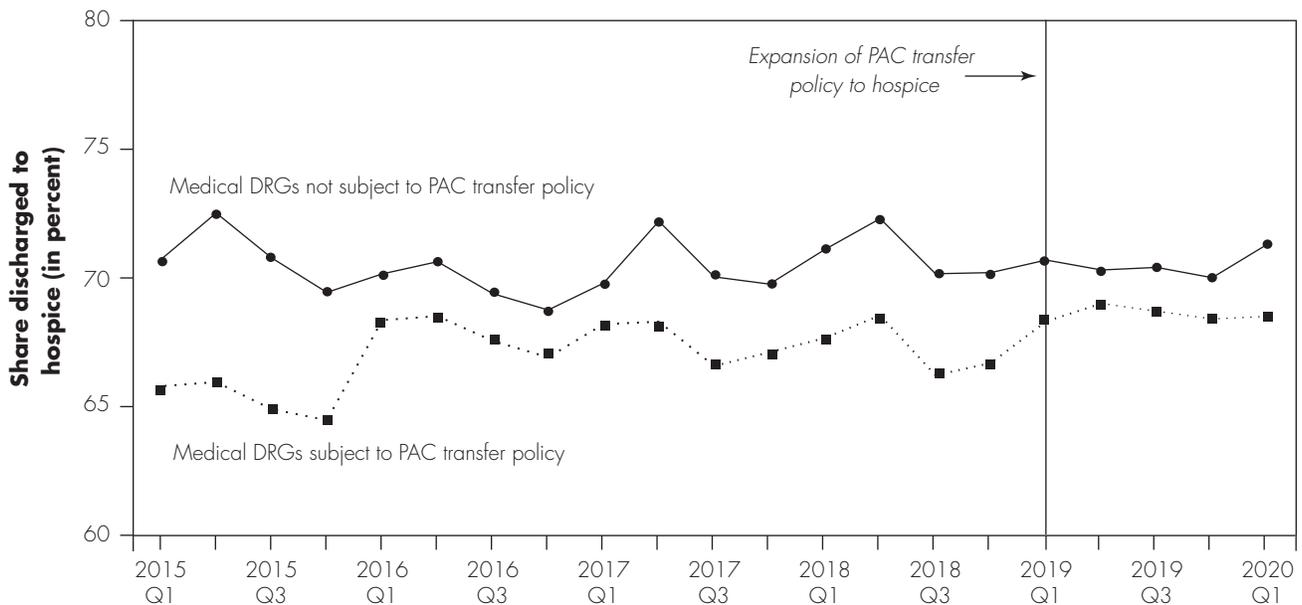
decision to refer a patient to hospice and the timing of a patient’s hospice election is complex and influenced by many factors, including the patient’s condition, providers’ communication with the patient and family about the patient’s prognosis, the patient’s and family’s understanding of the prognosis, and preferences for conventional care versus palliative care.

To examine whether hospital length of stay has changed with the expansion of the transfer policy, we analyzed inpatient length of stay for patients discharged to hospice and calculated the share of those patients with inpatient stays longer than the short-stay threshold (which we refer to as “long” inpatient stays). If the expansion of the transfer policy to hospice were resulting in hospice patients staying in the hospital

(continued next page)

FIGURE 3–12

Share of FFS Medicare inpatients discharged from medical MS–DRGs to hospice with inpatient lengths of stay greater than the short-stay threshold, 2015 to 2020



Note: FFS (fee-for-service), MS–DRG (Medicare severity–diagnosis related group), PAC (post-acute care), Q (quarter). Data displayed by fiscal year and quarter. Analysis includes FFS Medicare beneficiaries’ inpatient stays across inpatient prospective payment system hospitals in the U.S.

Source: MedPAC analysis of Medicare claims data.

Mandated report: Expanding the post-acute care transfer policy to hospice (cont.)

longer, we would expect the share of patients with long inpatient stays to increase.

Overall, the data on inpatient length of stay do not indicate discernable changes in FFS Medicare beneficiaries' timely access to hospice care in the first five quarters of the policy. Figure 3-12 (p. 85) and Figure 3-13 show the share of patients transferred to hospice with "long" inpatient stays for medical and surgical MS-DRGs, respectively. In general, the share of inpatients discharged to hospice with long inpatient stays oscillates over time, which suggests that caution should be taken in interpreting any quarter-to-quarter changes. For both medical and surgical MS-DRGs that are subject to the transfer policy, the share of inpatients discharged to hospice who had "long" inpatient stays

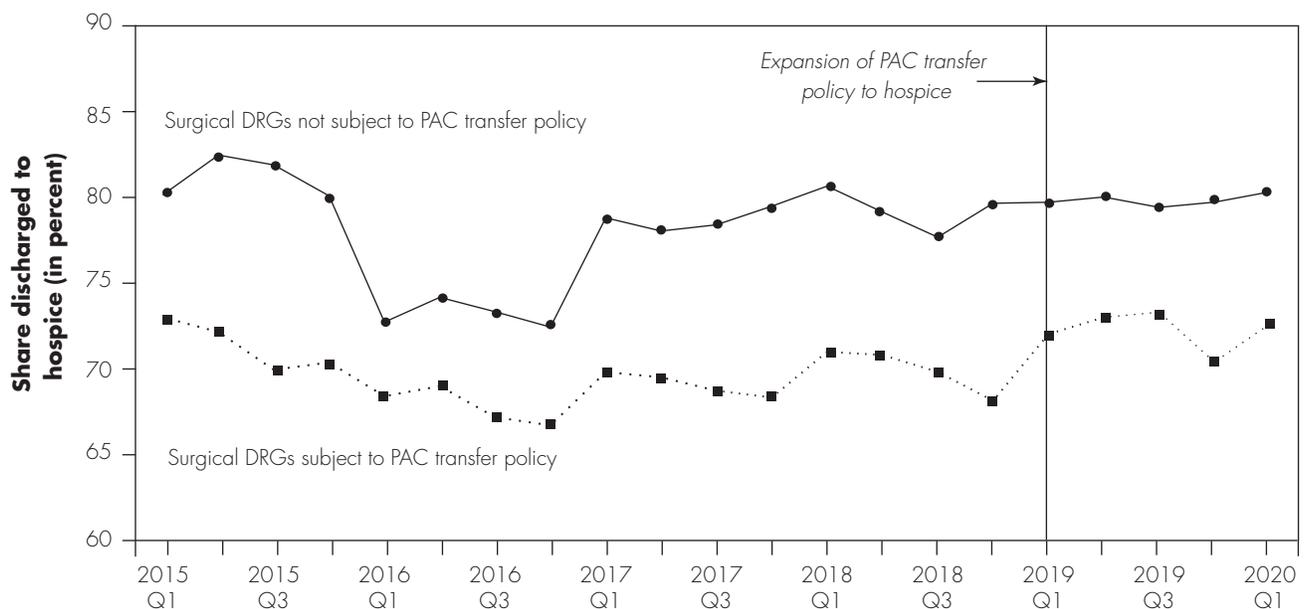
increased modestly between first quarter 2018 and first quarter 2020 but remains within the historical range (Figure 3-13).

Examining the 10 MS-DRGs with the most hospice discharges, we do not see evidence suggesting that the hospice transfer policy has led to longer hospital stays for patients referred to hospice. For 7 of 10 MS-DRGs, the share of patients discharged to hospice who had long inpatient stays declined or changed little between first quarter 2018 and first quarter 2020 (Table 3-7). Over this period, the share of inpatients discharged to hospice with long inpatient stays increased modestly for MS-DRG 280 (acute myocardial infarction) and MS-DRG 853 (infectious and parasitic diseases). The increase in long inpatient stays for MS-DRG 853 is

(continued next page)

FIGURE 3-13

Share of FFS Medicare inpatients discharged from surgical MS-DRGs to hospice with inpatient lengths of stay greater than the short-stay threshold, 2015 to 2020



Note: FFS (fee-for-service), MS-DRG (Medicare severity–diagnosis related group), PAC (post-acute care), Q (quarter). Data displayed by fiscal year and quarter. Analysis includes FFS Medicare beneficiaries' inpatient stays across inpatient prospective payment system hospitals in the U.S.

Source: MedPAC analysis of Medicare claims data.

Mandated report: Expanding the post-acute care transfer policy to hospice (cont.)

consistent with historic trends for this MS-DRG and predates expansion of the transfer policy to hospice (data not shown). For MS-DRG 280, the share of patients discharged to hospice with long inpatient stays has oscillated over time, and the 2020 level is within the historical range since 2015 (data not shown). For MS-DRG 54 (nervous system neoplasm), the share of patients discharged to hospice with long inpatient stays appears to have increased substantially; however, this increase is an artifact of a change in the definition of what constitutes a short stay versus a long stay for this

MS-DRG, rather than an increase in inpatients' actual lengths of stay.²³

In summary, this evaluation of data on hospice referrals from inpatient hospitals and on inpatient length of stay for FFS Medicare beneficiaries referred to hospices finds no evidence of adverse effects on beneficiary access to hospice care over the first five quarters of the new policy expanding the PAC transfer policy to hospice. ■

**TABLE
3-7**

Hospice referral rates and inpatient lengths of stay for the 10 MS-DRGs with the most hospice referrals, first quarters 2018 and 2020

MS-DRG	Description	Share of inpatients discharged to hospice in first quarter of:		Share of inpatients discharged to hospice with inpatient lengths of stay greater than the short-stay threshold in first quarter of:	
		2018	2020	2018	2020
871	Septicemia or severe sepsis without MV >96 hours and with MCC	8.5%	8.9%	66.4%	66.5%
291	Heart failure and shock with MCC or peripheral extracorporeal membrane oxygenation	5.1	5.0	70.1	69.3
064	Intracranial hemorrhage or cerebral infarction with MCC	12.9	13.7	56.5	55.3
177	Respiratory infections and inflammations with MCC	11.2	11.8	61.5	61.4
682	Renal failure with MCC	7.9	8.6	66.3	66.4
280	Acute myocardial infarction, discharged alive with MCC	7.6	7.7	63.4	65.3
193	Simple pneumonia and pleurisy with MCC	4.4	4.6	68.8	68.7
640	Miscellaneous disorders or nutrition, metabolism, fluids/electrolytes with MCC	5.8	6.0	75.0	74.1
853	Infectious and parasitic diseases with operating room procedure and MCC	5.3	5.5	62.6	65.5
054	Nervous system neoplasms with MCC	3.8	3.8	62.0	79.4*

Note: MS-DRG (Medicare severity–diagnosis related group), MV (mechanical ventilation), MCC (major comorbidities and complications), CC (comorbidities and complications). Data displayed are for first quarter of the fiscal year. Analysis includes fee-for-service Medicare beneficiaries' inpatient stays across inpatient prospective payment system hospitals in the U.S.

*For MS-DRG 54, the short-stay threshold changed from two days in 2018 to one day in 2020. This change in definition caused the share of stays exceeding the short-stay threshold to increase between 2018 and 2020.

Source: MedPAC analysis of Medicare claims data.

Endnotes

- 1 Other types of hospitals provide post-acute or other specialized care, such as inpatient rehabilitation facilities (Chapter 9), long-term care hospitals (Chapter 10), and psychiatric hospitals. Short-term acute care hospitals can also provide other services, such as post-acute care services, in distinct units.
- 2 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents to the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms, but which are designed to create different financial incentives. Examples of other Medicare payment methodologies for inpatient and outpatient services at short-term acute care hospitals include cost-based reimbursement to small hospitals designated as critical access hospitals and Maryland’s all-payer global budget. In addition, even at PPS hospitals, certain inpatient costs are paid separately, such as organ acquisition costs. Hospitals also receive Medicare payments for post-acute care services and for their costs of direct medical education. These other payment methodologies are beyond the scope of this chapter but are included in our estimates of IPPS hospitals’ overall Medicare margin.
- 3 Under each Medicare payment methodology, Medicare pays the approved amount minus any beneficiary liability, such as a deductible or copayment; the provider then needs to collect the remaining amount from the beneficiary or a supplemental insurer. Medicare reimburses providers for 65 percent of bad debts resulting from beneficiaries’ nonpayment of deductibles and copayments after providers have made reasonable efforts to collect the unpaid amounts. This total payment estimate does not reflect any unreimbursed bad debt.
- 4 Medicare uses the OPSS to pay for outpatient services at all IPPS hospitals (other than those that are part of the Indian Health Service); certain specialized short-term acute care hospitals (cancer and children’s hospitals); and other types of hospitals, such as psychiatric, long-term care, and rehabilitation hospitals.
- 5 In 2019, the Department of Veterans Affairs finalized regulations to implement the new Veterans Community Care program under the MISSION Act. This rule maintains payment rates for most care at non-VA facilities not to exceed FFS Medicare rates, but includes exceptions, such as allowing higher rates in highly rural areas and clarifying that reference Medicare rates include those for critical access hospitals (Department of Veterans Affairs 2019).
- 6 For example, beginning in 2016, Montana’s state employee health plan implemented contracts with Montana hospitals in which hospital payments were based on a percentage above Medicare rates (http://benefits.mt.gov/Portals/195/HCBD%20Annual%20Report_Proof10.pdf). Oregon followed in 2017, setting hospital payment rates for its state employee plan at 200 percent of Medicare payment rates for in-network hospitals and 185 percent for out-of-network hospitals (ORS §243.256). Other states, such as Colorado and North Carolina, have made proposals to base payment rates on a percentage of Medicare rates. In addition, Washington State created a public option beginning in 2021 in which aggregate payments for all covered benefits (exclusive of pharmacy) are capped at 160 percent of Medicare (WSL RCW §41.05.410).
- 7 For more details on the IPPS, see the Hospital Acute Inpatient Services Payment System document in our *Payment Basics* series at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_hospital_final_sec.pdf?sfvrsn=0.
- 8 For more details on the OPSS, see the Outpatient Hospital Services Payment System in our *Payment Basics* series at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_opd_final_sec.pdf?sfvrsn=0.
- 9 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 10 For the first three categories in our payment adequacy framework—access to care, quality, and access to capital—we generally include all short-term acute care hospitals in the U.S., regardless of Medicare’s payment methodology. However, because the primary goal of our assessment of hospital payment adequacy is to make recommendations on the annual update to IPPS operating and OPSS base payment rates, our examination of the relationship between hospitals’ payments and costs is limited to hospitals paid under the IPPS.
- 11 Hospital closures are defined as cessation of Medicare beneficiaries’ access to inpatient services at a general short-term acute care hospital or critical access hospital in the U.S. (exclusive of territories). Closures do not include the

- relocation of inpatient services from one hospital to another under common ownership within 10 miles, nor do closures include hospitals that both opened and closed within a 5-year time period. The number of hospital closures and openings in a given year can change over time as hospitals reopen or dates of closure are updated.
- 12 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality.
 - 13 We used monthly hospital employment estimates from the Bureau of Labor Statistics' national current employment statistics, December 2020 (<https://www.bls.gov/ces/data.htm>). The employment data sample includes all private and government hospitals, while data on weekly hours and earnings are limited to private hospitals.
 - 14 The American Taxpayer Relief Act of 2012 required CMS to recover overpayments to hospitals to account for changes in the Medicare severity–diagnosis related group documentation and coding that do not reflect real changes in case mix, totaling \$11 billion over fiscal years 2014 to 2017. The Medicare Access and CHIP Reauthorization Act of 2015 replaced the single positive adjustment CMS intended to make in 2018 with a positive adjustment for each of fiscal years 2018 through 2023.
 - 15 Similar to other FFS Medicare payments, uncompensated care payments are subject to sequestration.
 - 16 For more details on how we identified hospitals under fiscal pressure, see our March 2011 report (Medicare Payment Advisory Commission 2011).
 - 17 While Medicare pays critical access hospitals 101 percent of their allowable costs, the 2 percent sequestration and unreimbursed bad debt caused these hospitals' margin to be slightly negative.
 - 18 The objective of this analysis is to find a subset of the relatively efficient hospitals rather than to identify all efficient hospitals. For example, we exclude small hospitals with under 500 discharges from our analysis, not because we know they are inefficient, but because we have an insufficient volume of claims to know whether or not they performed at a relatively efficient level.
 - 19 We use medians rather than means to limit the influence of outliers on our set of efficient providers.
 - 20 The 1,473 hospitals are a smaller sample than in past years, attributable to delays in the reporting of some cost report data.
 - 21 We do not adjust our costs per discharge for economies of scale. However, we excluded all hospitals with fewer than 500 Medicare discharges from our analysis. For the remaining hospitals, economies of scale are not a material factor when evaluating costs per discharge because costs are roughly proportionate to the volume of discharges for hospitals with over 500 Medicare discharges per year (generally over 1,000 all-payer discharges). Teaching hospitals tend to have higher costs per discharge, but we standardize costs per discharge by adjusting for the effect of case mix, outlier cases, and the cost of training residents. After these adjustments, teaching hospital costs on average are similar to nonteaching hospital costs. For a more complete description of the methodology, see online Appendix 3-B from our March 2016 report to the Congress, available at <http://www.medpac.gov/docs/default-source/reports/chapter-3-online-only-appendixes-hospital-inpatient-and-outpatient-services-march-2016-report-.pdf>.
 - 22 The efficient hospitals' shares of Medicaid discharges ranged from 4 percent at the 25th percentile to 11 percent at the 75th percentile compared with an interquartile range of 3 percent to 12 percent for all hospitals.
 - 23 Annually, CMS updates the short-stay threshold for each MS–DRG based on the geometric mean length of stay for that MS–DRG using claims data from two years prior. For MS–DRG 54, the geometric mean length of stay changed from 3.1 days for fiscal year 2018 to 3.0 days for fiscal year 2020. Because short stays are defined as stays that are more than one day below the geometric mean length of stay for the MS–DRG, in fiscal year 2018, one-day and two-day stays were considered short stays, and in fiscal year 2020 only one-day stays were considered short stays. This change in definition caused the increase in “long” inpatient stays between 2018 and 2020.

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CHAPTER 4

**Physician and other health
professional services**

R E C O M M E N D A T I O N

- 4** For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Physician and other health professional services

Chapter summary

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. Medicare pays for these clinician services using a fee schedule. In 2019, Medicare paid \$73.5 billion for clinician services, accounting for just under 18 percent of traditional fee-for-service (FFS) Medicare spending. In the same year, almost 1.3 million clinicians billed the fee schedule, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners.

In this chapter we recommend a payment rate update for the conversion factor (a fixed dollar amount) for Medicare’s fee schedule for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. Where relevant, we have considered the effects of the 2020 coronavirus pandemic on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the pandemic are temporary or vary significantly across clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians’ payment rates in 2022 and future years. Based on information available at the time of publication, we do not anticipate any long-term effects related to the public health emergency that would warrant changing the annual update to Medicare’s fee schedule for 2022.

In this chapter

- Are Medicare fee schedule payments adequate in 2021?
- How should Medicare payments change in 2022?
- Appendix: Findings from the Commission’s 2020 access-to-care telephone survey

Assessment of payment adequacy

To assess the adequacy of current payment rates for clinicians, we assess beneficiaries' access to care, the quality of their care, and providers' payments and costs.

Beneficiaries' access to care—Overall, beneficiaries' access to clinician services is comparable with prior years, despite the current public health emergency.

- ***Beneficiaries report relatively good access to care.*** Consistent with longstanding trends, the vast majority of beneficiaries reported having a usual source of care and that their usual care provider spent enough time with them. In the Commission's 2020 telephone survey, we also found that higher shares of Medicare beneficiaries reported being satisfied with their care and reported having a primary care provider than did privately insured individuals. Despite being fielded during a pandemic, our survey also found no statistically significant increase this year in the share of respondents who waited longer than they wanted for appointments or who reported forgoing care. This finding may in part be attributable to the substitution of telehealth visits for in-person visits: 15 percent of beneficiaries reported having a video visit in the past year, and 37 percent reported having an audio-only phone visit. Although a majority of beneficiaries reported being able to find a new doctor without any problem, among the small share who reported difficulties, more beneficiaries reported problems obtaining a new primary care provider than obtaining a new specialist. We also found that Black beneficiaries reported more problems finding a new specialist than did White beneficiaries, and Hispanic beneficiaries reported longer waits for appointments. Non-elderly Medicare beneficiaries (most of whom qualify for the program because of disability and have lower incomes than elderly beneficiaries) reported noticeably more difficulties accessing care than did elderly beneficiaries.
- ***The supply of clinicians continues to grow.*** From 2014 to 2019, growth in the number of clinicians billing the fee schedule outpaced growth in the number of beneficiaries. However, during this time, the mix of clinicians changed: The number of primary care physicians decreased slightly, while the number of specialists steadily increased, and the number of advanced practice registered nurses and physician assistants grew rapidly. The share of providers billing Medicare who are enrolled in Medicare's participating provider program—meaning they accept fee schedule amounts as payment in full—remains very high.
- ***The number of clinician encounters per beneficiary is growing.*** The number of clinician encounters per beneficiary increased modestly over time, with faster growth from 2018 to 2019 (2.1 percent) compared with the average

annual growth rate from 2014 to 2018 (1.1 percent). Growth rates varied by specialty and type of provider. From 2018 to 2019, the number of encounters per beneficiary with primary care physicians declined by 2.3 percent, while encounters per beneficiary with advanced practice registered nurses and physician assistants increased by 10.9 percent. These findings suggest that beneficiaries are able to access the care they seek even though different clinicians may be furnishing it.

Quality of care—Geographic variation in traditional Medicare beneficiaries’ ambulatory care–sensitive hospitalizations and emergency department visits signals opportunities to improve the quality of ambulatory care. There is substantial use of low-value care among Medicare beneficiaries. (Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit.) We estimate that, in 2018, between 22 percent and 36 percent of beneficiaries in traditional Medicare received at least one low-value service, and Medicare spending for these services ranged from \$2.4 billion to \$6.9 billion.

Medicare payments and providers’ costs—Clinicians’ Medicare payments and input costs continue to rise.

- **Medicare payments per beneficiary are growing.** Between 2018 and 2019, traditional Medicare’s allowed charges (i.e., payments to providers, including beneficiary cost sharing) for clinician services per beneficiary grew 3.7 percent, a higher growth rate than in prior years. Among broad service categories, allowed charges for evaluation and management services between 2018 and 2019 grew 2.9 percent, while imaging services grew 3.5 percent, major procedures grew 5.1 percent, other procedures grew 5.6 percent, and anesthesia services grew 2.6 percent.
- **Private insurance payment rates continue to be higher than Medicare payment rates.** In 2019, private insurance payment rates for clinician services were 136 percent of traditional Medicare’s rates, up slightly from 135 percent in 2018. The growth of private insurance prices could be a result of increased consolidation of physician practices, which gives physicians greater leverage to negotiate higher prices with private plans.
- **Physician compensation is rising.** From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average. However, median compensation in 2019 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties—underscoring concerns about the mispricing of fee schedule services and its impact on primary care.

- ***Clinicians' input costs are growing.*** In 2019, the Medicare Economic Index—which measures input costs—grew by 1.5 percent. CMS projected that it would increase by 1.7 percent in 2020 and that it will increase by 1.3 percent in 2021 and 1.6 percent in 2022

How should payment rates change in 2022?

The Medicare Access and CHIP Reauthorization Act of 2015 mandates no update for clinicians for 2022 (however, clinicians are eligible for performance-based payment adjustments or can receive an incentive payment worth 5 percent of their professional services payments if they participate in an advanced alternative payment model). The Commission's analyses suggest that Medicare's aggregate payments for clinicians are adequate. Therefore, the Commission recommends that the Congress update the 2022 Medicare payment rates for physician and other health professional services by the amounts determined under current law. ■

Background

Physicians and other health professionals billing under traditional Medicare’s physician fee schedule deliver a wide range of services—including office visits, surgical procedures, and diagnostic and therapeutic services—in a variety of settings.¹ The Medicare program paid \$73.5 billion for clinician services in 2019, or just under 18 percent of spending in fee-for-service (FFS) Medicare (Boards of Trustees 2020).² In 2019, almost 1.3 million clinicians, including physicians, nurse practitioners, physician assistants, therapists, chiropractors, and other practitioners, billed traditional Medicare for at least one beneficiary.

Medicare uses a fee schedule to pay for clinician services, which consists of about 8,000 services. In determining payment rates for each service, CMS considers the amount of clinician work required to provide a service, expenses related to maintaining a practice, and professional liability insurance costs. These three factors are adjusted for

variation in the input prices in different markets, and the sum is multiplied by the fee schedule’s conversion factor (a fixed dollar amount) to produce a total payment amount.³ The conversion factor was \$36.09 in 2020.

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a set of updates for clinicians billing under the fee schedule. MACRA established two paths: (1) a payment path for clinicians who participate in advanced alternative payment models (A-APMs), such as the Comprehensive Primary Care Plus model or certain accountable care organization models, and (2) the Merit-based Incentive Payment System (MIPS) for other clinicians (Table 4-1).

For 2022, there is no update to clinicians’ base payment rates scheduled under current law. Instead, clinicians qualifying for the A-APM incentive payment will receive a lump sum payment worth 5 percent of their annual professional services payments. MACRA allows CMS to give the clinicians in MIPS payment adjustments between –9 percent and +9 percent (or higher) in 2022 based on

**TABLE
4-1**

Clinicians are eligible for MIPS performance-based payment adjustments and A-APM bonuses, but no updates to their base payment rates in 2022

	2021	2022	2023	2024	2025	2026 and later
A-APM clinicians						
Update	0%	0%	0%	0%	0%	0.75%
A-APM bonus	5%	5%	5%	5%	N/A	N/A
Other clinicians						
Update	0%	0%	0%	0%	0%	0.25%
Potential MIPS adjustments	(–7% to +7%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)	(–9% to +9%)
Additional MIPS adjustments for “exceptional” performance	\$500 million	\$500 million	\$500 million	\$500 million	N/A	N/A
All clinicians						
One-time payment increase	3.75%	N/A	N/A	N/A	N/A	N/A

Note: MIPS (Merit-based Incentive Payment System), A-APM (advanced alternative payment model), N/A (not applicable). The annual change to the conversion factor (a fixed dollar amount) for Medicare’s physician fee schedule is based on the statutory payment updates listed above and an adjustment to ensure that changes to the fee schedule’s work relative value units are budget neutral. The 5 percent incentive payment for A-APM participation expires after 2024, as does the additional \$500 million per year used to increase MIPS adjustments for “exceptional” performance. In the Consolidated Appropriation Act of 2021, the Congress increased fee schedule payments by 3.75 percent in 2021 only; this increase does not continue after 2021.

Source: Medicare Access and CHIP Reauthorization Act of 2015; Bipartisan Budget Act of 2018; and Consolidated Appropriations Act, 2021. www.congress.gov.

The impact of the coronavirus pandemic on clinicians

To examine the impact of the coronavirus pandemic on clinician services in Medicare, we analyzed preliminary Medicare fee-for-service (FFS) claims data for physician fee schedule (PFS) services furnished during the first six months of 2020. We found that allowed charges (i.e., total payments to providers, including beneficiary cost sharing) for clinician services dropped sharply starting in March 2020. By April 2020, total allowed charges were roughly half what they were in April 2019. Some types of services (e.g., anesthesia and imaging) experienced larger decreases than others (e.g., evaluation and management, or E&M). We also looked at whether changes in allowed charges were concentrated in particular areas of the country or age groups, but we found that by April the declines were generally consistent among different geographic regions, urban and rural areas, and age groups. In May 2020, total allowed charges started returning to historic levels, and by June 2020 allowed charges were only about 5 percent less than in June 2019. However, the change in allowed charges continued to vary by type of service, and the recovery among certain age groups (beneficiaries under age 65 and over age 84) and regions of the country (New England and Mid-Atlantic) lagged behind others.

During the coronavirus public health emergency (PHE), the Congress and CMS temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and to reduce the risk of exposure to COVID-19. For example, clinicians may bill for telehealth services provided to beneficiaries located in their homes and in urban as well as rural areas; prior to the PHE, Medicare paid for telehealth services only if they were provided to beneficiaries in a clinician's office or a facility in a rural area. (For more information on the telehealth expansions, see Chapter 14.) Clinicians responded to these changes by rapidly adopting telehealth services.

The rapid growth of allowed charges for telehealth services partially offset the sharp drop in allowed charges for in-person PFS services in March and April 2020. Telehealth accounted for 16 percent of total allowed charges for all PFS services in April 2020, compared with 0.1 percent in April 2019. This share declined to 11 percent in May 2020 and 7 percent in June as in-person services began to rebound. Telehealth accounted for a larger share of allowed charges for all E&M visits than it did for all PFS services; for example, telehealth made up 26 percent of allowed charges for all E&M visits in April 2020, compared with 16 percent of allowed charges for all PFS services.

We also examined more highly aggregated but less complete FFS claims data to analyze trends after June 2020. Between June and early December, the volume of total primary care visits (which includes both in-person and telehealth) and elective services such as colonoscopies and total knee replacement remained close to or just below the volume of those services during the same time period in 2019.⁴ It is notable that the volume of these services did not decline substantially even though the number of coronavirus cases began to increase rapidly in October.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for most payment adequacy indicators. We use these data to make payment recommendations for 2022. To the extent the effects of the coronavirus pandemic are temporary or vary significantly across clinicians, they are best addressed through targeted temporary funding policies rather than a permanent change to all clinicians' payment rates in 2022 and future years. (For an overview of how our payment adequacy analysis takes account of the pandemic, see Chapter 2.) ■

their performance, but historically CMS has given much smaller adjustments of less than 2 percent. For example, in 2021, top performance on MIPS measures will yield a 1.79 percent MIPS adjustment, which is comparable with

prior years' top MIPS adjustment. In 2021, about a million clinicians will receive additional payments beyond their base Medicare payment rates: About 800,000 will receive a positive MIPS adjustment based on their performance

on measures, and about 200,000 will receive the 5 percent A-APM bonus. A few hundred thousand clinicians will receive no payment adjustment because they are exempt from MIPS (e.g., due to a low volume of Medicare patients). About 3,000 clinicians will receive negative MIPS adjustments, primarily because they failed to report MIPS measure data (Centers for Medicare & Medicaid Services 2020c, Centers for Medicare & Medicaid Services 2018a).

As currently implemented, MACRA creates incentives for clinicians to participate in A-APMs—first through bonuses that are larger than MIPS adjustments, then through differential payment updates. Starting in 2026, Medicare payment rates for clinicians in A-APMs will increase by 0.75 percent per year, while rates for MIPS clinicians will increase only by 0.25 percent per year. Over time, the difference between payment rates for clinicians in A-APMs and MIPS will grow, making nonparticipation in A-APMs increasingly unattractive financially.

Since early 2020, the coronavirus public health emergency (PHE) has had tragic effects on beneficiaries' health.⁵ It also has had material effects on providers' patient volume, revenues, and costs. The effects of the pandemic have varied considerably over time, and it is not clear when they will end. In recognition of the disruptive effects the PHE has had on providers' ability to meet program requirements, CMS offered clinicians the option of not reporting results for some or all MIPS measure categories when calculating their eligibility for MIPS adjustments in 2021 and 2022. More details about the impact of the pandemic on clinicians can be found in the text box and throughout this chapter.

Are Medicare fee schedule payments adequate in 2021?

We assess the adequacy of existing payment rates by reviewing beneficiaries' access to care (including beneficiaries' reports of their experience accessing care, growth in the supply of clinicians, and growth in the number of clinician encounters per beneficiary). We also assess the quality of beneficiaries' care (rates of ambulatory care-sensitive (ACS) hospitalizations and emergency department visits and low-value care). Finally, we assess Medicare payments and providers' costs (including growth in Medicare payments per

beneficiary, the ratio of private insurance payment rates to Medicare's rates for clinician services, growth in physician compensation from all payers, and the change in input costs for clinician services). Overall, most indicators show no significant change from prior years.

Beneficiaries' access to care

Beneficiaries' access to care is largely comparable with (or in some cases, better than) access for privately insured individuals. Most beneficiaries report no difficulty accessing care, the number of clinicians billing the fee schedule is growing faster than beneficiary enrollment in Medicare, and the number of clinician encounters per beneficiary is growing.

Beneficiaries report relatively good access to care

Overall, findings from the surveys and focus groups we use to assess Medicare beneficiaries' access to care (see text box, p. 102) are consistent with one another and similar to prior years. The vast majority of beneficiaries report being satisfied with their care and not experiencing trouble accessing care. Our 2020 telephone survey found that, although wait times for routine care appointments continue to be experienced by a sizable minority of beneficiaries, there was no statistically significant *increase* this year in the share of beneficiaries who waited longer than they wanted to for appointments or who reported forgoing care, compared with last year—even with the pandemic. This finding may in part be due to the temporary wide-scale availability of telehealth visits during this period. Notwithstanding these generally positive indicators, non-elderly Medicare beneficiaries reported more difficulties accessing care than elderly beneficiaries, Hispanic beneficiaries reported longer waits for appointments, and Black beneficiaries reported more difficulty finding a new specialist than did White beneficiaries.

Medicare beneficiaries' overall satisfaction with care is higher than that of privately insured patients In our 2020 phone survey, a higher share of Medicare beneficiaries reported that they were very or somewhat satisfied with the overall quality of their care (88 percent) compared with privately insured individuals ages 50 to 64 (82 percent) (Figure 4-1, p. 103). Similarly, CMS's Medicare Current Beneficiary Survey (MCBS) found that, in 2018, 93 percent of Medicare beneficiaries were satisfied or very satisfied with the overall quality of the care they received in the past year. Similar shares of beneficiaries in our focus groups rated their Medicare coverage as excellent or good.

Beneficiary surveys and focus groups used to assess access to care

We used three data sources to assess beneficiaries' access to care this year:

- ***Findings from our customary annual telephone survey of approximately 4,000 Medicare beneficiaries ages 65 and over and 4,000 privately insured individuals ages 50 to 64.*** The goal in surveying these two populations is to assess whether any access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year's survey was fielded from April through October of 2020. Our survey includes beneficiaries in traditional Medicare and Medicare Advantage (MA) since it is difficult to differentiate between these two types of coverage in a brief survey. MA plans often pay providers rates that are comparable with traditional fee-for-service Medicare. This year, we also compare our survey's results with those of the National Institutes of Health–funded Health and Retirement Study (see text box, p. 106).
- ***CMS's 2018 Medicare Current Beneficiary Survey (MCBS), a nationally representative***

in-person survey that yielded 14,000 Medicare beneficiary responses for our analysis. Findings from the MCBS are not as recent as those from the Commission's survey, but the data are more comprehensive. Therefore, we use the MCBS to confirm and supplement the trends we observe in our phone survey. The MCBS's large sample—which includes both elderly and non-elderly beneficiaries—allows us to examine differences between numerous subgroups of beneficiaries.

- ***Virtual focus groups conducted by the Commission in three markets around the country to obtain an in-depth description of beneficiary and provider experiences with the Medicare program.*** This year, we conducted three focus groups of Medicare beneficiaries (in both traditional Medicare and MA) in each of three markets. One of the groups in each market was composed of beneficiaries dually eligible for Medicare and Medicaid. We also conducted three focus groups with clinicians in each location: primary care physicians, specialist physicians, and a mix of primary care and specialist nurse practitioners and physician assistants. ■

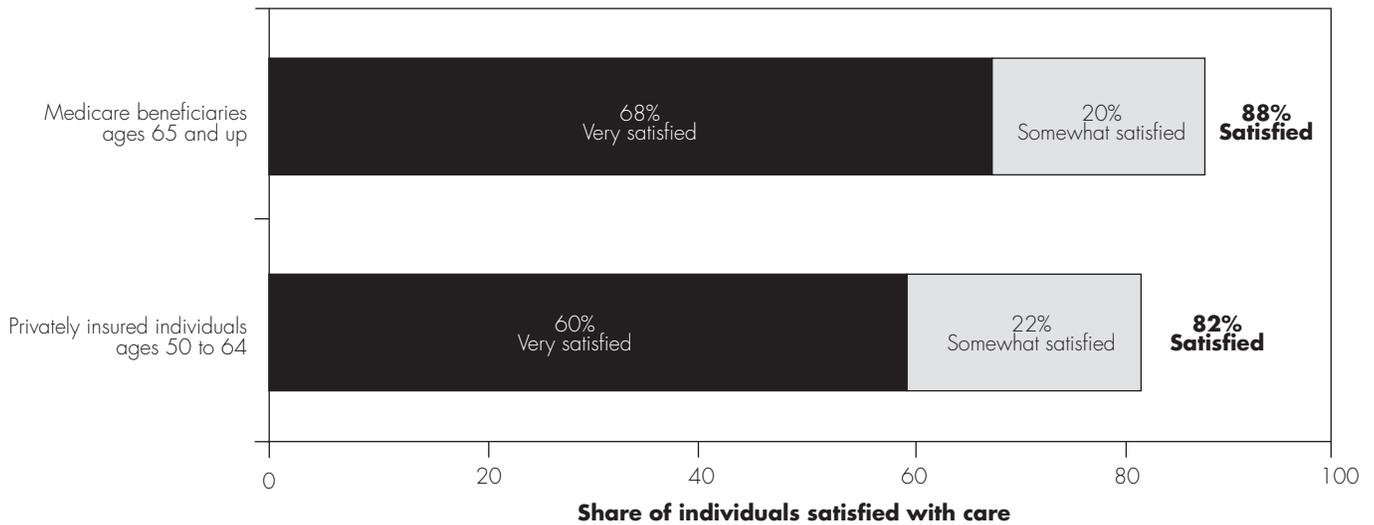
The MCBS found that 93 percent of Medicare beneficiaries reported no trouble accessing care in 2018. Among the 7 percent of beneficiaries who reported trouble, difficulty affording the cost of care was the most commonly cited barrier, mentioned by a third of these respondents (amounting to about 3 percent of all respondents).

In our focus groups, most beneficiaries reported timely access to primary care. Most beneficiaries were able to get appointments with specialists that they needed and did not report encountering any specialties not accepting new patients in their area. However, some beneficiaries mentioned that, when they called a specialist to make an appointment, the wait was longer than they expected.

Beneficiaries maintained good access to care during the pandemic A majority of the beneficiaries in our 2020 phone survey reported that they were able to see a doctor without waiting longer than they wanted (see Table 4A-1 in the appendix to this chapter, p. 125). Among the subset of respondents needing an appointment for routine care, there was no statistically significant difference in the shares of Medicare beneficiaries and privately insured respondents who reported waiting longer than they wanted for this type of care (28 percent vs. 26 percent). Similarly, among those needing an appointment for an *illness or an injury*, identical shares reported waiting longer than they wanted (19 percent). These percentages were not statistically different from those reported last year (i.e., statistically the same).

**FIGURE
4-1**

More Medicare beneficiaries are satisfied with the overall quality of their health care than privately insured individuals, 2020



Note: Figure does not show the share of respondents who said that they were somewhat dissatisfied, very dissatisfied, did not receive health care in past 12 months, don't know, or refused to answer the question.

Source: MedPAC-sponsored telephone survey, 2020.

Our finding that Medicare beneficiaries were more likely to experience delays getting appointments for routine care than for illnesses or injuries is consistent with other surveys fielded by the Centers for Disease Control and Prevention (CDC) and CMS during the pandemic (Centers for Medicare & Medicaid Services 2020a, Czeisler et al. 2020).

During the coronavirus PHE, the Congress and CMS temporarily expanded coverage of telehealth services (including audio-only telephone services) to ensure that beneficiaries continue to have access to care and to reduce the risk of exposure to COVID-19. (For more information on the telehealth expansions, see Chapter 14.) As a result, many clinicians began to offer care by means of telehealth—either through interactive video calls or audio-only phone calls (Verma 2020).

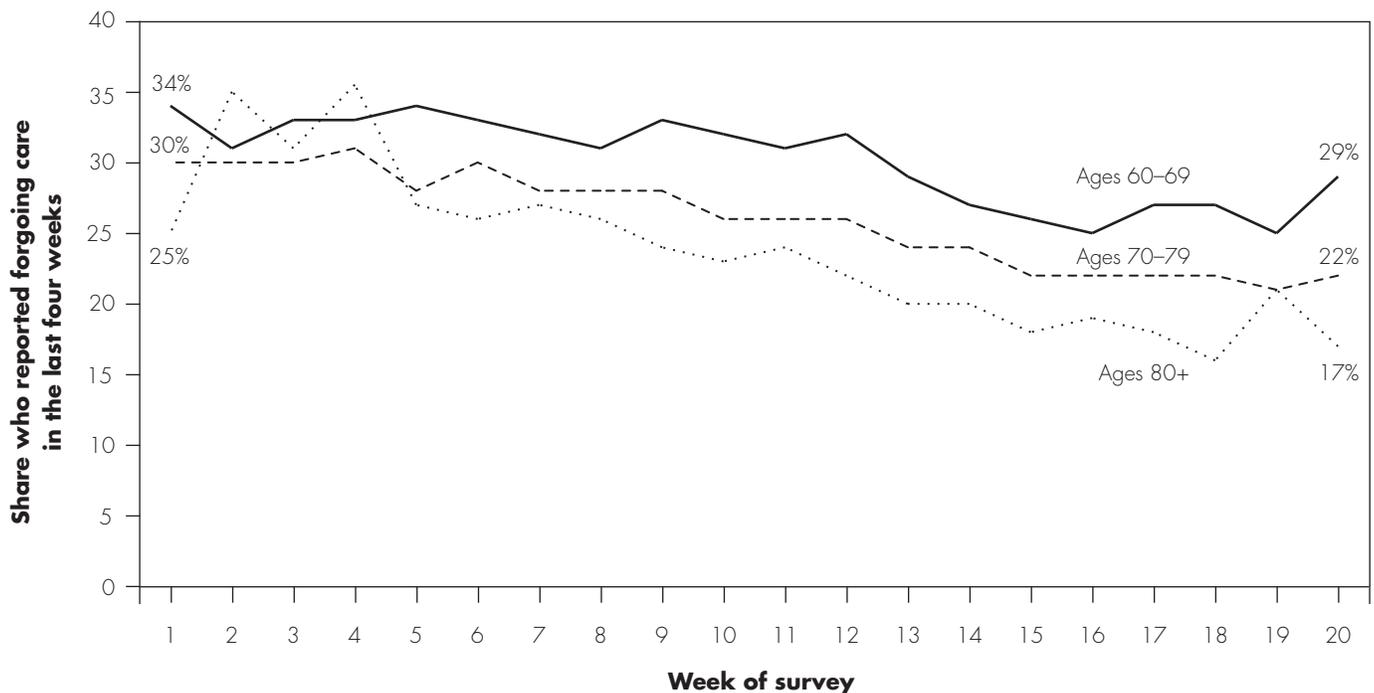
The Commission's 2020 survey (fielded from April to October) found that 15 percent of Medicare beneficiaries had had a video visit in the past year, and 37 percent had had an audio-only phone visit. In comparison, privately insured individuals were less likely than Medicare beneficiaries to have had an audio-only phone visit (30

percent) and more likely to have had a video visit (18 percent). Medicare beneficiaries' satisfaction with these visits was slightly higher than satisfaction with overall health care: 91 percent of Medicare beneficiaries were satisfied with their video visits and 92 percent were satisfied with their phone visits, while 88 percent were satisfied with their overall health care. Similar trends were observed among the privately insured. However, in our focus groups, beneficiaries who had had a telehealth visit and clinicians who provided these visits generally liked the idea of telehealth, but their reactions to actual visits were mixed. They cited the benefits of increased access and convenience and the challenges of loss of in-person contact and technology issues.

The Commission's survey found that only 10 percent of Medicare beneficiaries reported forgoing care that they thought they should have received in the past year—statistically the same as last year and statistically the same as the share of the privately insured reporting this (see Table 4A-1 in the appendix to this chapter, p. 125). Only 4 percent of each insurance group reported forgoing

**FIGURE
4-2**

The share of elderly individuals who reported forgoing care in the past four weeks declined from June to December, 2020



Note: "Week 1" refers to April 23–May 5, 2020; "Week 6" refers to June 4–9, 2020; "Week 20" refers to November 25–December 7, 2020. Similar trends were observed for the share reporting *delaying* (as opposed to forgoing) care in the past four weeks.

Source: Census Bureau's Household Pulse Survey, fielded 20 times between April 23 and December 7, 2020. (<https://www.census.gov/programs-surveys/household-pulse-survey/data.html>.)

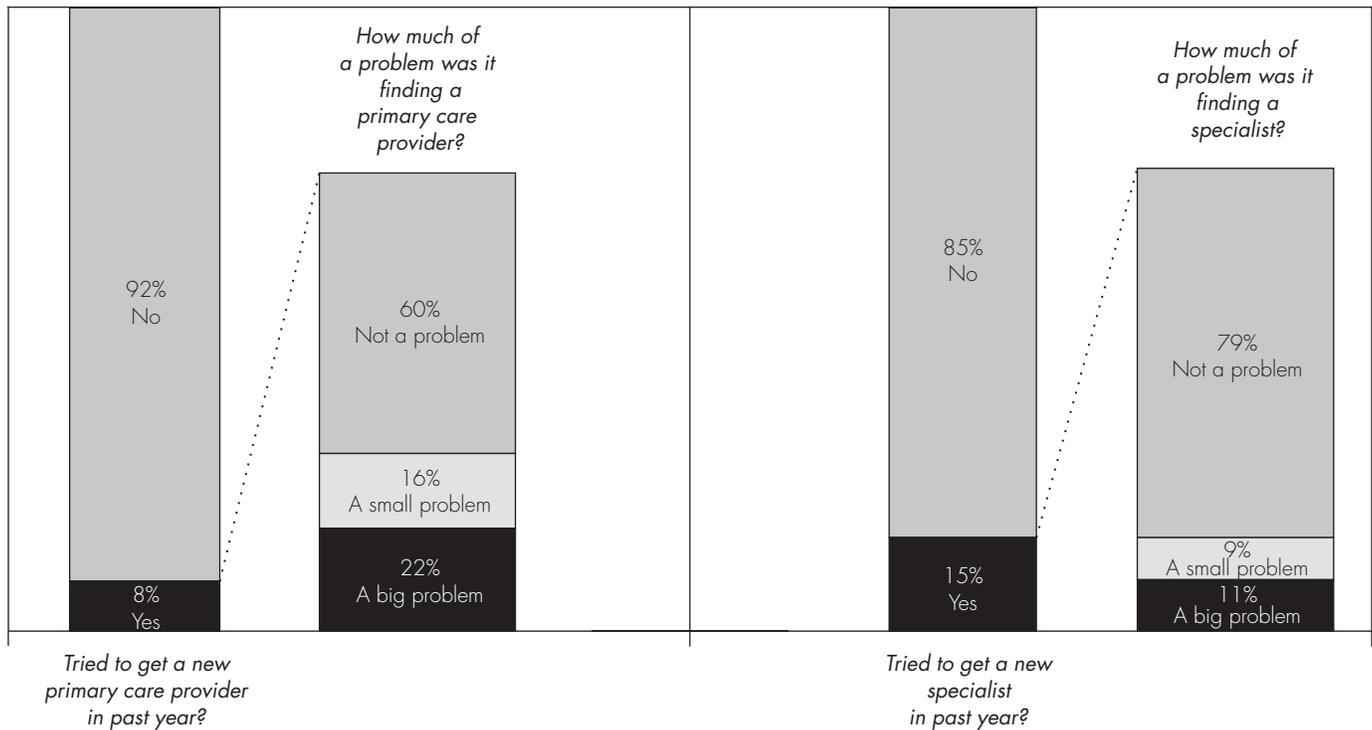
care specifically because of the pandemic. (Similarly, the CDC survey found that 4 percent of elderly respondents delayed or avoided urgent or emergency care during the pandemic (Czeisler et al. 2020).) In our focus groups, some beneficiaries reported delaying some preventive and routine visits (e.g., colonoscopies and yearly check-ups), and some canceled appointments during the early months of the pandemic. Many said that their appointments had been rescheduled after being canceled earlier in the pandemic or that their clinicians had reopened their offices and were encouraging patients to schedule visits. This finding is consistent with a Census Bureau survey fielded every few weeks during the pandemic, which found several noteworthy trends. First, from April to December, most elderly individuals did not report forgoing

or delaying care. Second, the shares of elderly individuals that did report forgoing or delaying care steadily declined from June to early December. Third, older elderly individuals were less likely to forgo or delay care than younger elderly individuals (Figure 4-2) (Census Bureau 2020).

Patients have a harder time finding a new primary care provider than finding a new specialist Nationally, both Medicare beneficiaries and those who are privately insured have an easier time finding a new specialist than finding a new primary care provider. Our telephone survey asks respondents whether, when they are looking for a new doctor, they are able to find one without difficulty. Most beneficiaries reported that they were able to find a new doctor without a problem in 2020. Among the 15 percent

FIGURE 4-3

Medicare beneficiaries' experiences finding a new doctor, 2020



Note: Numbers may not sum to 100 percent because the figure does not show the share of respondents who said they didn't know or refused to answer the question.

Source: MedPAC's annual access-to-care telephone survey, 2020.

of Medicare beneficiaries who looked for a new specialist, 79 percent of this subset reported no problem finding one. In contrast, among the 8 percent who looked for a new primary care provider, only 60 percent reported no problem finding one (Figure 4-3). This pattern of greater difficulty in finding a new primary care provider relative to finding a specialist is consistent with experience in prior years, other surveys, and our beneficiary focus groups, and is also a trend seen among respondents in our survey who are privately insured (data not shown). However, because relatively few individuals were looking for a new clinician and most of those looking reported no problem finding one, the share of respondents who reported a big problem finding a new clinician was very small (1 percent to 2 percent of respondents, depending on the insurance group and the type of clinician) (see Table 4A-1 in the appendix to this chapter, p. 125).

The oldest Medicare beneficiaries have slightly better access to care than younger elderly beneficiaries In our annual phone survey, Medicare beneficiaries ages 65 to 74, 75 to 84, and 85 and over reported similar experiences accessing care, with only a few statistically significant differences between these age cohorts. Beneficiaries ages 85 and older reported better access compared with younger cohorts on two important dimensions. First, smaller shares of beneficiaries ages 85 and over reported being dissatisfied with their care in the past year (2 percent) compared with beneficiaries in the two younger cohorts (5 percent for each of these groups). Second, among beneficiaries ages 85 and over looking for a new primary care provider, only 6 percent had “a big problem” finding a new one (amounting to 0.3 percent of Medicare beneficiaries).

The Commission's survey finds results similar to National Institutes of Health's survey

Each year, the Commission sponsors a telephone survey of about 4,000 Medicare beneficiaries ages 65 and older and about 4,000 privately insured individuals ages 50 to 64. The goal in surveying these two populations is to assess whether any access concerns reported by Medicare beneficiaries are unique to the Medicare population or are part of trends in the broader health care delivery system. This year, to confirm the accuracy of the trends observed in our phone survey, we compared our survey results with those of a larger survey, the Health and Retirement Study (HRS), which is funded by the National Institutes of Health. The HRS is a biennial, longitudinal survey of a representative sample of approximately 20,000 Americans over the age of 50.

Our analysis uses data from 2016 since it is the most recent year of HRS data available that can be weighted

to produce nationally representative estimates. In 2016, HRS interviews were conducted either in person or by phone, and like the Commission's survey, interviews were conducted in English or Spanish depending on the respondent's preference. We analyzed HRS responses from about 9,000 Medicare beneficiaries ages 65 and older and about 6,000 privately insured individuals ages 51 to 64.

We analyzed four survey questions that are roughly comparable with each other in these two surveys (shown below in Table 4-2, with differences in question wording noted). We found similar trends in responses to these questions: Both surveys suggest that Medicare beneficiaries' access to care is comparable with, or better than, that of older privately insured individuals. ■

**TABLE
4-2**

The Commission's telephone survey and the National Institutes of Health's Health and Retirement Study survey produced similar results, 2016

	Medicare beneficiaries ages 65 and older		Privately insured ages 50 or 51 to 64	
	MedPAC survey	NIH survey	MedPAC survey	NIH survey
Satisfied with their health care ^a	86%	86%	80%	77%
Have a usual source of primary care ^b	94	89	91	89
Had trouble finding a primary care provider ^c	3	3	4	3
Needed medical care, but did not get it because could not afford it ^d	1	3	4	6

Note: NIH (National Institutes of Health). Medicare's telephone survey includes about 4,000 Medicare beneficiaries ages 65 and older and about 4,000 privately insured individuals ages 50 to 64. The Health and Retirement Study (HRS) is a biennial, longitudinal survey of a representative sample of approximately 20,000 Americans over age 50. This comparison uses 2016 data because it is the most recent year of HRS data available that can be weighted to produce nationally representative results.

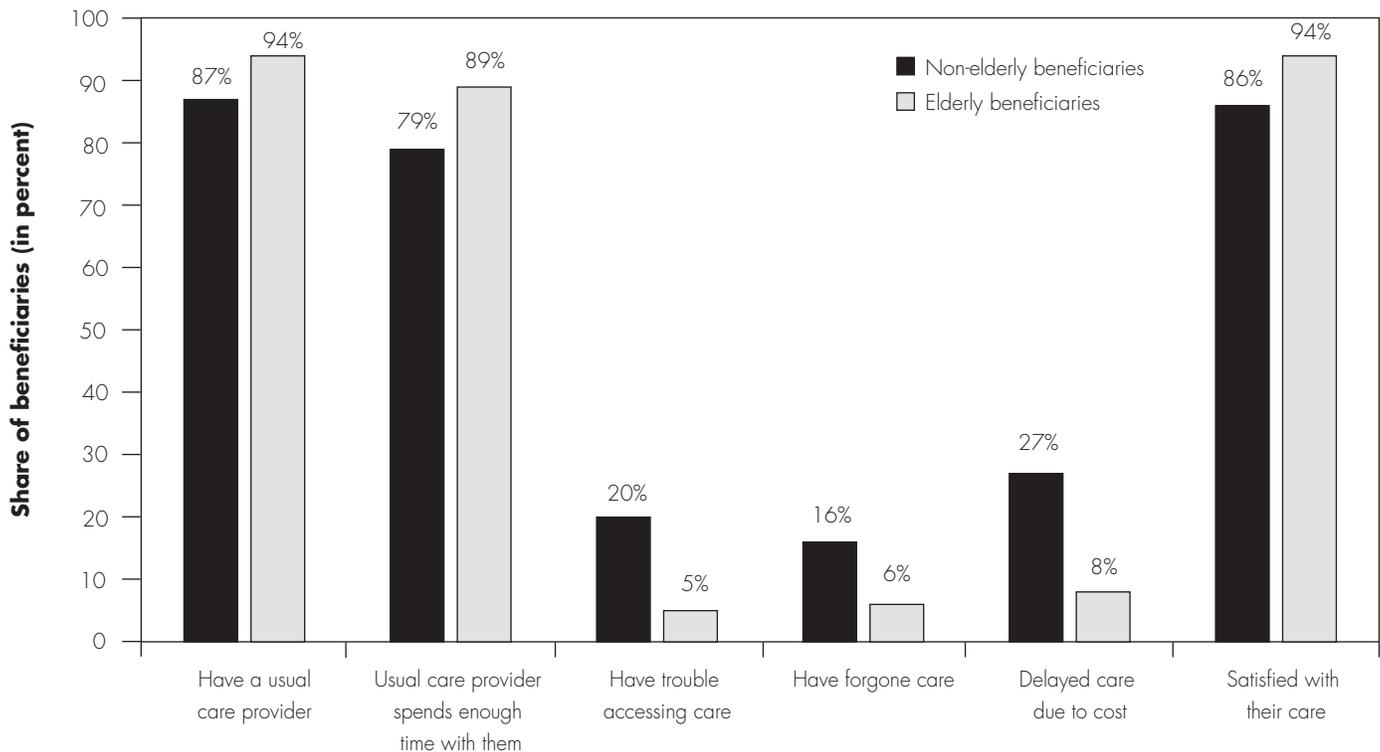
^aThis row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "Thinking about the quality, cost, and convenience of your health care, how satisfied are you overall?" The MedPAC survey question asks: "How satisfied have you been with the overall quality of health care you have received in the past 12 months?"

^bThis row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "Is there a place that you usually go to when you are sick or need advice about your health?" The MedPAC survey asks: "A primary care doctor is the doctor you see in an office or a clinic for routine medical care, medical check-ups, or when you first experience a medical problem. Do you have a primary care doctor that you go to for this type of care?"

^cThis row compares two related questions in the NIH and MedPAC surveys. The NIH survey question asks: "In the last two years, did you have any trouble finding a general doctor or provider who would see you?" The MedPAC survey question asks: "How much of a problem was it finding a primary care doctor who would treat you?" (combining the share who reported "a big problem" and "a small problem").

^dThis row compares several related questions in the NIH and MedPAC surveys. The NIH survey question asks: "In the last two years, was there any time when you needed medical care, but did not get it because you couldn't afford it?" The MedPAC question—based on the share of respondents who answered yes to the question "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"—states: "There are different reasons why people do not see a doctor or other medical person about a health problem or condition. Which of these was the main reason you did not see a doctor about this condition during the past 12 months?" with the response option: "You thought it would cost too much."

Source: MedPAC analysis of MedPAC's 2016 access-to-care telephone survey, fielded by SSRS, and the 2016 Health and Retirement Study core public use data set, collected by the University of Michigan, Ann Arbor, MI, with funding from NIH's National Institute on Aging.

**FIGURE
4-4****Non-elderly Medicare beneficiaries reported more difficulty accessing care than elderly Medicare beneficiaries, 2018**

Note: The vast majority of non-elderly beneficiaries are disabled.

Source: MedPAC analysis of CMS's Medicare Current Beneficiary Survey, 2018.

Non-elderly disabled beneficiaries have more trouble accessing health care due to cost Non-elderly Medicare beneficiaries (most of whom qualify for Medicare because of disability) report noticeably more difficulty accessing care than elderly beneficiaries (Figure 4-4). The 2018 MCBS found that a lower share of these beneficiaries reported having a usual care provider (87 percent) compared with elderly beneficiaries (94 percent). Fewer non-elderly than elderly beneficiaries reported that their usual care provider spent enough time with them (79 percent vs. 89 percent). Even starker differences exist between the shares of non-elderly and elderly beneficiaries who reported trouble accessing care (20 percent vs. 5 percent) and the shares who reported forgoing care that they thought they should have gotten (16 percent of non-elderly vs. 6 percent of elderly). A particularly troubling finding was the substantial share of non-elderly beneficiaries who reported delaying care in the past year due to cost (27 percent) compared with elderly beneficiaries (8 percent). These difficulties could stem from

the fact that non-elderly beneficiaries typically have lower incomes than elderly beneficiaries (Jacobson et al. 2017), yet are no more likely to have supplemental insurance than other types of Medicare beneficiaries (Cubanski et al. 2018). As a result, the one in five non-elderly beneficiaries who lack supplemental coverage are likely to have less income available for copayments than elderly beneficiaries who go without supplemental coverage. Given these difficulties, it is perhaps not surprising that lower shares of non-elderly beneficiaries reported being satisfied with their care (86 percent) than did elderly beneficiaries (94 percent).

Similar trends have been found in more recent surveys. A 2020 CDC survey found that respondents with disabilities (regardless of the type of insurance they had) were nearly twice as likely as nondisabled respondents to report delaying or forgoing care because of the pandemic (60 percent vs. 35 percent)—although, like elderly Medicare beneficiaries, they were far more likely to delay or avoid

routine care as opposed to urgent or emergency care (Czeisler et al. 2020).

Hispanic Medicare beneficiaries report longer waits for appointments, and Black Medicare beneficiaries report more problems finding a specialist Our 2020 survey found only a few differences in access to care for different racial and ethnic groups (see Table 4A-2 in the appendix to this chapter, p. 126, which compares White respondents to Black and Hispanic respondents, which we collectively refer to as “Non-White” respondents).

As with prior years, among those needing an appointment for routine care, slightly more non-White than White Medicare beneficiaries reported waiting longer than they wanted for such appointments (31 percent vs. 27 percent). A similar trend was observed for appointments for illnesses or injuries, with 21 percent of non-White beneficiaries experiencing waits compared with 18 percent of White beneficiaries, among those needing such appointments. (Neither of these differences was statistically significant.)

We found no notable differences in the shares of White and non-White beneficiaries who looked for a new primary care provider or a new specialist in the past year or in the shares who reported problems finding new providers. Smaller shares of Black beneficiaries reported looking for a new *specialist* in the past year (9 percent) compared with White beneficiaries (15 percent) and markedly higher shares of Black beneficiaries reported experiencing “a small problem” finding a new specialist compared with White beneficiaries (22 percent vs. 8 percent). A similar, but less pronounced, trend exists among those who are privately insured. There was no difference in the share of White and non-White beneficiaries who reported forgoing care in the past year (10 percent of each group).

Among those beneficiaries seeking an appointment for care, higher shares of Hispanic beneficiaries reported waiting longer than they wanted, compared with White beneficiaries, to get appointments for routine care (35 percent vs. 27 percent) and to get appointments for illnesses and injuries (24 percent vs. 18 percent). Given these trends, it is perhaps not surprising that lower shares of Hispanic beneficiaries reported being satisfied with their health care compared with White beneficiaries (83 percent vs. 89 percent) (data not shown). The same trend was observed among those who were privately insured.

The 2018 MCBS also allows examination of access-to-care trends by race and ethnicity. According to this survey, the majority (usually 90 percent or more) of racial and

ethnic subgroups reported that they had a usual source of care, the clinician they normally saw spent enough time with them, they had no trouble accessing care, they did not forgo care they thought they should have gotten, and they were satisfied with the quality of their health care. There were some small differences in the shares that reported delaying care due to cost: 13 percent of Black beneficiaries reported delaying care, compared with 11 percent of Hispanic beneficiaries, 10 percent of White beneficiaries, and 7 percent of Asian beneficiaries.

Rural beneficiaries have access to care similar to urban beneficiaries, but report slightly different care patterns

The Commission’s telephone survey usually finds no substantive differences in access to care for urban and rural Medicare beneficiaries. In keeping with that trend, the share of beneficiaries in rural and urban areas who reported waiting longer than they wanted for an appointment was statistically the same this year—both for routine care and for illness or injury care (see Table 4A-3 in the appendix to this chapter, p. 127). There was also no statistical difference between the share of urban and rural beneficiaries who reported forgoing care they thought they should have gotten in the past year.

Some new trends emerged this year, however. First, slightly lower shares of rural Medicare beneficiaries reported being satisfied with the quality of their health care (85 percent) than urban beneficiaries (89 percent)—though these rates are both relatively high. Second, more rural beneficiaries reported not seeing any specialists in the past year (37 percent) compared with urban beneficiaries (31 percent). This divergence was also observed in 2016, but the trends for seeing specialists returned to similar levels in subsequent years.

Other 2020 survey trends were in keeping with prior years, such as the higher share of rural beneficiaries who reported getting most or all of their care from a nurse practitioner or physician assistant (26 percent) compared with urban beneficiaries (19 percent).

The 2018 MCBS survey found no substantive differences between urban and rural beneficiaries’ access to care, including identical rates of satisfaction with care (93 percent), trouble accessing care (7 percent), and forgoing care (7 percent).

Nearly all Medicare beneficiaries have a regular source of care In 2020, nearly all beneficiaries (94 percent) in the Commission’s telephone survey reported that they had a regular source of primary care. This finding is consistent

**TABLE
4-3**

The number of clinicians billing under the fee schedule increased, but the mix of clinicians changed, 2014-2019

Year	Number (in thousands)					Number per 1,000 beneficiaries				
	Physicians					Physicians				
	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total	Primary care specialties	Other specialties	APRNs and PAs	Other practitioners	Total
2014	141	432	161	156	890	2.9	8.8	3.2	3.2	18.0
2015	141	439	178	161	919	2.8	8.7	3.5	3.2	18.1
2016	141	447	198	167	952	2.7	8.6	3.8	3.2	18.3
2017	140	455	218	172	985	2.6	8.5	4.1	3.2	18.4
2018	139	461	237	178	1,015	2.5	8.4	4.3	3.2	18.5
2019	139	468	258	184	1,048	2.5	8.3	4.6	3.3	18.7

Note: APRN (advanced practice registered nurse), PA (physician assistant). "Primary care specialties" include family medicine, internal medicine, pediatric medicine, and geriatric medicine, with an adjustment to exclude hospitalists. Hospitalists are counted in "other specialties." "Other practitioners" include clinicians such as physical therapists, psychologists, social workers, and podiatrists. The number of clinicians shown in this table includes only those with a caseload of more than 15 beneficiaries in the year. Beneficiary counts used to calculate clinicians per 1,000 beneficiaries include those enrolled in traditional Medicare Part B and those in Medicare Advantage, based on the assumption that clinicians generally furnish services to beneficiaries in both programs. Numbers exclude nonperson providers such as clinical laboratories and independent diagnostic testing facilities. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

with the MCBS data: 93 percent of beneficiaries reported having a usual source of care in 2018. Among Medicare beneficiaries with a usual source of care, the MCBS found that the vast majority used appropriate care settings as their usual source of care: Only 1 percent used a hospital emergency room or an urgent care clinic as their usual source of care in 2018. The MCBS also found that 94 percent of respondents with a usual care provider felt this provider spent enough time with them.

In our beneficiary focus groups, nearly all beneficiaries reported a regular source of primary care, including physicians, nurse practitioners (NPs), or physician assistants (PAs). In the Commission's telephone survey, 53 percent of beneficiaries responded that they saw an NP or PA for some, most, or all of their primary care—comparable with the 53 percent of privately insured respondents who reported this same response.

Growth in the supply of clinicians billing Medicare has outpaced enrollment growth, but the mix of clinicians is changing

From 2014 to 2019, the number of clinicians billing the fee schedule grew faster than the Medicare population. However, the mix of clinicians has changed over time.

We limited this part of our analysis of clinicians to those who billed for more than 15 beneficiaries in a given year. This minimum threshold helps us (1) better measure clinicians who substantially participate in Medicare and are therefore likely critical to ensuring beneficiary access to care and (2) avoid year-to-year variability in clinician counts (i.e., excludes physicians who billed for one or two beneficiaries in one year but may not have billed for any beneficiaries the following year).⁶

Using the 15-beneficiary threshold, we found that the number of clinicians billing the fee schedule between 2014 and 2019 grew from about 890,000 to 1,048,000 (Table 4-3). Over the same period, the total number of clinicians per 1,000 beneficiaries increased from 18.0 to 18.7.⁷

While the number of clinicians billing the fee schedule has increased, trends varied by type and specialty of clinicians. The number of primary care physicians billing the fee schedule held steady from 2014 to 2016 but declined modestly from 2016 to 2019. On net, these changes resulted in about 2,500 fewer primary care physicians billing the fee schedule in 2019 compared with 2014.

**TABLE
4-4**

Total encounters per beneficiary increased but mix of clinicians furnishing them changed from 2014 to 2019

Specialty category	Encounters per beneficiary			Percent change in encounters per beneficiary	
	2014	2018	2019	Average annual (2014-2018)	2018-2019
Total (all clinicians)	20.8	21.7	22.2	1.1%	2.1%
Primary care physicians	3.9	3.6	3.5	-2.4	-2.3
Specialists	12.6	12.7	12.9	0.3	1.1
APRNs/PAs	1.4	2.2	2.5	11.6	10.9
Other practitioners	2.9	3.3	3.4	2.8	4.9

Note: APRN (advanced practice registered nurse), PA (physician assistant). We define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. Numbers do not account for “incident to” billing, meaning, for example, that encounters with APRNs/PAs that are billed under Medicare’s “incident to” rules are included in the physician totals. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Components may not sum to totals due to rounding, and percent change columns were calculated on unrounded data.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

In contrast, the number of advanced practice registered nurses (APRNs) and PAs billing the fee schedule increased rapidly; from 2014 to 2019, the number of APRNs and PAs grew from about 161,000 to 258,000.⁸ The number of specialist physicians and other practitioners, such as physical therapists and podiatrists, who billed the fee schedule increased modestly.

Most clinicians who bill Medicare are participating providers

In 2019, 97 percent of clinicians billing the fee schedule were participating providers. Participating providers agree to take assignment for all claims, which means that they accept the fee schedule amount (which includes Medicare’s payment plus beneficiary cost sharing) as payment in full. Nonparticipating providers can choose whether to take assignment for their claims on a claim-by-claim basis. Nonparticipating providers who take assignment on a claim receive 95 percent of the fee schedule amount. Nonparticipating providers who do not take assignment on a claim may “balance bill” beneficiaries up to 109.25 percent of the fee schedule amount for participating providers.⁹ While balance billing is allowed, clinicians rarely balance bill beneficiaries for fee schedule services; in 2019, 99.6 percent of fee schedule claims were paid on assignment.

Clinicians can also sign up as an opt-out provider if they wish to bill beneficiaries for services directly, outside of the Medicare benefit. The 26,000 clinicians who chose to opt out of Medicare as of October 2020 were concentrated in the specialties of behavioral health (41 percent),¹⁰ oral health (29 percent),¹¹ and primary care (11 percent)¹² (Centers for Medicare & Medicaid Services 2018b). The number of clinicians who opted out in 2020 was comparable with the number in 2019.

Total number of clinician encounters per beneficiary grew faster from 2018 to 2019 than in recent years

We use encounters between beneficiaries and clinicians as another measure of access to care. Encounters are a measure of entry into the health care system. Entry can be a first step toward timely use of services (Office of Disease Prevention and Health Promotion 2019).

We use a claims-based definition of encounters.¹³ Clinicians submit a claim when they furnish one or more services to a beneficiary in traditional Medicare. For example, if a physician billed for an evaluation and management (E&M) visit and an X-ray on the same claim, we would count that as one encounter. About 98 percent of

beneficiaries enrolled in traditional Medicare had at least one encounter in 2019.¹⁴

We found that the number of encounters per traditional Medicare beneficiary increased modestly over time, with faster growth from 2018 to 2019 than in recent years. Specifically, from 2014 to 2018, the number of total encounters per beneficiary increased from 20.8 to 21.7, an average annual increase of 1.1 percent (Table 4-4). From 2018 to 2019, the number of encounters per beneficiary increased from 21.7 to 22.2, an increase of 2.1 percent. Preliminary claims data during the first six months of 2020 indicate that, in March and April, the total number of encounters declined sharply in response to the coronavirus pandemic, but had largely recovered by June. More recent but less complete claims data indicate that the volume of primary care visits and certain elective procedures remained fairly constant from June through early December, despite the rising number of coronavirus cases.

Growth in the number of encounters per beneficiary varied by specialty and type of provider From 2018 to 2019, the number of encounters per beneficiary with primary care physicians declined by about 2.3 percent (Table 4-4). Over the same period, the number of encounters per beneficiary with APRNs or PAs increased by about 10.9 percent, the number of encounters with specialist physicians (who account for a majority of all encounters) increased slowly (1.1 percent), and encounters with other clinicians (e.g., physical therapists) increased moderately (4.9 percent). The changes from 2018 to 2019 are part of a longer-term trend. For example, from 2014 to 2018, we also found declines in encounters per beneficiary with primary care physicians, rapid growth in encounters with APRNs or PAs, and slow or moderate growth in encounters with all other clinicians.

The decline in beneficiary encounters with primary care physicians occurred across a broad range of services. For example, from 2014 to 2019, the average annual change in the number of encounters per beneficiary with primary care physicians for E&M services, other procedures, imaging services, and tests was -2.4 percent, -3 percent, -3.4 percent, and -5.1 percent, respectively (data not shown).¹⁵

Not only did beneficiaries have fewer encounters with primary care physicians, but the number of beneficiaries with at least one primary care physician encounter also declined during the year. From 2014 to 2019, the total

number of primary care physician encounters decreased by more than 11 percent, whereas the number of beneficiaries who had at least one encounter with a primary care physician fell by only 4 percent (data not shown).

Recent research has documented that similar decreases in encounters with primary care physicians have occurred among the privately insured population (Ganguli et al. 2019). This trend suggests that primary care physicians are not filling their patient panels with privately insured patients in lieu of Medicare beneficiaries. Rather, the consistent declines across patient populations suggest that systematic changes in the delivery of primary care are occurring.

The rapid growth in encounters with APRNs and PAs raises questions about whether they are replacing services that were once provided by primary care physicians. Using claims data, we are unable to determine whether APRNs and PAs work in primary care practices or specialist practices. Therefore, the Commission has recommended that the Secretary collect more detailed information on the specialties in which APRNs and PAs practice (Medicare Payment Advisory Commission 2019). Studies published between 2011 and 2019 estimate that about half of nurse practitioners (the largest subgroup of APRNs) and one-quarter of PAs work in primary care, although these practice patterns might have changed since then (Agency for Healthcare Research and Quality 2011, Health Resources & Services Administration 2014, National Commission on Certification of Physician Assistants 2019). While these studies suggest that only a portion of APRNs and PAs work in primary care, our analysis found that the decline in beneficiary encounters with primary care physicians coincided with a dramatic rise in encounters with APRNs or PAs, suggesting that these clinicians may be furnishing at least some services once performed by primary care physicians. These findings could also help explain why the Commission's annual telephone survey has not found a decline in the share of beneficiaries with a primary care provider in recent years (94 percent), even though our claims analysis finds that encounters with primary care physicians have declined substantially; beneficiaries are still able to access primary care, but different clinicians may be furnishing it.

Encounters per beneficiary grew across service types Examining beneficiary encounters by service type, we found that encounters grew modestly, with some differences across categories. From 2018 to 2019, the number of E&M encounters per beneficiary provided

**TABLE
4-5**

Encounters grew modestly across all service types, 2014–2019

Type of service	Encounters per beneficiary			Percent change in encounters per beneficiary	
	2014	2018	2019	Average annual (2014–2018)	2018–2019
Total (all services)	20.8	21.7	22.2	1.1%	2.1%
Evaluation and management	12.4	12.9	13.1	1.1	1.4
Major procedures	0.2	0.2	0.2	0.8	1.7
Other procedures	4.2	4.6	4.8	2.2	4.2
Imaging	3.9	4.0	4.1	0.8	2.0
Tests	2.1	2.1	2.2	0.6	2.0
Anesthesia	0.5	0.5	0.6	3.6	2.5

Note: We define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service. We use the number of fee-for-service Medicare beneficiaries enrolled in Part B to define encounters per beneficiary. Values by type of service do not sum to totals because encounters with multiple service types are counted separately for each type of service but counted only once for the total. For example, if an imaging service and a test were billed in the same encounter, we count that as one encounter for imaging and one for tests (for a total of two encounters), but we count the services as one encounter for the total row. All numbers in the table are rounded, but unrounded data are used for calculations.

Source: MedPAC analysis of Medicare claims data for 100 percent of beneficiaries and 2019 annual report of the Boards of Trustees of the Medicare trust funds.

by all clinicians rose most slowly, by 1.4 percent, from 12.9 to 13.1 (Table 4-5). Over the same period, major procedure encounters grew slightly more (1.7 percent), and encounters involving a procedure other than a major procedure (i.e., “other procedures”) grew most rapidly (4.2 percent). Other procedures include skin procedures and various forms of outpatient therapy (physical therapy, occupational therapy, and speech–language pathology). With the exception of anesthesia services, growth in encounters per beneficiary from 2018 to 2019 was similar to or faster than the average annual growth rates from 2014 to 2018.

We also examined how the number of encounters billed in traditional Medicare changed during the early months of the coronavirus pandemic. Based on our analysis of preliminary Medicare claims data for the first six months of 2020, we found that changes in the total number of encounters for clinician services was largely consistent with the pattern we observed in allowed charges (see text box about the effects of the coronavirus pandemic, p. 100). Encounters dropped sharply starting in March 2020, and by April 2020 the total number of encounters was about

half of its level in April 2019. As with allowed charges, there is variation in how much encounters declined among different types of services, with E&M encounters dropping less than other services. By June 2020, encounters for all services were about 6 percent less than what they were in June 2019.

Quality of care

We assessed the quality of the ambulatory care environment for traditional Medicare beneficiaries using outcome measures assessing ambulatory care–sensitive (ACS) hospitalizations, emergency department (ED) visits, and measures of low-value care. (In this year’s assessment, we were not able to report on the patient experience of traditional Medicare beneficiaries during the 2019 calendar year because CMS halted collection of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) survey at the start of the pandemic.¹⁶) This approach is consistent with the Commission’s principle that Medicare’s quality incentive programs should use a small set of population-based outcome, patient experience, and value measures to assess the quality of care across different populations, such as

beneficiaries enrolled in Medicare Advantage (MA) plans, traditional Medicare, and accountable care organizations (ACOs) in defined market areas as well as those cared for by particular hospitals, groups of clinicians, and other providers (Medicare Payment Advisory Commission 2018a).

By contrast, CMS measures the performance of clinicians using the Merit-based Incentive Payment System (MIPS). The basic design principle of MIPS is that clinician 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 is inequitable because clinicians are evaluated and compared on dissimilar measures. The majority of the measures focus on processes of care as opposed to patient outcomes, and many have compressed performance (i.e., “topped out,” which means that all clinicians are performing well on the measure). In addition, many clinicians are not evaluated at all because, as individuals, they do 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.

For these reasons, in March 2018, the Commission recommended eliminating MIPS. In MIPS’s place, we recommended a voluntary value program, through which groups of clinicians would receive increases or decreases to their payment rates based on their performance on a uniform set of measures assessing outcomes, patient experience, and value (Medicare Payment Advisory Commission 2018b).

Measures of ambulatory care-sensitive hospitalizations and emergency department visits signal opportunities for improvement

The Commission developed two claims-based outcome measures—ACS hospitalizations and ED visits—to compare quality of care within and across different populations (i.e., traditional Medicare in different local market areas), given the adverse impact on beneficiaries and high cost of these events. Conceptually, an ACS hospitalization or ED visit refers to hospital use that could have been prevented with appropriate, high-quality, and timely care in ambulatory care settings. Two categories of ACS conditions are included in the measures: chronic (e.g.,

diabetes, asthma, hypertension) and acute (e.g., bacterial pneumonia, cellulitis). Although payers often examine total hospital utilization or measures of total spending in cost containment efforts, identification of potentially avoidable hospital admissions or ED visits for ACS conditions can offer more useful insights into a market area’s quality of care and may inform quality improvement initiatives in Medicare.

We continue to find wide variation in the distribution of risk-standardized rates of avoidable hospitalizations and ED visits per 1,000 traditional Medicare beneficiaries across Dartmouth-defined hospital service areas (HSAs), which signals opportunities to improve the quality of ambulatory care (Table 4-6, p. 114).¹⁷ The HSA at the 90th percentile of ACS hospitalizations had a rate that was 1.9 times the HSA at the 10th percentile. The HSA at the 90th percentile of ACS ED visits had a rate that was 2.4 times the HSA in the 10th percentile. Relatively poor performance on a local market’s ACS hospitalization and ED visit measures can identify opportunities for improvement in those ambulatory care systems, while relatively good performance on the measures can identify best practices for ambulatory care systems.

Substantial use of low-value care in traditional Medicare

We also calculated rates of low-value care in traditional Medicare, which is another indicator of ambulatory care quality. Low-value care is the provision of a service that has little or no clinical benefit or care in which the risk of harm from the service outweighs its potential benefit (Chan et al. 2013, Kale et al. 2013). In addition to increasing health care spending, low-value care has the potential to harm patients by exposing them to risks of injury from inappropriate tests or procedures and can lead to a cascade of additional services (Keyhani et al. 2013, Korenstein et al. 2012). The “Choosing Wisely” campaign, an initiative of the American Board of Internal Medicine Foundation, identifies low-value services. Thus far, more than 80 specialty societies have identified over 550 tests and treatments that are often overused (ABIM Foundation 2020).

A team of researchers developed 31 measures of low-value care drawn from evidence-based lists (such as Choosing Wisely), recommendations by the U.S. Preventive Services Task Force, and the medical literature, which the team applied to Medicare claims data from 2009 to 2012 (Schwartz et al. 2015, Schwartz et al. 2014).

**TABLE
4-6**

Distribution of risk-standardized rates of ambulatory care-sensitive hospitalizations and ED visits across hospital service areas signals opportunities for improvement, 2019

Risk-standardized rate per 1,000 FFS beneficiaries

	10th percentile (high performing)	50th percentile	90th percentile (low performing)	Ratio of 90th to 10th percentile
Ambulatory care-sensitive hospitalizations	35.1	48.9	66.6	1.9
Ambulatory care-sensitive ED visits	62.4	98.6	150.0	2.4

Note: ED (emergency department), FFS (fee-for-service). Lower rates are better. To measure population-based outcomes for FFS Medicare beneficiaries, we calculated the risk-standardized rates of admissions and ED visits tied to a set of acute and chronic conditions per 1,000 FFS Medicare beneficiaries in hospital service areas (HSAs). There are about 3,400 Dartmouth-defined HSAs. The average population of FFS Medicare beneficiaries in each HSA is about 10,000 beneficiaries. We excluded any HSA with fewer than 1,000 FFS Medicare beneficiaries.

Source: Analysis of 2019 Medicare FFS claims data.

For more detail about these measures and our previous analysis of low-value care, see the Commission’s June 2018 report to the Congress (Medicare Payment Advisory Commission 2018a). We updated our analysis by applying the measures’ algorithms to Medicare claims data from all providers for 2018. Similar to our previous analysis, we calculated two versions of each measure: a broader version (more sensitive, less specific) and a narrower version (less sensitive, more specific).¹⁸ For each version, we calculated the number of low-value services per 100 traditional Medicare beneficiaries, the share of beneficiaries who received at least one low-value service, and total spending across all beneficiaries for each service.

Our results show substantial use of low-value care in traditional Medicare in 2018 (Table 4-7). Based on the broader versions of the measures (which may misclassify some appropriate care as inappropriate), our analysis found 70 instances of low-value care per 100 beneficiaries, with 36 percent of beneficiaries receiving at least one low-value service. We estimate that Medicare spending for these services was \$6.9 billion, or 1.9 percent of traditional Medicare spending. Based on the narrower, more conservative versions of the measures (which may miss some instances of inappropriate care), our analysis showed 33 instances of low-value care per 100 beneficiaries, with 22 percent of beneficiaries receiving at least one low-value service. We estimate that Medicare spending for these services totaled \$2.4 billion, or 0.6 percent of traditional

Medicare spending. Between 2016 and 2018, there was a modest decline in the volume of, and spending on, low-value services based on the narrower versions of the measures, but there was no change based on the broader versions of the measures (data not shown).

Using the broader versions of the measures, low-value services with the highest volume in 2018 were imaging for patients with nonspecific low back pain (12.6 per 100 beneficiaries), prostate-specific antigen (PSA) screening for men ages 75 and over (8.7), and colon cancer screening for adults older than age 85 (6.9). Low-value services with the highest Medicare spending were percutaneous coronary intervention (PCI) with balloon angioplasty or stent placement for stable coronary disease (\$1.4 billion), spinal injection for low back pain (\$1.4 billion), and stress testing for stable coronary disease (\$1.1 billion).

Using the narrower versions of the measures, low-value services with the highest volume in 2018 were PSA screening for men ages 75 and over (4.9 per 100 beneficiaries), parathyroid hormone measurement for patients with early chronic kidney disease (4.6), and total or T3 level testing for patients with hypothyroidism (4.3). Those with the highest Medicare spending were spinal injection for low back pain (\$633 million), vertebroplasty or kyphoplasty for osteoporotic vertebral fractures (\$328 million), and PCI with balloon angioplasty or stent placement for stable coronary disease (\$254 million).

**TABLE
4-7**

Between 33 and 70 low-value services were provided per 100 beneficiaries in 2018; Medicare spent between \$2.4 billion and \$6.9 billion on these services

	Count per 100 beneficiaries	Share of beneficiaries affected	Spending (in billions)
Broader measures	70	36	\$6.9
Narrower measures	33	22	\$2.4

Note: "Count" refers to the number of unique services provided to beneficiaries in traditional Medicare. "Spending" includes Medicare Part A and Part B program spending and beneficiary cost sharing for services detected by measures of low-value care. Spending is based on a standardized price for each service from 2009 that was updated to 2018. The broader measures are more sensitive and less specific, while the narrower measures are less sensitive and more specific. Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure's specificity leads to less misclassification of appropriate use as inappropriate, at the expense of potentially missing some instances of inappropriate use.

Source: MedPAC analysis of 100 percent of Medicare claims using measures developed by Schwartz and colleagues (Schwartz et al. 2015, Schwartz et al. 2014).

Our analysis likely represents a conservative estimate of the number and cost of low-value services in Medicare. The measures of low-value services we used exclude many services that Choosing Wisely and other clinicians may consider low value (e.g., imaging for pulmonary embolism without moderate or high pretest probability) because it was difficult to distinguish between inappropriate and appropriate use of these services with claims data (Schwartz et al. 2014). In addition, we did not estimate the downstream cost of low-value services because of the difficulty in determining whether a specific low-value service led directly to a downstream service (e.g., a follow-up test or procedure). A literature review of five low-value services suggests that downstream service use and spending related to these services is substantial (Chang et al. 2019). For example, one study estimated that the mean cost per patient of downstream services related to imaging for nonspecific low back pain was more than \$23,000 over two years (Webster et al. 2013).

Medicare payments and providers' costs

To assess Medicare payments, we examine growth in traditional Medicare-allowed charges (i.e., payments to providers, including beneficiary cost sharing) for fee schedule services. We also consider how private insurance rates paid by preferred provider organizations (PPOs) for clinician services compare with Medicare's rates. In addition, we examine growth in all-payer physician compensation and compare compensation across specialties. Because clinicians do not report their costs to

CMS, we assess the change in input prices for clinician services using the Medicare Economic Index (MEI).

Overall, Medicare's payments to clinicians, as well as overall physician compensation, are climbing faster than input costs. We found that allowed charges per beneficiary for clinician services between 2018 and 2019 grew 3.7 percent, a higher growth rate than in prior years. In 2019, private PPO payment rates were 136 percent of traditional Medicare rates for clinician services, compared with 135 percent in 2018. From 2015 to 2019, median physician compensation from all payers grew by 3.3 percent per year, on average, but median compensation in 2019 remains much lower for primary care physicians than for physicians in certain other specialties, such as radiology and surgical specialties. Meanwhile, the MEI increased by 1.5 percent in 2019, and CMS projects that it will increase by 1.6 percent in 2022.

Allowed charges grew faster from 2018 to 2019 than in recent years

Allowed charges are the total payments a provider receives (including beneficiary cost sharing) from providing fee schedule services to beneficiaries enrolled in traditional Medicare. Allowed charges are a function of the fee schedule's relative value units (RVUs), the fee schedule's conversion factor, and other payment adjustments, such as those determined by geographic practice cost indexes.

We used claims data from 2014, 2018, and 2019 to analyze changes in allowed charges for the services

furnished by clinicians billing under Medicare's fee schedule. We grouped individual service codes into broad service categories that are clinically meaningful (e.g., E&M, major procedures). Each broad service category contains multiple subcategories of similar services (e.g., E&M includes office/outpatient services, hospital inpatient services, and other subcategories).

We also present changes in units of service per beneficiary. A difference between a change in allowed charges and a change in units of service means that a factor other than volume is affecting the amount of allowed charges being generated. For example, if providers substitute higher-RVU computed tomography scans for lower-RVU X-rays, the allowed charges for imaging services would increase at a higher rate than would units of service for imaging. However, we recommend caution in interpreting such data. Decreases in allowed charges could be related to the movement of services from freestanding offices to hospitals (see text box on shifts in billing, p. 118).

Between 2018 and 2019, across all services, allowed charges per beneficiary grew by 3.7 percent (Table 4-8). Among broad service categories, growth rates were 2.9 percent for E&M services, 3.5 percent for imaging services, 5.1 percent for major procedures, 5.6 percent for other procedures, 2.9 percent for tests, and 2.6 percent for anesthesia services. Growth in allowed charges per beneficiary from 2018 to 2019 was faster than the average annual growth rates from 2014 to 2018 for all services (combined) and for each broad service category.

Within broad service categories, services for some subcategories experienced more rapid growth in allowed charges per beneficiary. For example, from 2018 to 2019, growth in the other procedures category was 5.6 percent, but growth in the subcategory of physical, occupational, and speech therapy was 12.9 percent.

From 2018 to 2019, among the service categories, vascular major procedures had the highest rate of growth in allowed charges per beneficiary at 14.4 percent. This growth was largely driven by procedures categorized as revascularization of the lower extremity (used to treat leg pain caused by poor circulation). Allowed charges for these procedures increased by 24.1 percent (data not shown). Most of this growth was concentrated in the three most frequently billed revascularization procedures, where the number of units of service increased by between 6.4 percent and 13.9 percent, and RVUs increased by between 6.3 percent and 13.3 percent (data not shown). Although

vascular major procedures experienced high growth, they accounted for 1.5 percent of total fee schedule spending in 2019.

Physical, occupational, and speech therapy is another service category with a high growth rate. Allowed charges per beneficiary within this category grew between 2014 and 2018 by an average of 8.3 percent and from 2018 to 2019 by 12.9 percent. Payment rates during these periods were largely constant; the growth in allowed charges was driven almost entirely by increases in the volume of therapy services. From 2018 to 2019, total units of service per beneficiary increased by 11.8 percent, which was driven by volume growth among a small number of therapy services.

From 2018 to 2019, a few types of services experienced decreases in allowed charges. For example, the largest decrease (8.3 percent) was for nononcologic injections and infusions. This decrease occurred despite a 1.4 percent increase in units of service delivered per year. The difference is explained by a 19 percent decrease in RVUs implemented in 2019 for the most frequently billed service (which includes certain therapeutic, prophylactic, and diagnostic injections and infusions) in this category (data not shown).

To gauge the impact of the coronavirus pandemic, we used preliminary claims data to examine changes in Medicare's payments to clinicians during the first six months of 2020. We found that allowed charges for clinician services dropped sharply starting in March 2020. By April 2020, total allowed charges were roughly half what they were in April 2019. In May 2020, allowed charges began to recover, and, by June 2020, they were only about 5 percent less than in June 2019 (see text box on the effect of the pandemic, p. 100). Similarly, clinicians' revenue for privately insured patients declined sharply at the beginning of the pandemic before rebounding. According to an analysis by FAIR Health of its national private insurance claims database (which includes Medicare Advantage claims), clinician revenue was 45 percent lower in March 2020 than in March 2019 (FAIR Health 2020). Revenues began to recover in May and were higher than the prior year starting in July. By October (the most recent month of data available), revenues were 20 percent higher than the prior year. These results suggest that patients' higher-than-usual demand for services in the summer and fall of 2020 helped offset the temporary revenue drop experienced by clinicians during the first few months of the pandemic.

**TABLE
4-8**

Allowed charges per beneficiary continued to grow, 2014-2019

Type of service	Change in units of service per beneficiary		Change in allowed charges per beneficiary		Share of 2019 allowed charges
	Average annual 2014-2018	2018-2019	Average annual 2014-2018	2018-2019	
All services	1.1%	3.1%	1.3%	3.7%	100.0%
Evaluation and management	0.7	1.5	1.3	2.9	50.0
Office/outpatient services	0.8	1.3	1.5	3.4	25.6
Hospital inpatient services	-1.3	-0.3	-0.6	0.5	10.5
Nursing facility services	1.0	4.2	1.8	5.1	3.0
Emergency department services	-0.3	-1.7	0.5	-0.6	2.9
Ophthalmological services	0.3	1.4	0.9	3.1	2.7
Behavioral health services	2.4	4.3	3.0	5.7	1.9
Critical care services	2.0	3.7	2.0	3.6	1.4
Care management/coordination	32.5	11.2	31.7	7.4	0.9
Observation care services	4.0	5.8	4.2	5.8	0.7
Home services	-1.6	3.8	-1.7	5.9	0.3
Imaging	0.1	2.6	0.9	3.5	11.0
Standard X-ray	-1.6	1.8	-0.9	3.1	3.1
Ultrasound	0.5	2.6	0.7	3.2	2.9
CT	4.1	4.9	4.2	5.9	2.1
Nuclear	-1.8	-0.1	0.4	2.4	1.3
MRI	2.3	2.7	1.4	1.6	1.2
Major procedures	0.3	2.2	1.7	5.1	7.6
Musculoskeletal	0.6	2.9	2.0	3.5	2.8
Vascular	0.1	1.0	6.5	14.4	1.5
Cardiovascular	1.7	3.0	1.3	3.6	1.0
Other organ systems	0.3	1.0	0.1	2.3	0.9
Digestive/gastrointestinal	-1.4	0.6	-1.3	0.9	0.8
Skin	0.5	2.0	0.3	2.5	0.5
Eye	-0.8	3.9	-4.9	4.3	0.2
Other procedures	2.8	6.1	1.3	5.6	23.0
Skin	1.2	3.2	1.6	6.6	4.5
Physical, occupational, and speech therapy	7.3	11.8	8.3	12.9	4.4
Musculoskeletal	0.5	2.0	3.0	3.7	2.5
Eye	2.4	3.2	0.5	2.0	2.3
Radiation oncology	-0.4	3.8	-1.6	3.6	2.0
Other organ systems	1.7	3.7	1.4	6.8	1.7
Digestive/gastrointestinal	0.1	1.6	-2.6	2.0	1.2
Dialysis	-2.0	0.0	0.0	1.5	1.1
Vascular	-4.8	-3.6	-3.9	0.8	1.0
Chiropractic	-1.1	1.2	-1.2	4.8	0.8
Chemotherapy administration	-2.5	0.8	-0.9	0.8	0.5
Injections and infusions: non-oncologic	-1.1	1.4	-3.8	-8.3	0.4
Tests	0.7	2.8	1.9	2.9	5.1
Anatomic pathology	0.6	3.4	1.2	2.3	2.1
Cardiography	1.0	2.5	4.8	7.8	1.3
Neurologic	0.7	1.8	1.7	-0.1	0.8
Anesthesia	3.7	2.4	0.7	2.6	2.9

Note: FFS (fee-for-service), CT (computed tomography), MRI (magnetic resonance imaging). Some low-spending categories are not shown but are included in the calculations. We use the number of traditional Medicare beneficiaries enrolled in Part B to define allowed charges per beneficiary.

Source: MedPAC analysis of claims data for 100 percent of traditional Medicare beneficiaries.

Shifts in billing from freestanding offices to hospitals reduce fee schedule-allowed charges but raise overall Medicare spending

Medicare spending is sensitive to shifts in the site of care. Medicare makes both a physician fee schedule payment and a facility payment under the outpatient prospective payment system (OPPS) when a service is provided in a hospital outpatient department (HOPD) (the facility payment accounts for the cost of the service in an HOPD). However, the program makes only a fee schedule payment when a service is furnished in a freestanding office. In 2021, for example, a Level 3 evaluation and management (E&M) office/outpatient visit (Healthcare Common Procedure Coding System code 99213) has an average nonfacility (freestanding office) fee schedule payment rate of \$92. By contrast, the average fee schedule payment rate for the visit when provided in an HOPD is \$68, and the facility payment to the HOPD is \$119 (for a combined payment of \$187).¹⁹ Thus, the shift of office visits from freestanding offices to HOPDs reduces the allowed charge billed under the fee schedule (from \$92 to \$68) but increases the total Medicare payment amount (from \$92 to \$187).

In recent years, the number of services billed in HOPDs has been increasing, while the number of services provided in freestanding offices has been declining. From 2013 to 2019, for example, the number of E&M office/outpatient visits performed in HOPDs grew by 25 percent, compared with a 5 percent decline in physician offices. Similarly, the number of chemotherapy administration services delivered in HOPDs grew 45 percent, while the number provided in physician offices declined 12 percent. This change in the billed setting increases overall Medicare program spending and beneficiary cost sharing because Medicare generally pays more for the same or similar services in HOPDs than in freestanding

offices (Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013, Medicare Payment Advisory Commission 2012). For example, we estimate that in 2019, the Medicare program spent \$1.4 billion more than it would have if payment rates for E&M office/outpatient visits in HOPDs were the same as freestanding office rates. In addition, in the same year, beneficiaries' cost sharing was \$360 million more than it would have been had payment rates been the same in both settings.

To address the increased spending that results when services shift from freestanding offices to HOPDs, the Commission has recommended adjusting payment rates in the OPPS so that Medicare pays the same amount for E&M office/outpatient visits in freestanding offices and HOPDs (Medicare Payment Advisory Commission 2012). Medicare currently pays a comparable amount for E&M office/outpatient visits in freestanding offices and off-campus HOPDs; however, Medicare continues to pay a higher amount for these visits when provided in on-campus HOPDs.²⁰ The Commission also has recommended adjusting OPPS rates for services in ambulatory payment classification (APC) groups that meet certain criteria so that payment rates are equal or more closely aligned between HOPDs and freestanding offices (Medicare Payment Advisory Commission 2014).²¹ APCs that meet these criteria are those that are unlikely to have costs associated with operating an emergency department, do not have extra costs associated with higher patient complexity in HOPDs, and include services that are frequently performed in physicians' offices (which indicates that these services are likely safe and appropriate to provide in a physician's office). ■

Private PPO payment rates remain higher than Medicare payment rates for clinician services

We compare rates paid by private insurance plans with Medicare rates for clinician services because extreme disparities in payment rates might create an incentive for clinicians to focus primarily on patients with private

insurance (this issue is discussed in more detail in Chapter 1). In 2019, payment rates paid by private PPOs for clinician services were 136 percent of traditional Medicare's payment rates, up slightly from 135 percent in 2018.²² The ratio in 2019 varied by type of service. For example, private insurance rates were 128 percent

of Medicare rates for E&M office visits for established patients but 168 percent of Medicare rates for coronary artery bypass graft surgery.

The gap between private insurance rates and Medicare rates has grown in recent years as private insurance rates have risen while Medicare rates have remained relatively stable. In 2011, private insurance rates were 122 percent of Medicare rates. Notwithstanding the growth in the ratio of private insurance rates to Medicare rates, the vast majority of clinicians continue to participate in the Medicare program. The number of clinicians who opted out of Medicare as of October 2020 (26,000) is substantially outweighed by the number who continue to bill the physician fee schedule (almost 1.3 million in 2019).

The growth in private insurance prices could be a result of greater consolidation of physician practices, which gives physicians greater leverage to negotiate higher prices with private plans. In recent years, an increasing number of physicians have joined larger groups, hospitals, and health systems. For example, between 2009 and 2014, the share of physicians working in practices with more than 50 physicians grew from 16 percent to 22 percent (Medicare Payment Advisory Commission 2017). Between 2016 and 2018, the share of all physicians who were vertically affiliated with health systems grew from 40 percent to 51 percent (Furukawa et al. 2020).²³

Studies show that private insurance prices for physician services are higher in markets with larger physician practices and in markets with greater physician–hospital consolidation (Baker et al. 2014, Capps et al. 2018, Clemens and Gottlieb 2017, Neprash et al. 2015). Our research found that independent practices with larger market shares and hospital-owned practices received higher private insurance prices for E&M visits than other practices in their market (Medicare Payment Advisory Commission 2017). For example, independent practices with a large market share of E&M visits received an average private insurance price for an E&M visit that was 141 percent of the traditional Medicare rate. By contrast, the average private insurance price received by the smallest independent practices for an E&M visit was about equal to Medicare’s rate.

In addition to varying within markets, evidence suggests that private insurance prices for physician services vary widely across markets. A study by the Congressional Budget Office (CBO) using data from 2014 found that the average ratio of private insurance prices to traditional

Medicare prices for 20 common physician services was at least 70 percent higher in the most costly market than in the least costly market (Congressional Budget Office 2018). CBO found much less variation in the average ratio of Medicare Advantage (MA) prices to traditional Medicare prices across and within markets. MA plans paid much lower prices than private insurance plans for the 20 services examined in the study, and the median MA prices for these services were almost the same as the median traditional Medicare prices.

Considering our other payment adequacy indicators, we do not believe beneficiaries’ access to clinician services is at risk in the near term. However, in the long run, if private payers do not restrain the growth in clinicians’ payment rates, eventually the difference between private insurance rates and Medicare rates could grow so large that some clinicians would have an incentive to focus primarily on patients with private insurance instead of Medicare patients.

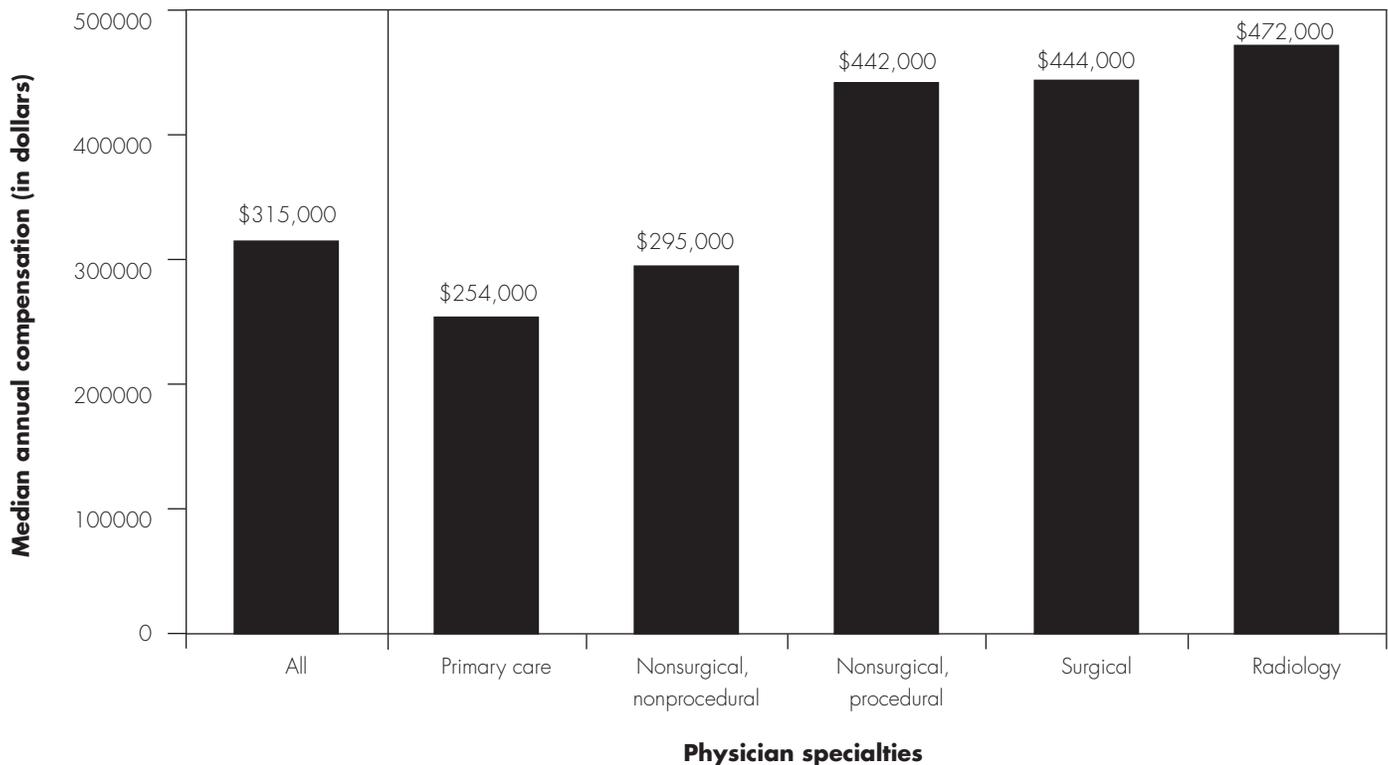
Median physician compensation grew 3.3 percent per year from 2015 to 2019; compensation remains much higher for certain specialties than for primary care

To examine compensation physicians received from all payers, we analyzed 2019 data from SullivanCotter’s Physician Compensation and Productivity Survey. From 2015 to 2019, median compensation across all specialties grew at an average annual rate of 3.3 percent and in 2019 was \$315,000. From 2015 to 2019, median compensation for primary care physicians increased at an average annual rate of 3.3 percent, the same as for all specialties in the aggregate, but slower than nonsurgical, nonprocedural specialties (4.3 percent) and nonsurgical, procedural specialties (4.1 percent); about the same as surgical specialties (3.4 percent); and faster than radiology (2.4 percent).²⁴

Compensation was much higher for some specialties than others. Specialties with the highest median compensation were radiology (\$472,000); surgical specialties (\$444,000); and nonsurgical, procedural specialties (\$442,000) (Figure 4-5, p. 120).²⁵ Median compensation for radiology was 85 percent higher than median compensation for primary care (\$254,000), and median compensation for surgical specialties was 75 percent higher than that of primary care. Psychiatry—which is in the nonsurgical, nonprocedural group—had median compensation of \$254,000, the same as primary

**FIGURE
4-5**

Disparities in physician compensation are widest when primary care physicians are compared with nonsurgical proceduralists, surgeons, and radiologists, 2019



Note: Figure includes all physicians who reported their annual compensation in the survey ($n = 89,272$). The primary care group includes family medicine, internal medicine, and general pediatrics. The nonsurgical, nonprocedural group includes psychiatry, emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The nonsurgical, procedural group includes cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.

Source: SullivanCotter's Physician Compensation and Productivity Survey, 2020.

care physicians' median compensation.²⁶ The difference in compensation between primary care and other specialties cannot be explained by differences in hours worked; previous Commission work using data from the Medical Group Management Association (MGMA) showed that there are similar disparities in hourly compensation (Medicare Payment Advisory Commission 2011c).²⁷

Physician compensation from all payers reflects the structure of Medicare's fee schedule because many private insurers use a system of RVUs that is similar to Medicare's RVUs but negotiate a conversion factor (a fixed dollar amount) that is different from Medicare's (Clemens and Gottlieb 2017, Congressional Budget Office 2018). Therefore, physician compensation from all payers probably

reflects the underpricing of ambulatory E&M visits relative to other services, such as procedures, in Medicare's fee schedule (Medicare Payment Advisory Commission 2018a).²⁸ Ambulatory E&M visits make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology). The underpricing of these services in the fee schedule contributes to an income disparity between primary care physicians and certain specialists, which has contributed to the decline in the number of primary care physicians in the U.S. in recent years.

Effective January 1, 2021, CMS substantially increased the RVUs for E&M office/outpatient visits—the most common type of ambulatory E&M visit (Centers for

Medicare & Medicaid Services 2020b). For example, CMS increased the total RVUs for a Level 3 E&M visit for an established patient in a freestanding office (Healthcare Common Procedure Coding System code 99213) by 27 percent between 2020 and 2021. CMS increased the national average payment rate (which is a function of the conversion factor and the RVUs) for this code by 21 percent, from \$76.15 to \$92.47. Owing to budget-neutrality requirements, CMS offset the increase to payment rates for E&M office/outpatient visits in 2021 by reducing payment rates for all fee schedule services. In the Consolidated Appropriations Act, 2021, the Congress scaled back this reduction to the payment rates for fee schedule services. Specifically, the Congress increased payment rates for all fee schedule services by 3.75 percent in 2021 (this increase does not apply after 2021) and delayed implementation of a new add-on code for E&M office/outpatient visits by three years.²⁹

The Commission strongly supports raising the RVUs for E&M office/outpatient visits because this action is an important first step to address the long-term devaluation of these services. We also support CMS's decision to implement this change in a budget-neutral manner because doing so will help rebalance the fee schedule from services that have become overvalued (e.g., procedures, imaging, and tests) to services that have become undervalued—thus improving payment accuracy (Centers for Medicare & Medicaid Services 2020b). Maintaining budget neutrality could also help reduce the large gap in compensation between primary care physicians and certain specialists, which could help increase the supply of primary care physicians in the U.S. However, CMS still needs to improve the overall accuracy of the fee schedule and further rebalance the fee schedule toward primary care. The Commission has previously recommended that CMS collect accurate, timely data to set RVUs and that the Congress establish a per beneficiary payment for primary care practitioners (see text box on previous recommendations, p. 123).

Input costs for clinicians are projected to increase from 2021 to 2022

The MEI, which measures the average annual price change in the market basket of inputs used by clinicians to furnish services and is adjusted for economy-wide productivity, increased by 1.5 percent in 2019 (Centers for Medicare & Medicaid Services 2013). CMS's forecasted growth for the MEI (as of the third quarter of 2020) in 2020, 2021, and 2022 is 1.7 percent, 1.3 percent, and

1.6 percent, respectively (projections subject to change). The MEI consists of two main categories: (1) physicians' compensation and (2) physicians' practice expenses (e.g., compensation for nonphysician staff, rent, equipment, and professional liability insurance). The index's cost categories (e.g., physician compensation, medical equipment) and cost weights (each category's share of total costs) are based on data on physicians' expenses from 2006, which raises questions about the continued accuracy of the MEI.³⁰ CMS lacks a reliable, ongoing source of data to update the MEI's cost categories and cost weights. In 2011, the Commission recommended that CMS regularly collect data from a cohort of efficient practices to establish more accurate work and practice expense RVUs. As part of this data collection, CMS could gather data on physicians' practice costs and use that information to update the MEI.

How should Medicare payments change in 2022?

The Commission's deliberations on payment adequacy for clinicians are informed by data assessing beneficiaries' access to services, the quality of their care, and Medicare payments and providers' costs. We find that, on the basis of these indicators, there should be no update to payment rates in 2022, as specified in current law. We note that, under current law, the 3.75 percent increase to payment rates for 2021 expires after 2021.

On measures of access to clinician services, the Commission continues to find that beneficiaries' access to care appears generally stable. Overall, Medicare beneficiaries generally have access to clinician services comparable with that of privately insured individuals ages 50 to 64. A large majority of beneficiaries report using an appropriate usual source of care, say their usual care provider spends enough time with them, report being satisfied with their care, and do not forgo or delay care. Growth in the number of clinicians billing the program outpaced beneficiary growth from 2014 to 2019, but the mix of clinicians changed. The number of primary care physicians decreased slightly, while the number of specialists steadily increased, and the number of APRNs and PAs grew rapidly. The share of clinicians who bill Medicare as a participating provider remains very high. The number of clinician encounters per beneficiary increased modestly over time, with faster growth from 2018 to 2019 (2.1 percent) compared with the average

annual growth rate from 2014 to 2018 (1.1 percent). The number of encounters with primary care physicians declined while encounters with APRNs and PAs grew dramatically.

In terms of quality, geographic variation in ACS hospitalizations and ED visits signals opportunities to improve the quality of ambulatory care in traditional Medicare. In addition, there is substantial use of low-value care in traditional Medicare.

Traditional Medicare's allowed charges for clinician services grew faster from 2018 to 2019 than in prior years. From 2018 to 2019, across all services, allowed charges per beneficiary grew by 3.7 percent. In 2019, private insurance payment rates for clinician services were 136 percent of traditional Medicare's payment rates, up slightly from 135 percent in 2018. Median physician compensation from all payers grew at an average annual rate of 3.3 percent from 2015 to 2019, although compensation was much lower for primary care physicians than for physicians in certain other specialties in 2019. As of the third quarter of 2020, input prices for clinicians were projected to increase by 1.6 percent in 2022.

RECOMMENDATION 4

For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.

RATIONALE 4

Overall, access to clinician services for Medicare beneficiaries appears stable and comparable with that for privately insured individuals. Other measures of payment adequacy are stable and consistent with prior years. Therefore, the Commission does not see a reason to diverge from the current-law policy of no update for 2022. We note that, under current law, the 3.75 percent increase to payment rates for 2021 expires after 2021.

IMPLICATIONS 4

Spending

- No change as compared with current law.

Beneficiary and provider

- The Commission's recommendation of the current-law update should not affect beneficiaries' access to care or providers' willingness and ability to furnish care. ■

Previous Commission recommendations to improve the accuracy of prices for ambulatory evaluation and management services and establish a per beneficiary payment for primary care clinicians

The Commission has long been concerned that ambulatory evaluation and management (E&M) services, which make up a large share of the services provided by primary care clinicians and certain other specialties (e.g., psychiatry, endocrinology, and rheumatology), are underpriced in the physician fee schedule compared with other services, such as procedures (Medicare Payment Advisory Commission 2018a). Ambulatory E&M services include office visits, hospital outpatient department visits, nursing facility visits, and home visits.

In 2011, the Commission recommended that CMS use a streamlined method to regularly collect data from a cohort of efficient practices—including service volume and work time—to establish more accurate work and practice expense relative value units (RVUs) (Medicare Payment Advisory Commission 2011a, Medicare Payment Advisory Commission 2011b). These data should be used to calculate the amount of time that a clinician worked over the course of a week or month and compare it with the time estimates in the fee schedule for all of the services that the clinician billed over the same period. If the fee schedule's time estimates exceed the actual time worked, this finding could indicate that the time estimates—and, hence, the work RVUs—are too high. CMS could use this approach to identify groups of services that are likely overpriced, carefully review those services, and adjust the work RVUs accordingly.

Practice expense RVUs—which account for the cost of operating a practice—are based on data from a survey of total practice costs incurred by nearly all specialty groups. Because this survey was conducted in 2007 and 2008, practice expense RVUs probably do not reflect current practice costs. CMS has not developed a strategy

for updating practice cost data. However, CMS could regularly collect data on total practice costs along with data on volume and work time from a cohort of efficient practices, as the Commission recommended in 2011 (Medicare Payment Advisory Commission 2011a).

In addition to concern about the mispricing of ambulatory E&M services, the Commission contends that the fee schedule—with its orientation toward discrete services that have a definite beginning and end—is not well designed to support primary care, which requires ongoing care coordination for a panel of patients. Consequently, in 2015 the Commission recommended that the Congress establish a per beneficiary payment for primary care clinicians to replace the expired Primary Care Incentive Payment (PCIP) program, which provided a 10 percent bonus payment on fee schedule payments for certain E&M visits provided by primary care clinicians (Medicare Payment Advisory Commission 2015). A monthly payment based on the total amount of PCIP payments in 2015 (\$686 million) would initially amount to about \$2.35 per beneficiary.³¹

The Commission recommended that the additional payments to primary care clinicians be in the form of a per beneficiary payment to move away from the approach of paying separately for each discrete service. The payment would provide funds to support the investment in infrastructure and staff that facilitate care management and care coordination. Funding for the per beneficiary payment would come from reducing payment rates for all services in the fee schedule other than ambulatory E&M visits provided by any clinician. This method of funding would be budget neutral and would help rebalance the fee schedule toward primary care clinicians. ■

4 APPENDIX A

Findings from the Commission's 2020 access-to-care telephone survey

**TABLE
4A-1**

Elderly Medicare beneficiaries and older privately insured individuals had comparable access to clinician care, 2016–2020

Survey question	Medicare (ages 65 and older)					Private insurance (ages 50–64)				
	2016	2017	2018	2019	2020	2016	2017	2018	2019	2020
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, “How often did you have to wait longer than you wanted to get a doctor’s appointment?”										
For routine care										
Never	68%	73% ^{ab}	70% ^a	72% ^b	69% ^a	67% ^b	69% ^{ab}	64% ^{ab}	74%	73% ^a
Sometimes	22	20 ^{ab}	20 ^a	20	22 ^a	23 ^b	22 ^{ab}	26 ^{ab}	19	20 ^a
Usually	4 ^b	3	5 ^b	3	3	5	4	5	4	4
Always	3	3	3 ^a	3	3	4 ^b	3	4 ^{ab}	3	3
For illness or injury										
Never	79 ^a	80 ^a	79 ^a	80	79	75 ^{ab}	76 ^{ab}	74 ^{ab}	81	80
Sometimes	16 ^a	15 ^a	15 ^a	14	15	19 ^{ab}	18 ^{ab}	19 ^{ab}	15	15
Usually	2 ^a	2	2	2	2	3 ^a	2	3	2	3
Always	2 ^a	1 ^a	2 ^b	2	2	3 ^a	2 ^a	2	1	2
Not accessing a doctor for medical problems: “During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?”										
Share answering “Yes”	11 ^a	11	11 ^a	9	10	12 ^{ab}	12	14 ^{ab}	10	11
Looking for a new provider: “In the past 12 months, have you tried to get a new...?” (Share answering “Yes”)										
Primary care provider	8 ^a	9 ^a	10 ^b	8	8	10 ^{ab}	11 ^{ab}	10 ^b	9	7
Specialist	18 ^b	17 ^{ab}	19 ^{ab}	17 ^b	15	18 ^b	20 ^{ab}	21 ^{ab}	15	13
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, “How much of a problem was it finding a primary care provider/specialist who would treat you? Was it...”										
Primary care provider										
No problem	64	69 ^{ab}	71 ^b	72 ^{ab}	60	63	59 ^a	67 ^b	62 ^a	57
Share of total insurance group	5	6 ^b	7 ^b	5	5	6 ^b	6 ^b	7 ^b	5 ^b	4
Small problem	15	13	13	13 ^a	16 ^a	16 ^b	18	16 ^b	20 ^a	24 ^a
Share of total insurance group	1	1 ^a	1	1 ^a	1	2	2 ^a	2	2 ^a	2
Big problem	20	14 ^{ab}	14 ^b	14 ^b	22	20	22 ^a	16	17	18
Share of total insurance group	2	1 ^a	1	1	2	2	2 ^{ab}	2	2	1
Specialist										
No problem	82	83	84 ^b	85 ^{ab}	79	79	81	80	79 ^a	77
Share of total insurance group	15 ^b	14 ^b	16 ^b	14 ^{ab}	12	14 ^b	16 ^b	17 ^b	12 ^{ab}	10
Small problem	10	11	7	6 ^a	9	9	11	9	11 ^a	11
Share of total insurance group	2	2 ^b	1	1	1	2	2 ^b	2	2	1
Big problem	8 ^{ab}	5 ^{ab}	8 ^b	8	11	11 ^a	8 ^a	10	9	11
Share of total insurance group	1	1 ^{ab}	1	1	2	2	2 ^a	2	1	2

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: “Don’t know” and “Refused.” Sample sizes for each group (Medicare and private insurance) are approximately 4,000. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in fee-for-service Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

^a Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

^b Statistically significant difference from 2020 within the same insurance category (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone surveys conducted from 2016 to 2020.

**TABLE
4A-2**

Slightly higher shares of certain non-White individuals reported unwanted delays in accessing care compared with White individuals, regardless of insurance type, 2020

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50-64)		
	All	White	Non-White	All	White	Non-White
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	69% ^a	71%	62%	73% ^a	75%	69%
Sometimes	22 ^a	22	24	20 ^a	19	22
Usually	3	3	3	4	4	4
Always	3	2	4	3	2	4
For illness or injury						
Never	79	80	74	80	81	77
Sometimes	15	15	17	15	15	15
Usually	2	2	2	3	2	4
Always	2	1	2	2	1	3
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	10	10	10	11	10	11
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care provider	8	8	9	7	7	7
Specialist	15	15	13	13	14	11
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."						
Primary care provider						
No problem	60	61	57	57	54	68
Share of total insurance group, by race	5	5	5	4	4	5
Small problem	16 ^a	16	16	24 ^a	25	24
Share of total insurance group, by race	1	1	1	2	2	2
Big problem	22	22	23	18	20	8
Share of total insurance group, by race	2	2	2	1	1	1
Specialist						
No problem	79	81	76	77	78	71
Share of total insurance group, by race	12	12	9	10	11	8
Small problem	9	8	13	11	10	14
Share of total insurance group, by race	1	1	2	1	1	2
Big problem	11	11	10	11	11	15
Share of total insurance group, by race	2	2	1	2	2	2

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Respondents who did not report race or ethnicity were not included in "White" or "Non-White" results, but were included in "All" results. "White" in the table refers to non-Hispanic White respondents. "Non-White" refers to Hispanic respondents and non-Hispanic Black respondents. Sample sizes for each group (Medicare and private insurance) were approximately 4,000 in 2020. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in traditional Medicare or Medicare Advantage and excludes beneficiaries under the age of 65.

^a Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

^b Statistically significant difference by race within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2020.

**TABLE
4A-3**

No statistically significant difference in access to care for urban and rural residents, 2020

Survey question	Medicare (ages 65 and older)			Private insurance (ages 50-64)		
	All	Urban	Rural	All	Urban	Rural
Unwanted delay in getting an appointment: Among those who needed an appointment in the past 12 months, "How often did you have to wait longer than you wanted to get a doctor's appointment?"						
For routine care						
Never	69% ^a	68% ^a	72%	73% ^a	73% ^a	75%
Sometimes	22 ^a	23 ^a	20	20 ^a	20 ^a	19
Usually	3	3	3	4	4	3
Always	3	3	1	3	3	2
For illness or injury						
Never	79	78	82	80	79	84
Sometimes	15	16	13	15	15	12
Usually	2	2	2	3	3	1
Always	2	2	1	2	2	2
Not accessing a doctor for medical problems: "During the past 12 months, did you have any health problem or condition about which you think you should have seen a doctor or other medical person, but did not?"						
Share answering "Yes"	10	10	10	11	11	9
Looking for a new provider: "In the past 12 months, have you tried to get a new...?" (Share answering "Yes")						
Primary care provider	8	8	8	7	8	8
Specialist	15	15	13	13	14	13
Getting a new provider: Among those who tried to get an appointment with a new primary care provider or a specialist in the past 12 months, "How much of a problem was it finding a primary care provider/specialist who would treat you? Was it..."						
Primary care provider						
No problem	60	59	61	57	57	53
Share of total insurance group, by area	5	5	5	4	4	4
Small problem	16 ^a	18	11	24 ^a	25	20
Share of total insurance group, by area	1	1	1	2	2	2
Big problem	22	21	26	18	17	28
Share of total insurance group, by area	2	2	2	1	1	2
Specialist						
No problem	79	80	77	77	78	68
Share of total insurance group, by area	12	12	10	10	11	9
Small problem	9	8	13	11	11	17
Share of total insurance group, by area	1	1	2	1	1	2
Big problem	11	11	10	11	11	15
Share of total insurance group, by area	2	2	1	2	2	2

Note: Totals may not sum to 100 because of rounding and because the table excludes the following responses: "Don't know" and "Refused." Sample sizes for each group (Medicare and private insurance) were approximately 4,000 in 2020. Sample sizes for individual questions varied. Survey includes beneficiaries enrolled in traditional Medicare or Medicare Advantage and excludes beneficiaries under the age of 65. The Commission uses the Census Bureau definitions of "urban" and "rural." The Census Bureau classifies as "urban" all territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC). It delineates UA and UC boundaries to encompass densely settled territory, which consists of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. In addition, under certain conditions, less densely settled territory may be part of each UA or UC. The Census Bureau's classification of "rural" consists of all territory, population, and housing units located outside of UAs and UCs.

^a Statistically significant difference between the Medicare and private insurance groups in the given year (at a 95 percent confidence level).

^b Statistically significant difference by area type within the same insurance category in the given year (at a 95 percent confidence level).

Source: MedPAC-sponsored telephone survey conducted in 2020.

Endnotes

- 1 Throughout this chapter, we use the term “fee-for-service (FFS) Medicare” or “traditional Medicare” as equivalents to the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models, such as Medicare Advantage or advanced alternative payment models, that may use FFS mechanisms, but which are designed to create different financial incentives.
- 2 Although nearly all clinician services are paid under the fee schedule, some are paid under other payment systems, such as the prospective payment system for federally qualified health centers.
- 3 For further information, see the Commission’s *Payment Basics: Physician and Other Health Professional Payment System* at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_physician_final_sec.pdf?sfvrsn=0.
- 4 Primary care visits include E&M office visits, wellness visits, preventive medicine counseling, and other services.
- 5 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed several times for 90 days periods and is set to expire in mid-April 2021.
- 6 A substantial number of clinicians billed for 15 or fewer beneficiaries in a given year, but they accounted for a small share of services and allowed charges. For example, in 2019, about 17 percent of clinicians who billed the fee schedule billed for 15 or fewer beneficiaries, but these clinicians billed for less than 1 percent of total allowed charges.
- 7 We used the number of total Part B beneficiaries, including those in traditional Medicare and Medicare Advantage, to calculate the ratio of physicians and other health professionals per 1,000 beneficiaries because we assume that clinicians generally furnish services to beneficiaries covered under both programs.
- 8 APRNs include clinical nurse specialists, nurse practitioners, certified registered nurse anesthetists, and certified nurse midwives.
- 9 In such scenarios, the beneficiary is billed 20 percent cost sharing for 95 percent of the fee schedule amount, plus the difference between 95 percent of the fee schedule amount and the total amount billable by the provider (which can reach up to 109.25 percent of the fee schedule amount for participating providers).
- 10 The behavioral health clinicians referenced here are psychiatrists, clinical psychologists, and clinical social workers.
- 11 The oral health professionals referenced here are dentists, oral surgeons, and maxillofacial surgeons.
- 12 The primary care specialties referenced here are family medicine, internal medicine, and pediatric medicine.
- 13 Specifically, we define “encounters” as unique combinations of beneficiary identification numbers, claim identification numbers (for paid claims), and national provider identifiers of the clinicians who billed for the service.
- 14 This number is based on our count of beneficiaries who had at least one encounter recorded in claims data and the total number of traditional Medicare beneficiaries enrolled in Part B in the 2020 Medicare Trustees report.
- 15 Primary care physicians billed for very few services classified as “major procedures” or “anesthesia,” so these categories of services were excluded from this analysis.
- 16 CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality.
- 17 The roughly 3,400 Dartmouth-defined HSAs are a collection of ZIP codes whose residents receive most of their hospitalizations from that respective area’s hospitals.
- 18 It is challenging to reliably identify low-value care with claims data because claims may not have enough clinical detail to distinguish between appropriate and inappropriate use. Thus, these measures allow for trade-offs between the sensitivity and specificity of each measure. Schwartz and colleagues developed two versions of each measure: a broader one with higher sensitivity (and lower specificity) and a narrower one with lower sensitivity (and higher specificity) (Schwartz et al. 2014). Increasing the sensitivity of a measure captures more potentially inappropriate use but is also more likely to misclassify some appropriate use as inappropriate. Increasing a measure’s specificity leads to less misclassification of appropriate use as inappropriate, at the expense of potentially missing some instances of inappropriate use.

- 19 When this type of visit is provided in an HOPD, it is billed as Healthcare Common Procedure Coding System code G0463. We used the OPSS rate for the HOPD payment.
- 20 Section 603 of the Bipartisan Budget Act of 2015 prohibits HOPDs that began billing under the OPSS on or after November 2, 2015, and are located off a hospital campus from billing under the OPSS after January 1, 2017. In 2020, the payment rate for services provided at these off-campus HOPDs was equal to 40 percent of the rate under the OPSS. On-campus HOPDs, off-campus HOPDs that began billing before November 2, 2015, and dedicated emergency departments were not affected by this policy change. However, as of 2019, Medicare pays all off-campus HOPDs (regardless of when they began billing under the OPSS) an amount equal to 40 percent of the OPSS rate for office/outpatient E&M visits.
- 21 For the OPSS, CMS classifies services into APC groups on the basis of clinical and cost similarity; all services within an APC group have the same payment rate.
- 22 This analysis used data on paid claims for PPO enrollees of a large national insurer that covers a wide geographic area across the U.S. The payments reflect the insurer's allowed amount (including allowed cost sharing). The data exclude any remaining balance billing and payments made outside of the claims process, such as bonuses or risk-sharing payments. Only services paid under Medicare's physician fee schedule were included, and anesthesia services were excluded.
- 23 In this study, health systems are organizations with at least one acute care hospital and one physician group providing comprehensive care that are connected through common ownership or joint management (Furukawa et al. 2020).
- 24 To control for annual changes in survey respondents, we based the percentage change on a cohort analysis in which the sample was restricted to physicians who were present in both the 2015 and 2019 data.
- 25 The nonsurgical, procedural specialties in the analysis are cardiology, dermatology, gastroenterology, pulmonary medicine, and hematology/oncology.
- 26 In addition to psychiatry, the nonsurgical, nonprocedural group includes emergency medicine, endocrinology, hospital medicine, nephrology, neurology, physical medicine, rheumatology, and other internal medicine/pediatrics. The primary care specialties in the analysis are family medicine, internal medicine, and general pediatrics.
- 27 This analysis was based on MGMA data from 2007. It found that hourly compensation for nonsurgical, procedural specialties and radiology was more than double hourly compensation for primary care.
- 28 Ambulatory E&M services include office visits, hospital outpatient department visits, visits to patients in certain other settings such as nursing facilities, and home visits.
- 29 The new add-on code is G2211 (visit complexity inherent to evaluation and management).
- 30 CMS uses price proxies (such as the consumer price index and employment cost index) to calculate annual changes in the MEI.
- 31 We estimate, based on claims data from 2015, that primary care clinicians would receive per beneficiary payments for 127 beneficiaries, on average.

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CHAPTER

5

**Ambulatory surgical
center services**

R E C O M M E N D A T I O N S

5-1 For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare conversion factor for ambulatory surgical centers.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

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5-2 The Secretary should require ambulatory surgical centers to report cost data.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Ambulatory surgical center services

Chapter summary

Ambulatory surgical centers (ASCs) provide outpatient procedures to patients who do not require an overnight stay. In 2019, the 5,816 ASCs that were certified by Medicare treated 3.5 million traditional fee-for-service (FFS) Medicare beneficiaries. Medicare program and beneficiary spending on ASC services was about \$5.2 billion.

In this chapter, we make a recommendation on a payment rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. The coronavirus public health emergency (PHE) created some additional data lags. Where relevant, we have considered the effects of the 2020 coronavirus PHE on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary or vary significantly across ASCs, they are best addressed through targeted temporary funding policies rather than a permanent change to all ASC payment rates in 2022 and future years. Based on information at the time of publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to ASC payments in 2022.

Assessment of payment adequacy

To examine the adequacy of Medicare's payments to ASCs, we analyze beneficiaries' access to care (including the supply of providers and volume of

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payments change in 2022?

services), quality of care, and provider access to capital. Cost data are not available for ASCs. The available indicators of payment adequacy for ASC services are positive.

Beneficiaries' access to care—Our analysis of facility supply and volume of services indicates that beneficiaries' access to ASC services is adequate.

- ***Capacity and supply of providers***—From 2014 to 2018, the number of ASCs increased by an average annual rate of 1.7 percent. In 2019, the number of ASCs increased 2.5 percent. Most new ASCs in 2019 (96 percent) were for-profit facilities.
- ***Volume of services***—From 2014 through 2018, the volume of services per Part B FFS beneficiary increased by an average annual rate of 2.1 percent. In 2019, volume increased by 2.7 percent.

Quality of care—The first six years of ASC-reported quality data show improvement in performance from 2013 through 2017 and a plateau from 2017 to 2018. However, the measures used within the ASC Quality Reporting (ASCQR) Program will change substantially in the next few years. Among the eight quality measures for which data were available for multiple years through 2018, performance among the ASCs that reported data improved for most measures from 2013 through 2017, but from 2017 to 2018 performance was largely unchanged and decreased for one measure. For 2019 and beyond, CMS has been making several changes to the ASCQR Program. However, we remain concerned about the delayed use of Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) measures, the lack of a value-based purchasing program for the ASC sector, and the lack of claims-based outcome measures that apply to all ASCs. For example, CMS could add measures targeting the frequency of ASC patients receiving hospital care after ASC discharge or rates of surgical site infection.

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

Medicare payments and providers' costs—From 2014 through 2018, Medicare payments for ASC services per FFS beneficiary increased by an average annual rate of 5.8 percent. However, in 2019, growth in these payments increased by 8.3 percent. 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.

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. Therefore, the Commission continues to recommend that the Secretary of Health and Human Services collect cost data from ASCs without further delay. Considering the available evidence of payment adequacy, the Commission recommends that for calendar year 2022, the Congress eliminate the update to the 2021 Medicare conversion factor for ambulatory surgical centers. ■

Background

An ambulatory surgical center (ASC) is a distinct entity that primarily provides outpatient surgical procedures to patients who do not require an overnight stay. In addition to ASCs, hospital outpatient departments (HOPDs) and, in some cases, physicians' offices are locations where providers perform outpatient surgical procedures.

Since 1982, Medicare has covered and paid for surgical procedures provided in ASCs. Medicare covers surgical procedures represented in about 3,500 Healthcare Common Procedure Coding System (HCPCS) codes under the ASC payment system. However, ASC volume for services covered under Medicare is concentrated in a relatively small number of HCPCS codes. For example, in 2019, 29 HCPCS codes accounted for 75 percent of the ASC volume for surgical services provided to Medicare beneficiaries. For procedures performed in an ASC, Medicare makes two payments: one to the facility through the ASC payment system and the other to the physician for his or her professional services through the payment system for physicians and other health professionals known as the physician fee schedule (PFS). According to surveys, most ASCs have partial or complete physician ownership (Ambulatory Surgery Center Association 2017, Leapfrog 2019). Physicians who perform surgeries in ASCs they own receive a share of the ASC's profit in addition to payment for their professional services. To receive payments from Medicare, ASCs must meet Medicare's conditions of coverage, which specify standards for administration of anesthesia, quality evaluation, operating and recovery rooms, medical staff, nursing services, and other aspects of care.

Medicare pays ASCs for a bundle of facility services and items—such as nursing, recovery care, anesthetics, and supplies—through a system that is linked primarily to the outpatient prospective payment system (OPPS), which Medicare uses to set payment rates for most services provided in HOPDs. The ASC payment system is also partly linked to the PFS. A more detailed description of the ASC payment system can be found online at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_asc_final_sec.pdf?sfvrsn=0.

For most covered procedures, payment rates in the ASC payment system are the product of a relative weight and a conversion factor. The ASC relative weight, which

indicates a procedure's resource intensity relative to other procedures, is based on its relative weight under the OPPS. Although CMS links the ASC payment system to the OPPS, payment rates for all services covered under both systems are lower in ASCs for two reasons. First, CMS makes proportional adjustments to the relative weights of the OPPS because budget neutrality requirements do not allow changes in the relative weights to affect the level of Medicare spending from one year to the next. In 2020, this adjustment resulted in ASC relative weights that were 14.5 percent lower than the relative weights in the OPPS. Second, for most procedures covered under the ASC system, the payment rate is the product of its relative weight and an ASC conversion factor, set at \$47.75 for 2020, which was 41 percent lower than the OPPS conversion factor of \$80.78 for 2020.

The ASC conversion factor is lower than the OPPS conversion factor because it started at a lower level in 2008 and was updated at a lower rate than the OPPS conversion factor until 2019. CMS set the initial ASC conversion factor in 2008 such that total payments to ASCs under the revised payment system would equal what they would have been under the pre-2008 ASC payment system. From 2010 through 2018, CMS updated the ASC conversion factor based on the consumer price index for all urban consumers (CPI-U), while it used the hospital market basket (MB) index to update the OPPS conversion factor. The CPI-U has generally been lower than the hospital MB index. Therefore, before 2019, the ASC conversion factor was updated by smaller percentages than the OPPS conversion factor.

In a change of regulatory policy, CMS has instituted a policy of updating the ASC conversion factor using the hospital MB index from 2019 through 2023. Under this change, the updates to the ASC conversion factor will align with the updates to the OPPS conversion factor.

We are concerned that neither the CPI-U nor the hospital MB index reflects ASCs' cost structure (see text box, p. 155). Beginning in 2010, the Commission has repeatedly recommended that CMS collect cost data from ASCs with the purpose of identifying a price index that would be an appropriate proxy for ASC costs (Medicare Payment Advisory Commission 2010). CMS has shown occasional interest in collecting cost data and requested comments from stakeholders on whether the Secretary should collect cost data from ASCs to use in determining ASC payment

rates. Representatives of individual ASCs provided comments that generally opposed a requirement for ASCs to submit formal cost reports but indicated a willingness to complete surveys on the condition that they would not be administratively burdensome (Centers for Medicare & Medicaid Services 2017). The Commission asserts, however, that all other institutional providers submit at least abbreviated versions of cost reports to CMS, including small entities such as hospices and home health agencies. Moreover, ASCs in Pennsylvania submit revenue and cost data each year to the Pennsylvania Health Care Cost Containment Council, so it is clear that submission of cost data is feasible for ASCs. Nevertheless, CMS has not acted on this issue.

CMS uses a different method from the one described above to determine payment rates for “office-based” procedures, which are procedures that are predominantly performed in physicians’ offices and were first covered under the ASC payment system in 2008 or later. Payment for office-based procedures is the lesser of the amount derived from the standard ASC method or the practice expense portion of the PFS rate that applies when the service is provided in a physician’s office (the nonfacility practice expense, which covers the equipment, supplies, nonphysician staff, and overhead costs of a service).¹ CMS set this limit on the rate for office-based procedures to prevent migration of these services from physicians’ offices to ASCs for financial reasons. Physicians who provide office-based procedures in ASCs receive a separate payment under the PFS (the full facility payment rate).

The ASC payment system somewhat parallels the OPSS in terms of which ancillary items are paid separately and which are packaged into the payment of the associated surgical procedure. However, the connection between the ASC payment system and the OPSS has been declining as CMS has increased the number of services in comprehensive ambulatory payment classifications (C-APCs), which combine all hospital outpatient services reported on a claim that are covered under Medicare Part B into a single payment, with a few exceptions. CMS has not implemented C-APCs for services provided in ASCs, stating that the system of processing ASC claims does not allow for the type of packaging of ancillary items necessary to create C-APCs. Therefore, the payment bundles for services in the C-APCs under the OPSS have greater packaging of ancillary items than the same

services under the ASC payment system. Consequently, a disconnect exists between OPSS payment rates and ASC payment rates for the services that are in C-APCs under the OPSS, and this disconnect has grown over time as CMS has substantially expanded the number of C-APCs. Forty-two percent of ASC surgical volume in 2019 comprised procedures that are in C-APCs under the OPSS, and about 72 percent of HCPCS codes for surgical procedures that are covered under the ASC payment system in 2020 are in C-APCs under the OPSS. The Commission supports the use of C-APCs in the OPSS and encourages CMS to implement them in the ASC payment system because the greater packaging of ancillary items that occurs with C-APCs gives providers an incentive to furnish care more efficiently.

Although we do not have recent ASC cost data that would allow us to quantify cost differences between settings, evidence suggests that ASCs are a lower cost setting than HOPDs. Studies that used data from the National Survey of Ambulatory Surgery found that the average time for ambulatory surgical visits for Medicare patients was 25 percent to 39 percent lower in ASCs than in HOPDs, which likely contributes to lower costs in ASCs (Hair et al. 2012, Munnich and Parente 2014). An additional study using data from a facility that has both an ASC and a hospital found that surgeries took 17 percent less time in the ASC (Trentman et al. 2010). Beneficiaries who are sicker may require more time to treat, and the studies that accounted for differences in health status between patients treated in ASCs and those in HOPDs generally estimated a somewhat smaller differential in average surgical time between ASCs and HOPDs. This finding is consistent with the Commission’s analyses that found that, on average, beneficiaries receiving surgical services in HOPDs are not as healthy as beneficiaries receiving those services in ASCs, as indicated by risk scores from the CMS hierarchical condition categories risk adjustment model (Medicare Payment Advisory Commission 2017).

Although Medicare spending on services provided in ASCs has been increasing, ASCs represent only about 1 percent of total Medicare fee-for-service (FFS) spending. The small role of ASCs in total spending has likely contributed to the fact that little is known about the effect of the coronavirus public health emergency (PHE) on the ASC industry. To the extent that information is available, we include the effects of the coronavirus PHE on ASCs throughout our discussion of payment adequacy in the ASC sector (see text box).²

Overview of the effects of the coronavirus pandemic on the ASC sector

Since early 2020, the coronavirus pandemic and associated public health emergency (PHE) has had tragic effects on beneficiaries' health. It also has had material effects on providers' patient volume, revenues, and costs. The impacts of COVID-19 have varied considerably both geographically and over time, and it is not clear when or whether the full effects of the pandemic's effects will end. Information about the effect of the PHE on ambulatory surgical centers (ASCs) is limited, but the information we have suggests that ASC surgical volume dropped sharply in March and April of 2020 but rebounded by June. It is not clear the extent to which the volume in the ASC industry has returned to its previous level, but limited claims data and information from financial statements of large health care management companies that hold many ASCs suggest that volume has returned to 80 percent to 90 percent of its prepandemic level. The health care management companies also received federal grants that offset lost revenue; for example, United Surgical Partners received \$49 million and Surgery Partners received \$48 million in grants. While ASCs' surgical volume appears to have rebounded to some degree, uncertainty remains as to whether the pandemic will continue to affect patient care patterns, ASC volume, and ASC financial performance in 2021

and 2022. Some costs related to preventing the spread of coronavirus among ASC patients and staff may be ongoing. As applicable, more details about the impact of COVID-19 on ASCs can be found throughout this chapter.

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for most payment adequacy indicators. We use available data as well as changes in payment policy to make payment recommendations for 2022. To the extent that the effects of the coronavirus PHE are temporary or vary significantly across individual ASCs, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and future years. Nevertheless, for each payment adequacy indicator in this chapter, we discuss whether the effects of the coronavirus PHE on those indicators will more likely be temporary or permanent. Only permanent effects of the pandemic are factored into recommended permanent changes in Medicare payment rates. (For an overview of why our payment adequacy framework takes account of the PHE, see Chapter 2). ■

Are Medicare payments adequate in 2021?

To address whether payments for the current year (2021) are adequate to cover the costs of efficient providers and how much payments should change in the coming year (2022), we examine several measures of payment adequacy. We evaluate beneficiaries' access to care by examining the supply of ASC facilities and changes over time in the volume of services provided, providers' access to capital, and changes in ASC revenue from the Medicare

program. However, our assessment of quality of care (another measure of payment adequacy) is limited and does not fully represent quality in ASCs. Our available indicators of payment adequacy are positive.

Beneficiaries' access to care: Supply of ASCs and volume of services indicate adequate access

Beneficiaries have adequate access to care in ASCs. The number of ASC facilities has increased, and the volume of services provided to Medicare beneficiaries in ASCs also has increased. Access to ASCs may be beneficial

**TABLE
5-1****Number of ASCs and operating rooms grew, 2014–2019**

	2014	2018	2019	Average annual percent change	
				2014–2018	2018–2019
Total number of ASCs	5,301	5,674	5,816	1.7%	2.5%
New	191	230	226	N/A	N/A
Closed or merged	126	103	84	N/A	N/A
Total number of ORs	16,544	17,376	17,848	1.2	2.7
New	514	660	676	N/A	N/A
Closed or merged	347	271	204	N/A	N/A

Note: ASC (ambulatory surgical center), N/A (not applicable), OR (operating room). The average annual percentage change data for the “new” and “closed or merged” categories are shown as “N/A” because they are outside the purpose of this table, which is to show the growth in the total number of ASCs and ORs.

Source: MedPAC analysis of Provider of Services file from CMS, 2020.

to patients and physicians compared with HOPDs, the provider type most similar to ASCs. For patients, ASCs can offer more convenient locations, shorter waiting times, and easier scheduling relative to HOPDs. ASCs offer physicians more control over their work environment and specialized staff. However, these same qualities could lead to overuse of surgical procedures.

Capacity and supply of providers: Number of ASCs is increasing

From 2018 to 2019, the number of ASCs increased 2.5 percent to 5,816 ASCs (Table 5-1). This annual growth rate was faster than growth in the period from 2014 to 2018, when the number of ASCs increased, on average, 1.7 percent per year. In 2019, 226 new ASCs opened, while 84 ASCs closed or merged with other facilities. The number of ASCs that closed or merged had been consistent from 2015 through 2018 (between 100 and 110 each year, data not shown), but a smaller number of ASCs closed in 2019. Finally, the number of ASCs that billed Medicare for at least one surgical service in 2019 was 5,143 (data not shown).

From 2014 to 2019, the number of ASCs has been increasing at a faster rate than preceding years. For example, the rate of growth from 2014 through 2019 was

1.9 percent but only 0.8 percent from 2010 through 2014 (data not shown). The increased growth in the number of ASCs in more recent years is attributable, at least in part, to a change in payment policy for newly acquired ASCs under which health care management companies, such as Tenet and HCA, continued investments in outpatient surgical capacity (Oliver 2020). Companies that acquire ASCs have the option of maintaining the facility as an ASC or converting it to an off-campus provider-based department (PBD) of a hospital (most likely an outpatient surgery department).

However, in response to provisions in Section 603 of the Bipartisan Budget Act of 2015, CMS in 2017 aligned payment rates for all services provided in newly acquired facilities established as off-campus PBDs with PFS payment rates, which are typically lower than ASC rates. Therefore, beginning in 2017, there has been little incentive for a hospital system to acquire an ASC and convert it to an off-campus PBD. Instead, it is now more financially beneficial to maintain the facility as an ASC.

The number of operating rooms (ORs) in ASCs is also growing (Table 5-1). In 2019, there were more than 17,800 ORs in ASCs, or an average of 3.1 per facility. From 2014 to 2018, the total number of ASC ORs increased 1.2 percent per year, a slower rate than the growth in the

number of ASCs over the same period (1.7 percent per year). However, from 2018 to 2019, the number of ORs in ASCs increased by about 2.7 percent, slightly higher than the growth rate in the number of ASCs during this period, which suggests the size of ASCs decreased from 2014 to 2018 but increased slightly from 2018 to 2019.

Consistent with previous years, most ASCs in 2019 were for profit (94.9 percent) and located in urban (including urban and suburban) areas (93.3 percent) (Table 5-2). ASCs that were new in 2019 were still likely to be for profit, but compared with existing ASCs, new ASCs were slightly more likely to be nonprofit and urban. Beneficiaries who do not live near an ASC can obtain ambulatory surgical services in HOPDs and, in some cases, physicians' offices. Beneficiaries who live in rural areas can travel to urban areas to receive care in ASCs.

Geographic distribution of ASCs is uneven

In addition to ASCs locating more in urban than rural areas, the concentration of ASCs varies widely among states. In 2019, Maryland had the most ASCs per Medicare beneficiary (38 ASCs per 100,000 Part B beneficiaries), followed by Georgia, Alaska, and New Jersey (23 to 18 ASCs per 100,000 Part B beneficiaries) (Figure 5-1, p. 144).³ Kentucky, the District of Columbia, West Virginia, and Vermont had the fewest ASCs per beneficiary (fewer than 4 ASCs per 100,000 beneficiaries). The number of ASCs in Vermont increased from 1 to 2 in 2019, making the number of ASCs per 100,000 beneficiaries in Vermont greater than 1 for the first time since we started tracking this measure.

Even though beneficiaries can receive largely the same services in HOPDs if an ASC is not located near them, the small number of ASCs in some states and rural areas raises concerns about beneficiaries' access to ambulatory surgical services if payment rates for surgical services provided in HOPDs are set at the level in the ASC payment system (site-neutral payments). In its June 2013 report, the Commission identified surgical services that are viable for site-neutral payments between the ASC payment system and the OPPS (Medicare Payment Advisory Commission 2013a). If implemented, this policy would lower payment for some services in HOPDs. Hospitals could respond by reducing their provision of these services. In areas that have low ASC concentration, site-neutral payments could make it more difficult for beneficiaries to access ambulatory surgical services.

TABLE 5-2

Most ASCs are for profit and urban

Type of ASC	ASCs that were:		
	Open in 2014	Open in 2019	New in 2019
For profit	94.9%	94.9%	95.6%
Nonprofit	3.6	3.7	4.0
Government	1.5	1.3	0.4
Urban	92.9	93.3	93.8
Rural	7.1	6.7	6.2

Note: ASC (ambulatory surgical center). Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of Provider of Services file from CMS, 2020.

We found that rural beneficiaries—defined as those who live outside metropolitan statistical areas (MSAs)—are less likely to receive care in an ASC than urban beneficiaries—defined as those living in an MSA. In 2019, 7.4 percent of rural beneficiaries received care in an ASC compared with 10.8 percent of urban beneficiaries.

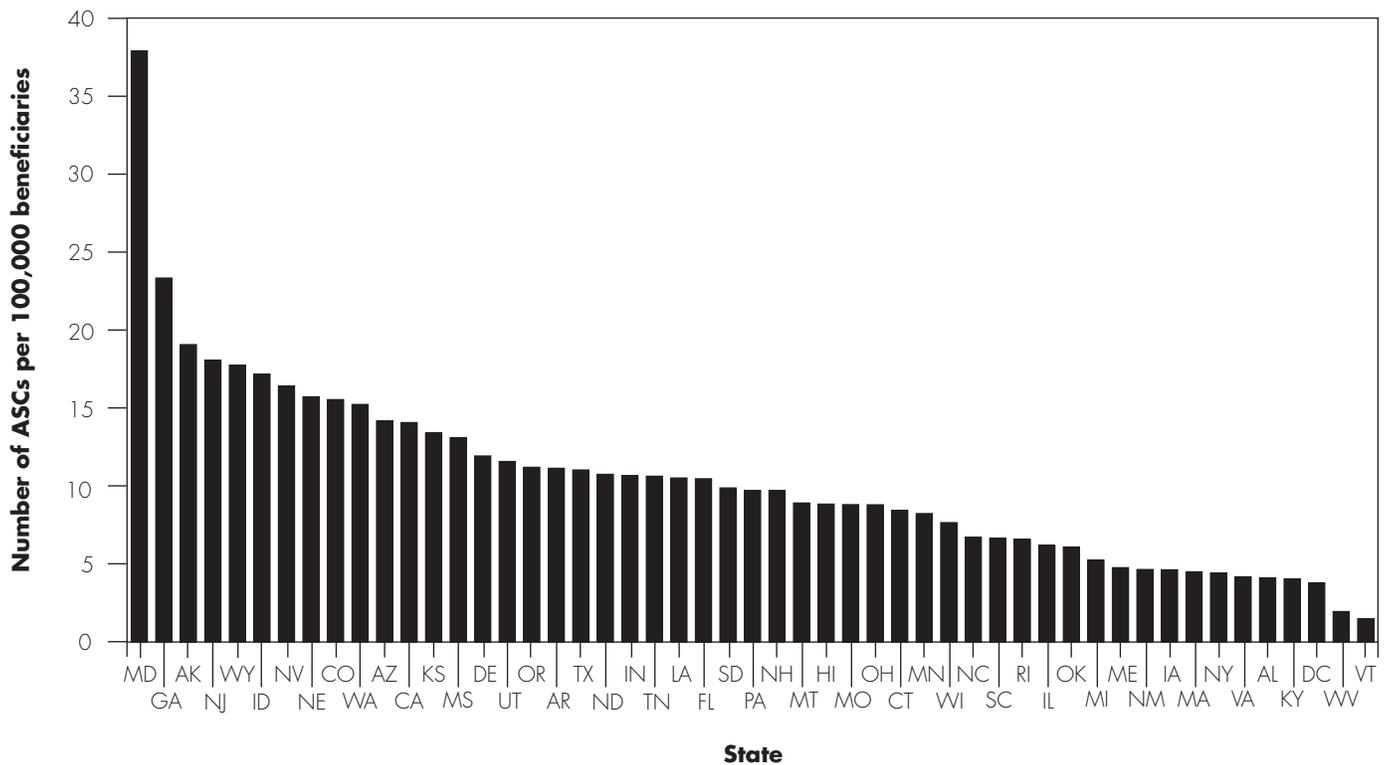
Specialization of ASCs largely unchanged, some growth in pain management

In 2019, the majority of ASCs that billed Medicare specialized in a single clinical area, of which gastroenterology (21 percent of ASCs) and ophthalmology (21 percent of ASCs) were the most common. Overall, in 2019, 65 percent of ASCs were single-specialty facilities and 35 percent were multispecialty facilities (Table 5-3, p. 145).⁴ In 2019, multispecialty ASCs most commonly focused on two specialties: pain management and orthopedic services or gastroenterology and ophthalmology (8 percent of all ASCs). From 2014 to 2019, ASCs specializing in pain management services grew most rapidly.

Continued growth in the number of ASCs suggests that Medicare's payment rates have been adequate. Other factors also have likely influenced the long-term growth in the number of ASCs:

**FIGURE
5-1**

Number of ASCs per beneficiary varies widely by state, 2019



Note: ASC (ambulatory surgical center).

Source: MedPAC analysis of CMS Provider of Services file for 2020 and Medicare Common Medicare Environment file.

- Changes in clinical practice and health care technology have expanded the provision of surgical procedures in ambulatory settings. There is potential for this trend to continue as momentum grows for knee and hip arthroplasty (knee and hip replacement) to be done in ambulatory settings.
- ASCs can offer patients greater convenience than HOPDs, such as the ability to schedule surgery more quickly.
- For most procedures covered under the ASC payment system, beneficiaries' coinsurance is lower in ASCs than in HOPDs.⁵
- Physicians have greater autonomy in ASCs than in HOPDs, which enables them to design customized surgical environments and hire specialized staff.
- Physicians who invest in ASCs and perform surgeries on their patients in those ASCs can increase their revenue by receiving a share of ASC facility payments. The federal anti-self-referral law (also known as the Stark Law) does not apply to ASC services.
- Because physicians are able to perform more procedures in ASCs than in HOPDs in the same amount of time, they can earn more revenue from professional fees.

**TABLE
5-3**

Specialization of ASCs billing Medicare in 2014 and 2019

Type of ASC	2014		2019	
	Number of ASCs	Share of all ASCs	Number of ASCs	Share of all ASCs
Single specialty	2,978	62%	3,356	65%
Gastroenterology	1,059	22	1,082	21
Ophthalmology	1,049	22	1,057	21
Pain management	364	8	619	12
Dermatology	201	4	209	4
Urology	129	3	134	3
Cardiology	12	0	88	2
Podiatry	98	2	83	2
Orthopedics/musculoskeletal	30	1	32	1
Respiratory	19	0	26	1
OB/GYN	10	0	13	0
Neurology	5	0	6	0
Other	2	0	7	0
Multispecialty	1,862	38	1,787	35
More than 2 specialties	1,460	29	1,283	25
Pain management and orthopedics	163	3	195	4
Gastroenterology and ophthalmology	167	3	194	4
Other with 2 specialties	72	1	115	2
Total	4,840	100	5,143	100

Note: ASC (ambulatory surgical center), OB/GYN (obstetrics and gynecology). A “single-specialty ASC” is defined as one with more than 67 percent of its Medicare claims in one clinical specialty. A “multispecialty ASC” is defined as one with more than 67 percent of its Medicare claims in more than one clinical specialty. ASCs included in this analysis are limited to those in the 50 states and the District of Columbia with a paid Medicare claim in 2019. Columns containing the share of all ASCs may not sum to 100 percent due to rounding. The share of single-specialty ASCs in 2019 does not sum to the listed total of 65 percent and the share of multispecialty ASCs in 2014 does not sum to the listed total of 38 percent due to rounding.

Source: MedPAC analysis of Medicare carrier file claims, 2019.

- Increased interest across the health care industry in value-based care and the provision of care in lower cost settings has increased the strategic investment interest of hospital systems, insurers, and private equity firms in ASCs (Barclays 2018, Japsen 2018).

Number of beneficiaries treated and volume of services per beneficiary increased from 2018 to 2019

The volume of ASC surgical procedures per FFS beneficiary increased from 2018 to 2019. Also, the number of FFS beneficiaries treated in ASCs and the volume of ASC surgical services per FFS beneficiary increased from 2018 to 2019. Because ASC services are covered under

Part B, we limited our analysis to FFS beneficiaries who have Part B coverage. The volume of services per 1,000 FFS beneficiaries increased by an average of 2.1 percent per year from 2014 through 2018 and increased by 2.7 percent in 2019 (Table 5-4, p. 146).

In addition, from 2014 through 2018, the number of FFS beneficiaries who received ASC services grew an average 1.4 percent per year and by 0.9 percent in 2019 (data not shown). Also, the number of services per beneficiary receiving care in ASCs from 2014 through 2018 increased at an average annual rate of 0.9 percent and by 1.0 percent in 2019 (data not shown).

**TABLE
5-4**

Volume of ASC services per FFS beneficiary increased in 2019

Average annual change

	2014	2018	2019	2014-2018	2018-2019
Volume of services (in millions)	6.0	6.6	6.7	2.3%	1.8%
Volume per 1,000 FFS beneficiaries	180.5	196.3	201.6	2.1	2.7

Note: ASC (ambulatory surgical center), FFS (fee-for-service). The volume of services for 2014 and 2018 have been modified to reflect the volume of services covered under the ASC payment system in 2019 that was provided in those years.

Source: MedPAC analysis of physician/supplier standard analytic files from CMS, 2014-2019.

The coronavirus PHE undoubtedly depressed ASC volume among Medicare beneficiaries in 2020, but data limitations prevent us from providing a precise estimate of this effect. However, we used ASC claims from the first 6 months of 2020 to evaluate how volume of the 29 most frequently provided services in ASCs changed each month. These 29 services constituted about 75 percent of the total ASC volume in 2019. Our analysis of these claims indicates that volume of these services in April 2020 was only 11 percent of the volume in January 2020, before the PHE began. After April 2020, volume of these services strongly rebounded, and in June 2020 the volume of these services was 87 percent of the volume in January 2020.

Services that have historically contributed the most to overall ASC volume continued to be a large share of the total in 2019. For example, the HCPCS code for cataract removal with intraocular lens insertion (HCPCS 66984) had the highest volume in both 2014 and 2019, accounting for 18.9 percent of the total in 2014 and 18.5 percent in 2019. Moreover, 19 of the 20 most frequently provided HCPCS codes in 2014 were among the 20 most frequently provided in 2019 (Table 5-5). These services made up about 71 percent of ASC Medicare volume in 2014 and about 69 percent in 2019.

A potential concern about the services most frequently provided in ASCs is the extent to which they are unnecessary or low value, such as spinal injections and other pain management services (Pinto et al. 2012). We have found that 7 of the 20 procedures listed in Table 5-5 were pain management services. Moreover, the procedures with the second-highest revenue for ASCs in 2019 were

insertion or replacement of spinal neurostimulators. Volume for these procedures increased sharply from about 2,600 in 2014 to 12,000 in 2019 (data not shown).

Volume of outpatient surgical procedures has been increasing at similar percentages in ASCs and HOPDs

In 2019, volume per FFS beneficiary of surgical procedures covered under the ASC payment system increased by 2.7 percent in ASCs and by 3.0 percent in HOPDs. From 2014 through 2018, average annual growth in volume per FFS beneficiary of surgical services covered by the ASC payment system was 2.1 percent in ASCs compared with 1.9 percent in HOPDs.

Maintaining or expanding access to ASCs can be beneficial for patients and Medicare

Maintaining beneficiaries' access to ASCs has some benefits because services provided in this setting are less costly to Medicare and beneficiaries than services delivered in HOPDs.⁶ Medicare payment rates for surgical services performed in HOPDs are almost twice as high as in ASCs. For example, the payment rate in 2021 for cataract surgery with intraocular lens insertion (the service most frequently provided in ASCs) is \$2,079 in HOPDs compared with \$1,045 in ASCs. The lower payment rate in ASCs for this service has been financially beneficial to Medicare and beneficiaries. Other studies similarly find that ASCs are less costly than HOPDs in the Medicare and non-Medicare context and that price growth at ASCs has been slower than price growth at HOPDs (Carey 2015, Robinson et al. 2015).

**TABLE
5-5**

The 20 most frequently provided ASC services in 2019 were similar to those provided in 2014

Surgical service	2014		2019	
	Percent of volume	Rank	Percent of volume	Rank
Cataract surgery w/ IOL insert, 1 stage	18.9%	1	18.5%	1
Upper GI endoscopy, biopsy	8.5	2	7.8	2
Colonoscopy and biopsy	6.7	3	6.8	3
Lesion removal colonoscopy (snare technique)	5.4	4	6.5	4
After cataract laser surgery	4.5	5	4.1	6
Inject foramen epidural: lumbar, sacral	4.5	6	4.6	5
Injection spine: lumbar, sacral (caudal)	3.4	7	2.5	8
Inject paravertebral: lumbar, sacral	2.8	8	3.4	7
Diagnostic colonoscopy	2.6	9	1.6	11
Colorectal screen, high-risk individual	2.1	10	2.1	9
Colorectal screen, not high-risk individual	2.0	11	1.5	12
Cataract surgery, complex	1.6	12	1.4	14
Injection procedure for sacroiliac joint, anesthetic	1.1	14	1.4	13
Upper GI endoscopy, diagnosis	1.1	14	0.9	19
Destroy lumbar/sacral facet joint	1.1	15	1.7	10
Inject spine, cervical or thoracic	1.0	16	1.0	17
Revision of upper eyelid	1.0	17	0.9	18
Cystoscopy	1.0	18	1.0	16
Inject paravertebral: cervical or thoracic	0.9	19	1.2	15
Lesion remove colonoscopy, hot biopsy forceps	0.9	20	0.4	34
Total	71.0		69.3	
Total volume for all ASC services	5,988,067		6,689,177	

Note: ASC (ambulatory surgical center), IOL (intraocular lens), GI (gastrointestinal). In both percentage columns, the numbers do not sum to the "Total" because of rounding.

Source: MedPAC analysis of physician/supplier standard analytic files from 2014 and 2019.

Medicare program spending and overall beneficiary cost sharing could be reduced if medical professionals provided more surgical services in ASCs than HOPDs or if Medicare reduced HOPD payment rates to the level of ASC payment rates. This issue is pertinent to the ASC sector because among even the most frequently provided services in ASCs, substantial volume is provided in HOPDs. For example, medical professionals performed 403,000 Medicare-covered cataract surgeries with intraocular lens insertion in HOPDs in 2019, which was 25 percent of the total volume for this service.

However, most ASCs have some degree of physician ownership, and as owners of a business, these physicians have an incentive to perform more surgical services than if they provided outpatient surgery only in HOPDs they do not own. It is not clear whether the physician owners of ASCs act on this incentive. The most recent studies on the effect of ASC physician ownership are somewhat dated, but these studies offer limited evidence that physicians who have an ownership stake in an ASC perform a higher volume of certain procedures than physicians who do not

**TABLE
5-6**

Quality measures used in the Medicare ASC Quality Reporting Program

Description of quality measure	Required in:	
	2020	2024
ASC-1: Patient burn	Yes ^a	No
ASC-2: Patient fall	Yes ^a	No
ASC-3: Wrong site, wrong side, wrong patient, wrong procedure, wrong implant	Yes ^a	No
ASC-4: Hospital transfer/admission	Yes ^a	No
ASC-9: Endoscopy/polyp surveillance: Appropriate follow-up interval for normal colonoscopy in average-risk patients	Yes	Yes
ASC-10: Endoscopy/polyp surveillance: Colonoscopy interval for patients with a history of adenomatous polyps—avoid inappropriate use	Yes ^b	No
ASC-11: Cataracts: Improvement in patient’s visual function within 90 days following cataract surgery	Voluntary	Voluntary
ASC-12: Facility seven-day risk standardized hospital visit rate after outpatient colonoscopy	Yes	Yes
ASC-13: Normothermia outcome: Percentage of patients under anesthesia who are normothermic within 15 minutes of arrival in the post-anesthesia care unit	Yes	Yes
ASC-14: Unplanned anterior vitrectomy: Percentage of cataract surgery patients who have an unplanned removal of the vitreous	Yes	Yes
ASC-15: Five patient experience measures from the Outpatient and Ambulatory Surgery Survey Consumer Assessment of Healthcare Providers and Systems (CAHPS®):		
ASC-15a: About facilities and staff		
ASC-15b: Communication about procedure		
ASC-15c: Preparation for discharge and recovery		
ASC-15d: Overall rating of facility		
ASC-15e: Recommendation of facility	No ^c	No
ASC-17: Hospital visits after orthopedic ASC procedures	No ^d	Yes
ASC-18: Hospital visits after urology ASC procedures	No ^d	Yes
ASC-19: Hospital visits after general surgery ASC procedures	No ^e	Yes

Note: ASC (ambulatory surgical center).
^aRetained in the ASC Quality Reporting (ASCQR) Program, but data collection was suspended by CMS starting in 2019.
^bDiscontinued by CMS from the ASCQR Program beginning in 2021.
^cCMS has delayed the implementation of this measure indefinitely.
^dCMS will activate this measure in 2022.
^eCMS will activate this measure in 2024.

Source: Final rule for outpatient prospective payment system and ambulatory surgical center payment system, 2020.

(Hollingsworth et al. 2010, Mitchell 2010, Strobe et al. 2009).

Other studies suggest that the presence of an ASC in a market is associated with a higher volume of outpatient surgical procedures (Hollenbeck et al. 2015, Hollenbeck et al. 2014, Hollingsworth et al. 2011, Koenig and Gu 2013). Although none of these studies assessed the

appropriateness of the additional procedures, they suggest that the presence of ASCs might increase overall surgical volume. It is plausible, based on the results of these studies, that reductions in Medicare spending due to lower payment rates for ASCs relative to HOPDs could be partially offset by a higher overall number of surgical procedures.

Research suggests that physician ownership has also increased use in health care sectors other than ASCs. Studies found that physician ownership of advanced imaging equipment has resulted in higher use of that equipment relative to physician nonowners (Hughes et al. 2010, Shreibati and Baker 2011). However, another study refuted those results, finding that physician ownership of advanced imaging equipment had no effect on use of that equipment (Ohsfeldt et al. 2015). A study of physician-owned cardiac hospitals suggests that markets with such hospitals had slightly higher growth rates in profitable cardiac surgeries relative to markets that did not have one of those hospitals (Stensland and Winter 2006).

Another setting that has a substantial overlap of services with ASCs is physician offices. In general, Medicare payment rates are higher in ASCs than in physician offices for the same procedure. Services that are frequently provided in both ASCs and physician offices include cystoscopy, pain management, and, to a lesser extent, cataract procedures. Cystoscopy is performed much more frequently in offices than in ASCs, pain management is about equally common in these two settings, and cataract procedures are done more frequently in ASCs than in offices.

Quality of care: Improvement in performance on ASC quality measures appears to have plateaued

ASC-reported quality data demonstrated modest improvement from 2013 to 2017 and largely plateaued from 2017 to 2018. CMS established the ASC Quality Reporting (ASCQR) Program in 2012 (Centers for Medicare & Medicaid Services 2011). Under this system, ASCs that do not successfully submit quality measurement data have their payment update for that year reduced by 2 percentage points. Actual performance on these quality measures does not affect an ASC's payments; CMS requires ASCs only to submit the data to receive a full update. The Commission has recommended a value-based purchasing program for ASCs that would reward high-performing providers and penalize low-performing providers (see text box, p. 152).

The quality measures for which ASCs submit data continue to evolve. In the last two years, CMS made several revisions to the initial ASCQR measure set, which resulted in CMS measuring ASC quality based on nine measures (plus one voluntary measure) for 2020 and seven

measures (plus one voluntary measure) for 2024 (Table 5-6). In recent years, CMS has chosen to discontinue or delay several measures that were considered “topped out” (meaning full or nearly full compliance with these measures has been reached), demonstrated less utility, or were not ready for use, including the discontinuation of the current adverse event measures (ASC–1 through ASC–4) and the delay of measures of patient experience.⁷ For 2022, CMS will implement two new claims-based measures of beneficiaries' visits to a hospital subsequent to an ASC orthopedic or urology procedure (ASC–17 and ASC–18, respectively). For 2024, CMS will implement a new claims-based measure of beneficiaries' visits to a hospital subsequent to general surgery procedures (ASC–19).

Results from reported ASC quality data

Data reported by ASCs for 2013 to 2018 suggest improvement in ASC quality of care from 2013 to 2017, but mixed results from 2017 to 2018 (Table 5-7, p. 150). For ASC–1 through ASC–4, it was difficult to precisely determine how ASC performance changed from 2017 to 2018 because it was not clear where to set the cutoff for outlier values to exclude from our analysis. We chose to exclude observations higher than 30 percent. Among the eight quality measures for which CMS made data available for both 2017 and 2018, performance improved slightly on two measures, stayed about the same on three measures, and declined slightly on three measures. For the four adverse event measures, the data show consistently low levels of these events in each of the five years. Also, the share of ASCs reporting zero adverse events increased for three of these measures and stayed at the same level for one of these measures. For example, from 2013 to 2018, the share of ASCs without any patient burns increased from 88 percent to 93 percent, and the share of ASCs without any patient falls increased from 91 percent to 94 percent (data not shown). However, from 2017 to 2018, the average share of patients experiencing falls increased slightly from 0.08 percent to 0.09 percent.

In addition to the adverse events measures, other ASCQR measures demonstrated improvement. For example, from 2014 to 2018, measures of the surveillance and follow-up of patients treated for certain gastroenterology procedures and the hospitalization rate within seven days of colonoscopy improved and had generally high levels of performance. However, performance on two of these

**TABLE
5-7**

ASC quality measure levels, 2013-2018

ASC quality measure	Mean percent among ASCs					
	2013	2014	2015	2016	2017	2018
ASC-1: Share of patients suffering burns	0.36%	0.25%	0.18%	0.18%	0.18%	0.17%
ASC-2: Share of patients suffering falls	0.15	0.10	0.11	0.08	0.08	0.09
ASC-3: Share of patients suffering a "wrong" event	0.03	0.03	0.03	0.02	0.02	0.02
ASC-4: Share of patients transferred to a hospital	0.51	0.45	0.39	0.36	0.35	0.33
ASC-9: Share of average risk patients with appropriate endoscopy/polyp surveillance		76	80	81	83	83
ASC-10: Share of patients with polyp history with appropriate endoscopy/polyp surveillance		79	79	80	81	80
ASC-11: Share of patients with vision improvement 90 days after cataract surgery			96	96	96	94
ASC-12: 7-day risk standardized hospital visit rate after outpatient colonoscopy*				1.3	1.2	1.2

Note: ASC (ambulatory surgical center). For measures ASC-1, ASC-2, ASC-3, and ASC-4, we removed from this analysis ASCs that reported that more than 30 percent of patients had one of these events.
*CMS reports this measure as the rate per 1,000 colonoscopies, but we report this measure as a percentage (the rate per 100 colonoscopies).

Source: Medicare Hospital Compare data for ASCs, 2013-2018.

measures declined slightly from 2017 to 2018, share of patients with polyp history with appropriate endoscopy/polyp surveillance (ASC-10) and share of patients with vision improvement 90 days after cataract surgery (ASC-11). Finally, room for improvement exists for measures ASC-9, ASC-10, ASC-11, and ASC-12.

We also compared the performance of ASCs with the performance of HOPDs in 2018 on the four measures from the ASCQR (ASC-9, ASC-10, ASC-11, and ASC-12) that match with measures in the Hospital Outpatient Quality Reporting (OQR) Program (OP-29, OP-30, OP-31, and OP-32) (the data from the OQR are not shown). The data indicate that ASCs performed better, on average, on one measure: 7-day risk standardized hospital visit rate after outpatient colonoscopy (1.2 percent in ASCs and 1.6 percent in HOPDs). Conversely, HOPDs performed better than ASCs on three measures: share of average risk patients with appropriate endoscopy/polyp surveillance

(89 percent vs. 83 percent in ASCs); share of patients with polyp history with appropriate endoscopy/polyp surveillance (92 percent vs. 80 percent in ASCs); and share of patients with vision improvement 90 days after cataract surgery (98 percent vs. 94 percent in ASCs).

CMS should continue to refine ASC quality measures

The Commission asserts CMS should continue to improve the ASCQR by moving toward more CMS-calculated claims-based outcome measures that apply to all ASCs. In addition, CMS should synchronize ASCQR measures with measures included in the Hospital OQR Program to facilitate comparisons between ASCs and HOPDs. The Commission commends CMS on its decisions to discontinue a measure in 2021 (ASC-10: Endoscopy/polyp surveillance, colonoscopy interval for patients with a history of adenomatous polyps) because cost of collection

exceeds the benefit and to add the three claims-based unplanned hospitalization measures by 2024. However, the Commission maintains concern about three issues related to the ASCQR:

- The four ASCQR measures that are claims based and measure clinical outcomes (ASC–12, ASC–17, ASC–18, and ASC–19) exclude many services provided at ASCs, such as eye procedures and pain management. Therefore, CMS could improve the ASCQR Program by including more claims-based measures that assess clinical outcomes that apply to the various specialties practiced at ASCs. CMS has made an improvement on this issue by adding a measure for payment determination in 2024, ASC–19: facility-level hospital visits within 7 days after general surgery procedures performed at ambulatory surgical centers. The general surgery procedures included in this measure are abdominal, alimentary tract, skin/soft tissue, wound, and varicose vein stripping. We applaud CMS’s decision to add this measure to the ASCQR. However, the procedures included in this measure accounted for just 3.3 percent of ASC surgical procedures provided to FFS Medicare patients in 2019, so CMS may need to add more measures to further address this issue.
- CMS’s delay of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS®) patient experience survey quality data excludes an important part of assessing quality of care.⁸ Among the Commission’s quality measurement principles is that quality programs include patient experience measures (Medicare Payment Advisory Commission 2018b). CAHPS is the only survey in the ASCQR Program that asks patients about their experience.
- ASCQR measures should be further synchronized with OQR measures to facilitate comparison across ASCs and HOPDs. For 2021, the ASCQR and the OQR possess four common quality measures that pertain to cataract procedures, colonoscopy procedures, and patient assessments. CMS should consider further expanding the overlap of the ASCQR and OQR, relying on either measures of general surgical procedures or measures of specific surgical procedures common to both settings. For example, CMS could consider implementing OQR measure OP–36 (the number of hospital visits after any outpatient surgery) within the ASCQR,

or implementing ASCQR measures ASC–17 and ASC–18 (the number of hospital visits following orthopedic and urology procedures, respectively) within the OQR. In addition, the previously mentioned delay in implementing the CAHPS patient experience measures affects both the ASCQR and OQR and impedes the comparison of ASCs and HOPDs.

CMS should develop other quality measures

Because of the concerns cited above and the potential value of clinical outcome measures that apply to all ASCs, we believe CMS could consider developing new ASC quality measures covering any or all three following areas:

- ***The share of Medicare beneficiaries discharged from ASCs who have subsequent unplanned hospital visits.*** CMS has already begun to implement these measures for certain specialties through ASC–12, ASC–17, ASC–18, and ASC–19, but CMS has not developed these measures for some specialty areas or individual procedures that are common to ASCs, such as pain management.
- ***Surgical site infections (SSIs) occurring at ASCs for the ASCQR Program.*** Researchers have found that lapses in infection control were common among a sample of ASCs in three states (Schaefer et al. 2010). The Hospital Inpatient Quality Reporting Program includes an SSI measure that applies primarily to inpatient procedures. Although CMS has considered an SSI measure for ASCs in the past (Centers for Medicare & Medicaid Services 2011), it is not currently working to develop one (Centers for Medicare & Medicaid Services 2016). In general, an SSI measure could be used to track infection rates for ASCs and identify quality improvement opportunities for ambulatory surgeries conducted in HOPDs and ASCs. In addition, measuring SSI rates could encourage providers to collaborate and better coordinate care for ambulatory surgery patients.
- ***Specialty-specific clinical guidelines to assess the appropriateness of specific services provided in ASCs.*** While the ASCQR currently includes two ASC-reported colonoscopy measures that assess appropriate follow-up care, CMS could consider claims-based measures that assess appropriateness. For example, current American Cancer Society guidelines state that patients over the age of 85 should no longer

Creating a value-based purchasing program for ambulatory surgical centers

In 2012, the Commission recommended that the Congress authorize and CMS implement a value-based purchasing (VBP) program for ambulatory surgical centers (ASCs). We restate the recommendation:

The Congress should direct the Secretary to implement a value-based purchasing program for ambulatory surgical center services no later than 2016.

A VBP would reward high-performing providers and penalize low-performing providers (Medicare Payment Advisory Commission 2012).⁹

CMS established a quality reporting program for ASCs in 2012. However, Medicare payments to ASCs are not adjusted based on how they perform on quality measures, only on whether they report the measures. The Commission believes that high-performing ASCs should be rewarded and low-performing facilities should be penalized through the payment system.

Consistent with the Commission’s overall position on Medicare quality measurement, an ASC VBP program should incorporate measures that are patient-oriented, encourage coordination across providers and time, and promote change in the delivery system. The ASC VBP should include outcomes, patient experience, and value measures (a value measure would address services that

are costly but of low value). Also, quality measurement should not be burdensome for providers. ASCs can choose to use more granular measures to manage their own quality improvement.

An ASC VBP should give rewards based on clear, absolute, and prospectively set performance targets (as opposed to “tournament models,” which require that some providers gain while others lose). The Medicare program should account for differences in a provider’s population, including social risk factors. Because adjusting results for social risk factors can mask disparities in clinical performance, Medicare should account for social risk factors by directly adjusting payment through peer grouping, under which benchmarks for achievement are group specific, and each provider is compared with its peers (defined as providers whose patient populations are similar in terms of their social risk factors). In addition, funding for VBP incentive payments should come from existing Medicare spending for ASC services. Initially, funding for the incentive payments should be set at 1 percent to 2 percent of aggregate ASC payments. The size of this pool should be expanded gradually as more measures are developed and ASCs become more familiar with the program. (The Commission’s March 2016 report to the Congress provides more detail about our recommendation to CMS about an ASC VBP program (Medicare Payment Advisory Commission 2016)). ■

receive colorectal cancer screening (American Cancer Society 2018). Using these guidelines, a new measure could identify ASCs’ share of colonoscopy cases for beneficiaries over age 85. CMS could consider similar appropriateness measures for certain procedures that have become more common in ASCs in recent years or for which concerns about appropriate use have been suggested, such as spinal injections or certain orthopedic procedures.

ASCs’ access to capital: Growth in number of ASCs suggests adequate access

Owners of ASCs require capital to establish new facilities and upgrade existing ones. The change in the number of ASCs is the best available indicator of ASCs’ ability to obtain capital. The number of ASCs increased in 2019 by 2.5 percent, faster than in previous years (Table 5-1, p. 142). However, Medicare accounts for a small share—perhaps 20 percent—of ASCs’ overall revenue, so factors other than Medicare payments could have a larger

**TABLE
5-8**

Medicare payments to ASCs grew, 2014-2019

Average annual change

	2014	2018	2019	2014-2018	2018-2019
Medicare payments (in billions of dollars)	\$3.7	\$4.9	\$5.2	6.1%	7.3%
Medicare payments per FFS beneficiary	\$116	\$145	\$157	5.8	8.3

Note: ASC (ambulatory surgical center), FFS (fee-for-service). "Medicare payments" includes program spending and beneficiary cost sharing for ASC facility services. Payments include spending for new-technology intraocular lenses.

Source: MedPAC analysis of data from the Office of the Actuary at CMS and data from physician/supplier standard analytic files.

effect on access to capital for this sector (Medical Group Management Association 2009).

From 2015 through 2017, hospital systems, private equity firms, and insurers were involved in vertical integration efforts that included acquisitions of and investments in businesses that own and operate ASCs. More recently, these acquisitions and investments have slowed. Indeed, no large-scale transactions occurred in the ASC industry in 2019. However, the ASC industry continued to consolidate in 2019, largely through small horizontal transactions such as Gastro Health LLC acquiring Puget Sound Gastroenterology on September 23, 2019. Gastro Health made two other acquisitions in 2019 (Park 2020).

Large health care management companies also continued to acquire ASCs in 2019. The six largest of these organizations (United Surgical Partners International, AmSurg, Surgical Care Affiliates, SurgCenter Development, HCA, and Surgery Partners Holding) increased the number of ASCs they held from 1,092 to 1,152—a 5.5 percent increase (Park 2020). Smaller organizations are also involved in increasing the number of ASCs, such as the University Hospitals in Cleveland partnering with ValueHealth (a digital health company) to develop an ASC network (Dyrda 2020).

Finally, data from the annual analysis of Pennsylvania's ASCs, conducted by the Pennsylvania Health Care Cost Containment Council (PHC4), indicate that ASCs are very profitable. PHC4 found that ASCs in Pennsylvania had an average total margin (an all-payer margin that includes Medicare) of 25 percent in 2019 (Pennsylvania Health Care Cost Containment Council 2020).¹⁰

Although the various entities noted above appear to have adequate access to capital, we caution that these companies have ownership in less than 20 percent of the more than 5,800 ASCs. Consequently, the experience of these entities collectively may not reflect that of the entire ASC sector.

During the coronavirus PHE, acquisition of ASCs has continued. In December 2020, Tenet Healthcare announced that it will acquire up to 45 ASCs from SurgCenter Development for \$1.1 billion (Oliver 2020).

Medicare payments: Payments have steadily increased

In 2019, ASCs received \$5.2 billion in Medicare payments and beneficiaries' cost sharing (Table 5-8). We estimate that spending by the Medicare program was \$4.2 billion and beneficiary cost sharing was \$1.0 billion (data not shown).

Spending per FFS beneficiary increased by an average annual rate of 5.8 percent from 2014 through 2018 and by 8.3 percent in 2019 (Table 5-8). The increase in 2019 reflects a 2.1 percent increase in the ASC conversion factor, a 2.7 percent increase in per capita volume, a 2.3 percent increase in the average relative weight of ASC services, and a 1.2 percent effect from an increase in spending from 2018 to 2019 on separately paid drugs provided to Medicare beneficiaries treated in ASCs.

The effects of the coronavirus PHE on Medicare revenue in ASCs are not reflected in this analysis. The pandemic undoubtedly reduced ASCs' Medicare revenue in 2020, but how much is uncertain. Our limited information

suggests that ASC volume and revenue substantially declined in March and April of 2020, rebounded strongly in May and June of 2020, but were still below prepandemic levels. We do not yet have data that provide a reasonable estimate of the effect of the PHE on ASC volume and revenue after June 2020, but we intend to determine the effects when data become available.

How should Medicare payments change in 2022?

Our analysis indicates that the number of ASCs has increased, beneficiaries' use of ASCs has increased, and access to capital has been adequate. Measures of ASC quality indicate that quality had been improving, but that improvement may have plateaued. Also, we have identified areas for improvement in ASC quality measurement. Our information for assessing payment adequacy, however, is limited because Medicare does not require ASCs to submit cost data, unlike other types of facilities. Since 2010, the Commission has recommended that the Congress require ASCs to submit cost data (Medicare Payment Advisory Commission 2010).

Cost data would enable the Commission to examine the growth of ASCs' costs over time and analyze Medicare payments relative to the costs of efficient providers, which would help inform our decisions about the ASC update. Cost data also are needed to examine whether an alternative input price index would be an appropriate proxy for ASC costs. As discussed in the text box about revisiting the ASC market basket index, the Commission has previously expressed concern that the price index CMS used to update the ASC conversion factor from 2010 through 2018 (the CPI-U) likely does not reflect ASCs' cost structure (Medicare Payment Advisory Commission 2010). Also, the price index that CMS is using to update the ASC conversion factor from 2019 through 2023—the hospital market basket—does not reflect ASCs' cost structure.

CMS has concluded that it needs data on ASC input costs, but to date has not required ASCs to submit cost data (Centers for Medicare & Medicaid Services 2012). CMS has requested public comment on whether the agency should collect cost data from ASCs for use in determining ASC payment rates. ASC representatives commented that they oppose a requirement for ASCs to submit formal cost

reports but expressed willingness to complete surveys if doing so is not administratively burdensome (Centers for Medicare & Medicaid Services 2017).

We contend it is feasible for ASCs to provide cost information. All other facility providers submit cost data to CMS. Indeed, ASCs in Pennsylvania submit cost and revenue data annually to a state agency that uses the data to estimate margins for those ASCs (Pennsylvania Health Care Cost Containment Council 2020). We recognize that ASCs are generally small facilities that may have limited resources for collecting cost data. However, such businesses typically keep records of their costs for filing taxes and other purposes, and other facility providers that are typically small, such as home health agencies and hospices, furnish cost data to CMS.

To minimize the burden on CMS and ASCs, CMS should create a streamlined process for ASCs to track and submit a limited amount of cost data. CMS has conducted surveys of random samples of ASCs (1986 and 1994), and we believe CMS could do these surveys annually, with mandatory response. CMS could also streamline ASC cost reporting by annually collecting a set of cost variables from all ASCs that is more limited than what is collected through formal cost reports, which would require less time for ASCs to complete. Alternatively, CMS could require ASCs to submit cost data from their existing cost accounting systems, provided the definitions of their reported cost variables are consistent with CMS's definitions. The Commission does not believe that a streamlined process for collecting cost data would place a large burden on ASCs. After all, individual taxpayers complete and submit lengthy income tax forms. Therefore, the Commission sees no reason why ASCs cannot submit at least minimal cost data.

For the Commission to determine the relationship between Medicare payments and the costs of efficient ASCs, ASCs would optimally submit the following information:

- total costs for the facility;
- Medicare unallowable costs, such as entertainment, promotion, and bad debt;
- the costs of clinical staff who bill Medicare separately, such as anesthesiologists and clinical nurse anesthetists (these costs would be excluded from the facility's costs because these clinicians are paid separately under Medicare);

Revisiting the ASC market basket index

From 2010 through 2018, CMS used the consumer price index for all urban consumers (CPI-U) as the market basket to update the conversion factor in the ambulatory surgical center (ASC) payment system. Because of our concern that the CPI-U likely does not reflect ASCs' cost structure, the Commission examined in 2010 whether an alternative market basket index would better measure changes in ASCs' input costs (Medicare Payment Advisory Commission 2010). Using data from a Government Accountability Office (GAO) survey of ASC costs in 2004, we compared the distribution of ASC costs with the distribution of hospital and physician practice costs. We found that ASCs' cost structure is different from that of hospitals and physician offices. ASCs have a much higher share of expenses for medical supplies and drugs than the other two settings, a much smaller share of employee compensation costs than hospitals, and a smaller share of all other costs (such as rent and capital costs) than physician offices. For more detail about our methods and findings, see Chapter 2C of our March 2010 report to the Congress (Medicare Payment Advisory Commission 2010).

Since our 2010 analysis, CMS has considered whether the hospital market basket (MB) or the practice expense component of the Medicare Economic Index (MEI) is a better proxy for ASC costs than the CPI-U (Centers for Medicare & Medicaid Services 2012). Both the hospital MB and the MEI reflect a different mix of inputs and, therefore, a different mix of costs from what is typical in ASCs. Most recently, CMS has decided

to use the hospital MB as the basis for updating ASC payment rates from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). However, because of differences between the ASC and hospital cost structures, we find that the hospital MB is not an appropriate market basket for ASCs.

The ASC cost data from GAO used in our comparative analysis are 17 years old and do not contain information on several types of costs. Therefore, the Commission has recommended many times that the Congress require ASCs to submit new cost data to CMS (Medicare Payment Advisory Commission 2020, Medicare Payment Advisory Commission 2019, Medicare Payment Advisory Commission 2018c, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014, Medicare Payment Advisory Commission 2013b, Medicare Payment Advisory Commission 2012, Medicare Payment Advisory Commission 2011b, Medicare Payment Advisory Commission 2010). In each of the last eight years, the Commission recommended eliminating the update to the ASC conversion factor, meaning the ASC conversion factor would not change from the previous year. CMS should use cost data to examine whether an existing Medicare price index is an appropriate proxy for ASC costs or an ASC-specific market basket should be developed. A new ASC MB could include the same types of costs that appear in the hospital MB or MEI but with different cost weights that reflect ASCs' unique cost structure. ■

- total charges across all payers and charges for Medicare patients (CMS could allocate total facility costs to Medicare based on Medicare's proportion of total charges); and
- total Medicare payments.

In addition, CMS would need to collect data on specific cost categories to determine an appropriate input price index for ASCs. For example, CMS would need

data on the share of ASCs' costs related to employee compensation, medical supplies, medical equipment, building expenses, and other professional expenses (such as legal, accounting, and billing services). CMS could use this information to examine ASCs' cost structure and determine whether an existing Medicare price index is an appropriate proxy for ASC costs or whether an ASC-specific market basket should be developed.

CMS used the CPI-U to update the ASC conversion factor from 2010 through 2018. However, CMS has indicated that the CPI-U does not reflect ASCs' input costs. CMS made a significant regulatory change and decided to use the hospital market basket (MB) as the basis for updating the ASC conversion factor for a five-year period—2019 through 2023. CMS used the hospital MB to increase the ASC conversion factor by 2.1 percent in 2019 and by 2.6 percent in 2020. For 2021, the update to the ASC conversion factor is 2.4 percent, which is based on a projected percent increase in the hospital MB minus a 0.0 percent reduction for multifactor productivity growth, as mandated by the Affordable Care Act. CMS based its decision to use the hospital MB in place of the CPI-U on concerns that the differences in payment rates between the ASC payment system and the OPSS have caused a shift of care from ASCs to HOPDs. CMS believes that using the same update mechanism for both ASCs and HOPDs could “encourage the migration of services from the hospital setting to the ASC setting and increase the presence of ASCs in health care markets or geographic areas where previously there were none or few, thus promoting better beneficiary access to care” (Centers for Medicare & Medicaid Services 2018). However, the growth in surgical volume per FFS beneficiary was higher in ASCs than in HOPDs in both 2017 and 2018, which suggests that services may have been shifting from HOPDs to ASCs without use of the hospital MB to update payments. Also, the growth in surgical volume was similar in ASCs and HOPDs in 2019, the first year that CMS used the hospital MB to update ASC payment rates. The increase in the rate of growth in ASCs relative to HOPDs may have been due to the provision in Section 603 of the Bipartisan Budget Act of 2015, which largely requires that ASCs acquired by hospitals will be paid at the relatively low payment rates in the PFS if the hospitals convert them to off-campus outpatient departments, while they would continue to be paid at the ASC rates if the hospitals keep them as ASCs.

During the five-year period of using the hospital MB, CMS states that it will:

- Assess whether there is a migration of services from hospitals to ASCs.
- Assess the possibility of working with stakeholders to collect cost data from ASCs in a minimally burdensome manner and possibly propose a plan to collect cost data (Centers for Medicare & Medicaid Services 2018).

Beginning with the Commission's March 2010 report to the Congress, the Commission has stated for several years in comment letters and in published reports that the CPI-U does not likely reflect the current input costs of ASCs (Medicare Payment Advisory Commission 2010). However, the Commission does not support using the hospital MB index as an interim method for updating the ASC conversion factor because this index also does not accurately reflect ASCs' costs (Medicare Payment Advisory Commission 2018a). CMS acknowledges that the ASC and hospital cost structures are not identical because ASCs tend to be single specialty and for profit and are not required to comply with the Emergency Medical Treatment and Labor Act. The Commission concurs with these observations and adds that, relative to hospitals, ASCs are more urban, serve a different mix of patients, have a much higher share of expenses related to medical supplies and drugs, and have a smaller share of employee compensation costs.

The Commission asserts that CMS should forgo the five-year period to assess the feasibility of ASC cost reporting and instead use its authority and resources to act quickly in gathering ASC cost data. ASCs are profitable organizations, and the number of ASCs and the volume of services continue to grow. Therefore, we believe it is unnecessary for CMS to spend five years assessing the feasibility of collecting cost data from ASCs.

Recommendation

In evaluating a need for an update to the ASC conversion factor for 2022, the Commission balanced the following objectives:

- maintain beneficiaries' access to ASC services;
- pay providers adequately;
- maintain the sustainability of the Medicare program by appropriately restraining spending on ASC services;
- keep providers under financial pressure to constrain costs; and
- require ASCs to submit cost data.

In balancing these goals, the Commission concludes that the ASC update for 2022 should be eliminated and that the Secretary should collect cost data from ASCs.

RECOMMENDATION 5-1

For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare conversion factor for ambulatory surgical centers.

RECOMMENDATION 5-2

The Secretary should require ambulatory surgical centers to report cost data.

RATIONALE 5-1 AND 5-2

On the basis of our payment adequacy indicators, combined with the importance of maintaining financial pressure on providers to constrain costs, we believe that the ASC conversion factor should not be increased for 2022. That is, the 2022 conversion factor in the ASC payment system should be the same as the conversion factor in 2021. Though we do not have cost data, and we have reservations about the measures used within the ASCQR, the indicators of payment adequacy for which we have information are positive: The volume of ASC services per beneficiary increased in 2019, the complexity of ASC services provided increased, and the number of ASCs increased. Also, ASCs appear to have adequate access to capital, ASC quality of care data have trended positive, and Medicare payments to ASCs have continued to grow.

The Commission has persistently recommended that the Secretary collect cost data from ASCs. Cost data would enable CMS and the Commission to examine the growth of ASCs' costs over time and evaluate Medicare payments relative to the costs of an efficient provider, which would help inform decisions about the ASC payment update. Cost data are also needed to evaluate whether an alternative input price index would be an appropriate proxy for ASC costs.

We see no reason why ASCs should not be able to submit cost data. CMS collects cost data from all other institutional providers participating in the Medicare program. To date, the ASC industry has asserted that ASCs are small operations that lack the capacity and accounting expertise to enable them to complete cost reports.

However, some of the sectors from which CMS collects cost data are predominantly small providers. Therefore, any ASC should be able to compile and submit a minimum set of cost data. Also, while the majority of ASCs consists of freestanding facilities, hospital corporations and other large health care entities have acquired more ASCs and have the capacity and expertise to complete cost reports. CMS could limit the scope of the cost reporting system to minimize administrative burden on ASCs and the program. In addition, to implement this change, CMS should make cost reporting a condition of ASC participation in the Medicare program.

IMPLICATIONS 5-1 AND 5-2

Spending

- The Secretary has the authority to update the ASC conversion factor and has decided to use the hospital MB index as the basis for updating the conversion factor from 2019 through 2023 (Centers for Medicare & Medicaid Services 2018). The ACA requires that the update factor be reduced by a multifactor productivity measure. The currently projected hospital MB index increase for 2022 is 2.7 percent, and the forecast of productivity growth for 2022 is 0.3 percent, resulting in a projected update of 2.4 percent to the conversion factor for 2022. Relative to current Medicare law, our recommendation would decrease federal spending by between \$50 million to \$250 million in the first year and by less than \$1 billion over five years.

Beneficiary and provider

- Because of the growth in the number of ASCs and the increase in ASCs' revenue from Medicare, we do not anticipate that these recommendations will diminish beneficiaries' access to ASC services or providers' willingness or ability to provide those services.
- ASCs may incur some minimal administrative costs to track and submit cost data, but we believe cost accounting is standard practice in the ASC industry, and ASCs should be able to draw cost data from that source. ■

Endnotes

- 1 CMS determines the payment rates in the ASC system independently from the payment rates in the PFS. Therefore, it is possible for an office-based procedure to have its payment rate based on the standard method in one year and on the PFS nonfacility rate the next year, or vice versa.
- 2 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of the coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 3 State certificate-of-need (CON) laws appear to affect the number of ASCs in a state. Twenty-five states and the District of Columbia have CON laws for ASCs. Nine of the 10 states with the fewest ASCs per capita have CON laws for ASCs, while only 5 of the 10 states that have the most ASCs per capita have CON laws. Among these five states, Georgia has an exception in its CON requirements that makes it easier to establish new ASCs, and the large number of ASCs in Maryland relative to other states is likely a response to a Medicare waiver under which Maryland hospitals operate under global budgets. Under this system, hospital budgets are capped, and they receive no additional revenue if they exceed their budgets. However, medical care received in ASCs falls outside the budgets, so there is an incentive for hospitals to shift outpatient surgical care to ASCs.
- 4 We define *single-specialty* ASCs as those with more than 67 percent of their Medicare claims in one clinical specialty. We define *multispecialty* ASCs as those with less than 67 percent of their Medicare claims in one clinical specialty.
- 5 By statute, coinsurance for a service paid under the OPPS cannot exceed the hospital inpatient deductible (\$1,484 in 2021). The ASC payment system does not have the same limitation on coinsurance; for a small percentage of HCPCS codes covered under the ASC payment system, the ASC coinsurance exceeds the inpatient deductible. In these instances, the ASC coinsurance exceeds the OPPS coinsurance.
- 6 Cost sharing is lower under the ASC payment system for 96.1 percent of HCPCS codes that are covered under the ASC payment system.
- 7 Rather than enact a full discontinuation of measures ASC–1 through ASC–4, CMS has decided to suspend data collection of these four measures. Suspension means that ASCs are no longer required to report data on these measures, but CMS will retain them in the ASCQR Program for possible future use. Patient experience will be assessed using the Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) survey measures but implementation of CAHPS measures has been delayed.
- 8 CAHPS is a registered trademark of the Agency for Healthcare Research and Quality, a U.S. government agency.
- 9 The Commission also described its principles for a VBP program for ASCs in a letter to the Congress that commented on the Secretary’s report to the Congress about a VBP program for ASCs (Medicare Payment Advisory Commission 2011a).
- 10 The margins for ASCs have important differences from the margins in other sectors such as hospitals. In particular, the cost data used to determine margins for most ASCs do not include compensation for physician owners or the taxes paid on that compensation.

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CHAPTER

6

Outpatient dialysis services

R E C O M M E N D A T I O N

- 6** For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare end-stage renal disease prospective payment system base rate.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Outpatient dialysis services

Chapter summary

Outpatient dialysis services are used to treat the majority of individuals with end-stage renal disease (ESRD). In 2019, nearly 395,000 beneficiaries with ESRD on dialysis were covered under traditional fee-for-service (FFS) Medicare and received dialysis from nearly 7,700 dialysis facilities. Since 2011, Medicare has paid for outpatient dialysis services based on a prospective payment system (PPS) bundle that includes certain dialysis drugs and ESRD-related clinical laboratory tests that were previously paid separately. In 2019, Medicare expenditures for outpatient dialysis services were \$12.9 billion. Ten percent of total spending in 2019 consisted of payments for two calcimimetics paid under the ESRD PPS's transitional drug add-on payment adjustment (TDAPA); this policy pays providers according to the number of units of a drug and the drug's average sales price.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators is from 2019. Where relevant, we have considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the PHE are temporary or vary significantly across outpatient dialysis facilities, they are best addressed through targeted temporary funding policies rather than a permanent change to all dialysis facilities' payment rates in 2022 and future years. Based on information

In this chapter

- Are Medicare payments adequate in 2021?
.....
- How should Medicare payments change in 2022?
.....

available at the time of publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to outpatient dialysis facility payments in 2022.

Assessment of payment adequacy

Our payment adequacy indicators for outpatient 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 beneficiaries' access to dialysis services has been adequate.

- ***Capacity and supply of providers***—Dialysis facilities appear to have the capacity to meet demand. Between 2018 and 2019, the number of dialysis treatment stations grew faster than the number of FFS dialysis beneficiaries (but kept pace with demand from all dialysis patients).
- ***Volume of services***—Between 2018 and 2019, growth in the number of FFS dialysis beneficiaries matched growth in the total number of treatments. At the same time, use of ESRD drugs in the bundle (including erythropoiesis-stimulating agents, which are used in anemia management) continued to decline, but at a slower rate than during the initial years of the ESRD PPS (2011 and 2012). The ESRD PPS created an incentive for providers to be more judicious about their provision of ESRD drugs that are included in the payment bundle.
- ***The marginal profit***—The 25 percent marginal profit in 2019 suggests that dialysis providers have a financial incentive to continue to serve Medicare beneficiaries.

Quality of care—Between 2014 and 2019, hospitalization, hospital readmission, and mortality rates remained steady, though the proportion of FFS dialysis beneficiaries using the emergency department slightly increased. Between 2014 and 2019, the share of beneficiaries using home dialysis, which is associated with better patient satisfaction, increased.

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

Medicare payments and providers' costs—Our analysis of Medicare payments and costs is based on 2018 and 2019 claims and cost report data submitted to CMS

by freestanding dialysis facilities, which provided 96 percent of all FFS dialysis treatments in both years. During this period, cost per treatment fell by 4 percent, while Medicare payment per treatment rose by 2 percent, and the aggregate Medicare margin increased from 2.1 percent to 8.4 percent. The increase in the aggregate Medicare margin is linked to the profitability of the TDAPA drugs, particularly generic oral calcimimetics that became available in 2019. We project the 2021 Medicare margin will drop to 4 percent, in part due to CMS including calcimimetics in the ESRD PPS bundled payment, which will promote provider efficiency.

How should Medicare payments change in 2022?

Under current law, the Medicare FFS base payment rate for dialysis services is projected to increase by 1.5 percent. Given that most of our indicators of payment adequacy are positive, the update recommendation is that for 2022, the Congress should eliminate the update to the 2021 ESRD PPS base rate. ■

Dialysis treatment choices

Dialysis replaces the filtering function of the kidneys when they fail. The two types (modalities) of dialysis—hemodialysis and peritoneal dialysis (PD)—remove waste products from the bloodstream differently. For each of these two dialysis types, patients may select various protocols.

Most dialysis patients travel to a treatment facility to undergo hemodialysis three times per week, although patients can also undergo hemodialysis at home. Hemodialysis uses an artificial membrane encased in a dialyzer to filter the patient’s blood. Because of recent clinical findings, there is increased interest in more frequent hemodialysis, administered five or more times per week while the patient sleeps, and short (two to three hours per treatment) daily dialysis administered during the day. Research also has increased interest in the use of “every-other-day” hemodialysis; reducing the two-day gap in thrice-weekly hemodialysis could be linked to improved outcomes.

PD, the most common form of home dialysis, uses the lining of the abdomen (peritoneum) as a filter to clear wastes and extra fluid and is usually performed independently in the patient’s home or workplace five

to seven days a week. During treatments, a cleansing fluid (dialysate) is infused into the patient’s abdomen through a catheter. This infusion process (an exchange) is done either manually (continuous ambulatory peritoneal dialysis) or using a machine (automated peritoneal dialysis).

Patients should be given the opportunity to make an informed choice about the type of dialysis they select. Each dialysis method has advantages and disadvantages; no one method is best for everyone. People choose a particular dialysis method for many reasons, including quality of life, patients’ awareness of different treatment methods and personal preferences, and physician training and recommendations. The use of home dialysis has grown since 2009, a trend that has continued under the end-stage renal disease prospective payment system. Some patients switch methods when their conditions or needs change. Although most patients still undergo in-center dialysis, home dialysis remains a viable option for many patients because of such advantages as increased patient satisfaction, better health-related quality of life, and fewer transportation challenges compared with in-center dialysis. ■

Background

End-stage renal disease (ESRD) is the last stage of chronic kidney disease (CKD) and is characterized by permanent, irreversible kidney failure. Patients with ESRD include those who are treated with dialysis—a process that removes wastes and fluid from the body—and those who have a functioning kidney transplant. Because of the limited number of kidneys available for transplantation and the variation in patients’ suitability for transplantation, about 70 percent of ESRD patients undergo maintenance dialysis (see text box on dialysis treatment choices). Patients receive additional items and services related to their dialysis treatments, including dialysis drugs and biologics to treat conditions such as anemia and bone disease resulting from the loss of kidney function.

The 1972 amendments to the Social Security Act extended Medicare benefits to people with ESRD, including those under age 65. For an individual with ESRD to qualify for Medicare, he or she must be fully or currently insured under the Social Security or Railroad Retirement program or be the spouse or dependent child of an eligible beneficiary.¹

In 2019, nearly 395,000 ESRD beneficiaries on dialysis were covered under fee-for-service (FFS) Medicare and received dialysis from nearly 7,700 dialysis facilities.^{2,3} Since 2011, Medicare has been paying facilities using a prospective payment system (PPS) bundle that includes dialysis drugs (for which facilities previously received separate payments) and services for which other Medicare providers (such as clinical laboratories) previously received separate payments.⁴ In 2019, Part B spending

**TABLE
6-1**

FFS dialysis beneficiaries are disproportionately younger, male, and Black compared with all Medicare FFS beneficiaries, 2019

Share of FFS:

	Dialysis beneficiaries	All other beneficiaries
Age		
Under 45 years	10%	3%
45–64 years	37	11
65–74 years	28	49
75–84 years	18	26
85+ years	6	12
Sex		
Male	56	47
Female	44	53
Race		
White	47	81
Black	35	9
Hispanic	8	2
Asian	4	2
All others	6	5
Residence, by type of county		
Urban	83	80
Micropolitan	10	11
Rural, adjacent to urban	5	5
Rural, not adjacent to urban	2	4
Frontier	1	1

Note: FFS (fee-for-service). “All other beneficiaries” excludes beneficiaries on dialysis and those who have received a kidney transplant. Beneficiary location reflects the beneficiary’s county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: Data compiled by MedPAC from enrollment data and claims submitted by dialysis facilities to CMS.

for Medicare-covered outpatient dialysis services was \$12.9 billion. This total includes payments of nearly \$1.3 billion for the two ESRD drugs classified as calcimimetics—Sensipar (oral cinacalcet) and Parsabiv (injectable etelcalcetide)—that qualified, beginning in 2018, for a transitional drug add-on payment adjustment (TDAPA) under the ESRD PPS. As of December 2020,

the calcimimetics’ add-on payment is the first and only TDAPA that CMS has implemented under the ESRD PPS. Additionally, in 2018 (the most recent data available), Part D payments for ESRD oral-only drugs that were not yet included in the PPS—multiple phosphate binders—totaled nearly \$1.2 billion.

In 2019, most of Medicare’s dialysis beneficiaries had FFS coverage. Historically, beneficiaries with ESRD were prohibited from enrolling in Medicare Advantage (MA) plans. However, beneficiaries enrolled in a managed care plan before receiving an ESRD diagnosis can remain in the plan after they are diagnosed. Over time, the share of all Medicare ESRD beneficiaries on dialysis under FFS has gradually declined, while the share of beneficiaries enrolled in MA plans has increased. For example, between 2014 and 2019, the share of MA beneficiaries on dialysis rose from about 17 percent to 24 percent and the share of FFS beneficiaries on dialysis fell from about 83 percent to 76 percent.

In 2000, the Commission recommended that the Congress lift the prohibition on ESRD beneficiaries enrolling in MA (Medicare Payment Advisory Commission 2000). The 21st Century Cures Act allows ESRD beneficiaries to enroll in MA beginning in 2021. In addition, dialysis beneficiaries residing in selected geographic areas have access to ESRD special needs plans (SNPs), a type of chronic condition SNP (C–SNP). As of October 2020, few dialysis beneficiaries—about 5,800—were enrolled in 10 ESRD SNPs operated by 7 managed care organizations in 6 states (Arizona, California, Connecticut, Nevada, New Jersey, and Texas). The Commission recommended that Medicare maintain C–SNPs for beneficiaries with ESRD, HIV/AIDS, or chronic and disabling mental health conditions (Medicare Payment Advisory Commission 2013).

Characteristics of fee-for-service dialysis beneficiaries, 2019

Compared with all other Medicare FFS beneficiaries, FFS dialysis beneficiaries are disproportionately younger, male, and Black (Table 6-1). In 2019, 75 percent of FFS dialysis beneficiaries were less than 75 years old, 56 percent were male, and 35 percent were Black. By comparison, of all FFS Medicare beneficiaries, 63 percent were less than 75 years old, 47 percent were male, and 9 percent were Black. A greater share of dialysis beneficiaries resided in urban areas compared with all FFS beneficiaries (83 percent vs. 80 percent).

To help pay for Part A and Part B cost sharing, some FFS beneficiaries have private or other public coverage that supplements the FFS benefit package. Compared with all FFS beneficiaries, FFS dialysis beneficiaries are:

- more likely to be dually eligible for Medicare and Medicaid (18 percent vs. 46 percent),
- less likely to have coverage from other sources such as Medigap and employer-sponsored health plans (58 percent vs. 30 percent), and
- as likely to have no supplemental coverage (about 24 percent for each group).

In addition, since 1997, the American Kidney Fund has maintained a Health Insurance Premium Program that helps pay dialysis patients' health insurance premiums, including Medicare Part B premiums.⁵

Over the last decade, the adjusted rate of new ESRD cases, or incidence rate (which includes patients of all types of health coverage who initiate dialysis or receive a kidney transplant), has declined. Between 2008 and 2018 (the most recent year of data available), the adjusted incidence rate decreased by 1 percent per year, from 417 per million people to 385 per million people, the lowest incidence rate since 1998 (United States Renal Data System 2020). We estimate that in 2019, nearly 84,000 FFS beneficiaries were new to dialysis, and about half (45 percent) were under age 65 and thus entitled to Medicare based on ESRD (with or without disability).⁶

The timing of starting dialysis is a matter of clinical judgment, guided by values of residual kidney function and the symptoms and comorbidities of affected patients. From the mid-1990s through 2010, the Commission's analysis of data (from CMS's ESRD Medical Evidence Report) suggests a trend toward initiating dialysis earlier in the course of CKD. The proportion of new dialysis patients (of all types of health coverage) with higher levels of residual kidney function steadily increased between 1996 and 2010, from 13 percent to nearly 44 percent. (An estimated glomerular filtration rate (eGFR)—a measure of residual kidney function—above 10 mL/min/1.73 m² is considered a higher level of residual kidney function. Lower values of this measure suggest comparatively less residual kidney function.)

While the share of patients initiating dialysis earlier in the course of CKD decreased modestly between 2011 and 2019 (from 43 percent to 40 percent), the share

remains three times higher than in 1996. Researchers have questioned this early initiation of dialysis in those with late-stage CKD, concluding that it is not associated with improved survival or clinical outcomes (Cooper et al. 2010, Evans et al. 2011, Kazmi et al. 2005, Stel et al. 2009, Traynor et al. 2002). Of the few randomized controlled trials (RCTs) on this topic, the most influential RCT found that survival is similar between patients for whom dialysis is initiated early (with an eGFR equal to 10.0 mL/min/1.73 m² to 14.0 mL/min/1.73 m²) and those for whom dialysis is electively delayed (with an eGFR equal to 5.0 mL/min/1.73 m² to 7.0 mL/min/1.73 m²) and concluded that dialysis can be delayed for some patients until the eGFR drops below 7.0 mL/min/1.73 m² or until more traditional clinical indicators for the initiation of dialysis are present (Cooper et al. 2010). Since publication of this RCT in 2010, the share of early dialysis initiation has begun to level off, but it has not yet returned to its earlier levels.

Better primary care management of the risk factors for CKD—particularly hypertension and diabetes, which together are the primary causes of roughly 7 of 10 new ESRD cases—can help prevent or delay the illness's onset. Payers and dialysis providers are testing interventions among CKD patients to improve their clinical outcomes (e.g., by reducing hospitalizations), prevent or slow kidney disease progression, and increase their preparedness for ESRD (e.g., by educating patients about treatment alternatives, including transplantation and home dialysis). The Center for Medicare & Medicaid Innovation (CMMI) has sponsored several voluntary and mandatory models to manage the care of individuals with late-stage CKD and with ESRD. Some dialysis providers have entered into agreements with commercial payers to provide care coordination to individuals with CKD and ESRD. The Commission has long argued that primary care services are undervalued in Medicare's fee schedule and has made recommendations to support primary care, which in turn could support better management of kidney disease risk factors.

Since 2011, Medicare has paid for dialysis services under the ESRD PPS

To treat ESRD, dialysis beneficiaries receive care from two principal providers: (1) the clinicians (typically nephrologists) who prescribe and manage the provision of dialysis and establish the beneficiary's plan of care and (2) facilities that provide dialysis treatments in a dialysis

center or support and supervise the care of beneficiaries on home dialysis. Medicare uses different methods to pay for ESRD clinician and facility services. Clinicians receive a monthly capitated payment established in the Part B physician fee schedule for outpatient dialysis-related management services (which includes managing the dialysis prescription and prescribing dialysis drugs); payment varies based on the number of visits per month, the beneficiary's age (adults vs. pediatric beneficiaries under age 20), and whether the beneficiary receives dialysis in a facility or at home.⁷ While our work in this report focuses on Medicare's payments to facilities, it is important to recognize that facilities and clinicians collaborate to care for dialysis beneficiaries. CMMI's models requiring facilities and nephrologists to work together—Medicare's Comprehensive ESRD Care Model, a shared savings program that began in 2015 and ends in 2021, and the ESRD Treatment Choices Model, a model that is intended to promote home dialysis and kidney transplantation, that begins in 2021 and ends in 2027—acknowledge the need for collaboration.

To improve provider efficiency, in 2011 Medicare began a PPS for outpatient dialysis services that expanded the prospective payment bundle to add (1) Part B dialysis drugs, laboratory tests, and other ESRD items and services that were previously billable separately and (2) Part D dialysis oral-only drugs—calcimimetics and phosphate binders. Clinicians use drugs in these two therapeutic classes to manage mineral bone disorders, a complication of advanced CKD.

Under the outpatient ESRD PPS, the unit of payment is a single dialysis treatment. For adult dialysis beneficiaries (18 years or older), the base payment rate does not differ by type of dialysis—in-center dialysis versus home dialysis—but rather by patient-level characteristics (age, body measurement characteristics, onset of dialysis, and selected acute and chronic comorbidities) and facility-level factors (low treatment volume, rural location, and local input prices).⁸ Medicare pays facilities furnishing dialysis treatments in the facility or in a patient's home for up to three treatments per week, unless there is documented medical justification for more than three weekly treatments.⁹

Since it was implemented in 2011, the outpatient ESRD PPS has undergone several significant changes. In 2014, CMS rebased the base payment rate, as mandated by the American Taxpayer Relief Act of 2012, to account for the

decline in dialysis drug use under the ESRD PPS.¹⁰ In 2016, the agency recalibrated and redefined the patient-level and facility-level payment adjusters that are used to calculate each patient's adjusted payment per treatment.¹¹ In addition, since 2018, transitional add-on payments have been used to pay for certain drugs (calcimimetics) and are available for qualifying equipment and supplies.

Transitional add-on payments for new drugs, devices, and equipment

CMS uses transitional add-on payment policies for:

- ***ESRD oral-only drugs that were intended to be in the bundle in 2011 but were delayed due to actions by regulatory and statutory provisions***—With the availability of an injectable calcimimetic in 2017, CMS no longer considered these drugs oral-only and, between 2018 and 2020, paid for them under the ESRD PPS using a transitional drug add-on payment adjustment (TDAPA).^{12,13} As summarized in the text box on injectable and oral calcimimetics, in 2021, CMS will pay for calcimimetics under the PPS bundled payment rate.
- ***New ESRD drugs in a new ESRD functional category***—To comply with the statute's mandate for including new ESRD-related injectable and intravenous drugs in the prospective payment bundle, the agency finalized a policy in 2016 that pays a TDAPA for new ESRD-related injectable drugs not in 1 of 11 ESRD-related functional categories of drugs included in the PPS payment bundle.¹⁴ (Functional categories are similar to therapeutic classes of drugs.) A qualifying drug is paid based on its average sales price (ASP) for at least two years, until sufficient rate-setting data are available. When the TDAPA period ends, CMS includes the drug in the prospective payment bundle (by adding a new functional category or modifying an existing one) and adjusts the PPS base rate, if appropriate, to reflect changes to the functional categories.
- ***Certain new ESRD drugs in an existing ESRD functional category***—CMS expanded the TDAPA policy in 2020 to apply to new ESRD drugs in an existing functional category (based on the agency's statutory authority). CMS pays a TDAPA using the product's ASP for a two-year period; thereafter, it is included in the PPS bundle without any change to the ESRD PPS base rate. CMS does not apply a

In 2021, injectable and oral calcimimetics are included in the ESRD PPS payment bundle

In 2021, injectable and oral calcimimetics are included in the end-stage renal disease (ESRD) prospective payment system (PPS) bundle, and the base rate increases by \$9.93 per treatment (in 2020 dollars). This one-time addition to the ESRD PPS base rate is based on oral and injectable calcimimetic utilization, using dialysis facility claims from the third quarter of 2018 through the fourth quarter of 2019. Using this period accounts for an increase in the use of oral generic calcimimetics, a steep decrease in the oral brand calcimimetic (following loss of its patent exclusivity), and an increase in the use of the injectable brand version. CMS then multiplied oral and injectable calcimimetic utilization by their respective average sales prices (ASPs) from the fourth quarter of 2020, which represents the lowest ASP value for both products between 2018 and 2020.¹⁵

The agency did not use 2020 calcimimetic utilization in the rate-setting process because the public health

emergency may have altered practice patterns. In addition, the rate-setting process is not based on only 2019 calcimimetic utilization out of concern that the increased use of the injectable in that year would have overestimated the PPS payment to account for the cost of calcimimetics. According to CMS, “the 2018 claims data may have demonstrated low uptake for the injectable calcimimetic, but it also may reflect that the significant upswings in utilization of the injectable calcimimetic in 2019 were from ESRD facilities anticipating CMS ending the TDAPA [transitional drug add-on payment adjustment] for calcimimetics” (Centers for Medicare & Medicaid Services 2020). During the early years of the ESRD PPS, drug utilization substantially declined as providers became more efficient. CMS intends to revisit the Medicare expenditures for calcimimetics in the future, such as when a generic injectable comes on the market. ■

substantial clinical improvement criterion to determine a new drug’s eligibility. Drugs that do not qualify for this TDAPA include generic equivalents and new dosage forms of an active ingredient that the Food and Drug Administration (FDA) has already approved, among others.¹⁶ To date, no new drugs (whether in an ESRD functional category or not) have qualified for this adjustment.

- ***New ESRD equipment and supplies that are not capital assets and home dialysis machines (a capital asset) when used in the home for a single patient***¹⁷—Based on its regulatory authority, CMS pays a transitional add-on payment adjustment for new and innovative equipment and supplies (TPNIES) for a two-year period; thereafter, it is included in the bundle, without any change to the ESRD PPS base rate. Unlike ESRD drugs, a substantial clinical improvement standard is used to determine eligibility

under this transitional payment policy. CMS sets the new item’s payment rate at 65 percent of the price that the Medicare administrative contractors (MACs) establish.¹⁸

In our June 2020 report to the Congress, the Commission recommended that the Congress direct the Secretary to eliminate the TDAPA for new drugs that are in an existing ESRD functional category that is already included in the payment bundle. Doing so would maintain the structure of the ESRD PPS and avoid the introduction of incentives to unbundle services covered under the PPS. In addition, eliminating the TDAPA for these drugs would create pressure for drug manufacturers to constrain the growth of prices for new and existing ESRD drugs. At market entry, such new drugs would be included in the ESRD PPS bundle, with no update to the base payment rate.

In our comment letters on CMS’s proposals to implement the TPNIES, the Commission argued for maintaining the

structure of the ESRD PPS and not creating policies that would unbundle services covered under the ESRD PPS or create incentives that encourage high launch prices of technologies. We said that if the agency proceeded with this policy, then CMS should require that the new product be an advance in medical technology that substantially improves beneficiaries' outcomes relative to technologies in the PPS payment bundle and should not make duplicative payments for new equipment and supplies by paying under the TPNIES for two years and paying for equipment and supplies with a similar purpose or use that is already paid under the ESRD PPS base rate.

Linking payments to quality of care

Since 2012, outpatient dialysis payments are linked to the quality of care that facilities provide under the ESRD Quality Incentive Program (QIP). Under statutory provisions, the maximum payment reduction that CMS can apply to any facility is 2 percent. In 2020, the QIP assessed quality using:

- clinical measures that assess dialysis adequacy, vascular access among hemodialysis beneficiaries, hospitalization rates, hospital readmission rates, blood transfusion rates, presence of hypercalcemia, bloodstream infections among hemodialysis beneficiaries, and the quality of care that in-center hemodialysis beneficiaries report that they receive from their nephrologist and dialysis facility; and
- process measures that assess whether dialysis facilities report on pain assessment, clinical depression screening, anemia management, management of serum phosphorus, ultrafiltration rates, influenza vaccination rates among their health care personnel, and infection events (reported to the Centers for Disease Control and Prevention's National Healthcare Safety Network).

In 2020, of the roughly 7,000 facilities with a QIP performance score, 58 percent had no payment reduction, 24 percent had their Medicare outpatient dialysis payments reduced by 0.5 percent, 12 percent had payments reduced by 1.0 percent, 4 percent of facilities had payments reduced by 1.5 percent, and 2 percent of facilities had payments reduced by the maximum, 2.0 percent.

In addition to the QIP, since 2015, CMS uses a second measurement system, the dialysis star ratings system, to assess the quality of care furnished by dialysis facilities.

This second measurement system, which CMS established through a subregulatory process, assigns each facility from 1 to 5 stars; more stars mean that a dialysis facility performs better on quality compared with all other facilities. The Commission has questioned why CMS finds a second quality system necessary for dialysis facilities and has raised concerns that beneficiaries and their families might be confused if a facility's star rating and QIP scores diverge, which could occur because the measurement systems use different methods and measures to calculate a facility's performance score (Medicare Payment Advisory Commission 2014).¹⁹

Are Medicare payments adequate in 2021?

To address whether payments for 2021 are adequate to cover the costs that efficient providers incur and how much providers' costs are likely to change in the update year (2022), we examine several indicators of payment adequacy. We assess beneficiaries' access to care by examining the capacity of dialysis facilities and changes over time in the volume of services provided. We also examine quality of care, providers' access to capital, and the relationship between Medicare's payments and facilities' costs.

While impossible to predict the future with any certainty given the evolving coronavirus pandemic, we anticipate most dialysis payment adequacy indicators will remain positive in 2021. (For a description of how the coronavirus pandemic has been incorporated into our payment adequacy framework, see text box, pp. 174–175.)

Beneficiaries' access to care: Indicators continue to be favorable

Our analysis of access indicators—including the capacity of providers to meet beneficiary demand, changes in the volume of services, and the marginal profitability of Medicare dialysis beneficiaries under the PPS—shows that beneficiaries' access to care remains favorable.

Capacity has exceeded FFS beneficiary demand

Growth in the number of dialysis facilities and in-center treatment stations alongside growth in the number of dialysis beneficiaries suggests that, between 2014 and 2019, provider capacity has exceeded demand for care

**TABLE
6-2**

Increasing number and capacity of freestanding, for-profit, and largest dialysis organizations

	2019				Average annual percent change			
	Total number of FFS treatments (in millions)	Total number of facilities	Total number of stations	Mean number of stations	Number of facilities		Number of stations	
					2014-2019	2018-2019	2014-2019	2018-2019
All	45.4	7,700	134,200	18	4%	3%	4%	3%
	Percent of total							
Freestanding	96%	95%	96%	18	4	3	4	3
Hospital based	4	5	4	14	-3	-1	-3	-3
Urban	86	83	86	18	4	3	4	3
Micropolitan	10	10	9	16	2	1	2	1
Rural, adjacent to urban	3	4	3	14	2	2	2	3
Rural, not adjacent to urban	1	2	1	12	1	-2	1	-0.4
Frontier	0.2	0.4	0.2	10	1	0	1	0
For profit	89	89	89	18	4	3	4	3
Nonprofit	11	11	11	17	-1	-0.1	0.2	-0.2
Two largest dialysis organizations	75	74	75	18	5	4	4	4
All others	25	26	25	17	1	1	1	1

Note: FFS (fee-for-service). Provider location reflects the county where the provider is located in one of four categories (urban, micropolitan, rural adjacent to urban, and rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes. Frontier counties have six or fewer people per square mile. Totals may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from the Dialysis Compare database from CMS and claims submitted by dialysis facilities to CMS.

from FFS beneficiaries. During that period, the number of facilities and their capacity to provide care—as measured by dialysis treatment stations—each increased by 4 percent annually (Table 6-2). By contrast, between 2014 and 2019, the number of FFS dialysis beneficiaries grew 1 percent annually (data not shown). However, in-center capacity is growing to keep pace with demand from all patients, not just FFS beneficiaries. During the most recent five-year period for which data are available (2013 to 2018), the number of dialysis patients with all types of health coverage grew 3 percent per year (United States Renal Data System 2020).

Between 2014 and 2019, capacity at facilities that were freestanding and for profit each grew by 4 percent per

year, while capacity at facilities that were hospital based decreased by 3 percent per year and capacity at nonprofit facilities grew by less than 1 percent per year (Table 6-2). Between 2014 and 2019, capacity at urban facilities grew 4 percent per year, while capacity at all rural facilities grew 2 percent per year (latter data not broken out). Growth of capacity across different provider types between 2018 and 2019 is generally similar to changes over the past five years.

Between 2014 and 2019, providers' capacity to furnish home dialysis remained relatively constant. Based on data from Medicare claims, freestanding dialysis reports, and Dialysis Facility Compare, roughly half of facilities offered home dialysis in 2014 and 2019 (47 percent of facilities in each year). Among facilities that furnished

The coronavirus public health emergency and the Commission's payment adequacy framework

The coronavirus pandemic and associated public health emergency (PHE) had tragic effects on beneficiaries' health in 2020.²⁰ According to the Centers for Disease Control and Prevention, dialysis patients are at high risk for serious illness and death related to infection with COVID-19. According to CMS, between January 2020 and May 2020, beneficiaries eligible for Medicare due to end-stage renal disease had greater rates of COVID-19 cases and hospitalizations compared with beneficiaries who were eligible for Medicare due to age or disability.

As an initial step to learn about the effect of the PHE on treatment volume and spending for fee-for-service dialysis beneficiaries, we analyzed facilities' claims for the first six months of 2019 and 2020. Compared with 2019, our analysis found the following:

- The number of dialysis beneficiaries decreased by 2 percent and the number of dialysis treatments furnished in 2020 declined slightly. These findings could be due to excess mortality during the PHE as well as new patients delaying the start of dialysis.
- Dialysis payment per treatment increased by 2 percent in 2020. This finding is associated with the 2020 statutory payment update and the temporary elimination of sequestration.

COVID-19 also had material effects on providers' patient volume, revenues, and costs. The impact of COVID-19 has varied considerably both geographically and over time, and it is not clear when or whether the pandemic's full effects will end. In their public statements, the large dialysis organizations (LDOs) (Fresenius Medical Care and DaVita) have said that mortality has increased among their patients, particularly the elderly. In-center capacity and the number of treatments furnished have increased but more slowly than in 2019. Treatment growth has been affected by increased mortality during the PHE and new patients delaying the start of dialysis, offset by a decline in patients undergoing kidney transplantation. There has been increased interest in home dialysis from these LDOs' patients. One LDO (Fresenius Medical Care) reported increased home dialysis trainings in 2020 compared with 2019 (Charnow 2020). Although both organizations have incurred increased costs (e.g., personal protective equipment (PPE) and testing) due to the PHE, in general the PHE has had a lesser impact on their operations during the third quarter of 2020 compared with the second quarter. In addition, higher COVID-19 expenses were partly offset by savings associated with the pandemic in the form of reduced travel and other items. During the PHE, their commercial-payer mix of patients (which is linked to

(continued next page)

home dialysis, the share of total treatments that were furnished in the home increased modestly between 2014 and 2019, from an average of 24 percent to 28 percent. (At the 75th percentile of facilities, the share increased from 28 percent to 31 percent.)

Providers of outpatient dialysis services In 2019, there were roughly 7,700 dialysis facilities in the U.S. that furnished about 45.5 million Medicare-paid treatments to FFS dialysis beneficiaries. FFS Medicare accounted for nearly 60 percent of all treatments furnished in 2019.²¹ According to CMS facility survey data, since the late 1980s, for-profit, freestanding facilities have provided

the majority of dialysis treatments. In 2019, freestanding facilities furnished 96 percent of FFS treatments, and for-profit facilities furnished 89 percent (Table 6-2, p. 173). In 2019, the capacity of facilities in urban and rural areas was generally consistent with where FFS dialysis beneficiaries lived.

The dialysis sector is highly consolidated, with two large dialysis organizations (LDOs)—Fresenius Medical Care and DaVita—dominating the industry. In 2019, these LDOs accounted for three-quarters of facilities and Medicare treatments.

The coronavirus public health emergency and the Commission's payment adequacy framework (cont.)

each company's financial performance) has remained relatively steady or improved.

Some dialysis providers benefited from federal grants and loans (which would affect total facility margins but not Medicare margins) and temporary policy changes (such as the elimination of the sequester between May 2020 and December 2020) that eased the PHE's impact on lower volume (and its associated revenue) and higher costs for staffing, PPE, and testing. For example, one of the LDOs (Fresenius Medical Care) accepted funds under the Coronavirus Aid, Relief, and Economic Security, or CARES, Act, while the other LDO (DaVita) returned such funds. As applicable, more information about the impact of COVID-19 on dialysis providers can be found throughout this chapter.

While the PHE has not changed the nature of dialysis care (multiple treatments per week), providers have coordinated with each other to ensure capacity is sufficient to treat all patients. For example, multiple dialysis providers, including DaVita, Fresenius Medical Care, U.S. Renal Care, American Renal Associates, Satellite Healthcare, and others have formed the Dialysis Community Response Network to coordinate care for patients when certain units are overwhelmed

with either staff- or patient-related COVID-19 illness (Kossman and Williamson 2020).

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have is from 2019 for most payment adequacy indicators. The coronavirus PHE has created additional data lags, most notably for cost reports, due to extensions of reporting deadlines. We use available data as well as changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent that the effects of the coronavirus PHE are temporary changes or vary significantly across individual dialysis facilities, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 and future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of the PHE on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare base payment rates. (For an overview of how our payment adequacy framework takes account of the PHE, see Chapter 2.) ■

In addition, many dialysis facilities are operated as joint ventures between a dialysis organization and physicians. Joint ventures allow participating partners to share in the management, profits, and losses. Between 2008 and 2018, DaVita more than doubled the number of its joint ventures (from 259 facilities to 651 facilities), increasing the share of the company's facilities that were joint ventures from 18 percent to 25 percent (DaVita 2020). Other dialysis organizations, including Fresenius Medical Care, American Renal Associates, and U.S. Renal Care, also have established joint ventures with physicians.

There is concern that joint ventures between dialysis organizations and physicians create financial incentives for participating physicians that could inappropriately

influence decisions about patient care (Berns et al. 2018). Under federal disclosure requirements, a dialysis facility must report certain ownership information to CMS and its state survey agency but is not required to disclose such information to its patients, researchers, or members of the public (Centers for Medicare & Medicaid Services 2008, 42 CFR 494.180(j)). In 2009, the Commission recommended that the Congress require all hospitals and other entities that bill Medicare to annually report the ownership share of each physician who directly or indirectly owns an interest in the entity (excluding owners of publicly traded stock) and that the Secretary should post this information on a searchable public website (Medicare Payment Advisory Commission 2009).

**TABLE
6-3**

Under the ESRD PPS, use per treatment of dialysis drugs has declined, shifting to less costly, clinically similar products

Dialysis drug	Mean units per treatment*			Aggregate percent change	
	2010	2018	2019	2010-2019	2018-2019
ESAs					
Epoetin alfa (reference biologic)	5,214	1,239	1,206	-77%	-3%
Darbepoetin alfa	1.26	1.6	0.9	-28	-44
Epoetin beta	N/A	3.9	4.5	N/A	18
Epoetin alfa (biosimilar)	N/A	N/A	33.4	N/A	N/A
Iron agents					
Sodium ferric gluconate	0.15	0.1	0.1	-46	-9
Iron sucrose	16.0	12.6	13.2	-17	5
Ferumoxytol	0.8	0.004	0.004	-99	6
Ferric carboxymaltose	N/A	0.0001	0.0001	N/A	14
Vitamin D agents					
Paricalcitol	2.3	0.3	0.3	-89	-9
Doxercalciferol	0.9	1.3	1.3	51	1
Calcitriol	0.13	0.03	0.01	-92	-67
Antibiotics					
Daptomycin	0.22	0.1	0.1	-64	-26
Vancomycin	0.02	0.01	0.01	-57	-15
Other drugs					
Levocarnitine	0.010	0.001	0.001	-93	-24
Alteplase	0.020	0.002	0.002	-90	-5

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent), N/A (not applicable). Individual units per treatment are rounded; the aggregate percentage change is calculated using unrounded units per treatment. Ferric carboxymaltose was introduced to the U.S. market in 2013, epoetin beta was introduced in 2015, and epoetin alfa (biosimilar) was introduced in 2019.

*Each drug is reported using its own drug units.

Source: MedPAC analysis of claims submitted by dialysis facilities to CMS.

Types of facilities that closed and their effect on beneficiaries' access to care Each year, we examine the types of facilities that closed and whether certain groups of Medicare dialysis beneficiaries are disproportionately affected by facility closures. Using facilities' claims submitted to CMS and CMS's Dialysis Compare database and provider of service file, we compare the characteristics of beneficiaries treated by facilities that closed in 2018 with beneficiaries treated at facilities that provided dialysis in 2018 and 2019.

Between 2018 and 2019, the number of dialysis treatment stations—a measure of providers' capacity—increased by 3 percent (Table 6-2, p. 173). There was a net increase in the number of facilities that were freestanding and located

in both urban and rural areas. Compared with facilities that treated beneficiaries in both years, facilities that closed in 2018 (about 50 facilities) were more likely to be hospital based, nonprofit, and smaller (as measured by the number of dialysis treatment stations), which is consistent with long-term trends in the supply of dialysis providers.

According to our analysis, few dialysis FFS beneficiaries (roughly 2,400 individuals) were affected by facility closures in 2018. Our analysis found that beneficiary groups who were disproportionately affected included beneficiaries who were Black and younger (under the age of 65 years), which is consistent with last year's findings. However, less than 1 percent of FFS beneficiaries in these

two groups were affected by facility closures. Our analysis of claims data suggests that beneficiaries affected by these closures obtained care elsewhere.

Travel distances for new FFS dialysis beneficiaries

Another way to assess whether facility closures and consolidations affect beneficiaries' access to care is to look at changes over time in the distance to services that new FFS dialysis beneficiaries travel. Longer travel time to the dialysis unit, which creates a substantial burden for many patients, has been linked to decreased patients' adherence to the dialysis prescription and increased mortality (Moist et al. 2008). We calculated driving distances for new FFS dialysis beneficiaries in 2013 and 2018 using claims submitted by facilities to CMS, CMS's Renal Management Information System file, and Dialysis Compare.

During this five-year period, median driving miles (defined as the distance between a beneficiary's residence and the dialysis facility that furnished treatment) did not substantially change. Median driving distance was about five miles for all new FFS dialysis beneficiaries. Driving distances remained constant for beneficiaries in the 25th percentile of driving distances (3 miles) and for beneficiaries in the 75th percentile (11 miles). Older beneficiaries and Black beneficiaries traveled fewer median miles than those who were younger or White. As expected, new FFS dialysis beneficiaries residing in rural areas drove longer distances than beneficiaries residing in urban areas; between 2013 and 2018, the median driving distance increased for new dialysis beneficiaries residing in rural areas. (For beneficiaries residing in rural areas, median driving distance was 11 miles in 2013 and 12 miles in 2018. By comparison, median driving distance was five miles in each year for beneficiaries residing in urban areas.)

Volume of services

To assess changes in the volume of dialysis services, we examined recent trends in the number of dialysis treatments provided to beneficiaries and in the use of injectable drugs administered during dialysis.

Trends in number of dialysis treatments provided

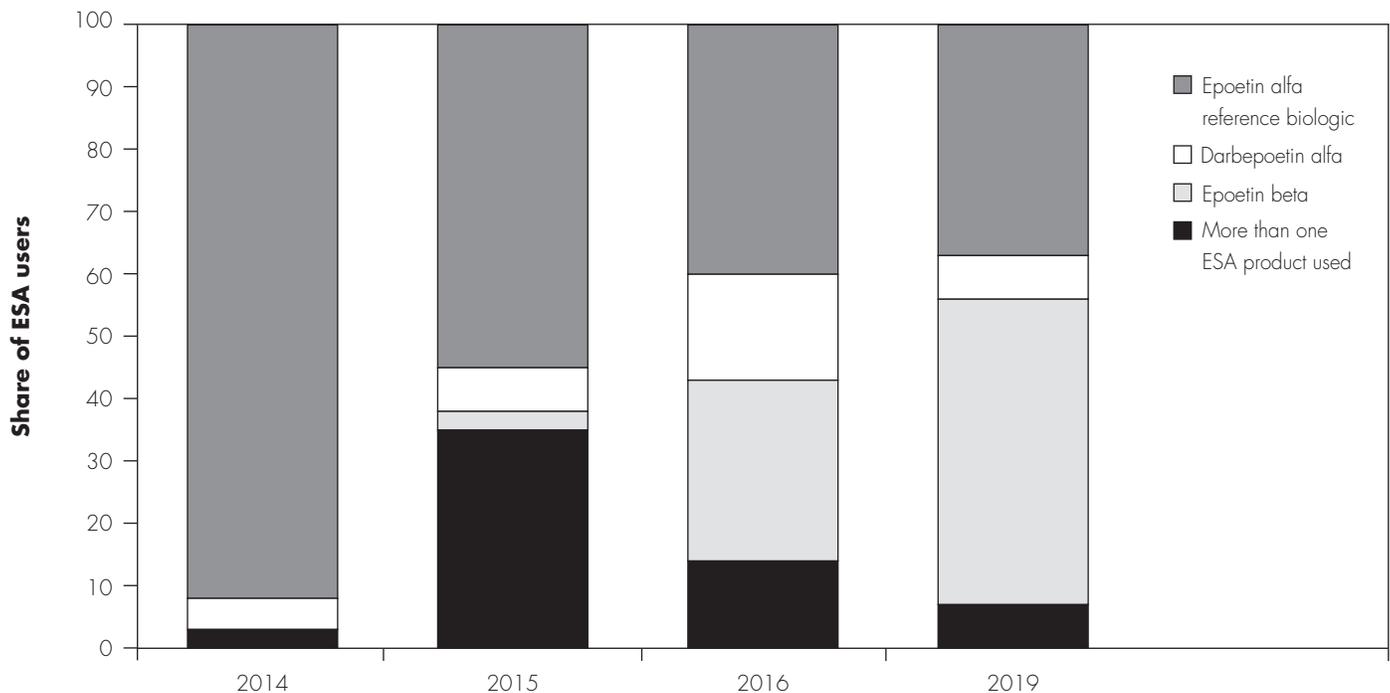
Between 2018 and 2019, there was little change in the number of FFS dialysis beneficiaries (395,000 beneficiaries in each year) and total Medicare-covered dialysis treatments (45.5 million treatments in 2018 and 45.4 million treatments in 2019). The number of dialysis treatments per beneficiary remained steady at 115.²² Over the most recent five-year period for which we have data

(2014 to 2019), the number of FFS dialysis beneficiaries increased by 0.6 percent per year, total dialysis treatments increased by 0.3 percent per year, while the number of treatments per beneficiary declined from 117 to 115.

Use of most ESRD drugs in the PPS bundle has declined with no sustained negative changes in beneficiaries' outcomes

Under the ESRD payment method used before 2011, ESRD drugs were paid according to the number of units of the drug administered: in other words, the more units of a drug provided, the higher the Medicare payment. The ESRD PPS increased the incentive for providers to be more judicious in providing dialysis drugs included in the payment bundle. When CMS broadened the payment bundle in 2011 to include ESRD-related drugs that were separately billable under the prior payment method, the agency set the PPS payment rate based on a per treatment basis using claims data from 2007. In 2014, to account for the decline in dialysis drug use under the ESRD PPS, the statute required that CMS rebase the PPS base rate by comparing drug use in 2007 with such use in 2012. Consequently, we examined changes between 2007 and 2019 (the most current year for which complete data are available) in the use per treatment for the leading dialysis drugs and aggregated them into four therapeutic classes—erythropoiesis-stimulating agents (ESAs), iron agents, vitamin D agents, and antibiotics.²³

As shown in Table 6-3, between 2018 and 2019, per treatment drug use increased for several products—epoetin beta, doxercalciferol, ferric carboxymaltose, ferumoxytol, and iron sucrose. In 2019, we began to see use of the biosimilar epoetin alfa, which was launched in late 2018. However, use of all dialysis drugs available between 2010 and 2019 declined except for one product: doxercalciferol. The shift over time in the use of products within the ESA and vitamin D therapeutic classes is linked to price competition between the products within each class. For example, Figure 6-1 (p. 178) shows the shift in ESA use from epoetin alfa and darbepoetin alfa to epoetin beta. In at least one situation, switching was an explicit goal: One of the LDOs announced its intent to have more than 70 percent of the company's ESA patients (110,000 patients) switched to epoetin beta (from epoetin alfa) by the end of the first quarter of 2016 (Reuters 2016).²⁴ According to several sources, the LDO reduced its total ESA costs by switching beneficiaries to epoetin beta (Reuters 2016, Seeking Alpha 2016). A midsize chain announced that between 85 percent and 90 percent of its facilities will have switched to epoetin beta by the end of 2018 (Seeking Alpha 2018).

FIGURE 6-1**Under the ESRD PPS, use of ESAs shifted due to price competition**

Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent).

Source: MedPAC analysis of claims submitted by dialysis facilities to CMS.

With the launch of a biosimilar for epoetin alfa in late 2018, we anticipate that competition among ESA products within the bundle will continue (and ESA costs for facilities could drop further).

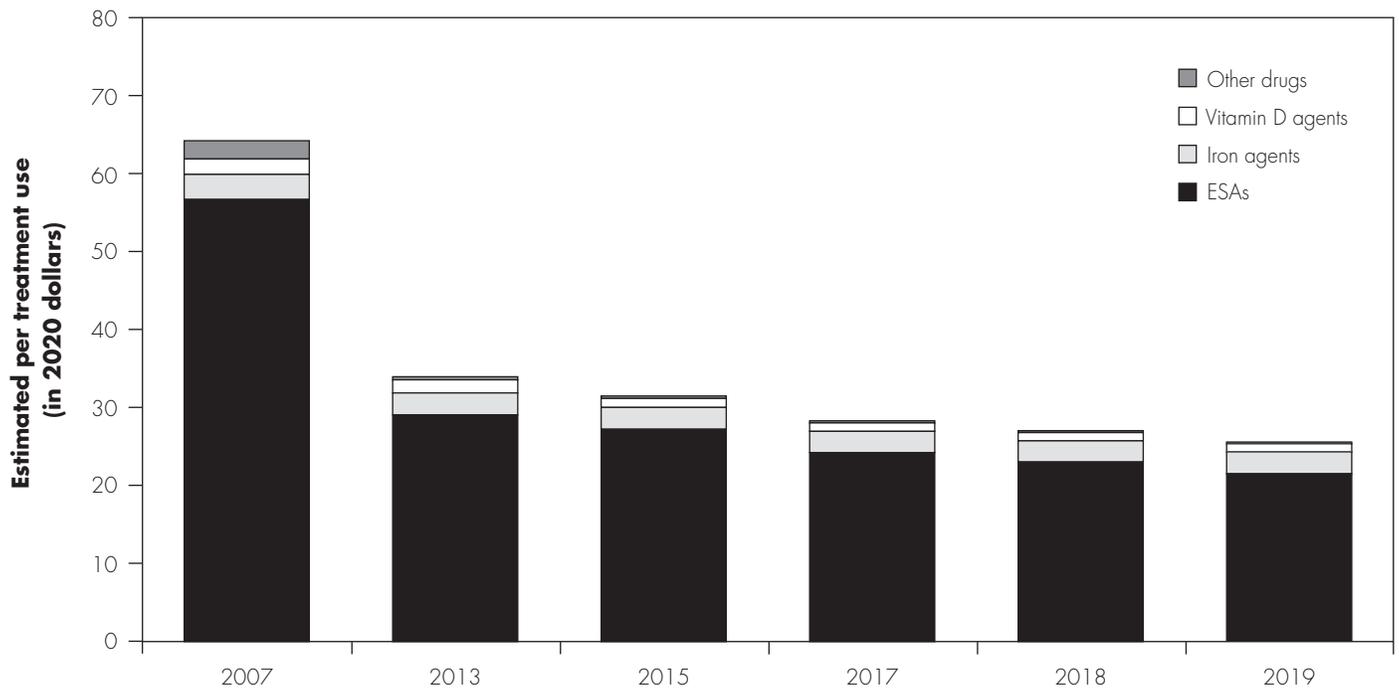
As shown in Figure 6-2, most of the decline in the per treatment use of ESRD drugs—which is estimated by multiplying drug units per treatment reported on CMS claims by each drug’s 2020 ASP + 0 percent (i.e., we hold price constant)—occurred in the early years of the PPS.²⁵ For example, between 2010 and 2012, use per treatment across all therapeutic classes declined by 23 percent per year (data not shown). Most of this decline was due to declining ESA use, which also fell by 23 percent per year during the same period. For ESAs, some of this decline may also have stemmed from clinical evidence showing that higher doses of these drugs led to increased risk of morbidity and mortality, which resulted in the FDA

changing the ESA label in 2011. Between 2018 and 2019, holding price constant, the use of all dialysis drugs in the four classes declined by 5 percent. Although the ESRD PPS affected use of certain ESRD-related services, particularly the provision of drugs paid under the bundle, CMS has concluded that the agency’s claims-based monitoring program has revealed no sustained negative changes in beneficiary health status (Centers for Medicare & Medicaid Services 2019).

Use of ESRD drugs paid under the TDAPA Our analysis of dialysis drug use also examines beneficiaries’ use of the calcimimetics paid for under the TDAPA policy—Sensipar (cinacalcet), the oral product, and Parsabiv (etelcalcetide), the injectable product. Before 2018, Medicare covered the oral calcimimetic under Part D. After the FDA approved the injectable calcimimetic Parsabiv in 2017, Medicare began to pay for both products under the ESRD PPS

**FIGURE
6-2**

Use of ESRD drugs in the payment bundle has declined under the outpatient ESRD PPS



Note: ESRD (end-stage renal disease), PPS (prospective payment system), ESA (erythropoiesis-stimulating agent). To estimate drug use by therapeutic class, we hold the price of each drug constant and multiply drug units reported on claims in a given year by 2020 average sales price + 0 percent. The ESRD drugs in this analysis are included under the outpatient ESRD PPS bundle and paid under the base payment rate. That is, included drugs are those for which Medicare paid dialysis facilities separately before the ESRD PPS or are in 1 of the 11 functional categories of drugs included in the ESRD PPS bundle. Drugs included are epoetin alfa (reference biologic), epoetin alfa (biosimilar), epoetin beta, darbepoetin (ESAs); iron sucrose, sodium ferric gluconate, ferumoxytol, ferric carboxymaltose, ferric pyrophosphate citrate (iron agents); calcitriol, doxercalciferol, paricalcitol (vitamin D agents); daptomycin, vancomycin, alteplase, levocarnitine (all other drugs).

Source: MedPAC analysis of 100 percent claims submitted by dialysis facilities to CMS.

(Medicare Part B) in 2018. CMS paid facilities 106 percent of each drug’s ASP in 2018 and 2019 and lowered the payment in 2020 to 100 percent of each drug’s ASP.²⁶ In 2021, both products are included and paid for under the PPS bundle.

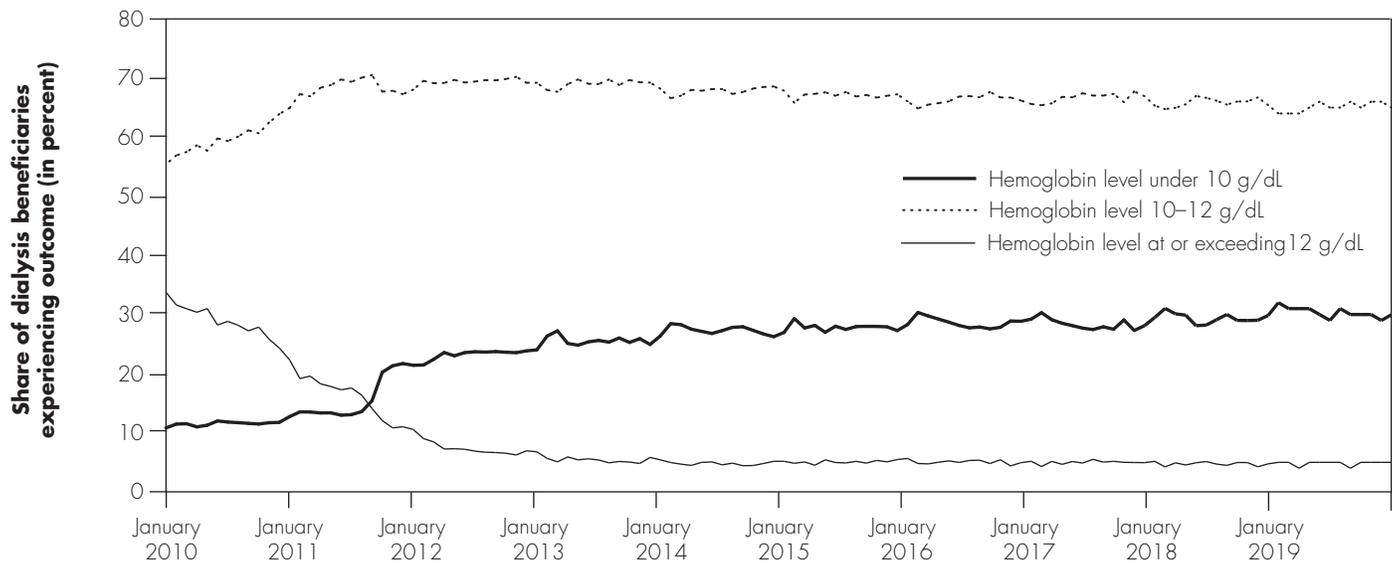
Between 2018 and 2019, TDAPA spending for both calcimimetics increased by 8 percent, from nearly \$1.2 billion to \$1.3 billion. The increase in calcimimetic spending between 2018 and 2019 is linked to greater use of the injectable product (Parsabiv), not the price Medicare paid for the drug:

- The share of beneficiaries receiving Parsabiv (the more costly product on a per user basis) increased

from 7 percent to 10 percent, while the share of beneficiaries receiving Sensipar (the less costly product on a per user basis) declined from 28 percent to 26 percent.

- Fourth quarter ASPs for each product declined (by 12 percent for Sensipar and by 13 percent for Parsabiv).

Dialysis marginal profitability suggests incentive to serve Medicare beneficiaries Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal

**FIGURE
6-3****Changes in hemoglobin levels under the ESRD PPS**

Note: ESRD (end-stage renal disease), PPS (prospective payment system), g/dL (grams per deciliter). According to the Food and Drug Administration's label for ESAs (erythropoiesis-stimulating agents): (1) in controlled clinical trials, patients experienced greater risks for death, serious adverse cardiovascular reactions, and stroke when administered ESAs to target a hemoglobin level of greater than 11 g/dL; (2) no trial has identified a hemoglobin target level, ESA dose, or dosing strategy that does not increase these risks; and (3) clinicians are advised to use the lowest ESA dose sufficient to reduce the need for red blood cell transfusions.

Source: MedPAC analysis of Medicare claims submitted by dialysis facilities to CMS.

costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare beneficiaries if it has the capacity to do so. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.²⁷

For dialysis facilities, Medicare payments exceed marginal costs by 25 percent, a positive indicator of patient access in that facilities with available capacity have an incentive to treat Medicare beneficiaries.

Quality of care

Our analysis focuses on changes in quality indicators—including mortality and morbidity, process measures that assess dialysis adequacy and anemia management, and treatment utilization (including home dialysis and kidney transplantation rates). The findings, except where indicated, are based on the Commission's analysis of Medicare FFS enrollment and claims data.

In assessing quality, we also examine the multiple factors that affect access to kidney transplantation. This procedure is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical and quality of life outcomes and Medicare spending, but demand far outstrips supply.

Quality under the ESRD PPS

Between 2014 and 2019, the Commission's analysis of claims data found that mean all-cause hospital stays remained relatively steady at 1.5 admissions per beneficiary, and 30-day readmission rates remained relatively steady at 22 percent of admissions. Between 2013 and 2018 (the most recent data that are available), CMS's monitoring data for cardiovascular outcomes among dialysis beneficiaries show that monthly hospitalization rates for stroke and acute myocardial infarction (measures of anemia management) remained steady while heart failure hospitalizations declined until 2013 and then increased beginning in 2015 (Centers for Medicare & Medicaid Services 2019).²⁸ Between 2014 and 2017, the proportion of dialysis beneficiaries who used

the emergency department on an outpatient basis increased from an average of 11.3 percent per month to 11.9 percent per month. In 2018 and 2019, the proportion of dialysis beneficiaries who used the emergency department held steady at 11.9 percent per month. According to CMS and Commission data, rates of mortality per beneficiary per month during this period remained relatively unchanged, at 1.5 percent per month.

Beneficiaries' fluid management is related to factors such as the adequacy of the dialysis procedure, defined as having enough waste removed from their blood. According to the Commission's analysis, between 2014 and 2019, from 97 percent to 98 percent of hemodialysis beneficiaries and from 91 percent to 93 percent of peritoneal dialysis (PD) beneficiaries received adequate dialysis.

We assess anemia management by examining trends over time in (1) beneficiaries' hemoglobin level, a blood test that measures the level of hemoglobin, the protein that carries oxygen in red blood cells, and (2) frequency of red blood cell transfusions.²⁹ Lower hemoglobin levels (which may suggest underuse of ESAs and iron agents) may increase the frequency of red blood cell transfusions while higher hemoglobin levels (greater than 11 g/dL) among patients maintained on higher doses of ESAs may increase their risk of death and cardiovascular events (congestive heart failure, myocardial infarction, and stroke).

Median hemoglobin levels fell during the initial years of the ESRD PPS, then stabilized; between 2014 and 2019, median levels ranged between 10.4 g/dL and 10.5 g/dL. Figure 6-3 shows that the proportion of dialysis beneficiaries with higher hemoglobin levels declined and the proportion with lower hemoglobin levels increased (which is generally associated with lower ESA use). According to CMS, during the initial years of the ESRD PPS, blood transfusion rates increased (from 2.7 percent per month to 3.4 percent per month). However, between 2013 and 2018 (the most recent year data are available), the proportion of beneficiaries receiving a blood transfusion declined (from 3.3 percent per month to 2.2 percent per month) (Centers for Medicare & Medicaid Services 2019). These findings—the decline in hemoglobin levels and increase in transfusion rates during the early years of the ESRD PPS—are consistent with the incentives under the prior and current ESRD payment methods. The pre-2011 payment method (which paid providers according to the number of units of each drug administered) gave some providers the incentive to overutilize dialysis drugs while the current payment method gives providers the incentive

to be more judicious in providing drugs included in the payment bundle. These findings may also be associated with the FDA's 2007 "black box warning" on ESA drug labels, which advised physicians that the risks of death and serious cardiovascular events are greater when ESAs are administered to achieve higher target hemoglobin levels and that dosing should be individualized to maintain hemoglobin levels between 10 g/dL and 12 g/dL.

Access to home dialysis

Researchers have shown that the ESRD PPS is associated with an overall increase in the use of home dialysis (Lin et al. 2017). Between January 2014 and December 2019, the share of beneficiaries dialyzing at home increased from 10.3 percent to 12.7 percent. While we are encouraged by this increase, differences by race persist: Black beneficiaries are less likely to use home methods. According to the Commission's analysis, about 35 percent of all beneficiaries with ESRD are Black, but only 26 percent of beneficiaries who dialyze at home are Black. Between 2014 and 2019, the proportion of beneficiaries undergoing home dialysis training was relatively small but increased slightly, ranging from a monthly average of 0.7 percent to 0.8 percent of dialysis beneficiaries.

Researchers have identified many factors that affect the use of home dialysis, including both clinical (patients' other health problems and prior nephrology care) and nonclinical (e.g., patients' social circumstances (including presence of a caregiver at home) and knowledge about treatment options and physician's training and preference). Some beneficiaries report that they were never informed about their options. Facility factors, such as unused in-center capacity or additional in-center shifts and dialysis facility's staff experience, can also affect use of home dialysis (Walker et al. 2010). During the PHE, however, both LDOs and midsize providers reported that their patients showed increased awareness of and interest in home dialysis.³⁰

Some clinical and nonclinical factors affecting home dialysis use are amenable to intervention. For example, between 2008 and 2018, under an integrated care delivery system (Kaiser Permanente Northern California), PD use among new dialysis patients more than doubled, from 15 percent to 34 percent. To augment the use of home dialysis, the health care system implemented a multidisciplinary, system-wide approach that increased patient and family education, educated health care professionals about the importance of PD, adopted operational improvements, monitored outcomes, and shared best practices with staff (Pravoverov et al. 2019).

**TABLE
6-4**

Between 2014 and 2019, the number of kidney transplants increased, and Black, Hispanic, and Asian American recipients accounted for an increasing share

	2014	2019
Total transplants	17,108	23,401
Share of transplants from live donors	32%	29%
Share of recipients who were:		
White	50%	45%
Black	25	27
Hispanic	16	19
Asian	6	7
Other	2	2

Note: Totals may not sum to 100 percent due to rounding.

Source: Organ Procurement and Transplantation Network 2020.

Access to kidney transplantation

Kidney transplantation is widely regarded as a better ESRD treatment option than dialysis in terms of patients' clinical and quality of life outcomes. In addition, transplantation results in lower Medicare spending. In 2018, average Medicare spending for patients who had a functioning kidney transplant was less than a third of the spending for dialysis patients (\$37,260 vs. \$91,800) (United States Renal Data System 2020). However, demand for kidney transplantation exceeds supply of kidneys available for transplantation. Besides donation rates, factors that affect access to kidney transplantation include the clinical allocation process; patients' health literacy, clinical characteristics, and preferences; the availability of education for patients; clinician referral for transplant evaluation at a transplant center; and transplant center policies.

Between 2014 and 2019, according to the Organ Procurement and Transplantation Network, the number of kidney transplants increased by 6 percent per year, to 23,401 (Table 6-4). During this period, the share of live-donor kidney transplants declined, from 32 percent of all transplants to 29 percent. In 2019, Black patients were less likely than White patients to receive kidney

transplants despite their fourfold greater likelihood of developing ESRD; however, between 2014 and 2019, the number of Black patients receiving a transplant grew by 8 percent per year (to 6,274 individuals, data not shown). According to Ephraim and colleagues, the lower rates of kidney transplantation for Black patients have been associated with multiple factors, including immunological incompatibility with deceased donor kidneys, lower rates of referral for transplantation, lower rates of cadaver kidney donation, and lack of knowledge and suboptimal discussions about kidney transplantation among recipients, their families, and health care providers (Ephraim et al. 2012).

Education efforts directed at patients can be effective in encouraging them to make an informed decision about their treatment, including home dialysis, in-center dialysis, kidney transplantation, and conservative care. For example, a recent review of educational interventions found a strong association between patient-targeted dialysis modality education and choosing and receiving PD (Devoe et al. 2016). An augmented nurse care management program that targeted persons with late-stage CKD resulted in a statistically significant reduction in the number of hospitalizations during the intervention period and, for those who required renal replacement therapy, higher use of PD or a preemptive kidney transplant (Fishbane et al. 2017).

In 2010, to help inform beneficiaries diagnosed with Stage 4 CKD (the disease stage before ESRD) about their treatment options and managing the disease and related comorbidities, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) established Medicare payment for up to six sessions of kidney disease education (KDE) per beneficiary. Since its implementation, relatively few beneficiaries have been provided KDE services. In 2019, 3,300 beneficiaries received KDE services, with spending nearing \$420,000.³¹

According to the Government Accountability Office, payment limitations regarding the providers who can furnish KDE services and the beneficiaries who are eligible might constrain the service's use (Government Accountability Office 2015). MIPPA specified the categories of providers who can furnish KDE services—physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certain providers of services in rural areas.³² MIPPA also specified that beneficiaries with Stage 4 CKD are eligible for the benefit. Some stakeholders contend that other categories of beneficiaries,

including those with Stage 5 CKD (i.e., ESRD) who have not started dialysis as well as individuals who have already initiated hemodialysis, might also benefit from Medicare KDE coverage.

Providers' access to capital: Growth trends indicate access is adequate

Providers need access to capital to improve their equipment and open new facilities so they can accommodate the growing number of patients requiring dialysis. The two LDOs as well as other renal companies appear to have had adequate access to capital. For example, in 2019 and 2020:

- DaVita purchased nearly 8 million shares of its common stock (representing 6.5 percent of total outstanding shares as of September 2020) for a total cost of \$702 million. The company is financing the share purchases with cash on hand.
- Fresenius Medical Care acquired all of the outstanding shares of NxStage Medical Inc., a company that develops, manufactures, and markets medical devices for use in home dialysis and in the critical care setting. As a condition to the closing of the acquisition set by the U.S. Federal Trade Commission, Fresenius Medical Care divested the NxStage bloodlines business.
- CVS is continuing its entry into furnishing kidney care with the launch of its CKD management program, which aims to delay the progression of renal disease. The program is available to 3.5 million people in commercial plans. The company launched a clinical trial for a new home dialysis device (“HemoCare” hemodialysis system) designed by the firm of Dean Kamen and aims to have the device in the market in late 2021. Rather than furnishing dialysis in its own stores, CVS intends to lease or sell home dialysis devices to other providers.
- Outset Medical, a manufacturer of portable hemodialysis machines, raised \$125 million in its initial public offering. The total capital raised 38 percent more in proceeds than the company expected (Nasdaq 2020).
- American Renal Associates, a midsize dialysis organization that currently operates 251 facilities in 27 states and Washington, DC, announced that it has entered into an agreement to be acquired by Innovative

Renal Care LLC (an affiliate of Nautic Partners, a middle market private equity firm). The all-cash transaction is valued at \$853 million, and shareholders of American Renal Associates will receive \$11.50 per share in cash, which represents an approximate premium of 66 percent to the company’s closing price on October 1, 2020.

Another indicator of the relatively good access to capital is that, during the past decade, several companies—both small and large—have entered the renal care field aiming to improve treatment of individuals with CKD and ESRD, including Outset Medical (in 2010), Cricket Health (in 2015), Somatus (in 2016), and CVS (in 2018).

In addition to private sector investment in renal care, in 2018, a public-private partnership between the Department of Health and Human Services and the American Society of Nephrology was initiated to accelerate innovation in the prevention, diagnosis, and treatment of kidney diseases. This initiative—referred to as the Kidney Innovation Accelerator (KidneyX)—sponsors cash prize competitions. For example, there is currently a competition offering up to \$10 million in prizes to accelerate artificial kidney development toward human clinical trials.

In public financial filings, the two LDOs reported generally positive financial performance related to their dialysis business for 2020, including improvements in productivity and revenue growth—that is, growth achieved apart from mergers and acquisitions. Since 2010, the two LDOs have also grown through large acquisitions of and mergers with other dialysis facilities and other health care organizations. For example, during this period, both of the largest dialysis organizations acquired midsize for-profit organizations: DaVita acquired Purity and Renal Ventures and Fresenius Medical Care acquired Liberty Dialysis.

The two LDOs, in addition to operating three-quarters of all dialysis facilities, are each vertically integrated. Both organizations operate an ESRD-related laboratory, a pharmacy, and one or more centers that provide vascular access services; they provide ESRD-related care coordination and disease management services to government and nongovernment payers (including MA plans); and they operate dialysis facilities internationally. One LDO manufactures, acquires, in-licenses, and distributes ESRD-related pharmaceutical products (e.g., phosphate binders and iron replacement products) and manufactures dialysis products (hemodialysis machines,

peritoneal cyclers, dialyzers, peritoneal solutions, hemodialysis concentrates, bloodlines, and systems for water treatment) and nondialysis products, including acute cardiopulmonary and apheresis products. This LDO supplies dialysis facilities that it owns, operates, or manages with dialysis products, and it sells dialysis products to other dialysis service providers.

Another positive indicator of the dialysis sector's strong access to capital is its all-payer margin. Using cost report data submitted by freestanding dialysis facilities to CMS, we estimate that the 2019 all-payer margin was roughly 18 percent. In their financial documents, dialysis providers reported that FFS Medicare payment rates were on average lower than commercial rates (DaVita 2018). In general, current growth trends among dialysis providers indicate that the dialysis industry is attractive to for-profit facilities and investors.

Medicare payments and providers' costs

Each year, we examine the relationship between Medicare's payments and providers' costs as part of our assessment of payment adequacy. To make this assessment, we reviewed Medicare expenditures for outpatient dialysis services in 2019 and examined trends in spending under the PPS. We also reviewed evidence regarding providers' costs under the PPS.

Medicare payments for outpatient dialysis services

In 2019, Medicare spending for outpatient dialysis services was \$12.9 billion, an increase of 2 percent compared with 2018. Per capita spending also increased by 2 percent to roughly \$32,700 in 2019. Between 2018 and 2019, dialysis spending for services in the bundle (which accounts for 90 percent of total spending) grew by 1.1 percent, while TDAPA spending (which accounts for 10 percent of total spending) grew by 8 percent. Other factors affecting spending growth include a statutory update (of 1.3 percent) to the base dialysis payment rate in 2019 and the number of dialysis treatments per beneficiary holding steady in 2018 and 2019.

Since 2017, dialysis facilities are able to furnish dialysis to beneficiaries with acute kidney injury (AKI), as mandated by the Trade Preferences Extension Act of 2015. AKI is the sudden loss of kidney function typically caused by an event that leads to kidney malfunction, such as dehydration, blood loss from major surgery or injury, or the use of medicines. By contrast, CKD is usually caused by a long-term disease, such as hypertension or diabetes,

that slowly damages the kidneys and reduces their function over time. AKI is more commonly reversible than late-stage CKD.

In 2019, Medicare spending for outpatient dialysis services for beneficiaries with AKI was nearly \$71 million, an increase from nearly \$40 million in 2017 and \$58 million in 2018. Medicare pays facilities the ESRD PPS base rate adjusted by the PPS wage index for the treatment of beneficiaries with AKI.³³ Medicare spending for treatment of AKI by dialysis facilities is not included in the Commission's analysis of Medicare's payments and costs for dialysis facilities.

Between 2017 and 2018, Part D spending for ESRD oral-only phosphate binders declined

As of 2018, phosphate binders are the only ESRD oral-only drug class that is paid for under the Part D program, and roughly 70 percent of dialysis beneficiaries with Part D coverage were prescribed such drugs.³⁴ Between 2017 and 2018 (the most recent year data are available), spending for phosphate binders furnished to dialysis FFS beneficiaries declined by 17 percent to \$1.1 billion. This decline is linked to the FDA's approval for a generic version of Renvela (sevelamer carbonate) in 2017. By contrast, spending grew 12 percent per year for the five-year period 2012 through 2017. In 2018, Part D spending for phosphate binders accounted for 40 percent of all Part D spending for dialysis beneficiaries. Medicare spending for dialysis drugs under Part D is not included in the Commission's Medicare analysis of dialysis facilities' financial performance under the ESRD PPS.

As of January 1, 2025, phosphate binders will be included in the ESRD PPS bundled payment. Including phosphate binders covered under Part D in the ESRD PPS bundle is intended to lead to better management of drug therapy and improve beneficiaries' access to these medications since some beneficiaries lack Part D coverage or have coverage less generous than the Part D standard benefit. Including phosphate binders in the ESRD PPS bundle might also improve provider efficiency. Between 2017 and 2018, Medicare total spending increased for the phosphate binders that did not have generic competitors, while spending decreased for products with generic competitors.

Providers' costs for outpatient dialysis services under the ESRD PPS

To assess the appropriateness of costs for dialysis services paid for under the ESRD PPS, we examine whether

aggregate dialysis facility ESRD-allowable costs reflect costs that efficient providers would incur in furnishing high-quality care. For this analysis, we used 2018 and 2019 cost reports and claims submitted to CMS by freestanding dialysis facilities. For those years, we looked at the growth in the cost per treatment and how total treatment volume affected that cost.

Cost growth under the PPS Between 2018 and 2019, total cost per treatment decreased by 4 percent, from nearly \$267 per treatment to \$255 per treatment. Total cost per treatment fell in part due to lower cost per treatment for calcimimetics (which Medicare pays for under a TDAPA policy based on each product’s ASP). We estimate that, between 2018 and 2019, the cost of calcimimetics dropped by more than half, from roughly \$15 per treatment to \$6 per treatment because of the launch of generic versions of Sensipar (the oral calcimimetic).^{35,36}

Excluding providers’ estimated costs of calcimimetics, the cost per treatment between 2018 and 2019 would have declined by about 1 percent. This decrease was due to lower cost per treatment for the four categories that made up 44 percent of the total 2019 cost per treatment. The cost per treatment for supplies, administrative and general expenses, laboratory services, and ESAs declined by 1 percent, 3 percent, 6 percent, and 13 percent, respectively. Lower cost per treatment for these categories was somewhat offset by the following increases:

- Labor costs, which accounted for about 33 percent of the cost per treatment, increased by 1 percent.
- Capital costs, which accounted for 18 percent of the cost per treatment, increased by 4 percent.
- Composite rate drugs, which accounted for less than 1 percent of the cost per treatment, increased by 2 percent.

Variation in cost growth across freestanding dialysis facilities shows that some facilities were able to hold their cost growth well below that of others. For example, between 2018 and 2019, per treatment costs decreased by 11 percent for facilities in the 25th percentile of cost growth, compared with a decrease of 0.4 percent for facilities in the 75th percentile.

The extent to which some of the variation in costs among facilities results from differences in the accuracy of facilities’ reported data is unknown. In 2018 and 2019,

we found substantial variation in the level of selected cost categories reported by the five largest dialysis organizations. For example, the cost per treatment for administrative and general services and labor each varied by roughly \$30 per treatment among these organizations. We anticipate that CMS’s audit of a representative sample of facilities’ ESRD cost reports will examine their accuracy. In the final rule for the 2020 ESRD PPS, CMS said that (1) the audit process is complete, (2) it is conducting follow-up activities related to the audit to obtain summary results and is investigating what adjustments were made on the cost reports of specific ESRD facilities, and (3) it intends to discuss the results when these follow-up activities are available in a future rule. Consistent with our 2014 recommendation, the Protecting Access to Medicare Act of 2014 funded CMS to audit a representative sample of ESRD facility cost reports.³⁷

Cost per treatment is correlated with facility service volume Cost per treatment is correlated with the total number of treatments a facility provides. To examine this relationship, we adjusted the cost per treatment to remove differences in the cost of labor across areas and included all treatments regardless of payer. Our analysis showed, in each year from 2011 through 2019, a statistically significant relationship between total treatments and cost per treatment (correlation coefficient equaled –0.5) (Figure 6-4, p. 186). That is, the greater the facility’s service volume, the lower its costs per treatment. Facilities that qualified for increased Medicare payment due to low volume had substantially higher cost per treatment for capital as well as administrative and general services compared with all other facilities.

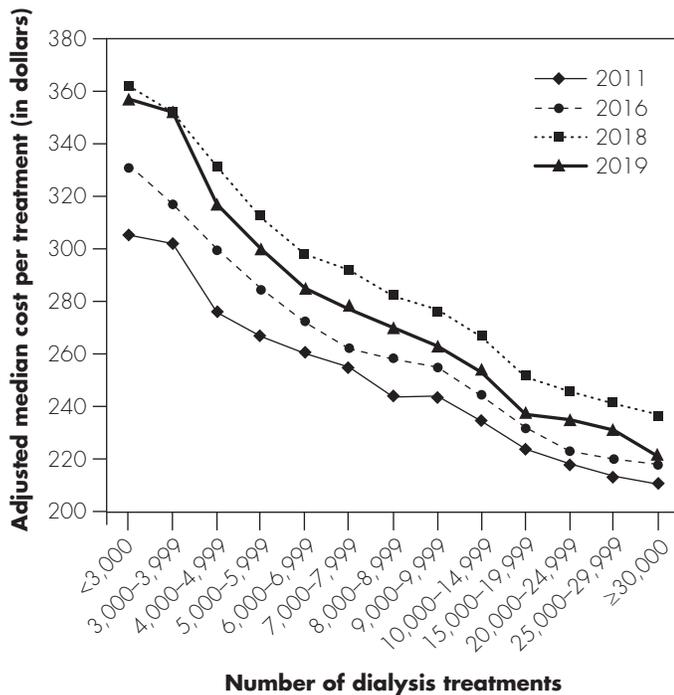
The trend in the aggregate Medicare margin for freestanding dialysis facilities

The Commission assesses current payments and costs for dialysis services for freestanding dialysis facilities by comparing Medicare’s payments with facilities’ Medicare-allowable costs. The latest and most complete data available on payments and costs are from 2019.

Under the ESRD PPS, dialysis facilities’ financial performance under Medicare has varied due to statutory and regulatory changes and the use and profitability of certain ESRD drugs (Figure 6-5, p. 187). During the initial years of the ESRD PPS, the aggregate Medicare margin increased, particularly because of declining use of

FIGURE 6-4

Higher volume dialysis facilities have lower cost per treatment, 2011-2019



Note: Cost per treatment is adjusted to remove differences in the cost of labor. "Dialysis facilities" includes those paid by all insurance sources. Medicare's coverage of calcimimetics under the end-stage renal disease prospective payment system primarily accounts for the cost per treatment decreasing in 2019.

Source: MedPAC analysis of cost reports submitted by freestanding dialysis facilities to CMS and the end-stage renal disease wage index files.

ESRD drugs between 2011 and 2012 (Table 6-3, p. 176). Between 2014 and 2017, facilities' financial performance under Medicare reversed, with the aggregate Medicare margin declining from 2.1 percent to -1.1 percent, which was not unexpected given the payment adjustments required by statute. To reflect more-current use of dialysis drugs, the American Taxpayer Relief Act of 2012 required that CMS rebase the base payment rate effective 2014, and the Protecting Access to Medicare Act of 2014 set the statutory update at (1) 0 percent in 2015, (2) market basket minus 1.25 percent in 2016 and 2017, and (3) market basket minus 1.0 percent in 2018.³⁸

In 2018 and 2019, the aggregate Medicare margin increased due to the profitability of the calcimimetics

paid under the TDAPA policy.³⁹ The aggregate Medicare margin was 2.1 percent in 2018 and 8.4 percent in 2019. Excluding calcimimetics' payments and estimated costs, we estimate that the 2018 aggregate Medicare margin would have been about -2 percent and the 2019 aggregate margin would have been 0.5 percent.

Most of the increase in the Medicare margin between 2018 and 2019 is associated with the availability of generic versions of the oral calcimimetic in 2019. There is a two-quarter lag in the data used to set ASP-based payment rates under the TDAPA policy, which can result in a difference between the average provider acquisition cost for a drug and the ASP used to set the Medicare payment amount for a quarter. When prices increase or decrease, it takes two quarters before that change is reflected in the ASP data that Medicare uses to pay providers. When newly available generic drugs enter the market, their ASPs are often substantially lower than their brand counterparts, but payment amounts remain at the higher brand level for typically two quarters (or more). In 2019, TDAPA payments (which account for 10 percent of total dialysis payments) averaged \$28 per treatment while providers' costs averaged an estimated \$6 per treatment (Table 6-5, p. 188).

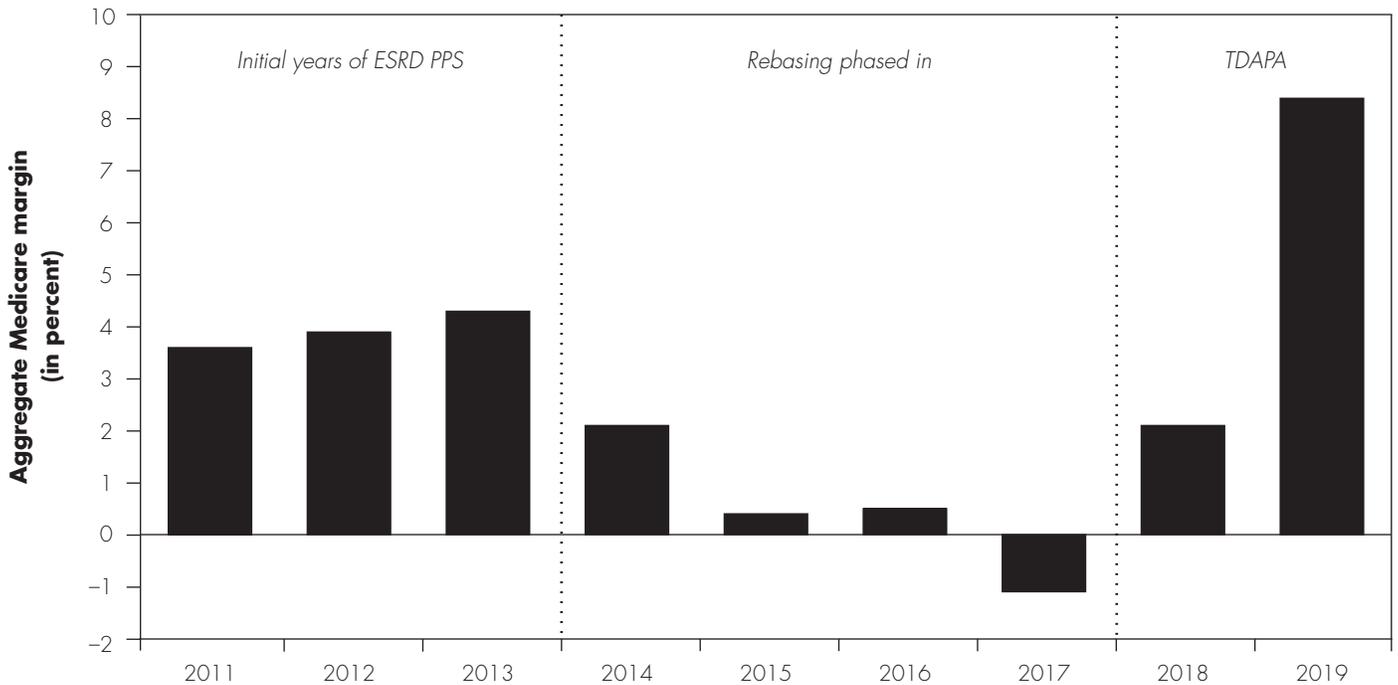
Medicare margin varies by treatment volume

Aggregate Medicare margins in 2019 decidedly varied by treatment volume: Facilities in the lowest volume quintile had margins below -14 percent, while facilities in the top volume quintile had margins of over 15 percent (Table 6-6, p. 189). Urban facilities averaged higher margins than rural facilities (9.0 percent vs. 5.0 percent). Total treatment volume accounted for much of the difference in margins between urban and rural facilities. Urban dialysis facilities are larger on average than rural facilities in the number of treatment stations and total treatments provided. For example, in 2019, urban facilities averaged about 12,000 treatments, while rural facilities averaged about 7,800 treatments (data not shown). And, as shown in Figure 6-4, higher volume facilities had lower cost per treatment.

The Commission has raised concerns about continued access to low-volume facilities that are located in isolated areas (Medicare Payment Advisory Commission 2020). Although some rural facilities have benefited from the ESRD PPS's 23.9 percent low-volume adjustment and 0.8 percent rural adjustment, the Commission has stated that neither adjustment targets low-volume, geographically

FIGURE 6-5

Aggregate Medicare margin changed in response to payment policies



Note: ESRD (end-stage renal disease), PPS (prospective payment system), TDAPA (transitional drug add-on payment adjustment).

Source: Compiled by MedPAC from cost reports and claims submitted by facilities to CMS and the Dialysis Compare database.

isolated facilities that are critical to beneficiary access (Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2015, Medicare Payment Advisory Commission 2014). In our June 2020 report, the Commission recommended that the Secretary replace the current low-volume and rural payment adjustments in the ESRD PPS with a single adjustment for dialysis facilities that are isolated and consistently have low volume, where low-volume criteria are empirically derived (Medicare Payment Advisory Commission 2020). The Commission intends to continue to monitor the adequacy of Medicare’s payments for rural and urban facilities.

Projecting the Medicare margin for 2021

We project the aggregate Medicare margin for 2021 to be 4 percent, less than the 2019 Medicare margin (8.4 percent). This projection considers providers’ historical cost growth and the policy changes that went into effect between 2019 (the year of our most recent margin estimates) and 2021, which include the following:

- In 2020 and 2021, the statutory dialysis base payment rate (based on the ESRD market basket offset by a productivity adjustment) will increase by 1.7 percent and 1.6 percent, respectively.
- CMS estimates that payments in 2021 will be reduced by 0.38 percent due to the ESRD Quality Incentive Program.
- CMS estimates that payments in 2021 will be reduced by 0.1 percent by including calcimimetics in the ESRD PPS bundle (i.e., Medicare will no longer pay a TDAPA for calcimimetics as of 2021).

How should Medicare payments change in 2022?

The evidence suggests that outpatient dialysis payments are adequate. It appears that facilities have become more

**TABLE
6-5**

The impact of calcimimetic costs and payments on the aggregate Medicare margin in 2019

ESRD PPS	Cost per treatment	Payment per treatment*	Aggregate Medicare margin
All items and services	\$255	\$278	8%
All items and services other than calcimimetics	249	250	0.5
Calcimimetics	6**	28	79

Note: ESRD (end-stage renal disease), PPS (prospective payment system).
 *Payment per treatment is net of uncollected bad debt for which Medicare does not compensate facilities.
 **We estimate calcimimetic costs because freestanding dialysis facilities report costs for these drugs, along with other non-erythropoiesis-stimulating agents and non-composite rate drugs, in the cost category “ESRD-related other drugs.” Calcimimetic costs are estimated by subtracting 2017 costs for “ESRD-related other drugs” (the year before Medicare covered calcimimetics under the ESRD PPS) from 2019 costs for this category.

Source: MedPAC analysis of claims and cost reports submitted by freestanding dialysis facilities to CMS.

efficient under the PPS, as measured by declining use of most injectable dialysis drugs, and we conclude that dialysis facilities can continue to provide services to beneficiaries with ESRD without an update to current rates.

We note that, beginning in 2020, in addition to the base payment rate, Medicare includes a TDAPA payment adjustment under the ESRD PPS that pays dialysis facilities for certain new drugs and biologics based on the product’s ASP + 0 percent for a two-year period. If a drug becomes eligible for a TDAPA payment, this policy will likely increase Medicare payments relative to facilities’ costs because CMS will not offset the ESRD PPS base rate (even for new drugs that fall into 1 of the 11 functional categories already included in the payment bundle). In 2021, Roxadustat, a new drug that treats anemia for dialysis patients, may be launched in the U.S. (Woolridge 2020). The manufacturer filed its application with the FDA in February 2020, and the FDA’s deadline to review the application (the Prescription Drug User Fee Act (PDUFA) date) is currently March 20, 2021. If CMS determines that Roxadustat meets the TDAPA eligibility criteria (set forth in CFR 413.234), then dialysis facilities would be paid a TDAPA for the drug. According to its manufacturer: “Assuming a positive decision by a PDUFA date of December 2020, the plan is to immediately apply for the transitional drug add-on payment adjustment, or TDAPA,

which would provide reimbursement for Roxadustat for dialysis-dependent patients outside of the prospective payment system bundle. The earliest Roxadustat could receive TDAPA coverage would be April 1, 2021” (Motley Fool 2020).⁴⁰

Further, beginning in 2020, Medicare also includes a payment adjustment under the ESRD PPS that pays dialysis facilities for new and innovative equipment and supplies based on the product’s invoice price for a two-year period. For non-capital-related technologies, this policy could raise Medicare payments relative to facilities’ costs because CMS will not offset the ESRD PPS base rate. (The payment adjustment for new and innovative home dialysis machines (a capital asset) includes an offset applied to the ESRD PPS base rate.)

RECOMMENDATION 6

For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare end-stage renal disease prospective payment system base rate.

RATIONALE 6

Most of our indicators of payment adequacy are positive, including beneficiaries’ access to care, the supply and capacity of providers, volume of services, and access to capital. Providers have become more efficient in the use

**TABLE
6-6****In 2019, Medicare margins of freestanding dialysis facilities varied by treatment volume**

Provider type	Medicare margin	Percent of freestanding dialysis facilities	Percent of freestanding dialysis facility treatments
All	8.4%	100%	100%
Urban	9.0	83	88
Rural	5.0	17	12
Treatment volume (quintile)			
Lowest	-14.4	20	7
Second	-1.4	20	13
Third	6.4	20	18
Fourth	10.4	20	24
Highest	15.2	20	39

Note: Totals may not sum to 100 percent due to rounding.

Source: Compiled by MedPAC from cost reports and outpatient claims submitted by facilities to CMS and the Dialysis Compare database.

of dialysis drugs under the PPS. Indicators of quality of care have generally remained stable; home dialysis is increasing; and hospital admissions and mortality have held steady, though emergency department use slightly increased. The Medicare margin was 8.4 percent in 2019 and is projected to be 4 percent in 2021. The 25 percent marginal profit is a positive indicator of beneficiary access.

IMPLICATIONS 6

Spending

- In 2022, the statute sets the payment update at the market basket, net of the productivity adjustment. The

Commission's recommendation would lower federal program spending relative to the statutory update by \$50 million to \$250 million over one year and \$1 billion to \$5 billion over five years.

Beneficiary and provider

- We expect beneficiaries to continue to have good access to outpatient dialysis care. Relative to current law, this recommendation is not expected to have any effect on reasonably efficient providers' willingness and ability to care for Medicare beneficiaries. ■

Endnotes

- 1 Generally, individuals are fully insured under Social Security if they have 40 credits of covered employment (i.e., the individual is employed in a job that pays Social Security taxes). Individuals are currently insured under Social Security if they have a minimum of six credits of covered employment in the three years before ESRD diagnosis.
- 2 In this chapter, the term *beneficiaries* refers to individuals covered by Medicare, and *patients* refers to all individuals who have ESRD.
- 3 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents for the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms but are designed to create different financial incentives.
- 4 In this chapter, the term *drugs* refers to both drugs and biologics.
- 5 According to the American Kidney Fund, the organization provided direct financial assistance to 84,000 low-income dialysis and transplant patients.
- 6 For individuals entitled to Medicare based on ESRD, Medicare coverage does not begin until the fourth month after the start of dialysis, unless the individual had a kidney transplant or began training for self-care, including dialyzing at home.
- 7 Under the Bipartisan Budget Act of 2018, beginning January 2019, clinicians who manage home-dialysis beneficiaries can furnish their visits through telehealth (rather than in person). Beneficiaries are required to receive a face-to-face visit for the first three months of home dialysis and once every three months thereafter.
- 8 For pediatric dialysis beneficiaries (younger than age 18 years), the base rate is adjusted for age and type of dialysis.
- 9 The Commission’s *Payment Basics* provides more information about Medicare’s method of paying for outpatient dialysis services (available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_dialysis_final_sec.pdf?sfvrsn=0).
- 10 The Commission’s March 2014 report to the Congress provides more information about the rebasing of the dialysis base payment rate (available at http://medpac.gov/docs/default-source/reports/mar14_ch06.pdf?sfvrsn=0).
- 11 More information about these payment changes can be found in the Commission’s March 2016 report to the Congress (available at <http://www.medpac.gov/docs/default-source/reports/march-2016-report-to-the-congress-medicare-payment-policy.pdf>). The Commission’s methodological concerns about these patient-level and facility-level refinements can be found in our comment letter to CMS (available at <http://medpac.gov/docs/default-source/comment-letters/medpac-comment-on-cms-s-proposed-rule-on-the-end-stage-renal-disease-prospective-payment-system-and-.pdf?sfvrsn=0>).
- 12 In 2011, CMS delayed including ESRD oral-only drugs (calcimimetics and phosphate binders paid for under Part D) in the Part B ESRD prospective payment bundle to give facilities additional time to make operational changes and logistical arrangements to furnish these products to their beneficiaries. Section 204 of the Stephen Beck, Jr., Achieving a Better Life Experience Act of 2014 delayed including oral-only renal dialysis services in the ESRD PPS bundled payment until January 1, 2025. According to CMS, these products were paid under a TDAPA because the base dialysis payment rate has not yet accounted for their costs.
- 13 In 2016, CMS established a drug designation process (as mandated by the Protecting Access to Medicare Act of 2014) for determining when ESRD oral-only drugs are no longer oral only and therefore must be paid under the ESRD PPS. Under the process, once the Food and Drug Administration (FDA) approves an equivalent injectable product (or other non-oral forms), the agency pays facilities for both the oral and non-oral products under a TDAPA until sufficient claims data (at least two years’ worth) for rate-setting analysis are available; thereafter, these drugs will be included in the PPS bundle.
- 14 Currently, drugs and biologics reported on dialysis facility claims are categorized into 1 of the following 11 functional categories: access management, anemia management, bone and mineral metabolism, cellular management, antiemetic, anti-infective, antipruritic, anxiolytic, excess fluid management, fluid and electrolyte management, and pain management.
- 15 To calculate an average per treatment cost (in 2020 dollars), CMS divided total calcimimetic expenditures (\$683,246,041) by the total number of hemodialysis-equivalent treatments furnished between the third quarter of 2018 and the fourth quarter of 2019 (68,148,651 treatments), and then reduced the product by 1 percent to account for the ESRD PPS outlier policy.

- 16 New drugs not eligible for a TDAPA include generic drugs, which the FDA approves under Section 505(j) of the Federal Food, Drug, and Cosmetic Act, and drugs approved for a new dosage form (e.g., pill size, time-release forms, chewable or effervescent pills); new drugs approved for a new formulation (e.g., new inactive ingredient); new drugs approved that were previously marketed without a new drug application (NDA); and approved new drugs that changed from prescription to over-the-counter availability. CMS will identify these drugs using the NDA classification code that the FDA assigns to an NDA.
- 17 CMS defines a capital-related asset as an asset that a provider has an economic interest in through ownership (as set forth in the *Provider Reimbursement Manual*, Chapter 1, Section 104.1). The agency includes the following items as examples of capital-related assets: dialysis machines, water purification systems, and systems designed to clean dialysis filters for reuse.
- 18 Because home dialysis machines are capital-related depreciable assets, CMS (1) applies a five-year straight-line depreciation method to determine an annual allowance, by dividing the MAC-determined price by its useful life of five years; (2) divides the annual allowance by the number of treatments expected to be furnished in a year; and (3) reduces the payment by an offset (of \$9.32) that is intended to represent the portion of payment attributable to home dialysis machines from the base rate.
- 19 For example, a Commission analysis found that in 2017, 30 percent of facilities assigned only 1 star did not have a QIP payment reduction in that payment year. Conversely, nearly 10 percent of facilities assigned 4 or 5 stars had some QIP payment reduction. The correlation coefficient between a facility's star rating and QIP score was 0.36, which means there is a positive but somewhat weak correlation between the two quality programs.
- 20 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 21 Based on the Commission's analysis of Medicare and total treatments reported by freestanding facilities on cost reports submitted to CMS.
- 22 Treatments are nonannualized, meaning that the calculation does not account for each beneficiary's length of dialysis (i.e., number of days) in a given year.
- 23 These drug classes accounted for nearly all dialysis drug spending (about 97 percent) in 2010, the year before the start of the new payment method.
- 24 The FDA approved epoetin beta under the biologics license application process, not under the biosimilar process.
- 25 To measure changes in the use of drugs in the payment bundle, we combine drugs within and across therapeutic classes by multiplying the number of drug units reported on claims in a given year by each drug's 2020 ASP. By holding the price constant, we account for the different billing units assigned to a given drug.
- 26 According to CMS, the agency decreased the TDAPA payment for calcimimetics from ASP plus 6 percent to ASP because (1) facilities have had sufficient opportunity to address any administrative complexities and overhead costs associated with the provision of calcimimetics and (2) the agency needs to take into account the financial burden that increased payments place on beneficiaries and Medicare.
- 27 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows: Marginal profit = (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments. This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 28 According to CMS, the increasing cumulative share of beneficiaries with heart failure beginning in 2015 could be associated with the issuance of local coverage determinations in that year by CMS's contractors that required certain conditions, including heart failure, to be reported on dialysis facility claims for Medicare to cover dialysis treatments exceeding thrice weekly (Centers for Medicare & Medicaid Services 2018).
- 29 Blood transfusions are of concern to patients because they (1) carry a small risk of transmitting blood-borne infections to the patient, (2) may cause some patients to develop a reaction, and (3) are costly and inconvenient for patients. Blood transfusions are of particular concern for patients seeking kidney transplantation because they increase a patient's alloantigen sensitization, which can require a patient to wait to receive a transplant.

- 30 See our March 2020 report to the Congress for more information on the factors that affect use of home dialysis and the factors associated with some patients' discontinuation of home dialysis (available at http://www.medpac.gov/docs/default-source/reports/mar20_medpac_ch6_sec.pdf?sfvrsn=0).
- 31 This analysis used 100 percent of 2014 through 2019 carrier and outpatient claims submitted for KDE services.
- 32 MIPPA does not permit other providers (such as registered nurses, social workers, and dieticians) or dialysis facilities to bill for KDE services.
- 33 In addition, for beneficiaries with AKI, Medicare pays dialysis facilities separately for drugs, biologicals, and laboratory services that are not renal dialysis services.
- 34 In 2018, about 90 percent of FFS dialysis beneficiaries were enrolled in Part D or had other sources of creditable drug coverage. About 10 percent of FFS dialysis beneficiaries in 2018 had either no Part D coverage or coverage less generous than Part D's standard benefit.
- 35 Freestanding dialysis facility cost reports do not collect the cost of calcimimetics separately from other ESRD drugs. To estimate providers' cost of calcimimetics, we determined the difference between 2017 and 2019 in the cost per treatment for other ESRD drugs (that are neither ESAs nor composite rate drugs). Between 2014 and 2017, the cost per treatment for other ESRD drugs declined by 13 percent per year.
- 36 One of the two LDOs reported calcimimetic costs ranging from \$4 per treatment to \$11 per treatment in 2019.
- 37 Given the vertical integration of the outpatient dialysis sector, such an audit could assess the reporting of costs by facilities for services purchased by a related organization. Under current regulation, if a provider obtains services from an organization that is owned or controlled by the provider's owner, reimbursable cost should include the costs for these items at the supplying organization's cost. However, if the price in the open market for comparable services is lower than the supplier's cost, the allowable cost to the provider may not exceed the market price.
- 38 As a result of rebasing, in 2014, CMS reduced the base payment rate by \$8.16 to \$239.02.
- 39 The Commission's longstanding approach to calculating the Medicare ESRD PPS margin uses only Medicare-allowable costs for ESRD services. Such an approach is consistent with the methods we use to calculate the Medicare margin for other FFS sectors. Our ESRD margin analysis relies on the cost data that freestanding dialysis facilities report on the cost reports that they submit to CMS. In 2019, there was an anomalous increase in non-ESRD drug costs compared to prior years. Consistent with our longstanding approach, non-ESRD drug costs are not included in the Commission's analysis of ESRD PPS costs incurred by freestanding dialysis facilities or in our calculation of the ESRD PPS margin.
- 40 The FDA delayed the drug's PDUFA date by three months (from December 30, 2020 to March 30, 2021) to review additional analyses of existing clinical data.

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CHAPTER

7

Skilled nursing facility services

R E C O M M E N D A T I O N

- 7** For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Skilled nursing facility services

Chapter summary

In skilled nursing facilities (SNFs), Medicare covers short-term skilled nursing and rehabilitation services to beneficiaries after a stay in an acute care hospital. In 2019, about 15,000 SNFs furnished about 2 million Medicare-covered stays to 1.5 million fee-for-service (FFS) beneficiaries (4 percent of Medicare’s FFS beneficiaries). FFS Medicare spending on SNF services was \$27.8 billion in 2019. Most SNFs are also certified as nursing homes that furnish long-term care services, which Medicare does not cover.

Nursing homes have been particularly hard hit by the coronavirus pandemic and the associated public health emergency (PHE). As devastating as the pandemic’s effects have been—on staff and residents and their families and friends, and on providers’ costs and volume—we expect the industry to eventually rebound, though its recovery may be sluggish and will vary by provider and market. To recommend a payment rate update for 2022, we review the adequacy of Medicare’s payments using the most recent complete data we have available and make our best effort to consider how Medicare’s payments will compare with the costs of Medicare-covered stays in 2021, noting that the future is highly uncertain. Where relevant, we have considered the effects of the coronavirus PHE on our payment adequacy indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary or vary significantly across SNFs,

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payment rates change in 2022?
- Medicaid trends

they are best addressed through targeted temporary funding policies rather than a permanent change to SNF payment rates in 2022 and future years. Based on information available at the time of publication, we expect certain long-term PHE-related effects that warrant inclusion in the annual update to SNF payments in 2022, including additional costs for testing and infection control.

Assessment of payment adequacy

To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, provider access to capital, and Medicare payments in relation to providers' costs to treat Medicare FFS beneficiaries. Most indicators of the adequacy of Medicare's payments are positive.

Beneficiaries' access to care—Before the PHE, access to SNF services was adequate for most beneficiaries.

- ***Capacity and supply of providers***—The number of SNFs participating in the Medicare program has been stable for many years. In 2019, the vast majority (90 percent) of beneficiaries lived 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). Between 2018 and 2019, the median occupancy rate declined slightly but remained high (about 85 percent). During the PHE, occupancy slid more than 10 percentage points and has not recovered as of the time of this writing. This decline is unrelated to the adequacy of Medicare's payments.
- ***Volume of services***—Between 2018 and 2019, Medicare-covered admissions per capita decreased 4.8 percent, consistent with a decrease in the number of hospital stays that last at least three days (required for Medicare coverage). The length of SNF stays also declined slightly, resulting in more than a 5 percent decrease in days per capita. During the PHE, temporary changes in coverage rules tempered the reductions in Medicare volume beginning in March 2020.
- ***Marginal profit***—An indicator of whether SNFs have an incentive to treat more Medicare beneficiaries, the marginal profit, in aggregate was almost 20 percent for freestanding facilities in 2019. This high level of marginal profit is a strong, positive indicator of beneficiary access to SNF care.

Quality of care—Between 2018 and 2019, consistent with the trend since 2015, rates of successful discharge to the community have increased and hospitalizations have decreased.

Providers' access to capital—Because most SNFs are part of nursing homes, we examine nursing homes' access to capital. Before the PHE, access to capital was

adequate, and though lending activity has stalled during the PHE, it is expected to be good in 2021. In 2019, the total margin (a measure of the total financial performance across all payers and lines of business for the facility) was 0.6 percent. Any lending wariness reflects broad changes in post-acute care, not the adequacy of Medicare's payments. Medicare is regarded as a preferred payer of SNF services.

Medicare payments and providers' costs—In 2019, Medicare's FFS spending on SNF care decreased 2 percent to \$27.8 billion. The aggregate Medicare margin for freestanding SNFs was 11.3 percent. Margins varied greatly across facilities, reflecting economies of scale and the share of days assigned to the most profitable rehabilitation case-mix group.

The level of Medicare's FFS payments remains well above the cost of Medicare-covered stays. Since 2000, the average Medicare margin has been above 10 percent, and the very high Medicare margin (19.2 percent) for efficient SNFs—those providers with relatively low costs and high quality—is further evidence that Medicare continues to overpay for SNF care. Medicare Advantage (MA) plans' payment rates, considered attractive by many SNFs, are much lower than the program's FFS payments and are unlikely to be explained by the differences in patient characteristics between SNF users enrolled in MA and FFS.

In 2021, providers are likely to incur higher costs associated with post-PHE changes in practices (e.g., higher expenditures for personal protective equipment and testing). We also expect Medicare volume to not fully recover to pre-PHE levels, at least in the near term. Providers will continue to adjust their practices to the new case-mix system that was implemented on October 1, 2019. Acknowledging the many uncertainties regarding the costs and payments after the PHE, we estimate the the aggregate Medicare margin in 2021 will be about 10 percent.

How should Medicare payment rates change in 2022?

Considering these factors, the Commission recommends that, for fiscal year 2022, the Congress eliminate the update to the fiscal year 2021 Medicare base payment rates for SNFs. While the projected level of payments indicates that payments need to be reduced to more closely align aggregate payments and costs, the lasting impacts of COVID-19 on SNFs and the effects of the new case-mix system are uncertain. Because the SNF industry is likely to undergo considerable changes as it adjusts to both, 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, we report on Medicaid use and spending and non-Medicare (private-payer and Medicaid) margins for nursing homes. Medicaid finances most long-term care services provided in nursing homes, but it also 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. Between 2019 and 2020, the number of Medicaid-certified facilities declined less than 1 percent, to about 15,000. Medicaid spending was \$39 billion in 2019, about 5 percent less than in 2018.

In 2019, the aggregate total margin—reflecting all payers and all lines of business—was 0.6 percent, an increase from 2018. The average non-Medicare margin (which includes all payers and all lines of business except Medicare FFS SNF services) was -2 percent, also an improvement from 2018. ■

Background

Skilled nursing facilities (SNFs) provide short-term skilled nursing care and rehabilitation services such as physical and occupational therapy and speech–language pathology services. Examples of SNF patients include beneficiaries recovering from surgical procedures such as hip and knee replacements or from medical conditions such as heart failure.¹ In 2019, almost 1.5 million Medicare fee-for-service (FFS) beneficiaries (4 percent of FFS Medicare Part A beneficiaries) used SNF services at least once; program spending on SNF services was \$27.8 billion (about 7 percent of FFS spending) (Boards of Trustees 2020, Office of the Actuary 2020b).² Medicare’s median payment per day was \$498, and its median payment per stay was \$18,559. In 2019, one-fifth of hospitalized beneficiaries were discharged to SNFs.

Medicare coverage

Medicare covers up to 100 days of SNF care per spell of illness after a medically necessary inpatient hospital stay of at least 3 days.³ For beneficiaries who qualify for a covered stay, Medicare pays 100 percent of the payment for the first 20 days of the spell of illness. Beginning with day 21, beneficiaries are responsible for copayments through day 100 of the covered stay. For fiscal year 2021, the copayment is \$185.50 per day.

To qualify for Medicare coverage, all SNF users have a preceding hospital stay of at least three days. In 2019, the five most common hospital conditions of patients referred to SNFs for post-acute care were septicemia; joint replacement; heart failure and shock; hip and femur procedures (except major joint replacement); and kidney and urinary tract infections. In 2019, CMS implemented a final rule requiring hospitals to provide beneficiaries at discharge with information about the quality of SNFs that may help them make more informed decisions about where to get this care (Centers for Medicare & Medicaid Services 2019).

During the public health emergency (PHE) declared by the Secretary of Health and Human Services, to help reserve hospital capacity for treating COVID-19 patients, CMS temporarily waived the three-day prior hospital stay requirement beginning in March 2020.⁴ This change allowed facilities to bill Medicare for long-stay residents requiring skilled care without a preceding hospitalization, referred to as “skilling in place.” The discharge information requirements for hospitals were also waived

during the PHE. The temporary policies are scheduled to end in April 2021.

Composition of the industry

The term *skilled nursing facility* refers to a provider that meets Medicare requirements for Part A coverage.⁵ Most SNFs (more than 90 percent) are dually certified as SNFs and nursing homes (which typically provide less intensive, long-term care services). Thus, a facility that provides skilled care often also provides long-term care services that Medicare does not cover. The less intensive long-term care services typically make up the bulk of a facility’s business, and Medicaid pays for the majority of this care.

The SNF industry is made up almost entirely of freestanding facilities, and the majority are for profit (Table 7-1, p. 202). In 2019, 96 percent of facilities were freestanding, and they accounted for an even larger share of Medicare spending (97 percent). For-profit facilities accounted for 71 percent of providers and Medicare-covered stays and 75 percent of Medicare spending.

Freestanding SNFs vary by size. In 2019, the median SNF had 100 beds, but 10 percent of facilities had 173 or more beds and 10 percent of facilities had 50 beds or fewer. Nonprofit facilities and rural facilities are generally smaller than for-profit and urban facilities. Small facilities (under 50 beds) are not limited to rural locations. The majority are located in metropolitan areas, and less than 10 percent are located in the most rural counties or in frontier areas (counties with six or fewer persons per square mile) (Medicare Payment Advisory Commission 2020).⁶

Medicare FFS–covered SNF days typically account for a small share of a facility’s total patient days but a disproportionately larger share of a facility’s revenues. In freestanding facilities in 2019, Medicare’s median share of facility days was 9 percent but 16 percent of facility revenue. FFS Medicare’s share of SNF revenue has steadily declined as an increasing share of beneficiaries are enrolled in Medicare Advantage (MA) plans, whose days and revenue are not included in these figures.

CMS implemented a new case-mix system on October 1, 2019

By statute, Medicare uses a prospective payment system (PPS) to pay SNFs for each day of service.⁷ By controlling length of stay, providers can influence how much Medicare will pay them for their services. Information

**TABLE
7-1****Freestanding SNFs and for-profit SNFs accounted for the majority of facilities, Medicare stays, and program spending, 2019**

Type of SNF	Facilities	Medicare-covered stays	Program spending
Total number	14,923	2,069,107	\$24.9 billion
Freestanding	96%	96%	97%
Hospital based	4	4	3
Urban	73	84	85
Rural	27	16	15
For profit	71	71	75
Nonprofit	23	25	22
Government	6	4	3

Note: SNF (skilled nursing facility). The spending amount included here is lower than that reported by the Office of the Actuary, and the count of SNFs is slightly lower than what is reported in CMS's Survey and Certification Providing Data Quickly system.

Source: MedPAC analysis of the Provider of Services and Medicare Provider Analysis and Review files for 2019.

gathered from a standardized patient assessment instrument—the Minimum Data Set—is used to classify patients into case-mix categories. How complete and accurate the patient assessment information is can also influence payments.

Before October 1, 2019, the PPS had two fundamental shortcomings: It encouraged the provision of excessive rehabilitation therapy services and did not accurately target payments for nontherapy ancillary (NTA) items such as drugs. As a result, providers preferred to admit patients requiring rehabilitation care and avoided medically complex patients. Spending between January and September 2019 reflected these incentives.

Beginning on October 1, 2019, CMS implemented a new case-mix system, the Patient-Driven Payment Model (PDPM), which shifted providers' incentives.⁸ The PDPM was expected to redistribute payments from rehabilitation care to medically complex care (Centers for Medicare & Medicaid Services 2018). Six components—nursing, physical therapy, occupational therapy, speech–language pathology, NTA, and room and board—are summed to establish a daily payment.⁹ Depending on the component, the following information is used to adjust payments: the primary reason for treatment, prior surgery, comorbidities, functional status, cognitive status, swallowing and

nutritional status, depression, and special treatments (such as ventilator care). Group and concurrent therapies together are limited to 25 percent of total therapy minutes—per stay and per therapy discipline—so that individual therapy remains the dominant modality.

With the profitable therapy services no longer encouraged, differences in financial performance across providers hinge on the recording of medical conditions and functional status rather than the provision of therapy. The trade press reports that the best performers under the PDPM had higher shares of “special care high” nursing days (e.g., patients with septicemia or chronic obstructive pulmonary disease who also had low functional ability) and patients recorded as having depression, but their therapy mixes did not differ (Spanko 2020c). Providers are likely to continue to improve the recording of patient information as they gain experience with the new case-mix system and understand the importance of certain patient assessment items for payment. The trade press has reported that the recording of depression and the need for respiratory therapy represent such opportunities (Flynn 2020a, Flynn 2020d).

Though intended to be budget neutral, the new case-mix system appears to have increased payments. Our analysis of claims from the first quarter of the PDPM (October

through December 2019) found that average payments per day were 7 percent higher than the average daily payments for the nine months of 2019 under the old case-mix system, and the increase was seen beginning in October. In addition to the update (2.4 percent), the increase reflects a combination of higher payments for the same cases and, if SNFs admitted a different mix of cases, higher case complexity. Before the PHE, publicly traded nursing home companies reported positive effects of the PDPM on payments (Genesis Healthcare 2020, Omega HealthCare Investors 2020, SABRA Health Care REIT 2020).

In the fiscal year 2021 final rule, CMS stated that an across-the-board adjustment may be needed to retain budget neutrality, but it did not have sufficient information to determine the adjustment (Centers for Medicare & Medicaid Services 2020c). The changes in costs, case-mix, and policy changes as a result of the PHE will further complicate and delay this assessment. By shifting providers' focus away from intensive therapy to clinical models of care, the industry reported that the new case-mix system enabled them to capture more of the comorbidities and costs associated with treating COVID-19 patients (American Health Care Association 2020).

Are Medicare payments adequate in 2021?

To examine the adequacy of Medicare's FFS payments, we analyze beneficiaries' access to care (including the supply of providers and volume of services), quality of care, providers' access to capital, Medicare FFS payments in relation to costs to treat Medicare beneficiaries, and changes in payments and costs. We also compare the characteristics of relatively efficient SNFs with other SNFs. Throughout the section, we note the effects of the coronavirus pandemic, starting with the text box on the impact on nursing homes (p. 204).

Beneficiaries' access to care: Access was adequate for most beneficiaries and volume is expected to slowly recover from PHE declines

We do not have direct measures of access to care in part because the need for SNF care, as opposed to the need for a different post-acute care (PAC) service or none at all, is not well defined. Instead, we consider the supply and capacity of providers and evaluate changes in service

volume. We also assess whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

SNF supply is stable

The SNF industry is highly fragmented and characterized by independent providers and local and regional chains. Of the 50 largest operators, most are privately held. In 2018, the 25 largest nursing home chains in the country operated about 19 percent of all facilities (IQVIA Institute for Human Data Science 2018). One study of chains found that new entrants tended to locate in the same state but not in the same markets in which the chains already have holdings (Hirth et al. 2019).

The number of SNFs participating in the Medicare program in 2020 was fairly stable at 15,127. Of the 43 new facilities, the majority were for profit, and of the 93 terminations as of November 2020 (less than 1 percent of SNFs), most closed at their own initiative (i.e., they were not terminated by the program). There were fewer terminations in 2020 than at the same point in 2019, indicating that, to date, the PHE has not resulted in an increase in the number of closures. In 2019 and 2020, the rates of closure were comparable between for-profit and nonprofit facilities, consistent with a study of nursing home closures since 2015 (Flinn 2020a). Typically, facilities close as the result of several factors: the reportedly low Medicaid rates, lower payment rates paid by MA plans and their lower use of SNFs, and the overexpansion of the SNF supply (in states that do not have certificate-of-need laws). Terminations will affect access to SNF care for those beneficiaries who live in a county with few options, further limited by a closure. In 2019, 90 percent of beneficiaries lived in counties with three or more SNFs or swing bed facilities (rural hospitals with beds that can serve as either SNF beds or acute care beds). If closures occur in counties with only one SNF or swing bed facility, beneficiaries who live in these areas (3.3 percent of beneficiaries) might have more difficulty obtaining SNF care.

Pre-PHE, median occupancy rates for freestanding SNFs were high, though they have slowly declined over time, from 88 percent in 2010 to 85 percent in 2019. Occupancy rates vary widely: In 2019, one-quarter of freestanding facilities had occupancy rates at or below 72 percent, while another quarter had rates 91 percent or higher. Median occupancy rates for rural facilities and for-profit facilities

The impact of COVID-19 on nursing homes

The coronavirus pandemic and associated public health emergency (PHE) has had tragic effects on beneficiaries' health. It also has had material effects on providers' patient volume, revenues, and costs. The effects of COVID-19 have varied considerably both geographically and over time, and it is not clear when the full effects of the pandemic will end. Though weekly cases and deaths decreased through the summer of 2020, both steadily increased after mid-September 2020, with spikes occurring late in the year due to holiday-related community outbreaks and new variants of the COVID-19 virus.

Nursing home residents and staff have been particularly hard hit by the PHE. For months, infection and mortality rates were high and facilities were often unable to access testing and affordable personal protective equipment (PPE). To help control infections, facilities were required to be closed to visitors and barred from conducting communal activities. Residents have borne the emotional and physical health effects of isolation, while frontline workers face challenging work conditions. By late summer, as nursing homes were able to access PPE and testing, homes were allowed to reopen to outside visitors and conduct limited communal activities. But as local infection rates flared, CMS guidance resulted in the reimposition of restrictions on visits.

Nursing homes have benefited from federal grants and loans and temporary policy changes that eased the impact of PHE-related lower volume (and associated reductions in revenue) and higher costs for staffing, PPE, and testing. The temporary suspension of the sequestration increased Medicare payments. The federal grants and loans will affect total facility margins, but

not Medicare margins, in 2020. Facility volume remains below prepandemic levels due to a combination of deaths, move-outs, restrictions on hospital transfers, fewer hospital referrals, and delayed or averted admissions. Eventually, the sector is likely to mostly recover, but the effects of the pandemic on patterns of care, volume, and financial performance in 2020 and 2021 are still unclear. The short-term effects of COVID-19 have been highly variable and, as discussed below, are best considered in temporary and targeted payments to individual providers. Volume may remain depressed for even longer as beneficiaries seeking long-term care or post-acute care avoid this setting.

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have are generally from 2019. The coronavirus PHE created additional data lags, most notably for cost reports because the deadlines for their submission were extended. As always, we use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the effects of COVID-19 are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that will also affect payments in future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of COVID-19 on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic are factored into recommended permanent changes in Medicare payment rates. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2). ■

were lower than for urban facilities and nonprofit facilities. By state, median occupancy rates ranged from 62 percent (Montana) to 95 percent (Alaska). Of the 12 states plus the District of Columbia with median occupancy rates at or above 90 percent, 10 have certificate-of-need laws limiting industry expansion (though 8 states suspended these laws during the PHE). Given the relatively high occupancy rates in many facilities, a bed may not be available in the market

when a beneficiary is seeking placement, particularly if he or she requires special services.

Between 2018 and 2019, SNF admissions decreased and stays shortened

In 2019, 3.9 percent of FFS beneficiaries used SNF services, nearly equal to the share in 2018. Between 2018 and 2019, SNF admissions per 1,000 FFS beneficiaries

**TABLE
7-2**

SNF admissions and days continued to decline in 2019

Volume measure	2010	2012	2014	2016	2018	2019	Percent change 2018–2019	Percent change 2010–2019
Covered admissions per 1,000 FFS beneficiaries	73.0	69.0	68.3	65.9	62.5	59.5	–4.8%	–18.5%
Covered days per 1,000 FFS beneficiaries	1,972	1,893	1,843	1,693	1,559	1,475	–5.4	–25.2
Covered days per admission	27.1	27.4	27.0	25.7	25.0	24.8	–0.8	–8.5

Note: SNF (skilled nursing facility), FFS (fee-for-service). “FFS beneficiaries” includes users and non-users of SNF services. Data include 50 states and the District of Columbia.

Source: Centers for Medicare & Medicaid Services 2020d.

decreased 4.8 percent (Table 7-2) (Centers for Medicare & Medicaid Services 2020d). We examine service use for only FFS beneficiaries because the CMS data on users, days, and admissions do not include service use by beneficiaries enrolled in MA plans. Covered days per admission also declined, to 24.8 days. The combination of fewer admissions and shorter stays resulted in 5.4 percent fewer days per 1,000 beneficiaries. Since 2010, admissions per capita have declined about 18 percent, and covered days per admission have dropped over 8 percent.

Several factors contributed to the decline in SNF admissions between 2018 and 2019. First, given coverage rules, the rate of SNF use parallels inpatient hospital use. During this period, per capita FFS inpatient hospital stays that were three days or longer declined 2.5 percent. The increased use of observation stays is another factor. Because patients who are treated in observation units are not technically admitted, their observation stays, even if three days or longer, do not qualify them for Medicare coverage of subsequent SNF use. Declines in service use also reflect a growing presence of alternative payment models (APMs), such as accountable care organizations and bundled payment demonstrations. These APMs create financial incentives for entities to lower their spending and use of services by avoiding PAC altogether (for example, referring beneficiaries to outpatient therapy instead), shortening SNF stays, and using lower cost home health care when possible.

Before the PHE, access to SNF care for beneficiaries was generally good. Medicare’s high payment rates ensured that short-stay beneficiaries were preferable to other patients. Some providers may have avoided beneficiaries who were likely to require long stays and exhaust their Medicare benefits. In such cases, a facility’s daily payments could decline if the patient became eligible for Medicaid or the stay resulted in bad debt.

During the PHE, access may be impaired depending on local-market COVID-19 conditions, hospital referral patterns, and an individual facility’s admitting policies (see text box on service use during the PHE, p. 206). CMS’s waiver of the required three-day hospital stay tempered what might have otherwise been larger volume declines.

Marginal profit: A measure of the attractiveness of Medicare patients

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.¹⁰ The aggregate marginal profit in 2019 was 19.7 percent, indicating that facilities

Service use during the public health emergency

During the public health emergency (PHE), skilled nursing facilities (SNFs) have had varying admission practices. Some states required nursing homes to admit COVID-19–positive cases; other SNFs restricted their capacity so they could isolate infected individuals; and a small number of facilities converted to treating only COVID-19–positive individuals. We have not assessed whether Medicare’s payments for COVID-19 patients cover the costs of care, which would be one indicator of whether Medicare beneficiaries would be attractive to admit.

The demand for SNF services declined when referring hospitals stopped performing elective surgery in mid-March 2020. Of the beneficiaries who were discharged from the hospital, many opted to bypass SNFs and go directly home when possible. The declines in occupancy rates varied considerably by local market and timing of COVID-19 case rates.

After hospital volume started to return in May, SNF occupancy rates have been slow to recover and remain, as of mid-December 2020, more than 10 percentage points below their levels in February. However, Medicare’s share of days and revenues increased between March and August, indicating that the “skilling in place” (which shifts financial responsibility for some care from Medicaid to Medicare) had a positive effect on facilities’ financial position (National Investment Center for Seniors Housing & Care 2020). When the temporary waiver expires, some Medicare utilization will revert to being covered by Medicaid. As a result, Medicare volume may decline and may not recover until staff and residents can be readily tested and vaccinated. We will have more information next year when we conduct our analyses of the adequacy of 2020 payments to support our update recommendation for fiscal year 2023. ■

with available beds had an incentive to admit Medicare patients. This high level of marginal profit is a strong positive indicator of beneficiary access to SNF care.

Quality of care: Measures indicate small improvements

We evaluate quality of care using two measures: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay. Successful discharge to the community includes beneficiaries discharged to the community (including those discharged to the same nursing home where the beneficiary was before the hospitalization) who did not have an unplanned hospitalization and did not die in the next 30 days. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that

occur during the stay. Each measure is uniformly defined and risk adjusted across home health agencies, SNFs, inpatient rehabilitation facilities, and long-term care hospitals—thus taking another step toward achieving a unified payment system and evaluation of outcomes across PAC settings.¹¹

Between 2015 and 2019, both quality measures—risk-adjusted rates of successful discharge to the community and hospitalization—improved. During that period, the average rate of successful discharge to the community rose from 43.9 percent to 45.8 percent (higher rates are better), while the average hospitalization rate dropped from 15.1 percent to 13.7 percent (lower rates are better) (Table 7-3). Nonprofit facilities and hospital-based facilities had better performance than their for-profit and freestanding counterparts: They had higher rates of discharge to the community and lower hospitalization rates.

**TABLE
7-3**

SNFs' quality measures improved slightly between 2015 and 2019

Measure/subgroup	2015	2016	2017	2018	2019	Average annual change	
						2018-2019	2015-2019
Successful discharge to the community							
All SNFs	43.9%	44.5%	44.4%	44.3%	45.8%	3.2%	1.1%
For profit	43.0	43.7	43.6	43.5	44.8	3.0	1.0
Nonprofit	47.2	47.7	47.6	47.4	48.7	2.7	0.8
Freestanding	43.4	44.1	44.0	44.0	45.4	3.3	1.1
Hospital based	52.9	53.3	53.8	52.8	53.8	2.0	0.4
Hospitalizations							
All SNFs	15.1	14.5	14.4	14.1	13.7	-3.1	-2.4
For profit	15.7	15.0	14.9	14.6	14.2	-2.6	-2.4
Nonprofit	13.3	12.8	12.9	12.7	12.3	-2.9	-2.0
Freestanding	15.3	14.7	14.6	14.3	13.8	-3.0	-2.5
Hospital based	10.6	10.1	10.2	10.6	10.0	-5.4	-1.5

Note: SNF (skilled nursing facility). "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home they were in before) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions, readmissions, and outpatient observation stays that occur during the SNF stay. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. The "All SNFs" category includes the performance of government-owned SNFs, which are not displayed separately in the table. The average annual changes were calculated using unrounded annual rates.

Source: MedPAC analysis of SNF claims and linked inpatient hospital stays 2015 through 2019 for fee-for-service beneficiaries.

Considerable variation exists across the industry in performance on the quality measures we track. The lowest performing quarter of facilities in 2019 had risk-adjusted rates of successful discharge to the community at or below 39.5 percent, whereas the best performing quarter of facilities had rates of 53.5 percent or higher (Table 7-4, p. 208). Even larger variation was seen in the hospitalization rates. The worst performing quartile had rates at or above 16.4 percent, whereas the best quartile had rates at or below 10.6 percent. The amount of variation across providers suggests considerable room for improvement, all else being equal.

We no longer include measures of functional improvement in our assessment of quality. While the Commission contends that maintaining and improving functional status

is a key goal of PAC, the Commission has raised serious questions about the integrity of this information (Medicare Payment Advisory Commission 2019). Because functional assessments are used in the case-mix system to establish payments, it is unlikely that this information can be divorced from payment incentives. Yet, because functional outcomes are critically important to patients, improving the reporting of assessment data such that these outcomes can be adequately assessed is desirable. In its June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

**TABLE
7-4**

Quality measures vary considerably across SNFs, 2019

Quality measure	Risk-adjusted rates		
	Mean	25th percentile	75th percentile
Successful discharge to the community	45.8%	39.5%	53.5%
Hospitalizations during the stay	13.7	10.6	16.4

Note: SNF (skilled nursing facility). Higher rates of discharge to community indicate better quality. Higher readmission rates indicate worse quality. Rates are the average of facility rates and calculated for all facilities with 60 or more stays.

Source: MedPAC analysis of 2019 SNF claims and linked inpatient hospital stays for fee-for-service beneficiaries.

A high-level summary of the effects of COVID-19 on nursing home quality and safety is discussed in the text box.

SNF value-based purchasing program

As part of the Protecting Access to Medicare Act of 2014 (PAMA), the Congress enacted a SNF value-based purchasing (VBP) program that began adjusting payments to providers in October 2018. The program uses one measure of performance—readmissions for any cause within 30 days of discharge from the preceding hospital stay. The VBP program withholds 2 percent of payments from providers meeting the minimum case count to participate in the program. Of the withheld amount, 60 percent is returned to providers as incentive payments and 40 percent is retained as program savings. In each of the first two years of the program, the majority of providers earned back some portion of the 2 percent of payments withheld, but, on net, their payments remained below what they would have been without the program. During the PHE, CMS announced that it would exclude claims from January 1, 2020, through June 30, 2020, from the VBP calculations but reserved the right to extend the exclusion period depending on the PHE.

The Consolidated Appropriations Act, 2021, made three changes to the SNF VBP. First, it gave the Secretary of Health and Human Services the authority to expand the measure set. An expanded measure set can affect payments beginning in fiscal year 2024. Second, the program cannot apply to providers that do not have a minimum number

of cases for each measure. Third, the measures and data submitted to calculate the measures must be validated.

PAMA required the Commission to report on the status of the VBP program and make recommendations as appropriate. In September 2020, the Commission discussed several shortcomings of the program’s design; in October 2020, it considered an alternative design that corrects them. Those discussions highlighted the lack of claims-based quality measures and a measure of patient experience for all PAC providers, including SNFs. Regarding the incentives established by the program, the trade press has noted that the size of the program’s payments may be too small to change behavior (Spanko 2018). Quality improvement might be accelerated if the program’s incentive payments were larger—either by fully paying out the amounts withheld from payments as incentive payments (rather than retaining a portion as program savings) or increasing the amount withheld. The Commission will include its review of the program and any recommendations in its June 2021 report to the Congress.

Providers’ access to capital remains adequate

Access to capital allows SNFs to maintain, modernize, and expand their facilities. The vast majority of SNFs are part of a nursing facility. Therefore, in assessing SNFs’ access to capital, we look at the availability of capital for nursing homes. With restrictions placed on bed supply in many states (35 states plus the District of Columbia have

Impact of COVID-19 on nursing home quality and safety

Nursing homes were hit especially hard by the public health emergency (PHE). Between late May (when facilities began reporting COVID-19–related information to CMS) and December 13, 2020, facilities reported 441,473 confirmed cases among residents and 86,775 COVID-19 resident deaths (Centers for Medicare & Medicaid Services 2020b). Case rates and deaths per 1,000 residents varied widely by state and over time, as the virus peaked and waned by local market. Researchers found that outbreaks were tied to facility location, prevalence of COVID-19 in the community, and facility size—and not quality ratings or ownership (Abrams et al. 2020, Gorges and Konetzka 2020). Nursing homes with relatively high shares of Black or Hispanic residents were more likely to have had at least one COVID-19 case (and their outbreaks were larger) and at least one death compared with other nursing homes (Chidambaram et al. 2020).

For months into the PHE, operators reported an inability to procure personal protective equipment (PPE) and testing, and they lacked adequate infection control practices to curb the virus’s spread. To increase the availability of COVID-19 testing, the federal government sent testing equipment and tests directly to nursing homes. Signaling improvement, the president

of the largest nursing home trade association reported in October that testing and PPE were more widely available and that operators had a better understanding of how to handle outbreaks (Flynn 2020b). Still, in mid-December, 10 percent of the facilities submitting data reported not having a week’s supply of masks, eye protection, gowns, gloves, and hand sanitizer (Centers for Medicare & Medicaid Services 2020b).

CMS and the Centers for Disease Control and Prevention undertook many actions aimed at mitigating the impact of COVID-19. They issued guidance on the use of telehealth, visitation and communal activities, infection control, isolation of suspected or confirmed cases, and the frequency of testing of staff and residents. To increase transparency during the PHE, they required nursing homes to report COVID-19–related metrics, including infection and mortality rates among residents and staff, facility capacity, staffing shortages, testing capacity and turnaround times, and the availability of PPE and ventilator capacity. A CMS-convened commission issued recommendations regarding testing and screening, equipment and PPE, visitation and cohorting of infected individuals, workforce, sharing of best practices, and the Nursing Home Compare website (Coronavirus Commission for Safety and Quality in Nursing Homes 2020). ■

certificate-of-need laws that regulate nursing home bed supply), capital is less likely to finance new construction than to update facilities or finance purchases of existing facilities (National Conference of State Legislatures 2019). Because Medicare makes up a minority share of most nursing homes’ revenues, access to capital generally reflects factors other than the adequacy of Medicare’s payments.

In 2020, access to capital slowed during the early months of the PHE but then started to open up and is reported to be widely available in many markets (Cain Brothers 2020). Valuations have been complicated by uncertainty

about the impact of COVID-19 on operations and how to consider the federal funds and policies in assessing an operator’s assets. Compared with other sectors, there were more deals involving long-term care, and those deals totaled over \$4 billion (PricewaterhouseCoopers 2020). The merger and acquisition activity was partly the result of real estate investment trusts (REITs) scaling back their holdings and private equity firms expanding theirs. The interest of private equity firms in the SNF setting is expected to continue (Flynn 2020c). Further sparking interest are low lending rates. Other activity was generated by national companies shedding assets that did

not fit into a more geographically focused portfolio. Some poor-performing SNFs were sold to investors looking for turnaround opportunities. Acquisitions and consolidations could accelerate in 2021 as SNFs with poor financial performance exit the market. In 2021, nursing homes may have increased demand for capital for renovations if facilities opt to create single-occupancy rooms and negative-pressure rooms and to improve their ventilation systems.

The Department of Housing and Urban Development (HUD) continues to be an important lending source for this sector. Section 232 loans help finance nursing homes by providing lenders with protection against losses if borrowers default on their mortgage loans. In fiscal year 2020, HUD financed 323 projects, with the aggregate insured amount totaling \$4.8 billion (Department of Housing and Urban Development 2020). Both the number of projects and amounts insured were substantial increases over 2019 (12 percent and 17 percent, respectively).

Total margins were positive in 2019

The estimated aggregate total margin for nursing homes (reflecting all lines of business and all payers) in 2019 was slightly positive (0.6 percent). Except for fiscal year 2018 (when the total margin was slightly negative, -0.3 percent), total margins have been slightly positive (ranging from 0.6 percent to 3.8 percent) since 2001. Because a “total margin” includes Medicaid-funded long-term care (the nursing home portion of the business), the overall financial performance of this setting is heavily influenced by state policies regarding the level of Medicaid payments and the ease of entry into a market (e.g., whether there is a requirement for a certificate of need). The industry has long argued that high Medicare margins are needed to subsidize its reported losses from Medicaid. The Commission contends that this cross-subsidization is poor policy for several reasons (see text box on not subsidizing other payments).

Access to federal and other coronavirus PHE-related funding helped maintain operations in 2020

During 2020, federal funds and programs greatly helped this sector maintain its operations. Provider relief funds, amounting to about 2 percent of total revenues, were slated to help prevent, prepare for, and respond to the COVID-19 outbreak and for reimbursing providers for

lost revenues and health care-related expenses attributable to COVID-19. Other programs included the Medicare accelerated and advance payments program, employer payroll tax deferral, paycheck protection program, and temporary elimination of the sequester.¹² SNFs varied in whether they participated in the optional paycheck protection and advanced payment programs.¹³ An additional \$11.2 billion was targeted to nursing homes. The industry reports that the federal funds were essential to offset the increased costs and decreased revenue that has accompanied the PHE. The Commission estimated that these funds would have underwritten the expected reductions to net revenues and increased costs for 8 to 10 months from the beginning of the PHE, though the impact would vary considerably across individual facilities. Evidence from two large nursing home companies illustrates the uneven and uncertain effects of COVID-19 on nursing home providers' finances, with one company unsure it will survive through 2021 and another returning federal funds after recording record profits (Ensign Group 2020, Genesis Healthcare 2020).

In addition to federal assistance, many states temporarily raised Medicaid rates (Flinn 2020b). Some REITs offered rent reductions to offset the financial difficulties some operators faced; these reductions are likely to be offered in 2021 as well (Spanko 2020b). In mid-December 2020, LTC Properties, a publicly traded REIT, announced that it would lower the rent escalators for its operating partners (LTC REIT 2020).

Although the PHE has had a profound impact on the industry, analysts remain optimistic about the sector (Cain Brothers 2020, Fitch Ratings 2020). The total margins are slim and occupancy rates will be slow to fully rebound, but the industry has the advantages of demographic trends and of being a lower cost alternative to other institutional PAC. Further, investors consider the setting a relatively “safe bet” given its reliance on government funds (Spanko 2020a). Any reluctance to invest in this setting does not reflect the adequacy of Medicare's FFS SNF payments: Medicare remains a preferred payer.

Medicare payments and providers' costs: Medicare margins remained high in 2019

In 2019, the aggregate Medicare margin for freestanding SNFs was 11.3 percent. Margins for individual facilities varied considerably across providers. Large SNFs, SNFs with lower average daily costs, and for-profit facilities had

Medicare's skilled nursing facility payments should not subsidize payments from Medicaid or other payers

Medicare payments to skilled nursing facilities (SNFs), which are financed by taxpayer contributions to the Part A Trust Fund, effectively subsidize payments from other payers, most notably Medicaid. High Medicare payments also likely subsidize payments from private payers. Industry representatives contend that this subsidization should continue, but the Commission believes such cross-subsidization is poor policy for several reasons. First, it results in poorly targeted subsidies. Facilities with high shares of Medicare beneficiary days receive the most in “subsidies” from higher Medicare payments, while facilities with low shares of Medicare beneficiary days—presumably the facilities with the greatest financial need—receive the smallest subsidies.

In addition, Medicare's subsidization does not differentiate among states with relatively high and low

Medicaid payments. If Medicare raises or maintains its high payment levels, states could be encouraged to further reduce their Medicaid payments and, in turn, create pressure to raise Medicare rates even more. These higher Medicare payments could also further encourage providers to select patients based on payer source or rehospitalize dual-eligible patients (those who have both Medicare and Medicaid coverage) to qualify them for a Medicare-covered, higher payment stay. Finally, Medicare's high payments represent a subsidy from trust fund dollars (and taxpayer support) of the low payments made by states and private payers. Moreover, raising Medicare's payments would exert additional fiscal pressure on the already fiscally strapped program. If the Congress wishes to financially support certain nursing facilities (such as those with high Medicaid shares) efficiently, it could do so through a separate, targeted policy. ■

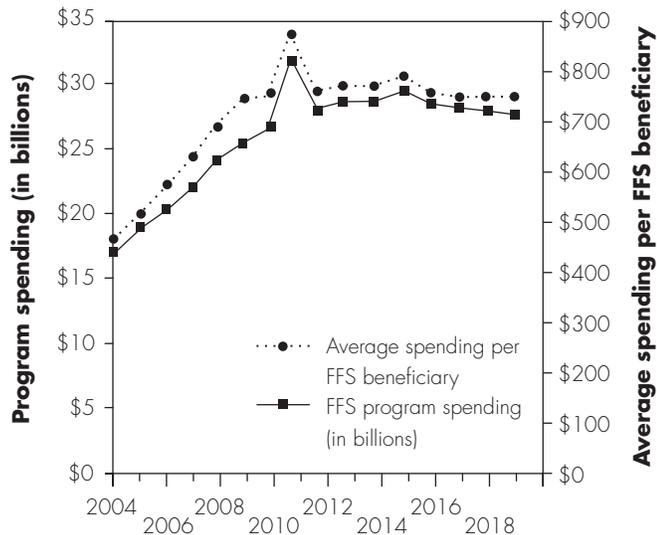
much higher margins compared with other facilities. The 9 percent of freestanding facilities defined as relatively efficient—providers with consistently low costs and higher quality care, in relative terms—had a median Medicare margins of over 19 percent, indicating Medicare overpays freestanding facilities for this care. Some MA plans' payment rates were considerably lower than Medicare's FFS payment rates, and the disparity is unlikely to be explained by differences in patient acuity.

Trends in FFS spending and cost growth

In fiscal year 2019, CMS estimates that Medicare FFS spending for SNF services was \$27.8 billion, almost 2 percent less than in 2018 (Figure 7-1, p. 212) (Office of the Actuary 2020b). Between 2004 and 2010, program spending increased an average of almost 8 percent a year. In 2011, program spending was unusually high because rates for a new case-mix classification system included an adjustment that was too large for the mix of rehabilitation

therapy modalities (i.e., individual versus group or concurrent) assumed in setting the rates. The industry took advantage of the new policies by quickly shifting its mix of modalities, and in 2011, spending increased by over 19 percent. To correct for the excessive payment, CMS revised the adjustment downward in 2012; as a result, total payments declined that year over 12 percent. Since 2013, program spending and spending per FFS beneficiary have declined by 3 percent and 5 percent, respectively. These declines reflect growing beneficiary enrollment in MA (whose spending on SNF care is not included in FFS spending data) and greater provider participation in APMs, which create incentives for participating entities to lower SNF use. Lower hospitalization rates are also a contributing factor.

Between 2018 and 2019, adjusted costs per day for freestanding facilities grew 1.5 percent. The low growth rate is likely due in part to lower therapy costs that accompanied the implementation of the new case-mix

**FIGURE
7-1****Since 2015, FFS program spending on SNF services has declined**

Note: SNF (skilled nursing facility), FFS (fee-for-service). Fiscal year-incurred spending (that excludes cost sharing) is shown.

Source: Office of the Actuary 2020b.

system. Between 2018 and 2019, average ancillary costs per day decreased 0.8 percent.

Consistent with past years, there were differences by ownership in the growth rates and level of costs. For example, between 2018 and 2019, nonprofit facilities' costs grew 2.1 percent compared with 1.3 percent growth at for-profit facilities. In 2019, nonprofit facilities also had higher average costs per day (12 percent higher) than did for-profit facilities in part because they are smaller and have lower average daily census, so they cannot achieve the same economies of scale as larger for-profit facilities.

SNF Medicare margin remains high

The Medicare margin is a key measure of the adequacy of the program's payments because it compares Medicare's FFS payments with providers' costs to treat FFS beneficiaries. In 2019, the aggregate Medicare margin for freestanding SNFs was 11.3 percent. The Medicare margin increased from 2018 because SNFs kept their cost growth

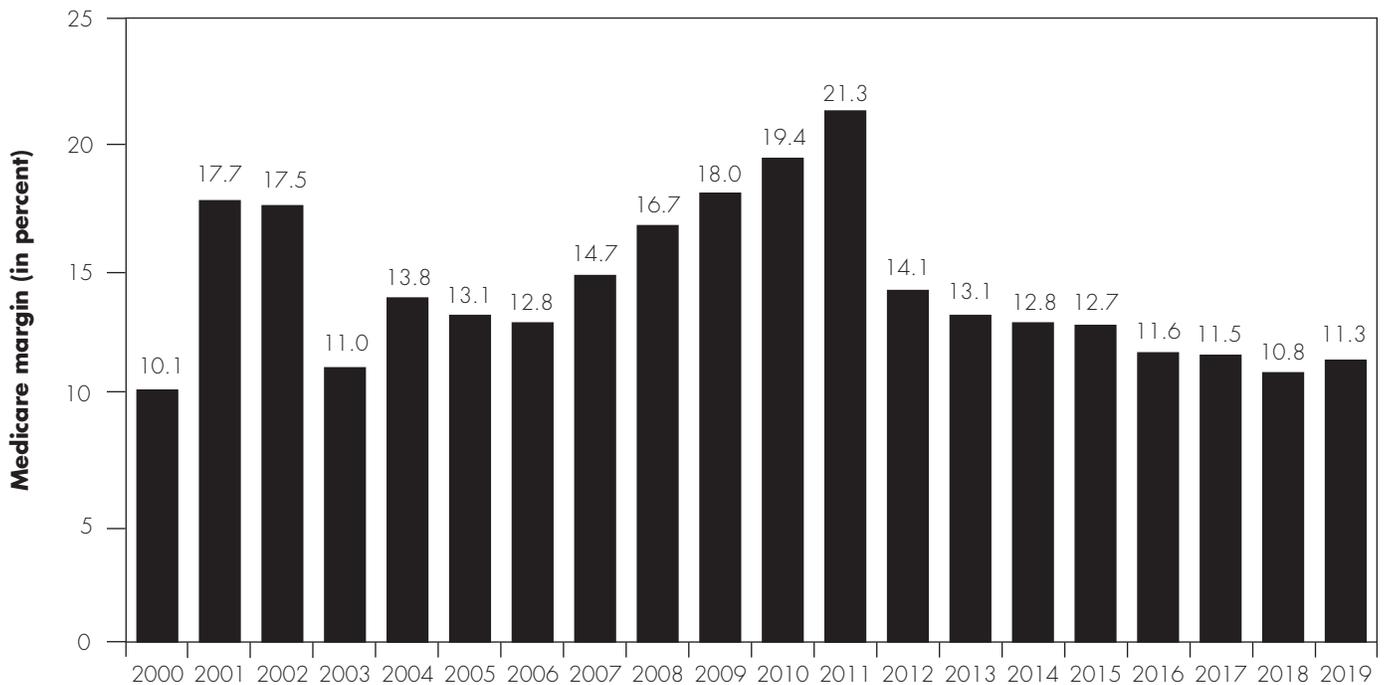
below the average increase in per day payments (2.5 percent). This marks the 20th consecutive year that SNFs' aggregate Medicare margin was over 10 percent (Figure 7-2).

In 2019, hospital-based facilities (3 percent of program spending on SNFs) continued to have an extremely negative Medicare margin (-64 percent; data not shown), in part because of the higher cost per day reported by hospital-based SNFs. However, hospital administrators consider their SNF units in the context of the hospital's overall financial performance and mission. Hospitals with SNFs can lower their inpatient lengths of stay by transferring patients to their SNF beds, thus making inpatient beds available to treat additional inpatients.

SNF Medicare margins varied widely in 2019

Medicare margins varied widely across freestanding SNFs (Table 7-5, p. 214). One-quarter of SNFs had Medicare margins that were 21.3 percent or higher; one-quarter had margins that were -0.9 percent or lower. Medicare margins reflect the economies of scale that larger SNFs are able to achieve. Small (20 to 50 beds) and low-volume facilities (bottom quintile of total facility days) had low aggregate Medicare margins (-3.7 percent and -0.8 percent, respectively) compared with large and high-volume facilities (12.8 percent and 14.4 percent, respectively). SNFs with the lowest cost per day (SNFs in the bottom 25th percentile of the distribution of cost per day) had an aggregate Medicare margin that was more than 20 percentage points higher than SNFs with the highest cost per day (SNFs in the top 25th percentile).

High-margin SNFs also pursued revenue strategies by having longer stays and larger shares of intensive therapy days (data not shown). SNFs with the highest Medicare margin (those in the top quartile of the distribution of Medicare margins) had 89 percent of their days assigned to the highest rehabilitation case-mix groups (the ultra-high and very high groups) compared with 81 percent of days for SNFs with the lowest margins (those in the bottom 25th percentile). Previous analysis found these days were more profitable than other types of care and that as therapy provision increased, the increases in costs were outpaced by increases in payments (Medicare Payment Advisory Commission and The Urban Institute 2015, Office of Inspector General 2015). Differences in Medicare margins across providers are likely to change under the new case-mix system.

**FIGURE
7-2****Freestanding SNFs' aggregate Medicare margins have been above 10 percent since 2000**

Note: SNF (skilled nursing facility). The aggregate Medicare margin is calculated as the sum of Medicare payments minus the sum of Medicare's costs, divided by Medicare payments.

Source: MedPAC analysis of freestanding SNF cost reports, 2000–2019.

Compared with low-margin SNFs, high-margin SNFs had larger shares of Medicaid days and dual-eligible beneficiaries (those who qualify for both Medicare and Medicaid). It is possible that given their large Medicaid mix (and the lower payments typically made by Medicaid), these facilities keep their costs lower, which contributes to their higher Medicare margins.

Since 2006, each year the aggregate Medicare margin for freestanding for-profit facilities has been about 10 percentage points higher than nonprofit facilities' margins, and this trend continued in 2019. The disparity reflects differences in costs and payments. Nonprofit facilities are smaller and have higher per day costs compared with for-profit facilities. They also have lower average payments per day (4 percent lower), in part reflecting their lower share of the high-payment intensive therapy days.

Relatively efficient SNFs further illustrate that Medicare's payments are too high

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of relatively efficient providers. First, the providers must do relatively well on both cost and quality metrics (see text box on identifying relatively efficient SNFs, p. 215). Second, performance must be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to

**TABLE
7-5**

Variation in freestanding SNF Medicare margins reflects differences in economies of scale, 2019

Provider group	Medicare margin
All providers	11.3%
For profit	14.3
Nonprofit	0.9
Rural	9.6
Urban	11.6
Frontier	6.0
25th percentile of Medicare margins	-0.9
75th percentile of Medicare margins	21.3
Cost per day: High	-0.3
Cost per day: Low	23.3
Small (20–50 beds)	-3.7
Large (100–199 beds)	12.8
Facility volume: Highest fifth	14.4
Facility volume: Lowest fifth	-0.8

Note: SNF (skilled nursing facility). Except for the margins reported for the 25th and 75th percentiles, the margins are aggregates for the facilities included in the group and were adjusted to account for the mix of facilities that had filed cost reports at the time of the analysis. “Frontier” refers to SNFs located in counties with six or fewer people per square mile. “Facility volume” includes all facility days. “Low” is defined as facilities in the lowest 25th percentile; “high” is defined as facilities in the highest 25th percentile.

Source: MedPAC analysis of 2019 freestanding SNF Medicare cost reports.

examine how many providers meet a preestablished set of criteria. It does not establish a set share (for example, 10 percent) of providers to be considered relatively efficient and then define criteria to meet that pool size.

To identify relatively efficient SNFs, we examined the performance of freestanding SNFs with consistent cost and quality performance. To measure costs, we examined costs per day that were adjusted for differences in area wages and case mix. The quality measures were risk-adjusted rates of successful discharge to the community and hospitalizations during the SNF stay (these measures are defined on p. 206). Our analysis included 5,174 SNFs

that had quality and cost report information for the 2016 to 2019 period and a minimum of 60 stays a year.

Nine percent of the SNFs met the criteria we use to define relatively efficient providers. Compared with other SNFs in 2019, relatively efficient SNFs had community discharge rates that were 15 percent higher and hospitalization rates that were 21 percent lower (Table 7-6, p. 216). Standardized costs per day were 7 percent lower than other SNFs’. Compared with other SNFs, they had higher shares of ultra-high therapy days, which raises payments per day. The aggregate Medicare margin for these SNFs was high (19.2 percent), indicating that although these providers were relatively efficient, the Medicare program could get better value for its purchases if its payments were lower. The high margin for these providers underscores the need to more closely align its payments with the costs of care.

In contrast to last year’s analysis, the measures of economies of scale (average daily census and occupancy) had smaller or no differences between relatively efficient and other SNFs. This is most likely due to the higher minimum stay requirements for the quality measures that exclude small providers from the analysis.

FFS payments for SNF care are considerably higher than MA payments

Another indicator that Medicare’s payments under the SNF PPS are too high is the comparison of Medicare FFS and MA payments. (We use “MA” as shorthand for all managed care payments since MA makes up the majority of rates reported as “managed care payments.”) We compared Medicare FFS and MA payments for three companies with SNF holdings for which such information was publicly available (Table 7-7, p. 217). For these companies, Medicare’s FFS per day payments were, on average, more than 24 percent higher than MA rates (data not shown).

We do not know whether the lower average daily payment by MA plans reflects differences in service intensity (for example, fewer intensive therapy days), lower payments for the same service, or some combination. It is possible that companies with SNF holdings differ in their ability to negotiate high payment rates from MA plans. We also do not know how these rates compare with rates paid to other SNF chains and independent facilities. However, similar payment disparities were reported by the National Investment Center for Seniors Housing & Care, a nonprofit organization that supports access and choice for

Identifying relatively efficient skilled nursing facilities

We defined relatively efficient skilled nursing facilities (SNFs) as those with relatively low costs per day and good quality of care for three years in a row, 2016 through 2018. The cost per day was calculated using cost report data and was adjusted for differences in case mix (using the nursing component relative weights) and area wages. To assess quality, we examined risk-adjusted rates of successful discharge to the community and hospitalizations during the SNF stay (for definitions of the measures, see p. 206.) To meet a reliability standard of 0.7, only facilities with at least 60 stays were included in the quality measures. To be included in the relatively efficient group, a SNF had to be in the best third of the distribution of at least one measure and not in the bottom third of any measure for three consecutive years. Another criterion was that SNFs not be part of CMS’s Special Focus Facility Initiative for any portion of time covered by the definition (2016 through 2018), which excluded one facility from the pool of efficient providers.¹⁴

We found that 9 percent (or 489 facilities of the 5,174 facilities that met the data requirements for this analysis) of SNFs were relatively efficient. They were more likely to be urban and for profit and were geographically dispersed (located in 40 states plus the District of Columbia).

The method we used to assess performance attempts to limit incorrect conclusions about performance based on poor data. Using three years of data to categorize SNFs as efficient (rather than just one year) avoids categorizing providers based on random variation or on one “unusual” year. In addition, by first assigning a SNF to a group and then examining the group’s performance in the next year, we avoid having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, a SNF’s erroneous data could result in its inaccurate assignment to a group, but because the group’s performance is assessed with data from later years, these “bad” data would not directly affect the assessment of the group’s performance. ■

seniors’ housing and care, including nursing homes and assisted living. It found that for the 1,537 SNF properties included in its sample, FFS payments per day were 22 percent higher than MA rates (National Investment Center for Seniors Housing & Care 2020).

We compared broad patient characteristics of beneficiaries enrolled in FFS and MA plans and found those differences are unlikely to explain the magnitude of the differences between FFS payments and payments typically made by MA plans. Compared with FFS beneficiaries, MA enrollees were, on average, the same age but had lower risk scores (8 percent lower, indicating fewer comorbidities). Previous analyses have found that MA enrollees were slightly more independent (Medicare Payment Advisory Commission 2020). The considerably lower MA payments indicate that some facilities accept much lower payments to treat MA enrollees who are

not that different from FFS beneficiaries. Some publicly traded post-acute care firms with SNF holdings report seeking managed care patients as a business strategy, indicating that the MA rates are attractive.

Payments and costs for 2021

To project the aggregate fiscal year 2021 Medicare margin for freestanding SNFs, the Commission considers the relationship between SNF costs and Medicare payments in 2019 as a starting point. The impact of the coronavirus PHE on providers’ volume, costs, and revenues makes this year’s projection more uncertain than those made in previous years. Delays in the availability of data have further complicated this estimate. To project the 2021 margin, we made many assumptions about how costs and payments will change and note how better and worse scenarios would affect it.

**TABLE
7-6****Financial performance of relatively efficient SNFs is a combination of lower cost per day and higher revenues per day, 2019**

Performance in 2019	Type of SNF		Ratio of relatively efficient to other SNFs
	Relatively efficient	Other SNFs	
Rate of successful discharge to the community	53%	46%	1.15
Hospitalization rate	11%	14%	0.79
Standardized cost per day	\$312	\$335	0.93
Standardized cost per discharge	\$8,373	\$10,755	0.78
Medicare revenue per day	\$547	\$517	1.06
Medicare margin	19.2%	11.9%	N/A
Total margin	2.6%	1.0%	N/A
Facility case-mix index	1.41	1.39	1.01
Medicare average length of stay	27 days	31 days	0.87
Occupancy rate	88%	88%	1.00
Average daily census	99	97	1.02
Share ultra-high therapy days	69%	64%	1.08
Share medically complex days	4%	3%	1.33
Medicaid share of facility days	56%	58%	0.97
Share urban	89%	82%	N/A
Share for profit	79%	70%	N/A
Share nonprofit	18%	26%	N/A

Note: SNF (skilled nursing facility), N/A (not applicable). To be included in the analysis, the SNF had to have quality and cost report information for 2016 to 2019 and a minimum of 60 days a year. The number of freestanding facilities included in the analysis was 5,174, of which 489 (or 9 percent) were identified as “relatively efficient” based on their cost per day and two quality measures (community discharge and readmission rates) between 2016 and 2018. Relatively efficient SNFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of three years and were not a facility under “special focus” by CMS. Costs per day and per discharge were standardized for differences in case mix (using the nursing component relative weights) and wages. Quality measures were rates of risk-adjusted successful discharge to the community (higher rates are better) and hospitalization during the SNF stay (lower rates are better). “Ultra-high therapy days” include days assigned to ultra-high case-mix groups. “Medically complex days” includes days assigned to clinically complex and special care case-mix groups. Table shows the medians for the measure.

Source: MedPAC analysis of quality measures and Medicare cost report data for 2016–2019.

Our projections include assumptions about COVID-19–related costs that we expect to remain for the foreseeable future and therefore should be incorporated into the update. Compared with 2019, we expect higher PPE and testing costs to continue to be a part of SNFs’ operating costs. While we expect the pricing of PPE to return to prepandemic levels, its use is likely to remain high. Regarding testing, we expect vaccines will become widely available in the first half of 2021. Clearly, a vaccine will affect case rates and the frequency of testing. However, even with a vaccine, we expect facilities will continue to test

staff at regular intervals and to test residents suspected of having the virus. Further, vaccine hesitancy will contribute to lingering case rates. But as county-level infection rates subside, we expect testing frequency to abate.

To estimate costs for 2020 and 2021, we assumed that all costs would increase at a rate equal to the average of the annual changes between 2016 and 2019 (2 percent), with additional cost increases for PPE and testing as discussed below. Between 2016 and 2019, cost growth was below the market basket, in part due to declining volume each year. During this period, annual volume reductions

**TABLE
7-7**

Comparison of Medicare fee-for-service and managed care daily payments to three companies, 2019

Company	Medicare payment		Ratio of FFS to MA payment
	FFS	Managed care (MA)	
Diversicare	\$491	\$407	1.21
Ensign Group	671	498	1.35
Genesis HealthCare	565	480	1.18

Note: FFS (fee-for-service), MA (Medicare Advantage). MA makes up the majority of managed care payments. The Genesis rate is reported as “insurance,” which includes managed care but excludes Medicaid managed care and private pay.

Source: Second quarter 10-Q 2020 reports available at each company’s website.

ranged from 3.6 percent to 5.0 percent, yet costs per day increased between 1.5 percent and 2.5 percent. If volume reductions were larger than estimated, cost growth might be lower, which would increase the projected margin (and conversely, higher-than-expected cost growth would lower the projected margin). However, a major component of SNF costs, labor, appears to be relatively slow to respond to declines in volume. For the 2016 to 2019 period, data from the Bureau of Labor Statistics indicate that decreases in employees were much smaller than the reductions in volume. Between January and September 2020, increases in weekly earnings (that reflect overtime and pandemic premium pay) offset much of the decline in number of employees.

We do not have accurate data on the increased costs for PPE, cleaning supplies, and testing during the PHE or afterwards, so we estimated them as follows:

- PPE and cleaning costs—We calculated the nonlabor share of facility costs in 2019 for four supply cost centers in the Medicare cost report, including central supplies, laundry and linen, medical supplies charged to patients, and housekeeping. These supply costs account for 2.3 percent of total facility costs. After increasing Medicare costs by 2 percent, we took 2.3 percent of costs and increased it by 25 percent to account for increased use and prices. Although there was considerable surge pricing early in the PHE, by late summer of 2020 prices had begun to moderate, and we expect them to become more normal in 2021.

We expect PPE use to remain high for the foreseeable future. Higher PPE costs would increase cost growth and lower the projected margin.

- Testing costs—To date, the Department of Health and Human Services (HHS) has provided most SNFs with testing machines so facilities can conduct timely, point-of-care testing of their employees and residents. We assumed that, by 2021, all facilities would be able to conduct in-house testing at an estimated cost of \$5 per test. We assumed that SNFs would make arrangements to retest all residents and staff who had positive or suspicious results (estimated at 10 percent of the in-house tests conducted) at an estimated cost of \$87.50 per test (more accurate tests are generally more costly).
- We assumed facilities would test all employees monthly and that providers would assume these costs. We apportioned this cost to Medicare based on its share of facility costs.
- Regarding residents, current HHS guidance is to not conduct routine testing of asymptomatic residents. We assumed that as of 2021, the rate of point-of-care testing would be half of the rate reported by facilities for the week of December 13, and we apportioned this cost based on Medicare’s share of facility residents.
- The combined cost of testing staff and residents added over \$54 million (or 0.2 percent) to Medicare’s estimated costs for 2021. Higher

testing rates (such as weekly testing) or higher cost per test would increase cost growth and lower the projected margin.

To estimate payments in 2020 and 2021, we assumed that payments each year would increase by the required updates, 2.4 percent and 2.2 percent, respectively. We also factored in the suspension of the 2 percent sequestration reduction to payments from May 1, 2020, through March 31, 2021.

We estimated that volume declines would lower aggregate revenues in 2020 and 2021. We assumed that before the PHE, volume would continue to decline at the same rate as the decline between 2018 and 2019. During the PHE, the industry reports that the skilling-in-place policy tempered what would have otherwise been larger declines in Medicare revenue. After the PHE, we expect that volume will be slow to recover as some beneficiaries remain reluctant to use SNFs. Therefore, for the period after the PHE, we assumed a larger decline in volume than the recent (2018 to 2019) decline. To estimate aggregate revenue, we calculated a weighted average of the volume declines during the months pre-PHE, the duration of the PHE, and the months post-PHE. If volume declines are larger than projected, without commensurate reductions in costs, the Medicare margin will be lower than estimated. Conversely, if volume rebounds more than projected, without commensurate increases in costs, the estimated margin would increase.

We also factored in higher payments under the new case-mix system in 2020 and 2021. Based on industry reports that providers have not coded certain patient characteristics, we assumed that providers would continue to improve their coding in 2021. Larger or smaller increases in payments as a result of the new case-mix system will raise or lower the projected margin.

We expect the aggregate Medicare margin to decrease in 2021 due to cost growth that will exceed the payment updates. Although the elevated COVID-19–related costs of 2020 will subside, the costs for PPE and testing in 2021 will remain high relative to 2019 because the industry will have incorporated infection control and COVID-19 monitoring into its standard operating practice. Given the many uncertainties regarding costs and volume post-PHE and the impact of the new case-mix system, the Medicare margin projected for 2021 is highly uncertain. We estimate that the aggregate Medicare margin for freestanding SNFs will

be 10 percent, though different assumptions about costs, volume, and revenues will raise or lower the projection.

How should Medicare payment rates change in 2022?

In considering how payments should change for 2022, we note that current law is expected to increase payment rates by 2 percent in 2022 (a market basket increase of 2.3 percent less a 0.3 percent productivity adjustment). As discussed above, SNFs' Medicare margin will depend on many factors that are unknown, including how much the elevated COVID-19–related costs remain a part of facilities' operations, the degree to which one or more vaccines reduce the frequency of testing, whether SNF volume reverts to pre-PHE trends, and the degree to which facilities adjust their costs to changes in volume.

Further complicating this picture is the impact of the new case-mix system. Although CMS estimated the redesign to be budget neutral, initial evidence suggests that it has raised payments. The PHE may delay any CMS action to revise payments so they are aligned with the cost of care.

Pre-PHE, indicators of the adequacy of Medicare's payments are positive. Supply has been relatively stable for years, and access has been good. Although service use declined, it is not a reflection of Medicare's payments: Medicare is a preferred payer. In 2019, the marginal profit for freestanding SNFs was high (19.7 percent), indicating facilities with an available bed have an incentive to admit Medicare patients. Pre-PHE, access to capital was good and is expected to remain so in 2022. Quality of care has improved slightly over time. The aggregate Medicare margin for freestanding SNFs has been above 10 percent since 2000. Relatively efficient SNFs had a median Medicare margin of 19.2 percent in 2019, further evidence that the level of payments is too high relative to the cost of care. Furthermore, FFS payments were considerably higher than the MA payments made to some SNFs, suggesting that many facilities are willing to accept much lower rates than FFS payments to treat Medicare beneficiaries. These factors show that the PPS continues to exert too little pressure on providers.

RECOMMENDATION 7

For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

RATIONALE 7

Indicators of the adequacy of Medicare’s payments are positive and are expected to remain so, despite the devastating impact of COVID-19 on nursing home staff and residents. There are many uncertainties about the pandemic’s long-term effects on nursing homes, but Medicare payments are expected to be more than adequate to accommodate the elevated costs and the sluggish volume returns that we have factored into our estimates of projected Medicare margin. The aggregate Medicare margin in 2019 for freestanding SNFs was 11.3 percent and is expected to be about 10 percent in 2021, indicating that payments will remain more than adequate to ensure beneficiary access to SNF care without an update to the base rate.

The level of Medicare’s payments indicates that a reduction to payments (i.e., not simply maintaining payment rates at current levels) is needed to align aggregate payments to aggregate costs. However, given the uncertainty over how long the PHE will last and what its long-term effects will be, the Commission will proceed cautiously in considering recommendations to lower SNF payments to more closely align them to costs. A zero update would begin to align payments with costs while exerting pressure on providers to keep their cost growth low. The Commission will monitor beneficiary access, quality of care, and providers’ financial performance and will consider future recommendations regarding the level of payments.

While Medicare’s payments are more than adequate to cover the costs to treat beneficiaries during their SNF stays, nursing homes may need additional financial support in 2021. However, an update to Medicare’s per day payments in fiscal year 2022 would be a poor approach to providing this support because assistance would not begin until October 2021. Instead, if additional financial support is required, it should be separate from the annual update and targeted to facilities that have been especially affected by the PHE.

IMPLICATIONS 7

Spending

- Relative to current law, this recommendation would lower program spending by between \$750 million and \$2 billion for fiscal year 2022 and between \$1 billion and \$5 billion over five years. Program savings would

occur because current law requires market basket increases for 2022 that would raise program spending relative to spending that would occur if payment rates remained at the 2021 levels.

Beneficiary and provider

- We do not expect this recommendation to have adverse effects on beneficiaries’ access to care. Given the current level of payments, we do not expect the recommendation to affect providers’ willingness or ability to care for Medicare beneficiaries.

Medicaid trends

Section 2801 of the Affordable Care Act requires the Commission to examine spending, use, and financial performance trends in the Medicaid program for providers with a significant portion of revenues or services associated with Medicaid. We report on nursing home spending trends for Medicaid and financial performance for non-Medicare payers. Medicaid revenues and costs are not reported in the Medicare cost reports. In a joint publication with the Medicaid and CHIP Payment Access Commission, we report on characteristics, service use, and spending for dual-eligible beneficiaries (Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission 2018).

Medicaid covers nursing home (long-term) care and a portion of the skilled nursing care furnished to beneficiaries who are dually eligible for Medicaid and Medicare. Medicaid pays the dual-eligible beneficiaries’ Medicare copayments that begin on day 21 of a SNF stay and for any skilled care for beneficiaries who exhaust their Part A coverage (that is, if their Part A stay exceeds 100 days). Medicaid also pays for long-term care services that Medicare does not cover.

Count of Medicaid-certified nursing homes

Between 2019 and 2020, the number of nursing facilities certified as Medicaid providers declined approximately 0.7 percent to 14,784, similar to the decline of Medicare providers (Table 7-8, p. 220). We do not know whether the providers that terminated participation in the Medicaid program remained open but no longer accepted Medicaid patients, closed, or were purchased by another entity and remained open.

**TABLE
7-8**

The number of nursing homes treating Medicaid enrollees declined slightly from 2019 to 2020

	2016	2018	2019	2020	Average annual percent change	
					2016-2019	2019-2020
Number of facilities	15,057	15,007	14,889	14,784	-1.11%	-0.71%

Note: The 2020 number is through November of that year; it does not include data from the full calendar year. Counts include dually certified skilled nursing facilities/nursing facilities, distinct-part skilled nursing facilities/nursing facilities, and nursing facilities.

Source: Certification and Survey Provider Enhanced Reporting on CMS's Survey and Certification Providing Data Quickly system, 2016-2020.

In 2020, of the 14,744 Medicaid nursing homes active in January, approximately 0.7 percent of providers had terminated as of November, while many providers opened during the same period (data not shown). The share of facilities that terminated varied by state. States with the highest termination rates during this period included Washington (3 percent) and Florida, Massachusetts, Texas, and Wisconsin (1 percent each). Historically, the lower payment rates paid by MA plans and their lower use of these facilities, as well as the overexpansion of supply in states with no certificate-of-need laws (such as Texas) contributed to these facilities' fiscal pressures.

The decline in the count of Medicaid-certified nursing homes may also reflect the expansion in some states of home- and community-based services (HCBS), which allow beneficiaries to remain in their homes rather than in an institution. State HCBS waivers and federal initiatives have accelerated the trend toward HCBS. In September 2020, CMS announced \$165 million in supplemental funding to help certain state Medicaid programs transition individuals with disabilities and older adults from nursing facilities to home and community-based settings (Centers for Medicare & Medicaid Services 2020a). In fiscal year 2020, 47 states expanded the number of beneficiaries served by HCBS, a decrease from 48 states in fiscal year 2019 (Gifford et al. 2019, Gifford et al. 2018).

Spending

FFS spending on Medicaid-funded nursing home services (combined state and federal funds) totaled \$39 billion in 2019 (Figure 7-3) (Office of the Actuary 2020a). CMS

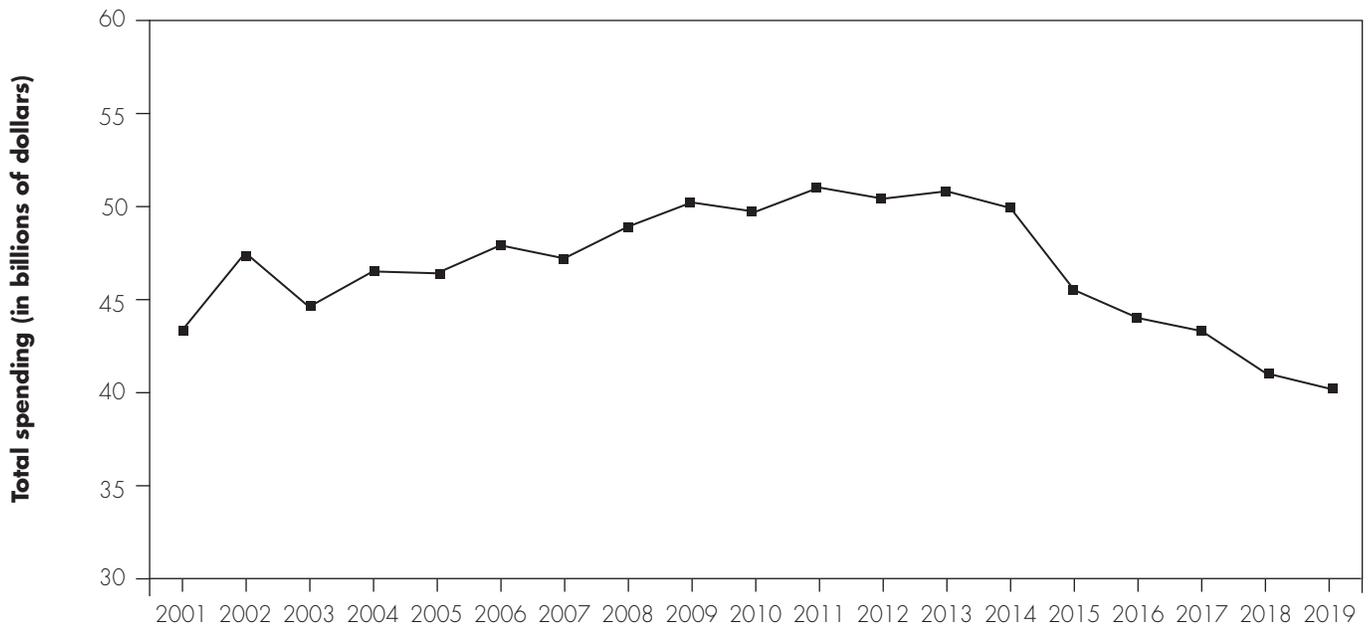
estimates that FFS Medicaid spending on nursing home services between 2017 and 2019 decreased 5 percent each year. The trend of lower spending is in part due to an increased use of managed care organizations, whose spending is not included in these data. As of July 2019, 25 states operated Medicaid managed care for long-term services and supports (Gifford et al. 2019). This figure represents a 56 percent increase from 2012, when only 16 states had such programs (Lewis et al. 2018). Year-to-year changes in spending have been variable, increasing in some years and decreasing in others, with overall spending in 2020 below what it was in 2001. The large decreases in FFS Medicaid spending beginning in 2015 reflect increased enrollment in Medicaid managed care.

Analysis of Medicaid rate-setting trends before the PHE found that 8 states restricted (froze or reduced) rates paid to nursing homes in 2020, while 40 states plus the District of Columbia increased nursing facility rates, with two states not reporting data (Gifford et al. 2019). In 2019, 10 states restricted rates to nursing homes and the same number of states increased rates (40 states plus the District of Columbia) (Gifford et al. 2018).

States continue to use provider taxes to raise federal matching funds. In fiscal year 2020, 44 states and the District of Columbia levied provider taxes on nursing homes to increase federal matching funds (Gifford et al. 2019).¹⁵ New Mexico has implemented a provider tax on nursing facilities, bringing the total number of states with taxes on nursing facilities to 45 states and the District of Columbia. The augmented federal funding may be split with the nursing homes.

**FIGURE
7-3**

Medicaid fee-for-service spending on nursing home services, 2001-2019



Note: Spending does not include any managed care organization spending on nursing homes.

Source: Office of the Actuary 2020a.

The majority of states (36 plus the District of Columbia) have expanded their Medicaid programs since the passage of the Affordable Care Act. More states (Missouri, Oklahoma, Utah) have passed initiatives to expand their Medicaid programs as of November 2020; however, some of these initiatives have not yet received CMS approval (National Academy for State Health Policy 2020).

The coronavirus pandemic is likely to have mixed effects on FFS Medicaid spending on nursing home services in 2020 and 2021. Spending will decrease because the industry overall has faced volume declines caused by potential residents avoiding this setting, some residents moving out, resident mortality, and the temporary skilling-in-place policy which shifted the financial responsibility for some care from Medicaid to Medicare. Countering these downward trends are the temporary increases in FFS Medicaid nursing home rates in 37 states (Kaiser Family Foundation 2020). We do not know whether these higher payment rates will cover the increased costs associated with more medically complex COVID-19 patients and the higher costs of PPE and testing.

Total and non-Medicare margins in nursing homes in 2019

Nursing homes' total margin reflects all payers (including all FFS and managed care funds from Medicare, Medicaid, and private insurers) across all lines of business (for example, nursing home care, hospice care, ancillary services, home health care, and investment income). In 2019, the aggregate total margin was 0.6 percent (Table 7-9, p. 222). Since 2000, except for 2018 (when the total margin was slightly negative), the total margin has ranged from 0.4 percent to 3.8 percent (data not shown).

Total margins in 2019 varied considerably: The median was 0.7 percent; 25 percent of nursing homes had total margins of -5 percent or lower and 25 percent of homes had total margins of 5.5 percent or higher (data not shown).

Nursing homes' total margins have declined since 2013, reflecting factors previously discussed: the impact of Medicare payment reductions mandated by the Congress,

**TABLE
7-9****Total and non-Medicare margins improved in 2019**

Type of margin	2015	2016	2017	2018	2019
Total margin	1.6%	0.7%	0.6%	-0.3%	0.6%
Non-Medicare margin	-2.1	-2.4	-2.4	-3.2	-2.0

Note: "Total margin" includes the revenues and costs associated with all payers and all lines of business. "Non-Medicare margin" includes the revenues and costs associated with Medicaid and private payers for all lines of business.

Source: MedPAC analysis of Medicare freestanding SNF cost reports for 2015 to 2019.

the growing share of facilities' revenues attributed to MA plans (whose payments are lower than Medicare's FFS payments), fewer high-payment Medicare FFS patients, and lower average occupancy rates (which raise the average cost per day).

Nursing homes' non-Medicare margins reflect the profitability of all services except FFS Medicare-covered SNF services. The aggregate non-Medicare margin in 2019 was -2 percent, an improvement from 2018. ■

Endnotes

- 1 Throughout this chapter, *beneficiary* refers to an individual whose SNF stay is paid for by Medicare (Part A). Some beneficiaries who no longer qualify for SNF Medicare coverage remain in the facility to receive long-term care services, which are not covered by Medicare. During long-term care stays, beneficiaries may receive care, such as physician services, outpatient therapy services, and prescription drugs, that is paid for separately under the Part B and Part D benefits. Services furnished outside the Part A-covered stay are not paid under the SNF prospective payment system and are not considered in this chapter. Except where specifically noted, this chapter examines fee-for-service (FFS) Medicare spending and service use and excludes services and spending for SNF services furnished to beneficiaries enrolled in Medicare Advantage plans. Some beneficiaries also qualify for Medicaid and are referred to as “dual-eligible beneficiaries.”
- 2 Throughout this chapter, we use the term “FFS Medicare” as equivalent to the CMS term “Original Medicare.”
- 3 A spell of illness ends when there has been a period of 60 consecutive days during which the beneficiary was an inpatient of neither a hospital nor a SNF. Coverage for another 100 days does not begin until a beneficiary has not had hospital care or skilled care in a SNF for 60 consecutive days. Observation days and emergency room stays do not count toward the three-day hospital stay requirement. In 2015, the Commission recommended that the time spent in observation care count toward the three-day requirement as long as the patient was formally admitted and had at least one day as an inpatient (Medicare Payment Advisory Commission 2015). The requisite prior three-day hospital stay was temporarily waived during the coronavirus public health emergency.
- 4 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021, for an additional 90 days.
- 5 For services to be covered, the SNF must meet Medicare’s requirements of participation and agree to accept Medicare’s payment rates. Medicare’s requirements relate to many aspects of staffing and care delivery, such as requiring a registered nurse in the facility for 8 consecutive hours per day and licensed nurse coverage 24 hours a day, providing physical and occupational therapy services and speech–language pathology services as delineated in each patient’s plan of care, and providing or arranging for physician services 24 hours a day in case of an emergency.
- 6 Rural counties are those that are not in or adjacent to metropolitan or micropolitan areas and are defined using Urban Influence Codes 11 and 12.
- 7 The program pays separately for some services, including certain chemotherapy drugs, certain customized prosthetics, certain ambulance services, and radioisotope services. All physician services are paid separately under Part B.
- 8 The Commission and the Office of Inspector General called for a redesign that would vary payments based on patient characteristics rather than the amount of therapy furnished (Medicare Payment Advisory Commission 2008, Office of Inspector General 2015).
- 9 A description of the SNF PPS is found in *SNF Payment Basics*, available at <http://medpac.gov/-documents-/payment-basics>.
- 10 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:
$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}$$

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 11 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay. Providers with at least 60 stays in the year, the minimum count to meet

a reliability of 0.7, were included in calculating the average facility rate.

12 Because the sequestration is not applied to beneficiary copayments, the reduction to SNF payments is slightly lower than 2 percent.

13 Affiliates of chains with more than 500 employees were not eligible for the paycheck protection program, even if individual nursing homes had fewer than 500 employees.

14 The Special Focus Facility Initiative is a program to stimulate improvements in the quality of care at nursing homes with a history of serious quality problems. The initiative targets homes with a pattern over three years of more frequent and

more serious problems (including harm or injury to residents) detected in their annual facility surveys. Facilities that improve and maintain those improvements can “graduate” from the program. Providers that do not improve face civil monetary penalties (fines) and eventual termination from Medicare and Medicaid.

15 A provider tax works as follows: A state taxes all nursing homes and uses the collected amount to help finance the state’s share of Medicaid funds. The provider tax increases the state’s contribution, which, in turn, raises the federal matching funds. The augmented federal funds more than cover the cost of the provider tax revenue, which is returned to providers. The provider tax is limited to 6 percent of net patient revenues.

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CHAPTER

8

Home health care services

R E C O M M E N D A T I O N

- 8** For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Home health care services

Chapter summary

Home health agencies (HHAs) provide services to beneficiaries who are homebound and need skilled nursing care or therapy. In 2019, about 3.3 million Medicare fee-for-service beneficiaries received care, and the program spent \$17.8 billion on home health care services. In that year, over 11,300 HHAs participated in Medicare.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment update indicators is 2019. When relevant, we have also considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether these effects are likely to be temporary or permanent. Though the PHE was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry. To the extent the effects of the PHE are temporary or vary significantly across HHAs, they are best addressed through targeted temporary funding policies rather than a permanent change to all HHA payment rates in 2022 and future years.

Assessment of payment adequacy

The indicators of payment adequacy for home health care are generally positive.

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payments change in 2022?

Beneficiaries' access to care—Access to home health care is adequate: Over 99 percent of beneficiaries lived in a ZIP code where at least one Medicare HHA operated in 2019, and 86 percent lived in a ZIP code with five or more HHAs.

- ***Capacity and supply of providers***—Between 2018 and 2019, the number of HHAs declined by 1.7 percent, continuing a slow decline since 2013. However, the decline follows a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by over 80 percent. The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.
- ***Volume of services***—Between 2018 and 2019, the number of 60-day episodes declined by 3.0 percent, continuing a slight decline that began in 2011. In 2019, episodes not preceded by a hospitalization accounted for 66 percent of episodes, similar to prior years.
- ***Marginal profit***—In 2019, freestanding HHAs' marginal profit—that is, the rate at which Medicare payments exceed providers' marginal costs—was 18 percent, suggesting a significant financial incentive for HHAs to increase their volume of Medicare patients.

Quality of care—In 2019, our outcome measures were mixed. The rate of home health patients who were hospitalized during their spell of home health services increased slightly, but the share that was successfully discharged to the community (did not experience an unplanned hospitalization within 30 days of the end of their spell of home health care) increased slightly.

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

Medicare payments and providers' costs—In 2019, Medicare spending for home health care declined by 0.5 percent to \$17.8 billion. For more than a decade, payments under the home health prospective payment system have consistently and substantially exceeded costs. In 2019, Medicare margins for freestanding agencies averaged 15.8 percent. 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. Though we expect higher per episode cost growth in 2020 due to the PHE, we project that Medicare margins for freestanding HHAs in 2021 will be 14 percent.

How should payments change in 2022?

Our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these overpayments diminish the service's value as a substitute for more costly services. On the basis of these findings, the Commission recommends that for calendar year 2022, the Congress reduce the 2021 Medicare base payment rate for home health agencies by 5 percent. ■

Background

Medicare home health care consists of skilled nursing, physical therapy, occupational therapy, speech therapy, aide services, and medical social work provided to beneficiaries in their homes. To be eligible for Medicare's home health benefit, beneficiaries must need part-time (fewer than eight hours per day) or intermittent skilled care to treat their illnesses or injuries and must be unable to leave their homes without considerable effort. In contrast to coverage for skilled nursing facility services, Medicare does not require a preceding hospital stay to qualify for home health care. Also, unlike for most services, Medicare does not require copayments or a deductible for home health services. In 2019, about 3.3 million Medicare beneficiaries received home care, and the program spent \$17.8 billion on home health services.

Medicare requires that a physician, nurse practitioner, clinical nurse specialist, or physician assistant certify a patient's eligibility for home health care.¹ In 2011, Medicare implemented a requirement that a beneficiary have a face-to-face encounter with the physician ordering home health care. The encounter must take place in the 90 days preceding or 30 days following the initiation of home health care. An encounter with a nonphysician practitioner or through telehealth services may be used to satisfy the requirement.²

Major changes to the home health prospective payment system in 2020

CMS implemented major changes required by the Bipartisan Budget Act of 2018 in 2020: a new 30-day unit of payment (replacing the 60-day unit of payment) and elimination of the number of therapy visits as a factor in the payment system. These changes follow several years of analysis by the Commission and CMS to identify possible reforms to the home health prospective payment system (PPS). The elimination of the therapy thresholds is consistent with a recommendation we first made in 2011 and reiterated in subsequent reports (Medicare Payment Advisory Commission 2017, Medicare Payment Advisory Commission 2016, Medicare Payment Advisory Commission 2011a). CMS also implemented a new case-mix system in 2020, the Patient-Driven Groupings Model.³

Payments for a 30-day period are adjusted by the case-mix system to account for differences in patient severity. If beneficiaries need additional home health services at the end of the initial 30-day period, another period

commences and Medicare makes an additional payment. Coverage for additional periods generally has the same requirements as the initial period (i.e., the beneficiary must be homebound and need skilled care). The analysis in this chapter uses claims data from 2019 and prior years, when the 60-day episode was the unit of payment.

The coronavirus public health emergency (PHE) has affected beneficiaries and home health agencies (HHAs) in 2020 (see text box on the PHE and the Commission's analysis of payment adequacy, p. 237). In response, CMS made several changes to the home health benefit (Centers for Medicare & Medicaid Services 2020). These changes were intended to maintain access to care during the emergency. Key changes included:

- Broadening the telehealth services permissible under the home health benefit to include additional services, such as two-way video and audio-only encounters.⁴ The services must be identified in a patient's plan of care and not replace in-person services. CMS subsequently made these additional telehealth services a permanent element of the benefit.
- Permitting the face-to-face encounter required for certification of home health care to be provided by means of telehealth.
- Extending the homebound requirement for home health care to beneficiaries who have been advised by a physician not to leave the home due to a confirmed or presumptive COVID-19 diagnosis, and considering beneficiaries homebound if they have a condition that makes them more susceptible to contracting COVID-19.

Medicare has always overpaid for home health services under the PPS

Payments for home health care have substantially exceeded costs since Medicare established the PPS. In 2001, the first full year of the PPS, average Medicare margins for freestanding HHAs equaled 23 percent.⁵ The high margins in the first year suggested that the PPS established a base rate well in excess of costs. Indeed, the base rate assumed that the average number of visits per episode between 1998 and 2001 would decline about 15 percent (with a corresponding reduction in costs); instead, the actual decline was 32.3 percent (Table 8-1, p. 236). Between 2001 and 2018, the number of visits per episode continued to decline, falling an additional 17.3 percent. The average number of therapy services per episode

**TABLE
8-1**

Medicare visits per episode before and after the implementation of the PPS

	Visits per episode				Percent change in visits per episode		
	1998	2001	2018	2019	1998-2001	2001-2018	2018-2019
Skilled nursing	14.1	10.5	8.2	8.1	-25.5%	-21.9%	-1.2%
Therapy (physical, occupational, and speech-language pathology)	3.8	5.2	8.0	8.1	38.6	53.8	1.3
Home health aide	13.4	5.5	1.4	1.3	-59.0	-74.5	-7.1
Medical social services	0.3	0.2	0.1	0.1	-35.8	-50.0	>0.01
Total	31.6	21.4	17.8	17.7	-32.3	-17.3	>-0.01

Note: PPS (prospective payment system). The PPS was implemented in October 2000. Data exclude low-utilization episodes. Components may not sum to totals due to rounding.

Source: MedPAC analysis of home health standard analytic file from CMS.

increased, but this increase was more than offset by the decline in visits per episode for all other service types (nursing, home health aide, and medical social services). Consequently, HHAs were able to hold the rate of episode cost growth below 1 percent in many years, lower than the rate of inflation assumed in the annual home health payment update. Thus, HHAs were able to garner extremely high average payments relative to the cost of services provided. Between 2001 and 2018, freestanding HHA margins averaged 16.2 percent (Figure 8-1, p. 238).

Ensuring appropriate use of home health care is challenging

Policymakers have long struggled to define the role of the home health benefit in Medicare (Benjamin 1993). From the outset, there was a concern that setting a narrow policy could result in beneficiaries using other, more expensive services, while a policy that was too broad could lead to wasteful or ineffective use of the home health benefit. Medicare relies on the skilled care and homebound requirements as primary determinants of home health eligibility, but these broad coverage criteria permit beneficiaries to receive services in the home even though they are capable of leaving home for medical care, which most home health users do (Wolff et al. 2008). Medicare does not provide any incentives for beneficiaries or providers to consider alternatives to home health care, such as outpatient services. Beneficiaries who meet program coverage requirements can receive an unlimited number of home health episodes, and they face no cost sharing. In

addition, the program relies on HHAs and physicians to follow program requirements for determining beneficiary needs, but evidence from prior years suggests that they do not consistently follow Medicare’s standards (Cheh et al. 2007, Department of Health and Human Services 2018, Office of Inspector General 2001). Concerns about ensuring the appropriate use of home health episodes not preceded by a hospitalization led the Commission to recommend a copayment for these episodes (Medicare Payment Advisory Commission 2011b). In 2020, Medicare estimated that 9.3 percent of home health payments were improper; that is, for these claims, the supporting documentation for the claim did not support the amount Medicare paid (Department of Health and Human Services 2020). Though this is a decline from the peak of 59 percent in 2015, the rate in 2020 is still higher than the improper payment rate for the entire Medicare program of 6.3 percent.

Are Medicare payments adequate in 2021?

The Commission reviews several indicators to determine whether payments are adequate to cover the costs of an efficient provider in 2021. We assess beneficiary access to care by examining the supply of home health providers, annual changes in the volume of services, and marginal profit. The review also examines quality of care, access to capital, and the relationship between Medicare’s payments

The coronavirus public health emergency and the Commission's payment adequacy framework

The coronavirus pandemic and associated public health emergency (PHE) has had tragic effects on beneficiaries' health in 2020. It also had material effects on providers' patient volume, revenues, and costs. The effects of COVID-19 have varied considerably both geographically and over time, and it is not clear when or whether the pandemic's full effects will end. For home health agencies (HHAs), reports indicate that volume dropped in March and April of 2020 (Amedisys 2020a, Encompass Health 2020a, LHC Group 2020). In some parts of the country, HHAs reported an increase in admissions because of COVID-19 infections, offsetting some of the decline. COVID-19 has required HHAs to use more personal protective equipment, and there have been reports that this equipment has increased in price and sometimes has been hard to procure. HHAs have also reported lower payments because beneficiaries were initially declining home health visits. While home health care volume returned to normal levels later in 2020, there remains uncertainty regarding the future effects of the pandemic on volume and provider

financial performance in 2021 and 2022 (Amedisys 2020b, Encompass Health 2020b).

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators are from 2019. We use available data as well as changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the effects of the coronavirus PHE are temporary changes or vary significantly across individual HHAs, they are best addressed through targeted temporary funding policies rather than a permanent change to all home health prospective payment system rates in 2022 and future years. For each payment adequacy indicator, we discuss whether the effects of the coronavirus PHE on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare base payment rates. (For an overview of how our payment adequacy framework has been affected by the PHE, see Chapter 2.) ■

and providers' costs. The indicators of payment adequacy for home health care are generally positive.

Beneficiaries' access to care: Almost all beneficiaries live in an area served by HHAs

Supply and volume indicators show that almost all beneficiaries have access to home health services. In 2019, over 99 percent of beneficiaries lived in a ZIP code served by at least one HHA, 97 percent lived in a ZIP code served by two or more HHAs, and 86 percent lived in a ZIP code served by five or more agencies. These findings are consistent with our prior reviews of access.⁶

Supply of providers: Agency supply remains high despite recent decline

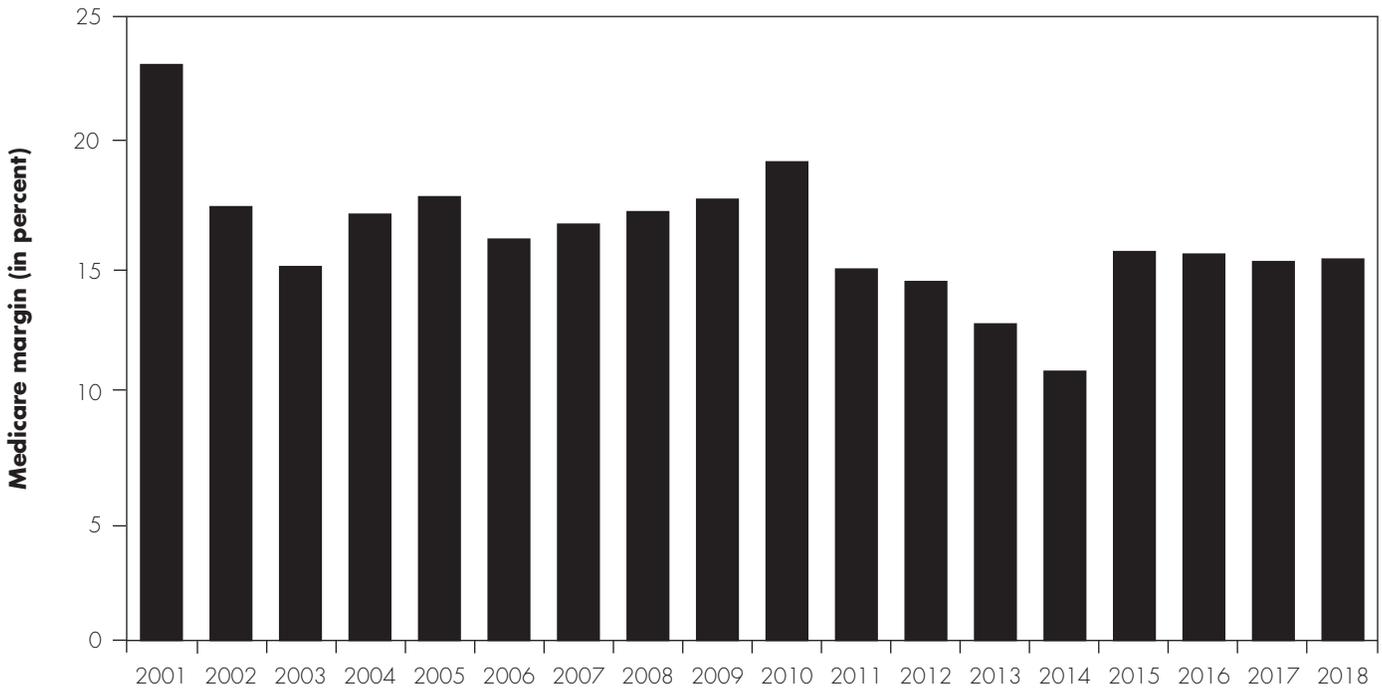
In 2019, the number of HHAs declined by 1.7 percent compared with 2018, and between 2013 and 2018, the supply of HHAs declined by 8.3 percent (Table 8-2, p.

239). However, the decline was preceded by a long period of growth in supply. From 2002 to 2013, the number of HHAs increased by 80 percent (data not shown). The decline since 2013 was concentrated in areas that experienced sharp increases in supply in prior years.

The decline in 2019 was concentrated in Florida and Texas, states with a history of program integrity concerns that experienced higher than average increases in supply in prior years. These states have been targeted by a myriad of antifraud measures, including criminal investigations and moratoriums on the entry of new HHAs. In recent years, the number of HHAs exiting the program has picked up in these states, and moratoriums have likely stopped the entry of new HHAs. Nevertheless, in 2019, the supply of agencies in Florida and Texas was well above the national average of 3 agencies per 10,000 FFS beneficiaries.

**FIGURE
8-1**

**Medicare margins of freestanding home health agencies
remained high between 2001 and 2018**



Source: MedPAC analysis of Medicare cost report data from CMS.

The supply of HHAs varies significantly among states. In 2019, Texas averaged 7.9 HHAs per 10,000 FFS beneficiaries, while New Jersey averaged less than 1 HHA per 10,000 FFS beneficiaries. The extreme variation demonstrates that the number of providers is a limited measure of capacity because HHAs can vary in size. Also, because home health care is not provided in a medical facility, HHAs can adjust their service areas as local conditions change. Even the number of employees may not be an effective metric because HHAs can use contract staff to meet their patients' needs.

Episode volume declined slightly in 2019

The number of episodes per FFS beneficiary declined by 1.7 percent in 2019 relative to the prior year (Table 8-3). This decline is part of a trend that began after 2011, but this period of decline was preceded by a period of rapid growth. Between 2002 and 2011, total episodes increased by 67 percent, from 4.1 million episodes to 6.8 million episodes.

The decline in home health utilization since 2011 reflects changes in both the demand for home health services and the supply of HHAs. From 2011 to 2019, the number of hospital discharges, a common source of referrals, declined by 19 percent on a per capita basis, suggesting that demand for posthospital care using home health services has not increased in Medicare FFS since 2011. In addition, several actions have been taken to curb fraud, waste, and abuse in Medicare home health care.

The decline in episode volume since 2011 has been concentrated in five states. Since 2011, Florida, Illinois, Louisiana, Tennessee, and Texas have seen a decline of about 32 percent in episode volume. However, utilization in these five states had more than doubled between 2002 and 2011, an increase higher than in most other areas. The remaining 45 states experienced aggregate growth of 2.4 percent for the 2011 to 2019 period, though there was a range of increases and declines across these states. This geographic variation underscores the fact that many

**TABLE
8-2****Number of participating home health agencies has declined since 2013**

	2013	2017	2018	2019	Cumulative percent change	
					2013-2018	2018-2019
Active home health agencies	12,613	11,844	11,556	11,356	-8.3%	-1.7%
Number of home health agencies per 10,000 FFS beneficiaries	3.3	3.0	3.0	3.0	-11.1	-0.3

Note: FFS (fee-for-service). "Active home health agencies" includes all agencies operating during a year, including agencies that closed or opened at some point during the year.

Source: MedPAC analysis of CMS's Provider of Services file and 2020 annual report of the Boards of Trustees of the Medicare trust funds.

areas continued to see growth despite the overall drop in episode volume since 2011. Among the 45 states, growth in California between 2011 and 2019 accounted for a significant share of the increase, with episode volume rising by 46 percent.

In March and April 2020, HHAs reportedly experienced substantial reductions in the demand for home health care services due to the coronavirus PHE (Amedisys 2020a,

Encompass Health 2020a, LHC Group 2020, The Motley Fool 2020). HHAs attributed the decline to several factors, including the decline in inpatient hospital discharges during the PHE, assisted living facilities limiting HHA staff access to residents, and beneficiaries declining home health care services. However, some reports indicate that, in aggregate, the demand for home health care services recovered in the remainder of 2020 (Amedisys 2020a, Amedisys 2020b, Encompass Health 2020b). In addition,

**TABLE
8-3****Number of home health episodes, beneficiaries using services, and total payments have declined since 2011, after a period of rapid growth**

	2002	2011	2017	2018	2019	Annual percent change		
						2002-2011	2011-2018	2018-2019
Home health users (in millions)	2.5	3.4	3.4	3.4	3.3	3.6%	-0.3%	-2.4%
Share of beneficiaries using home health care	7.2%	9.4%	8.8%	8.7%	8.6%	3.1	-1.1	-1.1
Episodes (in millions):	4.1	6.8	6.4	6.3	6.1	5.9	-1.2	-3.0
Per home health user	1.6	2.0	1.9	1.9	1.9	2.2	-0.9	-0.6
Per FFS beneficiary	0.12	0.19	0.16	0.16	0.16	5.4	-2.1	-1.7
Payments (in billions)	\$9.5	\$18.3	\$17.8	\$17.9	\$17.8	7.5	-0.3	-0.5
Per home health user	3,783	5,312	5,242	5,303	5,406	3.9	<-0.1	1.9
Per home health episode	2,645	2,916	3,039	3,089	3,167	1.1	0.8	2.5

Note: FFS (fee-for-service). Percent change is calculated on numbers that have not been rounded; payment per episode excludes low-utilization payment adjustment cases.

Source: MedPAC analysis of home health standard analytical file from CMS.

**TABLE
8-4**

Home health episodes not preceded by hospitalization or PAC stay account for two-thirds of home health episodes in 2019

	Episodes			Cumulative percent change	
	2001	2011	2019	2001-2011	2011-2019
Number of episodes preceded by a hospitalization or PAC stay (in millions)	1.9	2.2	2.1	14.8%	-0.5%
Number of episodes not preceded by a hospitalization or PAC stay (in millions)	2.1	4.6	4.0	127.4	-10.3
Share of episodes not preceded by a hospitalization or PAC stay	53%	67%	66%	N/A	N/A
Total (in millions)	3.9	6.8	6.1	74.0	-7.8

Note: PAC (post-acute care), N/A (not applicable). "Episodes preceded by a hospitalization or PAC stay" indicates the episode occurred fewer than 15 days after a stay in a hospital (including a long-term care hospital), skilled nursing facility, or inpatient rehabilitation facility. "Episodes not preceded by a hospitalization or PAC stay" indicates that there was no hospitalization or PAC stay in the 15 days before the episode began. Numbers may not sum to totals due to rounding. Percent change columns were calculated on unrounded data.

Source: MedPAC analysis of home health standard analytical file and Medicare Provider Analysis and Review file for 2001, 2011, and 2019, from CMS.

some HHAs have reported that the PHE has increased demand as beneficiaries seek to substitute home health care for a stay at a skilled nursing facility. While there is uncertainty about the impact of the PHE on home health care services in the future, the disruption caused by the emergency may have increased beneficiary preference for home health care services when they can substitute for institutional settings.

Length of home health service has increased and shifted to episodes not preceded by a hospitalization

Between 2002 and 2011, the average number of episodes per user increased from 1.6 to 2.0 (Table 8-3, p. 239), though the average number of episodes declined slightly from 2011 to 2019. The increase in episodes per user in the 2002 to 2011 period coincides with Medicare's PPS incentives that encourage additional volume: The per episode unit of payment in the PPS encourages more services (more episodes per beneficiary). The use of home health care for longer periods raises concerns that home health care, in some instances, serves more as a long-term care benefit. These concerns are similar to those in the

mid-1990s that led to major program integrity activities and payment reductions.

The rise in the average number of episodes per home health user coincided with a sharp increase in the number of episodes not preceded by a hospitalization or institutional post-acute care (PAC) service. Between 2001 and 2011, episodes not preceded by a hospitalization or institutional PAC stay increased by about 127 percent, compared with an almost 15 percent increase in episodes preceded by a prior PAC stay or hospitalization (Table 8-4). Between 2011 and 2019, the volume of episodes not preceded by a hospital or institutional PAC stay dropped by 10.3 percent, while the volume of episodes preceded by a hospitalization or PAC stay remained fairly steady. However, the 10.3 percent decrease did not significantly change the share of episodes not preceded by an inpatient or institutional PAC stay, which in 2019 accounted for 66 percent of episodes.

Marginal profits

Another factor we consider when evaluating access to care is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve.

**TABLE
8-5**

Since 2015, HHAs have reported a modest improvement in the rate of successful discharge from home health care to the community, but the rate of hospitalization during care has increased

	2015	2016	2017	2018	2019
Successful discharge to the community	68.3%	69.2%	69.6%	70.4%	72.2%
Hospitalization during home health care	20.6	20.8	21.4	21.5	21.4

Note: HHA (home health agency). “Successful discharge to the community” includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytical files from CMS.

In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments exceed the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider may have a disincentive to care for Medicare beneficiaries.⁷ In 2019, the marginal profit, on average, for freestanding HHAs was 18 percent. This substantial marginal profit indicates that these HHAs have a strong incentive to serve Medicare beneficiaries.

Quality of care: Rate of successful discharge to the community after home health care improved slightly, but rate of all-condition hospitalization within a home health care spell increased

This year, the Commission evaluated quality with two measures that are common across the four PAC settings (skilled nursing facilities, inpatient rehabilitation facilities, long-term care hospitals, and home health care): average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a set period (a spell of care in the case of home health care). Successful discharge to the community includes beneficiaries discharged to the community, including those discharged to the same nursing home, who did not have an unplanned hospitalization and did not die in the

next 30 days. The hospitalization measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur from the start of a home health care spell until the end of service. Both measures are uniformly defined and risk adjusted across the four PAC settings, thus representing another step toward evaluation of outcomes across PAC settings.⁸ Providers with at least 60 spells in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Over the five years between 2015 and 2019, the share of patients successfully discharged from home health care to the community rose from 68.3 percent to 72.2 percent (higher rates indicate better performance) (Table 8-5). In this period, the share of patients hospitalized during their care increased slightly from 20.6 percent to 21.4 percent (lower rates indicate better performance). In general, hospital-based HHAs, HHAs located in urban areas, and nonprofit HHAs performed better than their counterparts on these measures (Table 8-6, p. 242). Performance varied across providers; for example, the HHA at the 25th percentile of the distribution for hospitalization had a rate of 17.3 percent, while the agency at the 75th had a rate of 25.4 percent. Overall, these measures suggest modest improvement in the rate of successful discharge to the community after home health care, but a slight worsening in the rate of beneficiaries hospitalized during home health care.

This year, we no longer consider measures of functional improvement in our assessment of quality.

**TABLE
8-6**

Performance on quality measures varies by provider characteristic

	Successful discharge to the community	Hospitalization during home health stay
All	72.2%	21.4%
Nonprofit	78.9	19.0
For profit	70.7	22.0
Freestanding	71.6	21.6
Hospital based	77.5	19.4
Rural	70.4	22.2
Urban	72.5	21.3

Note: "Successful discharge to the community" includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability threshold of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review and home health standard analytical files from CMS.

While the Commission believes that maintaining and improving functional status is a key outcome of PAC, the Commission has raised serious questions about the integrity of this information (Medicare Payment Advisory Commission 2019). Because functional assessments are used in the case-mix system to establish payments, it is unlikely that this information can be divorced from payment incentives. In our June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019).

Providers’ access to capital: Access to capital is adequate

In 2019, the overall (all-payer) margins for freestanding HHAs averaged 5.9 percent, indicating that many HHAs yield positive financial results that should appeal to capital markets. HHAs are not as capital intensive as other providers because they do not require extensive physical infrastructure, and most are too small to attract interest from capital markets. Few HHAs access capital through

publicly traded shares or through public debt, such as issuance of bonds.

Information on publicly traded home health care companies provides some insight into access to capital, but it has limitations. Publicly traded companies may have other lines of business in addition to Medicare home health care, such as hospice, Medicaid-covered services, and private-duty nursing. Also, publicly traded companies are a small portion of the total number of HHAs in the industry. However, since they are the largest corporate entities in home health care, they can provide some insight about the industry’s financial status.

Analysis of the for-profit publicly traded companies indicates that they have access to capital. Though the coronavirus public health emergency reduced the demand for home health care for a period in the spring of 2020, firms reported implementing several efficiency measures to reduce the financial impact (Amedisys 2020a, Encompass Health 2020a, LHC Group 2020). For example, many companies pay staff on a per visit basis, so costs fall when fewer services are delivered. At the same time, firms also reported higher per episode costs for personal protective equipment. However, by the fall

**TABLE
8-7**

Medicare margins for freestanding home health agencies, 2018 and 2019

	Medicare margin		Share of home health agencies, 2019	Share of episodes, 2019
	2018	2019		
All	15.3%	15.8%	100%	100%
Geography				
Majority urban	15.7	16.1	82	84
Majority rural	12.6	13.9	18	16
Type of ownership				
For profit	16.8	17.2	87	79
Nonprofit	10.1	11.0	13	21
Volume quintile				
First (smallest)	10.4	9.8	20	3
Second	11.0	11.5	20	6
Third	13.8	13.3	20	11
Fourth	14.4	14.3	20	19
Fifth (largest)	16.7	17.4	20	61

Note: Home health agencies were classified as majority urban if they provided more than 50 percent of episodes to beneficiaries in urban counties and were classified as majority rural if they provided more than 50 percent of episodes to beneficiaries in rural counties.

Source: MedPAC analysis of Medicare home health cost report files from CMS.

of 2020, for-profit firms reported that demand for home health care services had returned to near pre-COVID levels (Amedisys 2020b, Encompass Health 2020b).

Medicare payments and providers’ costs: Payments per episode increased while cost per episode remained low in 2019

In 2019, average Medicare payments per episode for freestanding HHAs increased by 2.5 percent. In 2019, the average cost per episode increased by 1.8 percent, greater than the average annual increase between 2016 and 2018 of about 0.9 percent. Despite the greater increase in 2019, it was significantly lower than the cost growth experienced by other Medicare health care sectors. In addition, the cost growth rate was substantially below the rate implied by the home health care market basket, which averaged 2.5 percent for the 2017 to 2019 period. Meanwhile, low or no cost growth has been typical for home health care, and in some years, cost per episode has declined. In 2019, Medicare accounted for about 55 percent of revenue for freestanding HHAs.

Medicare margins for freestanding HHAs remained high in 2019

In 2019, the aggregate Medicare margin for freestanding HHAs was 15.8 percent (Table 8-7).⁹ The margin ranged from 3.0 percent to 24.5 percent for those at the 25th percentile and 75th percentiles, respectively, of the margin distribution (not shown in Table 8-7). For-profit HHAs had higher margins than nonprofit HHAs, and urban HHAs had higher margins than rural HHAs. Agencies with higher volume had better financial results, likely reflecting the economies of scale possible for larger operations. For example, margins for HHAs in the bottom quintile of episode volume averaged 9.8 percent, compared with a 17.4 percent average margin for HHAs in the top quintile.

The Commission includes hospital-based HHAs in its calculation of acute care hospitals’ Medicare margins because these agencies operate in the financial context of hospital operations (see Chapter 3). In 2019, margins for hospital-based HHAs were –19.8 percent (data not

shown). The lower margins of hospital-based HHAs are attributable chiefly to their higher costs, some of which are a result of overhead costs allocated to the HHA from its parent hospital. Hospital-based HHAs help their parent institutions financially if they can shorten inpatient stays, lowering expenses in the more costly inpatient hospital setting.

FFS payments are reportedly higher than rates paid by Medicare Advantage plans

Comparing FFS Medicare payments with those paid by Medicare Advantage (MA) plans is another way of assessing payment adequacy. MA plans are required to offer home health services that are comparable with what is available in FFS, though plans have the latitude to limit the HHAs in their network and may use utilization management tools like prior authorization. HHAs have reported that MA payment rates are lower than FFS, but that they accept the lower rates because they need managed care patients to remain competitive or economically viable (Pozniak et al. 2019). Some noted the need to accept managed care patients in markets where managed care beneficiaries are a significant share of the Medicare population. In addition, HHAs reported that they saw accepting these patients as a way of maintaining relations with referring physicians and institutions, and they were concerned that a referral source might be less likely to refer FFS patients if they did not also accept referrals for MA patients.

Relatively efficient HHAs serve patients similar to those served by other HHAs

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The analysis informs the Commission's update discussion by examining the adequacy of payments for those providers that perform relatively well on cost and quality measures.

The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on both cost and quality metrics. Second, performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission's approach is to examine how many providers meet a preestablished set of criteria. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size.

To identify efficient HHAs, we examined the quality and cost efficiency of freestanding HHAs to identify a cohort that demonstrated better performance on these metrics relative to its peers (Table 8-8). The cost measure was on a per episode basis, adjusted for risk (patient's health status) and local wages; the quality measures were risk-adjusted rates of hospitalizations during the home health spell and rate of successful discharge to the community after the home health spell. Our approach categorized an HHA as relatively efficient if it was in the best performing third on at least one measure (low cost per episode, a low hospitalization rate, or a high rate of beneficiaries with a successful discharge to the community) and was not in the worst performing third of any of these measures for three consecutive years (2016 to 2018). About 14 percent of freestanding HHAs met these criteria in this period.

In 2019, relative to other HHAs, efficient HHAs served a similar mix of patients but had a median margin that was 7.7 percentage points higher, a median hospitalization rate that was 5.2 percentage points lower (lower is better performance), a better median risk-adjusted rate of discharge to community, and a median cost per episode that was 12.2 percent lower. Relatively efficient HHAs tended to be larger in median volume but provided 1.7 fewer visits per episode. The mix of nursing, therapy, aide, and medical social services visits did not differ significantly between relatively efficient and other HHAs. Efficient providers were less likely to be for profit and tended to provide fewer episodes in rural areas.

The Commission projects that Medicare margins will remain high in 2021

In modeling 2021 payments and costs, we incorporate policy changes that will go into effect between the year of our most recent data, 2019, and the year for which we are making the margin projection, 2021. The major changes are:

- a 1.5 percent payment update for 2020;
- a 0.3 percent cumulative decrease in payments due to the phasing out of the rural add-on payments for home health in 2020 and 2021 required under the Bipartisan Budget Act of 2018;
- a 2.0 percent payment update for 2021;
- the suspension of the two percent sequester for Medicare payments from March 1, 2020, to March 31, 2021;

**TABLE
8-8**

Performance of relatively efficient home health agencies in 2019

Provider characteristics	All providers in analysis	Relatively efficient providers	All other providers
Number of home health agencies	3,561	532	3,029
Share that are for profit	88%	77%	90%
Median:			
Medicare margin	16.8%	23.4%	15.7%
Hospitalization during home health care	22.1%	17.8%	23.0%
Successful discharge to community relative to expected	0.95	1.07	0.97
Cost per episode	\$2,521	\$2,252	\$2,564
Patient severity case-mix index	1.00	1.00	0.99
Visits per episode			
Average visits per episode	16.3	15.0	16.7
Share of visits by type			
Skilled nursing visits	43%	42%	43%
Aide visits	6%	6%	6%
MSS visits	1%	1%	1%
Therapy visits	50%	51%	50%
Number of 60-day episodes			
Median	646	738	640
Mean	1,107	1,241	2,447
Share of episodes			
Low-use episode	8.5%	10.5%	8.0%
Outlier episode	3.5%	3.5%	3.8%
Provided to rural beneficiaries	23.0%	13.0%	25.5%

Note: MSS (medical social services). Sample includes freestanding agencies with complete data for three consecutive years (2016–2018). A home health agency is classified as relatively efficient if it is in the best third of performance for quality or cost and is not in the bottom third of either measure for three consecutive years. Low-use episodes are those with 4 or fewer visits in a 60-day episode. Outlier episodes are those that receive a very high number of visits and qualify for outlier payments.

Source: MedPAC analysis of Medicare cost reports and home health standard analytic file, from CMS.

- assumed case-mix growth of 2.18 percent for 2020 and 2021; and
- assumed cost growth of 3 percent in 2020. Two percentage points of the growth in 2020 reflect changes that will affect costs in future years, such as inflation, higher expenses for personal protective

equipment, and telehealth. We assume that 1 percentage point is temporary, reflecting surge pricing for personal protective equipment and other temporary costs associated with the PHE. The assumed cost growth for 2021 is 1.3 percent, the average annual cost increase in the 2017 to 2019 period.

On the basis of these policies and assumptions, the Commission projects a margin of 14 percent in 2021.

The margin projection for 2021 reflects the significant changes that occurred in home health in 2020, including the PHE and the planned changes to the home health PPS. Since complete cost and utilization data for 2020 are not yet available, our estimates of the impact of these events is an extrapolation based on prior experience and anecdotal industry reporting. We recognize that 2020 was a year of significant change for Medicare HHAs, and our projection assumes trends in cost and payments that depart significantly from prior projections. For example, the per episode cost growth of 3 percent we assumed in 2020 is more than twice the three-year average of 1.3 percent. In the past, home health agencies have been able to hold cost per episode growth below 1 percent a year, and if this trend returns in 2021, the aggregate margin for Medicare HHAs could be higher than our estimate.

Payment history under the home health PPS demonstrates that HHAs change coding, utilization, and the mix of services provided in reaction to new payment incentives. CMS has estimated that in 2020, a combination of coding and utilization changes by HHAs in response to the new Patient-Driven Groupings Model (PDGM) will increase payments by 4.36 percent. Statute requires that the PDGM be implemented in a budget-neutral manner, and CMS has accordingly included a 4.36 percent payment reduction in 2020. Because the PHE may have delayed the ability of providers to implement the anticipated behavioral changes, our projection includes a nominal payment increase of 2.18 percent, half the amount of the increase CMS expected.

How should Medicare payments change in 2022?

Our review of payment adequacy for Medicare home health services indicates that access is more than adequate in most areas and that Medicare payments are substantially in excess of costs. On the basis of these findings, the Commission has concluded that home health payments should be significantly reduced. We anticipate that

payments in 2021 will be well in excess of cost, even after accounting for the addition of new telehealth services and any incremental costs resulting from the PHE. These overpayments do not accrue to the advantage of the beneficiary or the Medicare program and do not encourage the efficient use of the home health care benefit.

Home health care can be a high-value benefit when it is appropriately and efficiently delivered. Medicare beneficiaries often prefer to receive care at home instead of in institutional settings, and home health care can be provided at lower costs than institutional care. However, Medicare's payments for home health services are too high, and these overpayments diminish the service's value as a substitute for more costly services. There are also indications that utilization under FFS Medicare is not always efficient, as suggested by the broad geographic variation in the use of the benefit.

RECOMMENDATION 8

For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

RATIONALE 8

- An immediate reduction of 5 percent in 2022 would represent a significant action to address the magnitude of the overpayments embedded in Medicare's rates. However, this reduction would likely be inadequate to align Medicare payments with providers' actual costs. Though the public health emergency was a disruption for HHAs, the emergency has not significantly changed the financial outlook or service delivery practices of the industry.

IMPLICATIONS 8

Spending

- This recommendation would decrease federal program spending relative to the expected payment update by \$750 million to \$2 billion in 2022 and by more than \$10 billion over five years.

Beneficiary and provider

- Beneficiaries' access to care should not be affected. Lowering payments should not affect providers' willingness to deliver appropriate home health care. ■

Endnotes

- 1 The Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 (P.L. 226-136) permanently expanded ordering and supervision authority for home health care to include nurse practitioners, clinical nurse specialists, and physician assistants (before this statute, only physicians had this authority). State medical scope of practice laws also govern the services these practitioners are permitted to deliver and may limit the ability of some practitioners to order home health care.
- 2 The requirement may also be satisfied by an encounter with a nurse practitioner, certified nurse midwife, or physician assistant.
- 3 An overview of the home health PPS is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_hha_final_sec.pdf?sfvrsn=0.
- 4 In 2019, CMS added remote patient monitoring to the Medicare home health benefit. Remote patient monitoring was defined as “the collection of physiologic data . . . digitally stored and transmitted by the patient or caregiver or both to the home health agency” (Centers for Medicare & Medicaid Services 2018).
- 5 Freestanding providers accounted for about 90 percent of the episodes provided in 2019.
- 6 As of November 2019, our measure of access is based on data collected and maintained as part of CMS’s Home Health Compare database. The service areas listed are postal ZIP codes where an HHA has provided services in the past 12 months. This definition may overestimate access because HHAs need not serve the entire ZIP code to be counted as serving it. At the same time, the definition may understate access if HHAs are willing to serve a ZIP code but did not receive a request in the previous 12 months. The analysis excludes beneficiaries with unknown ZIP codes.
- 7 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:

Marginal profit = (Medicare payments – (total Medicare costs – fixed costs)) / Medicare payment.

This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 8 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for Medicare entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay.
- 9 Freestanding agencies accounted for about 90 percent of home health episodes in 2019.

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CHAPTER

9

**Inpatient rehabilitation
facility services**

R E C O M M E N D A T I O N

- 9** For fiscal year 2022, the Congress should reduce the 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Inpatient rehabilitation facility services

Chapter summary

Inpatient rehabilitation facilities (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 occupational therapy, rehabilitation nursing, speech–language pathology, and prosthetic and orthotic services. In 2019, Medicare spent \$8.7 billion on IRF care provided to fee-for-service (FFS) beneficiaries in about 1,150 IRFs nationwide. About 363,000 beneficiaries had about 409,000 IRF stays. On average, the FFS Medicare program accounted for about 58 percent of IRF discharges.

In this chapter, we recommend a payment rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators is from 2019. Where relevant, we have considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary or vary significantly across IRF providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all IRF provider payment rates in 2022 and future years. Based on information available at the time of

In this chapter

- Are Medicare payments adequate in 2021?
.....
- How should Medicare payments change in 2022?
.....

publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to IRF payments in 2022.

Assessment of payment adequacy

Our indicators of Medicare payment adequacy for IRFs are positive.

Beneficiaries' access to care—Our analysis of IRF supply and volume of services provided and IRFs' marginal profit under Medicare's IRF prospective payment system suggest that access remains adequate.

- **Capacity and supply of providers**—The number of IRFs has been steady since 2014. From 2018 to 2019, the number of IRFs decreased slightly from 1,170 to 1,152. Over time, the number of hospital-based and nonprofit IRFs has fallen, while the number of freestanding and for-profit IRFs has mostly increased. In 2019, the average IRF occupancy rate remained at 67 percent, indicating that capacity is adequate to meet demand for IRF services.
- **Volume of services**—The number of Medicare cases per FFS beneficiary increased by 1.6 percent in 2019.
- **Marginal profit**—The marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was 19.4 percent for hospital-based IRFs and 40.2 percent for freestanding IRFs—a very positive indicator of patient access.

Quality of care—This year, the Commission evaluated quality by tracking two quality indicators across all post-acute care (PAC) providers: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within the IRF stay. These measures were steady or improved between 2015 and 2019.

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 about 31 percent of Medicare IRF discharges, continued expanding, indicating good access to capital. We were not able to determine the ability of other freestanding facilities to raise capital. IRFs' access to capital in large part depends on their total (all-payer) profitability, and in 2019, the total margin for freestanding IRFs averaged 10.4 percent.

Medicare payments and providers' costs—In the five-year period between 2015 and 2019, the IRF Medicare margin remained above 13 percent. Although the Medicare margin decreased slightly in 2019 to 14.3 percent, it remained high. In 2019, Medicare margins in freestanding and hospital-based IRFs also decreased

somewhat to 24.6 percent and 2.1 percent, respectively. Our analysis found that relatively efficient IRFs performed better on quality metrics and had costs 13 percent lower than other IRFs. Relatively efficient IRFs were on average larger and had higher occupancy rates, contributing to greater economies of scale and lower unit costs.

The coronavirus PHE has made 2020 an anomalous year in many respects, and it is impossible to predict with certainty the extent to which these effects will continue into 2021. Nevertheless, we expect IRFs' Medicare margin in 2021 to increase relative to 2019. Under current law, IRF base payment rates are projected to increase by about 2.2 percent in 2022. This amount is substantially higher than in 2019 and prior years because of the expiration of statutory reductions in IRF updates required by the Affordable Care Act in each year from 2010 through 2019. Overall, we expect the increase in revenue will more than offset cost growth over the period. Therefore, for 2021, we project an aggregate Medicare margin of 16 percent.

How should payment rates change in 2022?

Considering these factors, the Commission recommends that for fiscal year 2022, the 2021 IRF base payment rate be reduced by 5 percent. In addition, the Commission reiterates its March 2016 recommendations that (1) the high-cost outlier pool be expanded and (2) the Secretary conduct focused medical record review of IRFs (for a detailed discussion of these additional recommendations, see our March 2016 report to the Congress). ■

Background

After illness, injury, or surgery, some patients need intensive inpatient rehabilitative care, including physical, occupational, and speech therapy. Such services can be provided in inpatient rehabilitation facilities (IRFs).¹ IRFs must be focused primarily on treating conditions that typically require intensive rehabilitation, among other requirements. IRFs can be freestanding facilities or specialized units within acute care hospitals. To qualify for a covered IRF stay, a rehabilitation physician must document that the beneficiary is able to tolerate and benefit from intensive therapy and has a condition that requires frequent and face-to-face supervision by a rehabilitation physician. Other patient admission criteria also apply. In 2019, Medicare spent \$8.7 billion on IRF care provided to fee-for-service (FFS) beneficiaries in about 1,150 IRFs nationwide.² About 363,000 beneficiaries had about 409,000 IRF stays. On average, Medicare FFS beneficiaries accounted for about 58 percent of IRF discharges.

Since January 2002, Medicare has paid IRFs under a per discharge prospective payment system (PPS).³ Under the IRF PPS, each Medicare patient is assigned to a rehabilitation impairment code (RIC) based on the principal diagnosis or impairment and further classified within a RIC to a case-mix group (CMG) based on the patient's age and level of motor and cognitive function. Within each CMG, patients are further classified into one of four tiers based on the presence of certain comorbidities that have been found to increase the cost of care. The IRF PPS also has outlier payments for patients who are extraordinarily costly.

Medicare facility requirements for IRFs

To qualify as an IRF for Medicare payment, facilities must meet the Medicare conditions of participation for acute care hospitals.⁴ They must also:

- have a preadmission screening process to determine that each prospective patient is likely to benefit significantly from an intensive inpatient rehabilitation program;
- ensure that the patient receives close medical supervision and must, at minimum, provide—through qualified personnel—rehabilitation nursing, physical therapy, occupational therapy, and, as needed, speech—language pathology and psychological (including

neuropsychological) services, social services, and orthotic and prosthetic services;

- have a medical director of rehabilitation with training or experience in rehabilitation who provides services in the facility on a full-time basis for freestanding IRFs or at least 20 hours per week for hospital-based IRF units;
- use a coordinated interdisciplinary team led by a rehabilitation physician that includes a rehabilitation nurse, a social worker or case manager, and a licensed therapist from each therapy discipline involved in the patient's treatment;
- have a plan of treatment for each patient that is established, reviewed, and revised as needed by a physician in consultation with other professional personnel who provide services to the patient; and
- meet the compliance threshold, which requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 conditions specified by CMS.⁵ IRFs are not, however, limited to treating only patients with these specified conditions. The intent of the compliance threshold is to distinguish IRFs from acute care hospitals. If an IRF does not meet the compliance threshold, Medicare pays for all its cases on the basis of the inpatient hospital PPS rather than the IRF PPS.

Medicare coverage criteria for beneficiaries

Medicare applies additional criteria that govern whether IRF services are covered for an individual Medicare beneficiary. For an IRF claim to be considered reasonable and necessary, the patient must be reasonably expected to meet the following requirements at admission:⁶

- The patient requires active and ongoing therapy in at least two modalities, one of which must be physical or occupational therapy.
- The patient can actively participate in and benefit from intensive therapy that most typically consists of three hours of therapy a day at least five days a week.
- The patient is sufficiently stable at the time of admission to actively participate in the intensive rehabilitation program.
- The patient requires supervision by a rehabilitation physician. This requirement is satisfied by face-

**TABLE
9-1**

Patterns of use in IRFs have changed over time

Condition	Share of IRF Medicare FFS cases			Meets compliance threshold ^a	Percentage point change	
	2009	2018	2019		2009-2018	2018-2019
Stroke	20.5%	20.0%	19.8%	yes	-0.4	-0.3
Other neurological conditions	9.0	14.7	14.4	yes	5.7	-0.4
Debility	9.3	11.6	12.3	no	2.3	0.7
Brain injury	7.3	10.8	11.0	yes	3.5	0.2
Fracture of the lower extremity	15.1	10.3	10.0	yes	-4.8	-0.3
Other orthopedic conditions	6.4	7.9	8.1	no	1.5	0.2
Cardiac conditions	4.9	5.9	6.1	no	0.9	0.2
Spinal cord injury	4.4	4.9	4.9	yes	0.5	-0.1
Major joint replacement of lower extremity	11.7	4.1	3.7	^b	-7.5	-0.5
All other	11.3	9.7	10.0	^c	-1.6	0.2

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). "Other neurological conditions" includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Fracture of the lower extremity" includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. "Other orthopedic conditions" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. "All other" includes conditions such as amputations, arthritis, and pain syndrome. "Brain injury" and "spinal cord injury" include both traumatic and nontraumatic injuries. All FFS Medicare IRF cases with valid patient assessment information were included in this analysis. Yearly figures presented in the table are rounded, but figures in the percentage point change columns were calculated using unrounded data.

^aThe compliance threshold requires that at least 60 percent of an IRF's patients have 1 of 13 specified diagnoses or have a comorbidity that could cause significant decline in functional ability such that the patient requires intensive rehabilitation. Some FFS cases with conditions that do not meet the compliance threshold could thus be counted toward the threshold if they had certain comorbidities.

^bCases admitted for rehabilitation after major joint replacement of the lower extremity count toward the compliance threshold if joint replacement was bilateral, if the patient had a body mass index of 50 or greater, or if the patient was age 85 or older.

^cConditions in the "all other" category that meet the compliance threshold include congenital deformity, lower-limb amputations, major multiple trauma, burns, and certain arthritis cases.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

to-face physician visits with a patient at least three days a week. Beginning with the second week of admission to the IRF, a nonphysician practitioner who is determined by the IRF to have specialized training and experience in inpatient rehabilitation may conduct one of the three required face-to-face visits with the patient per week, provided that such duties are within the nonphysician practitioner's scope of practice under applicable state law.

- The patient requires an intensive and coordinated interdisciplinary team approach to the delivery of rehabilitative care.

Patterns of use in IRFs

In 2004, CMS began to consistently enforce the IRF compliance threshold and enacted revisions to some of

the qualifying conditions.⁷ The combination of renewed enforcement of the threshold and additional restrictions resulted in changes over time in the distribution of conditions treated by IRFs. Average case-mix severity and cost per case increased as IRFs shifted their mix of cases to conditions that counted toward the threshold, such as stroke, brain injury, and conditions classified as "other neurological" (an impairment group that includes multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders). For example, between 2009 and 2018, the number of IRF discharges with other neurological conditions climbed 75 percent and the number of discharges with brain injuries (traumatic and nontraumatic combined) rose 58 percent. During the same period, the total number of Medicare IRF discharges increased 7 percent. Notably, the number of

**TABLE
9-2**

Mix of Medicare FFS IRF cases differed by provider type, selected conditions, 2019

Condition	Freestanding		Hospital based	
	For profit	Nonprofit	For profit	Nonprofit
Stroke	16%	25%	18%	26%
Other neurological conditions	20	8	12	9
Fracture of the lower extremity	9	8	14	11
Debility	13	11	14	12
Brain injury	10	13	12	11
Other orthopedic conditions	10	6	6	6

Note: FFS (fee-for-service), IRF (inpatient rehabilitation facility). “Other neurological conditions” includes multiple sclerosis, Parkinson’s disease, polyneuropathy, and neuromuscular disorders. “Fracture of the lower extremity” includes hip, pelvis, and femur fractures. Patients with debility have generalized deconditioning not attributable to other conditions. “Other orthopedic conditions” excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. “Brain injury” includes both traumatic and nontraumatic injuries. All FFS Medicare IRF cases with valid patient assessment information were included in this analysis.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

cases with debility, other orthopedic conditions (excluding fractures of the hip, pelvis, and femur, and hip and knee replacements), and cardiac conditions also rose over this period, though a sizable share of these cases do not count toward the compliance threshold.⁸ The number of hip and knee replacement cases admitted to IRFs declined over the period, falling 62 percent. IRFs also saw a large decline in cases of fractures of the lower extremity, which fell 27 percent, even though these conditions count toward the compliance threshold. Although patterns of use were fairly stable between 2018 and 2019, we continue to observe disproportionate growth in the number of cases with debility—from 11.6 percent to 12.3 percent of FFS IRF cases (Table 9-1).

The most common condition treated by IRFs in 2019 was stroke—accounting for about one-fifth of cases—followed by other neurological conditions, debility, and brain injury (Table 9-1).

The distribution of case types differs by type of IRF and ownership (Table 9-2). For example, in 2019, only 16 percent of cases in freestanding for-profit IRFs were admitted for rehabilitation following a stroke, compared with 26 percent of cases in hospital-based nonprofit IRFs. By contrast, 20 percent of cases in freestanding for-profit IRFs were admitted with other neurological conditions,

over twice the share admitted to hospital-based nonprofit IRFs. Cases with other orthopedic conditions made up a higher share of cases in freestanding for-profit facilities than in all other IRFs. The share of cases with brain injury or debility was similar across IRF types.

A previous Commission analysis of differences in the mix of cases across IRFs suggested that patient selection contributes to provider profitability (Medicare Payment Advisory Commission 2016). We found that IRFs with the highest margins in 2013 had a higher share of other neurological cases and a lower share of stroke cases.⁹ Further, we observed differences in the types of stroke and other neurological conditions admitted to high-margin and low-margin IRFs. Stroke cases in the highest margin IRFs were two-and-a-half times more likely than those in the lowest margin IRFs to be coded as having no paralysis. Likewise, other neurological cases in the highest margin IRFs were almost three times more likely than those in the lowest margin IRFs to have a neuromuscular disorder (such as amyotrophic lateral sclerosis or muscular dystrophy) as opposed to neurological conditions such as multiple sclerosis or Parkinson’s disease. As noted in our March 2016 report to the Congress, these findings suggest that, under the IRF PPS, some case types are more profitable than others.

**TABLE
9-3**

Some case types are more profitable than others, 2017

Rehabilitation impairment category	Number of stays	Average per stay:		Payment-to-cost ratio
		Payment	Cost	
All conditions	376,336	\$20,346	\$18,371	1.11
Other neurological	53,419	20,680	17,174	1.20
Other orthopedic	29,485	18,451	15,947	1.16
Major multiple trauma w/o brain/spinal injury	7,322	20,991	18,241	1.15
Major multiple trauma w/ brain/spinal injury	2,164	24,995	21,923	1.14
Traumatic spinal cord injury	2,926	30,455	27,041	1.13
Nontraumatic brain injury	26,463	20,788	18,560	1.12
Pulmonary	7,457	19,982	17,983	1.11
Miscellaneous	44,437	19,416	17,471	1.11
Traumatic brain injury	12,066	21,694	19,879	1.09
Cardiac	20,742	18,298	16,777	1.09
Fracture of lower extremity	37,691	20,625	18,854	1.09
Amputation, lower extremity	9,246	23,034	21,365	1.08
Pain syndrome	1,162	17,337	16,136	1.07
Stroke	73,696	24,221	22,684	1.07
Non-traumatic spinal cord injury	14,867	23,349	21,918	1.07
Replacement of lower extremity joint	15,470	15,376	14,535	1.06

Note: "Other neurological" includes (nonstroke) neurological conditions such as multiple sclerosis, Parkinson's disease, polyneuropathy, and neuromuscular disorders. "Other orthopedic" excludes fractures of the hip, pelvis, and femur, and hip and knee replacements. Case types with less than 1,000 stays, short stays, and expired cases are not presented in the table.

Source: Urban Institute analysis of Medicare cost reports and Medicare fee-for-service claims data for IRF stays that began in 2017.

Using Medicare FFS claims data for IRF stays that began in 2017, we have confirmed this finding by comparing the profitability (i.e., payment-to-cost ratios) of different case types (i.e., case types as grouped under RICs). We found that profitability varies substantially. The average profit across all RICs was \$1,975 per stay, with an average payment-to-cost ratio of 1.11— that is, payments were 11 percent higher than costs for the average IRF stay (Table 9-3). Stroke, the most frequently occurring RIC, had a comparatively low payment-to-cost ratio of 1.07. By contrast, other neurological cases were among the most profitable, with a payment-to-cost ratio of 1.20. Other orthopedic cases (excludes fractures of the hip, pelvis, and femur, and hip and knee replacements) also made up a large number of IRF stays and were relatively profitable with a payment-to-cost ratio of 1.16.

In addition to our finding that some case types are more profitable than others, there may be a coding effect, due to the subjective nature of the assessment of IRF patients, that is playing a key role in IRF provider profitability. We anticipate providing more detail on this payment issue in the future.

Are Medicare payments adequate in 2021?

To assess whether payments for fiscal year (FY) 2021 are adequate to cover the costs providers incur and how much providers' costs are expected to change in the coming year (2022), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries' access to

The coronavirus public health emergency and the Commission's payment adequacy framework

Since early 2020, the coronavirus public health emergency (PHE) has had tragic effects on beneficiaries' health.¹⁰ It is also having material effects on providers' patient volume, revenues, and costs. Publicly traded inpatient rehabilitation facilities (IRFs) reported reductions in volume from March to May 2020 relative to pre-COVID-19 (January to mid-March 2020), largely because of the cancellation of elective surgeries in acute care hospitals (ACHs) (Encompass Health 2020a, Select Medical 2020b). However, as states began to ease restrictions in ACHs and surgery centers resumed performing elective surgeries, the largest publicly traded IRF reported that volume began to slowly recover, reaching at least 95 percent of prepandemic levels by late June 2020 (Encompass Health 2020a). This company attributes the residual lag in volume to the decrease in the number of orthopedic and lower extremity joint replacement cases compared with the same period of 2019 (Encompass Health 2020b). As a result of COVID-19, IRFs also had to use more personal protective equipment and this equipment has reportedly increased in price. Still, some of the negative impact of volume reductions and increased cost have been offset by a concurrent increase in net revenue per discharge because of the temporary suspension of sequestration and higher acuity patient mix resulting from the pandemic. In addition, some IRFs may have maintained higher volume levels by providing needed hospital surge capacity in their communities. While publicly traded IRFs continue to report substantial

recovery through the third quarter of 2020 (Encompass Health 2020b, Select Medical 2020a), it is not yet clear how the PHE has affected other IRFs nor how the pandemic will affect patient care patterns, hospital volume, and hospital financial performance in 2021 and 2022. As applicable, more details about the impact of the coronavirus PHE on IRFs can be found throughout this chapter.

In this chapter, we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators is from 2019. We use available data and expected changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the coronavirus PHE effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that would also affect payments in future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of the coronavirus PHE on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare payment rates. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2.) ■

care by examining the capacity and supply of IRFs and changes over time in the volume of services provided, quality of care, providers' access to capital, and the relationship between Medicare payments and providers' costs.

Although the impact of the coronavirus pandemic on IRFs is evolving (see text box), our indicators of IRF payment adequacy are positive. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2).

Beneficiaries' access to care: IRF supply and service volume suggest sufficient access

We have no direct indicators of beneficiaries' access to IRF care. Although there are criteria for admission to an IRF, it is not clear when IRF care is necessary or beneficial for a given patient or when another, potentially lower cost post-acute care (PAC) provider (such as a skilled nursing facility (SNF)) could provide appropriate care. The absence of IRFs in some areas of the country implies that beneficiaries in these areas receive similar services in

**TABLE
9-4**

Total IRF count declined, but the number of freestanding IRFs continued to grow in 2019

Type of IRF	Share of Medicare FFS discharges 2019	Number of IRFs						Average annual change	
		2014	2015	2016	2017	2018	2019	2014-2018	2018-2019
All IRFs	100%	1,177	1,182	1,188	1,178	1,170	1,152	-0.1%	-1.5%
Urban	91	1,013	1,020	1,026	1,019	1,014	1,000	0.0	-1.4
Rural	6	164	162	162	159	156	152	-1.2	-2.6
Freestanding	53	251	262	273	279	290	299	3.7	3.1
Hospital based	44	926	920	915	899	880	853	-1.3	-3.1
Nonprofit	35	681	681	676	655	642	634	-1.5	-1.2
For profit	56	338	352	370	392	400	393	4.3	-1.8
Government	6	149	138	133	125	121	116	-5.1	-4.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service). The number of facilities are for the calendar year. Components may not sum to totals due to missing data.

Source: MedPAC analysis of Provider of Services data and Medicare Provider Analysis and Review data from CMS.

other settings. Nevertheless, our analysis of IRF supply and volume of services provided suggests that capacity remains adequate to meet demand. Moreover, the marginal profit, an indicator of whether IRFs with excess capacity have an incentive to treat more Medicare beneficiaries, was robust for both freestanding and hospital-based IRFs, providing a very positive indicator of patient access.

Number of IRFs and occupancy rates suggest adequate capacity and supply

The number of IRFs has been steady since 2014 (Table 9-4). Between 2014 and 2018, the number of hospital-based IRFs and the number of nonprofit IRFs decreased while the number of freestanding IRFs and for-profit IRFs increased. From 2018 to 2019, the total number of IRFs decreased slightly from 1,170 to 1,152. Although IRFs provide a more intense level of therapy, IRFs are not the sole provider of rehabilitation services in communities; SNFs also provide rehabilitation services, and home health agencies, comprehensive outpatient rehabilitation facilities, and independent therapy providers furnish care at home or on an outpatient basis. Given the number and distribution of these other rehabilitation therapy providers, it is unlikely that areas exist where IRFs are the only

provider of rehabilitation therapy services available to Medicare beneficiaries.

In 2019, almost 75 percent of IRFs were distinct units in acute care hospitals; the rest were freestanding facilities. However, because hospital-based units have, on average, fewer beds and a lower share of Medicare discharges, they accounted for only 44 percent of Medicare discharges. Overall, 34 percent of IRFs were for-profit entities. Freestanding IRFs were far more likely to be for profit than were hospital-based IRFs (60 percent vs. 40 percent; data not shown). In 2019, 56 percent of Medicare discharges were from for-profit facilities.

In 2019, 47 IRFs closed; almost all were hospital-based units (43 IRFs). At the same time, 29 new IRFs opened. Slightly more than half of the new IRFs were hospital-based units. Of the new hospital-based units, half were for profit; of the new freestanding facilities, a majority were for profit. Previous Commission analyses have found that hospitals with IRF units have higher inpatient margins than hospitals without such units (Medicare Payment Advisory Commission 2015). This trend continued in 2019 when inpatient Medicare margins for hospitals

**TABLE
9-5**

In 2019, the number of IRF cases and payments increased, while length of stay and users decreased

	2010	2015	2016	2017	2018	2019	Average annual change	
							2010-2019	2018-2019
Number of FFS cases	365,095	393,475	396,247	396,294	408,038	409,059	1.3%	0.3%
Cases per 10,000 FFS beneficiaries	101.3	103.4	103.2	102.7	105.7	106.9	0.6	1.6
Payment per case	\$16,814	\$18,527	\$18,931	\$19,481	\$20,124	\$20,417	2.2	1.5
ALOS (in days)	13.1	12.7	12.7	12.7	12.7	12.6	-0.4	-0.5
Users	330,774	354,343	355,390	354,618	363,753	363,285	1.0	-0.1

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), ALOS (average length of stay).

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

with IRF units averaged 1.0 percentage point higher than margins for hospitals without such units.

In 2019, the average IRF occupancy rate slightly increased to 67 percent. In freestanding IRFs, the average occupancy rate was 70 percent, while the average rate for hospital-based IRFs was 64 percent. These rates suggest that capacity is more than adequate to meet demand for IRF services.

IRF Medicare volume increased in 2019

As discussed above, after CMS renewed its enforcement of the compliance threshold in 2004, IRF volume declined substantially between 2004 to 2008 (Medicare Payment Advisory Commission 2019b). At that point, volume began to increase slowly, rising each year (Table 9-5). After a stagnant period from 2016 to 2017, the number of FFS Medicare cases increased in 2018 and 2019 to about 409,000 cases.

In 2019, the number of IRF cases per 10,000 FFS beneficiaries grew to 106.9, up 1.6 percent from the previous year. Relatively few Medicare beneficiaries use IRF services because, to qualify for Medicare coverage, IRF patients must be able to tolerate and benefit from rehabilitation therapy that is intensive, which is usually

interpreted to mean at least three hours of therapy a day for at least five days a week. Yet, compared with all Medicare beneficiaries, those admitted to IRFs in 2019 were disproportionately over age 85 (data not shown).

With the increase in the number of IRF cases per FFS beneficiary, FFS Medicare’s share of IRF discharges in 2019 remains strong at 58 percent of total discharges.

The coronavirus PHE undoubtedly affected IRF volume among Medicare beneficiaries in 2020, but data limitations prevent us from providing an estimate of this effect on all IRF types. Information from publicly traded IRF companies’ earnings through the third quarter of 2020 gives us some indication of how freestanding, for-profit IRFs performed at the time this report was written. These companies reported that IRF volume decreased from mid-March to May 2020, largely as a result of fewer referrals stemming from suspension of elective surgeries in the acute care hospital setting, but that volume began to recover soon after, as states began to ease restrictions in acute care hospitals and surgery centers resumed performing elective surgeries (Encompass Health 2020a, Select Medical 2020b). According to the largest publicly traded IRF company, volume had recovered to at least 95 percent of prepandemic levels by late June 2020

**TABLE
9-6**

Risk-adjusted quality indicators for IRFs held steady or improved slightly from 2015 to 2019

	2015	2016	2017	2018	2019
All-condition hospitalizations within an IRF stay (all IRFs)	7.9%	7.7%	7.9%	7.7%	7.8%
Nonprofit	7.8	7.6	7.8	7.7	7.7
For profit	7.9	7.7	7.9	7.7	7.9
Hospital based	7.8	7.6	7.8	7.7	7.7
Freestanding	8.1	7.9	8.0	7.8	7.8
Successful discharge to community (all IRFs)	64.6%	64.6%	64.8%	65.1%	65.5%
Nonprofit	64.9	64.7	64.9	65.1	65.6
For profit	64.2	64.5	64.7	65.1	65.3
Hospital based	65.0	65.1	65.2	65.5	66.0
Freestanding	63.4	63.3	63.6	64.0	64.2

Note: IRF (inpatient rehabilitation facility). Successful discharge to the community includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The all-condition hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk-adjusted across the four PAC settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate. High rates of successful discharge to the community indicate better quality. High rates of hospitalizations within a stay indicate worse quality.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

(Encompass Health 2020a). However, the company also reported that the remaining lag in volume was largely a result of COVID-19-related challenges in certain geographic markets and of the drop in the number of orthopedic and lower extremity joint replacement cases compared with the same period in 2019 (Encompass Health 2020b).

Marginal profit provides incentive to treat more Medicare beneficiaries

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.

We examined freestanding and hospital-based IRFs’ marginal profit to assess whether both types of providers have a financial incentive to increase the number of Medicare beneficiaries they serve.¹¹ We found that Medicare payments in 2019 exceeded marginal costs by a substantial amount—19 percent for hospital-based IRFs and 40 percent for freestanding IRFs—suggesting that IRFs with available beds have a strong incentive to admit Medicare patients.

Quality of care: Steady or improved for most measures

This year, the Commission examined two broad categories of IRF quality indicators: average risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within an IRF stay.¹² Both measures are uniformly defined and risk-adjusted across the four PAC settings—thus taking one step closer to a unified payment system and evaluation of outcomes across PAC settings.¹³ Providers with least 60 stays in the year were included in calculating the average facility rate (60 stays in the year

**TABLE
9-7**

Performance on risk-adjusted quality measures varied across IRFs in 2019

Measure	Risk-adjusted rate		
	Mean	Worst performing quartile	Best performing quartile
All-condition hospitalizations within an IRF stay	7.8%	9.1%	6.2%
Successful discharge to community	65.5%	62.4%	68.9%

Note: IRF (inpatient rehabilitation facility). High rates of successful discharge to the community indicate better quality. High rates of hospitalizations during a stay indicate worse quality. Mean rates are calculated for all facilities with 60 or more Medicare fee-for-service stays.

Source: MedPAC analysis of Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS.

is the minimum count to meet a reliability threshold of 0.7). From 2015 through 2019, the two quality measures we examined were steady or improved.

Risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within the IRF stay

Rehospitalizations expose beneficiaries to hospital-acquired infections, increase the number of transitions between settings (which are disruptive to patients), and can result in medical errors (such as medication errors). In addition, they unnecessarily increase Medicare spending. The all-condition hospitalizations measure captures all unplanned hospitalizations (admissions and readmissions) and outpatient observation stays that occur during the stay (a lower rate of hospitalizations is better). Because IRFs are also hospitals, the rate of rehospitalizations is low. In 2019, the national average rate of risk-adjusted all-condition hospitalizations for IRFs remained steady at about 7.8 percent (Table 9-6). There were not large differences by type of IRF; however, nonprofit IRFs had a slightly lower rate of all-condition hospitalizations within the stay relative to for-profit IRFs (7.7 percent vs. 7.9 percent; data not shown).

We also examined average risk-adjusted rates of successful discharge to the community, which includes beneficiaries discharged to the community who did not have an unplanned hospitalization and did not die in the next 30 days (a higher rate of successful discharge to

the community is better). In 2019, the rate of successful discharge to the community was 65.5 percent (Table 9-6). There were not large differences by ownership, but hospital-based IRFs had a slightly higher rate of successful discharge to the community than freestanding IRFs (66.0 percent vs. 64.2 percent).

Variation in quality measures across IRFs

IRFs varied somewhat in their performance on Medicare’s quality measures (Table 9-7). In 2019, the best performing quartile of IRFs had a risk-adjusted rate of successful discharge to the community that was 68.9 percent or higher, 6 percentage points higher than the worst performing quartile. Hospitalization rates within a stay also varied: the best performing quartile had risk-adjusted rates of all-condition hospitalizations within an IRF stay that were 3 percentage points lower than the rate of the worst performing quartile, with a rate of 6.2 percent or below. The variation in performance among IRF providers suggests that quality of care is an area that needs improvement, even for measures with low rates. IRF providers should continue to prioritize the quality of care to improve outcomes for all beneficiaries.

This year we did not assess measures of provider-reported functional improvement. While the Commission contends that maintaining and improving functional status is a key outcome of PAC, over time we have become so concerned about the integrity of this information that we no longer believe it is a reliable indicator of provider quality (for a

detailed discussion of functional assessment data, see our June 2019 report to the Congress). Because functional assessments are used in the case-mix system to establish payments, it is difficult to separate this information from payment incentives. Yet, because functional outcomes are critically important to patients, improving the reporting of assessment data such that these outcomes can be adequately assessed is desirable. In its June 2019 report to the Congress, the Commission discussed possible strategies to improve the assessment data, the importance of monitoring the reporting of these data, and alternative measures of function (such as patient-reported surveys) that do not rely on provider-completed assessments (Medicare Payment Advisory Commission 2019a).

Providers' access to capital: IRFs appear to have adequate access to capital

Almost three-quarters of IRF providers are hospital-based units that would access any necessary capital through their parent institutions. Overall, as detailed in the hospital chapter of this report, hospitals' access to capital remained strong in 2019. Hospitals issued \$23 billion in bonds in calendar year 2019, including \$16 billion in new financing and \$7 billion in refinancing (Thomson Reuters 2019). This 2019 activity was a decline from 2018, corresponding with an increase in interest rates, but similar to the level in 2016 and higher than bond issuances in 2015 (Cain Brothers 2019). In 2019, hospital construction spending was \$26 billion, similar to prior years' spending. Hospital construction spending has been relatively stable since 2014 when the health care industry began to see a decrease in spending on inpatient hospital capacity (Census Bureau 2020). This trend is in part due to health systems focusing on lower cost outpatient facilities and renovations to existing facilities (Conn 2017). The coronavirus PHE affected hospitals' access to capital in 2020, with different effects on different groups of hospitals. However, in aggregate, the additional federal support hospitals received—as well as advanced Medicare payments—increased hospitals' access to capital in 2020.

Market analysts indicate that the IRF industry's largest chain, Encompass Health (formerly HealthSouth)—which owned over 40 percent of freestanding IRFs in 2019 and accounted for over 31 percent of all Medicare IRF discharges—has good access to capital. This assessment is reflected in the chain's continued expansion. Analysts note that Encompass Health traditionally has prioritized building new facilities over acquiring existing facilities,

which allows the company to maintain control over facility size, layout, and amenities. In 2019, the company opened three new facilities, two of which were joint ventures with other medical centers. In 2020, the company opened three additional facilities and made plans to open a total of eight new facilities in 2021 (Encompass Health 2020a). As part of a vertical integration strategy, the company has acquired home health agencies and hospice providers to expand its PAC business and drive more effective collaboration between its rehabilitation facilities and home health agencies.

Most other freestanding IRFs are independent or local chains with a limited number of facilities. The extent to which these providers have access to capital is less clear.

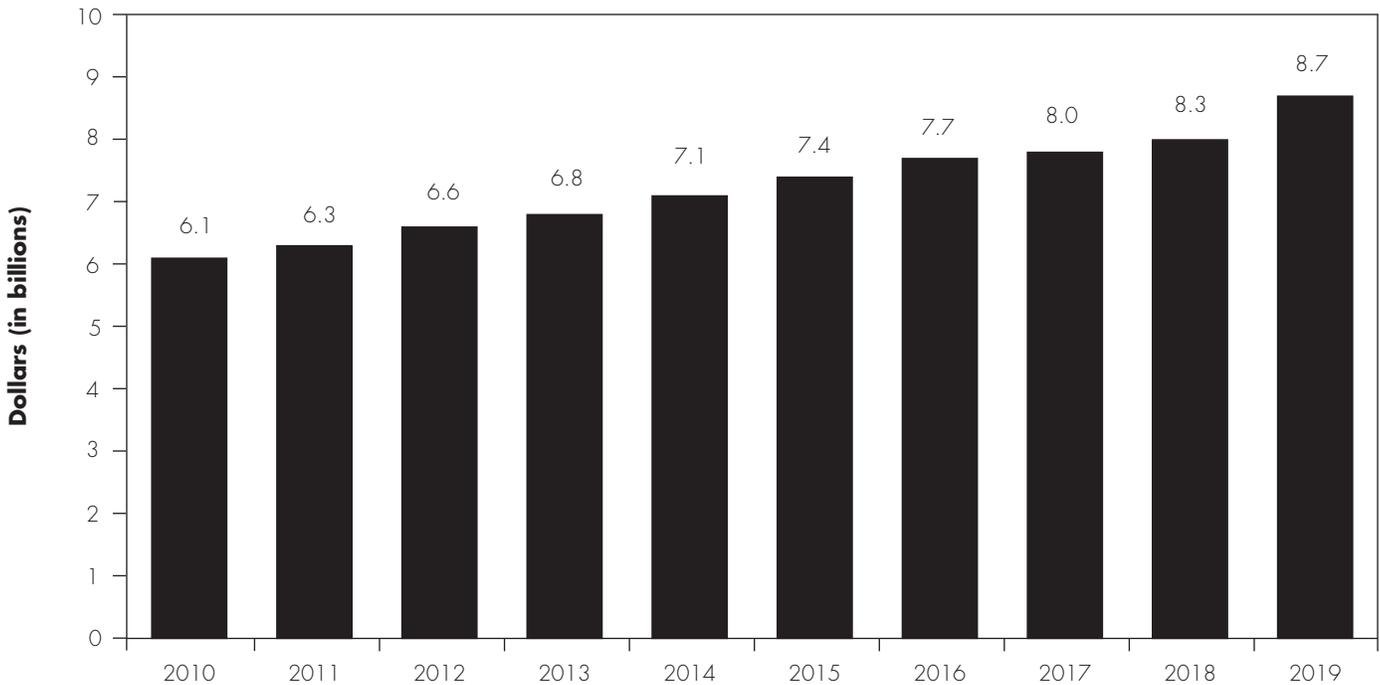
IRFs' access to capital depends in large part on their total (all-payer) profitability. In 2019, total margins for freestanding IRFs remained strong, with an aggregate margin of 10.4 percent. Profitability varied by ownership. In 2019, for-profit freestanding IRFs had an aggregate total margin of 14.0 percent compared with 1.6 percent for nonprofit freestanding IRFs. Data are not available to calculate total margins for hospital-based IRFs. However, in 2019, hospitals' aggregate total margins across all lines of service were slightly higher in hospitals with IRF units compared with those without such units (8.1 percent vs. 7.3 percent).

Beginning in FY 2010, IRFs are required to submit patient assessment instruments on Medicare Advantage (MA) beneficiaries for use in the 60 percent rule calculation (Centers for Medicare & Medicaid Services 2009). In 2019, the share of total IRF cases represented by MA enrollees was about 18 percent, despite the fact that over 40 percent of all Medicare beneficiaries with both Part A and Part B coverage are enrolled in MA. The average number of MA cases in IRFs was 7,700 cases per month compared with about 34,000 cases per month for beneficiaries in traditional FFS Medicare. At the time this report was written, the largest publicly traded IRF company reported that MA's share of revenues was approximately 16 percent, an increase of almost 5 percentage points compared with the same period in 2019, largely due to the reported temporary suspension of the private plans' prior authorization requirements during the PHE.

It is not clear why MA utilization is lower than Medicare FFS in the IRF setting. Previous research has highlighted

FIGURE 9-1

Program spending for IRF services has grown steadily since 2010



Note: IRF (inpatient rehabilitation facility).

Source: Office of the Actuary 2020.

that, in comparison with FFS, MA beneficiaries tend to have lower utilization of PAC overall, have longer acute care hospital stays that potentially mitigate the need for intensive PAC use, and have a greater likelihood of being discharged home or to lower cost PAC settings such as SNFs or home health care (Bentley 2017, Biniek et al. 2019, Huckfeldt et al. 2017, Xu et al. 2020). In a previous report to the Congress, we emphasized that some utilization management strategies used by MA plans, such as requiring prior authorization and recertification, may contribute to differences in utilization of various PAC settings (Medicare Payment Advisory Commission 2015).

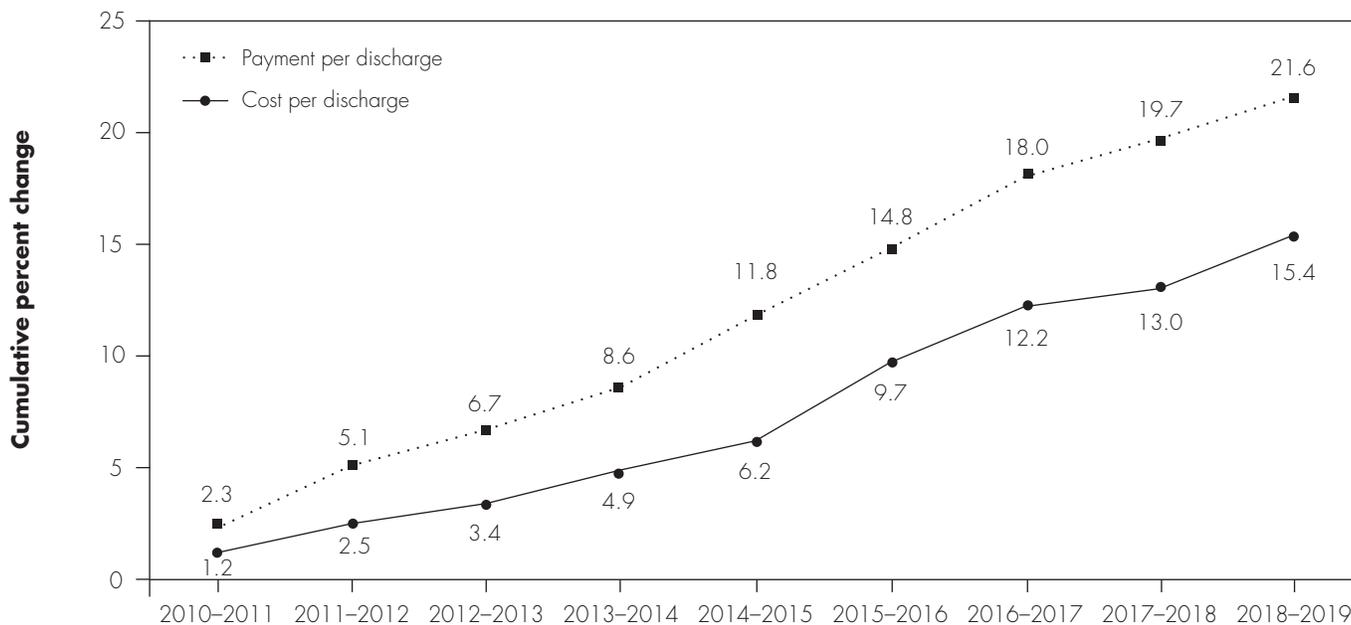
Medicare payments and providers' costs: Medicare margins remained high in 2019

Since 2012, aggregate Medicare margins have been above 11 percent. Although the aggregate margin decreased slightly in 2019, it remained high at 14.3

percent.¹⁴ Between 2015 and 2019, Medicare margins in freestanding IRFs fell slightly from a peak of 26.6 percent to 24.6 percent. Hospital-based IRF margins were comparatively low at 2.1 percent; however, one-quarter of hospital-based IRFs had Medicare margins greater than 12 percent, indicating that many hospitals can manage their IRF units profitably.

Trends in spending and cost growth

The Office of the Actuary estimates that FFS Medicare spending for IRF services in FY 2019 was \$8.7 billion (Figure 9-1). Between 2010 and 2019, growth in spending for these services averaged about 4 percent per year. A combination of increases in the number of Medicare beneficiaries receiving care in IRFs (average growth of 1.0 percent per year) and payment increases averaging 3.5 percent per year contributed to this spending growth.

**FIGURE
9-2****IRFs' payments per discharge increased cumulatively more than costs, 2010-2019**

Note: IRF (inpatient rehabilitation facility). Percent changes are calculated based on consistent two-year cohorts.

Source: MedPAC analysis of Medicare cost report data from CMS.

Since 2010, payments have been growing faster than costs (Figure 9-2). From 2010 to 2015, the cumulative growth in cost per discharge was 6.2 percent, an average of just 1.2 percent per year. The cumulative growth in cost per discharge for freestanding for-profit IRFs was especially slow over this period, at just 1.3 percent (data not shown). In contrast, payments per discharge grew more rapidly than costs, climbing to a cumulative 11.8 percent over this period (an average of 2.4 percent per year) and 11.9 percent for freestanding for-profit IRFs (latter figure not shown). These differences in per case cost and payment growth led to a steady rise between 2010 and 2015 in aggregate Medicare margins, which climbed from 8.6 percent to 13.9 percent (Table 9-8).

Between 2015 and 2016, cost growth outpaced payment growth for the first time since 2009, climbing 3.5 percentage points. However, from 2016 to 2017, payments per discharge again increased faster than costs, growing by 3.2 percentage points compared with 2.5 percentage points for

costs. Per case payments continued to grow faster than costs from 2017 to 2018 (1.7 percentage points compared with 0.8 percentage points). However, from 2018 to 2019, per case cost growth slightly outpaced per case payment growth (2.4 percentage points compared with 1.9 percentage points). As a result, the aggregate margin in 2019 declined 0.4 percentage points to 14.3 percent (Table 9-8).

Medicare margins are high on average but vary widely among individual IRFs

Financial performance varied across IRFs. In 2019, the Medicare margin for freestanding IRFs (which accounted for 53 percent of Medicare discharges from IRFs) averaged 24.6 percent, while hospital-based IRFs' Medicare margin was 2.1 percent (Table 9-8). Margins varied by ownership as well, with for-profit IRFs averaging a substantially higher Medicare margin in 2019 than nonprofit IRFs (24.2 percent vs. 1.2 percent). (Hospital-based IRFs are far more likely than freestanding

**TABLE
9-8**

Aggregate IRF Medicare margins declined in 2019 but remained high

Type of IRF	Share of Medicare discharges, 2019	Margins							
		2010	2012	2014	2015	2016	2017	2018	2019
All IRFs	100%	8.6%	11.2%	12.2%	13.9%	13.3%	13.9%	14.7%	14.3%
Hospital based	44	-0.5	0.76	0.6	2.1	0.9	1.5	2.5	2.1
Freestanding	53	21.4	24.0	25.2	26.6	25.9	25.6	25.4	24.6
Nonprofit	35	2.1	2.1	1.7	3.4	1.6	2.1	2.4	1.2
For profit	56	19.6	23.1	23.9	25.1	24.6	24.3	24.7	24.2
Government	6	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Urban	91	9.0	11.6	12.6	14.3	13.6	14.2	15.0	14.7
Rural	6	4.9	6.7	6.5	8.7	9.2	8.4	10.1	8.6
Number of beds									
1 to 10	2	-10.3	-6.9	-11.0	-7.7	-10.1	-10.8	-5.7	-3.8
11 to 24	18	-3.3	-1.2	-0.4	-0.4	-0.4	0.7	2.1	2.1
25 to 64	50	10.6	12.3	14.0	16.0	15.0	15.7	16.9	15.9
65 or more	30	17.5	21.0	20.6	23.0	22.5	21.9	21.2	21.0
Medicare FFS share									
<50%	23	0.3	3.2	2.7	4.5	3.4	3.2	3.8	4.5
50% to 75%	57	9.6	13.4	14.9	16.7	16.1	16.5	17.4	16.4
>75%	20	13.6	20.1	20.0	21.1	20.9	22.5	23.2	22.4

Note: IRF (inpatient rehabilitation facility), FFS (fee-for-service), N/A (not applicable). Government-owned facilities operate in a different financial context from other facilities, so their margins are not necessarily comparable. Their margins are not presented separately here, although they are included in the margins for other groups (e.g., "all IRFs"), where applicable. Percentages may not sum to 100 due to rounding.

Source: MedPAC analysis of cost report data from CMS.

IRFs to be nonprofit.) Among freestanding IRFs, nonprofit facilities (which accounted for 5.4 percent of Medicare discharges from IRFs) had an average Medicare margin of 8.0 percent (data not shown). Freestanding for-profit IRFs (which accounted for 50 percent of Medicare discharges from IRFs) had a Medicare margin of 27.0 percent (data not shown). Among hospital-based IRFs, the Medicare margin for nonprofit units (which accounted for 29.3 percent of Medicare discharges from IRFs) averaged -0.2 percent, compared with 10.3 percent for for-profit units (which accounted for 9.3 percent of Medicare discharges from IRFs; data not shown).

Higher unit costs were the primary driver of differences in financial performance between freestanding and hospital-

based IRFs. In 2019, freestanding IRFs had a median standardized cost per discharge that was 25 percent lower than that of hospital-based IRFs (\$13,066 vs. \$17,506).¹⁵ Hospital-based IRFs are far more likely than freestanding IRFs to be nonprofit, which could contribute to the disparity in unit costs. But even nonprofit freestanding IRFs had a median standardized cost per discharge that was 7.0 percent lower than that of hospital-based IRFs. Previous Commission analysis of underlying cost components found that hospital-based IRFs had higher costs than freestanding IRFs across all cost categories, with the biggest difference manifesting in routine costs (Medicare Payment Advisory Commission 2015).

Nevertheless, one-quarter of hospital-based IRFs had Medicare margins greater than 12 percent, indicating that many hospitals can manage their IRF units profitably. Further, despite comparatively low average margins in hospital-based IRFs, evidence suggests that these units make a positive financial contribution to their parent hospitals. For example, aggregate inpatient Medicare margins have been consistently higher for hospitals with IRF units versus hospitals without (1.0 percentage point higher in 2019).

Margins also varied by facility size. In 2019, the aggregate Medicare margin for IRFs with 10 or fewer beds was -3.8 percent, compared with 21.0 percent for IRFs with 65 or more beds (Table 9-8, p. 267). These differences are in large measure because of differences in economies of scale leading to higher costs in smaller facilities. The median standardized cost for IRFs with fewer than 10 beds was 53 percent higher than for IRFs with 65 or more beds (\$20,041 compared with \$13,113; data not shown). Smaller facilities also tend to have lower occupancy rates than large facilities (55 percent compared with 76 percent in 2019), which contributes to differences in costs.

Medicare margins have tended to rise as the share of Medicare patients increased. The aggregate Medicare margin in 2019 was 4.5 percent for IRFs in which less than half of discharges were covered by FFS Medicare, compared with 22.4 percent for IRFs in which more than three-quarters of discharges were covered by FFS Medicare (Table 9-8, p. 267). The high aggregate Medicare margin in IRFs with high Medicare shares indicates that Medicare payments substantially exceed the costs of caring for beneficiaries.

Numerous factors contribute to lower margins in hospital-based IRFs

Several factors account for the disparity in margins between hospital-based and freestanding IRFs, including differences in economies of scale (as described above), stringency of cost control, service mix, and patient mix. Differences in IRFs' assessment of patients' motor function and cognition likely also play a role.

Hospital-based IRFs may be less stringent in cost control

Hospital-based IRFs appear to be less stringent in their cost control. Between 2010 and 2019, costs per case for hospital-based IRFs grew 21.9 percent, compared with 12.3 percent for freestanding IRFs.

Hospital-based IRFs have a different mix of patients

There are marked differences in hospital-based and freestanding IRFs' mix of cases. In 2019, compared with freestanding IRFs, hospital-based IRFs admitted a larger share of patients with stroke as the primary reason for rehabilitation and smaller shares of cases with certain other neurological conditions and certain other orthopedic conditions (excluding fractures of the hip, pelvis, and femur, and hip and knee replacements). Because the other neurological and other orthopedic impairment groups are broadly defined, freestanding IRFs may selectively admit patients within these groups. Moreover, cases with other neurological conditions also count toward the compliance threshold, so IRFs with higher shares of these cases can more easily meet the requirements of the 60 percent rule while keeping down costs. Further, as discussed earlier, we found that other orthopedic and neurologic case types are more profitable than other cases (Table 9-3, p. 258), which could result in higher margins for facilities that admit larger shares of these cases.

Another factor contributing to differences in margins are outlier cases, cases with extraordinarily high costs. In general, hospital-based IRFs are much more likely than freestanding IRFs to have high-cost outlier cases (13.5 percent of cases compared with 2.5 percent). Indeed, 82 percent of Medicare's IRF outlier payments were made to hospital-based facilities in 2019.

Although these payments diminish losses per outlier case, by design they do not completely cover their costs. It is not clear whether the large number of outlier cases in hospital-based IRFs stems from differences in unit cost, unmeasured clinical complexity that is not fully captured by the case-mix system, or both.

Hospital-based IRFs appear to assess their patients differently

Historically, evidence suggests that assessments of patients' motor and cognitive function are not reliably consistent across IRFs. Some in the industry have postulated that hospital-based IRFs devote less time to training assessment staff and verifying the accuracy of assessments, resulting in less reliable measures of patients' motor and cognitive function in hospital-based IRFs. Others assert that some freestanding IRFs aggressively assess their patients in a way that maximizes payment. To the extent that hospital-based IRFs consistently assess their patients as less disabled than do their freestanding counterparts, for

Identifying relatively efficient inpatient rehabilitation facilities

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with an efficient provider. This year, we attempted to identify and examine the financial performance of inpatient rehabilitation facilities (IRFs) that had consistently low costs per discharge and high quality using our new cross-sector quality measures. We calculated the cost per discharge using cost report and claims data and adjusted for differences in area wages; mix of cases; and prevalence of high-cost outliers, short-stay outliers, and transfer cases. For quality measures, we used risk-adjusted rates of successful discharge to the community and all-condition hospitalizations within a stay. To be included in the group of IRFs that furnished relatively low-cost, high-quality care, an IRF had to be (1) in the best performing third of the distribution of adjusted cost per discharge or of one of the quality measures for three consecutive years (2016 through 2018) and (2) not in the worst performing third of the distribution of adjusted cost per discharge or either of the quality measures for three consecutive years. Only IRFs with

at least 60 Medicare fee-for-service discharges were included in the analysis.

The method we used to assess performance attempts to limit drawing incorrect conclusions about performance based on poor data. Using three years (rather than just one year) of data to categorize IRFs as efficient avoids categorizing providers based on random variation or on one “unusual” year. After determining whether an IRF was relatively efficient based on having relatively low costs and good quality care for three years in a row, we calculated performance on several quality and cost measures in 2019. By first assigning an IRF to a group (relatively efficient or other) and then examining the group’s performance in the next year, we avoid having a facility’s poor data affect both its own categorization and the assessment of the group’s performance. Thus, an IRF’s erroneous data in 2016, 2017, or 2018 could result in its inaccurate assignment to a group, but because the group’s performance is assessed with data from 2019, these “bad” data would not directly affect the assessment of the group’s performance. ■

whatever reason, their payments—and margins—will be systematically lower.

Efficient provider analysis

The Commission is required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 to consider the costs associated with efficient providers. The Commission follows two principles when selecting a set of efficient providers. First, the providers must do relatively well on a set of cost and quality metrics. Second, the performance has to be consistent, meaning that the provider cannot have poor performance on any metric in any of three consecutive years preceding the year under evaluation. The Commission’s approach is to develop a set of criteria and then examine how many providers meet

them. It does not establish a set share (for example, 10 percent) of providers to be considered efficient and then define criteria to meet that pool size. (For a more detailed discussion of the Commission’s methodology, see text box.)

Our analysis finds that relatively efficient IRFs had lower rates of hospitalization and higher rates of successful discharge to the community than other IRFs. While payment rates to all IRFs were similar, standardized costs per discharge for the relatively efficient group were 13 percent lower, leading to a large difference in the median Medicare margin, which was 15.8 percent for the relatively efficient group compared with 4.6 percent for other IRFs (Table 9-9, p. 270).

**TABLE
9-9**
Characteristics of relatively efficient providers, 2019

Performance in 2019	Type of IRF		Ratio of relatively efficient to other IRFs
	Relatively efficient IRFs	Other IRFs	
Quality measures:			
All-condition hospitalization rate	6.8%	7.7%	0.88
Successful discharge to community rate	69.1%	65.1%	1.06
Cost and payment measures:			
Payment per discharge	\$20,774	\$21,360	0.98
Standardized cost per discharge	\$15,040	\$17,367	0.87
Medicare margin	15.8%	4.6%	N/A
Facility characteristics:			
Facility case-mix index	1.26	1.24	1.02
Length of stay (in days)	12.3	12.5	0.98
Occupancy rate	69.9%	65.3%	1.07
Number of beds	29	24	1.21
Share of discharges for:			
Stroke	18.0%	18.8%	0.96
Other neurological conditions	10.7%	8.2%	1.30
Share of facilities:			
Freestanding	31.4%	25.0%	N/A
For profit	45.0%	35.2%	N/A
Hospital-based nonprofit	46.7%	49.9%	N/A

Note: IRF (inpatient rehabilitation facility), N/A (not applicable). All data are medians unless otherwise indicated. The analysis was conducted on 1,017 IRFs that met the data requirements and minimum case counts (60). IRFs were identified as “relatively efficient” based on a cost measure (costs per discharge) and two quality measures (rates of hospitalizations within the stay and successful discharge to community) between 2016 and 2018. Relatively efficient IRFs were those in the best third of the distribution for one measure and not in the worst third for any measure in each of the three years. Costs per discharge were standardized for differences in area wages, mix of cases, and prevalence of high-cost outliers, short-stay outliers, and transfer cases. Quality measures were calculated for all facilities with 60 or more fee-for-service stays. Successful discharge to the community includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The all-condition hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. High rates of hospitalization within the stay indicate worse quality and high rates of successful discharge to community indicate better quality. “Other neurological conditions” includes multiple sclerosis, Parkinson’s disease, polyneuropathy, and neuromuscular disorders.

Source: MedPAC analysis of Medicare cost report data, Medicare Provider Analysis and Review data, and Inpatient Rehabilitation Facility–Patient Assessment Instrument data from CMS for 2016 to 2019.

Relatively efficient IRFs were, on average, larger and had higher occupancy rates compared with other IRFs, leading to greater economies of scale. The mix of cases also differed somewhat between the relatively efficient and other IRFs. Relatively efficient IRFs had a slightly higher average case-mix index and more cases with other neurological conditions, but somewhat smaller shares of stroke cases compared with other IRFs.

Included in this analysis were the 1,017 IRFs that met the data requirements and minimum case counts (60). In total, 174 IRFs were defined as relatively efficient providers. Hospital-based nonprofit IRFs represented 46.7 percent of this group while freestanding IRFs and for-profit IRFs accounted for 31.4 percent and 45.0 percent of this group, respectively (Table 9-9).

Previous Commission analyses suggest that assessment and scoring practices contribute to greater profitability in some IRFs (Medicare Payment Advisory Commission 2016). The results of the efficient provider analysis must therefore be interpreted with caution because of the subjective nature of the function measures used to categorize patients and their direct association with Medicare payment and profitability.

How should Medicare payments change in 2022?

The coronavirus PHE has made 2020 an anomalous year in many respects, and it is impossible to predict with certainty the extent to which these effects will continue into 2021. Our best estimate is that IRFs' Medicare margin in 2021 will increase relative to 2019, driven by substantially higher payment rate updates in 2020 and 2021 than in 2019 and prior years.

To estimate 2021 payments, costs, and margins with 2019 data, the Commission considers policy changes effective in 2020 and 2021. The changes in payments that affect our estimate of the 2021 margin include:

- an update of 2.5 percent in 2020 based on an IRF market basket increase of 2.9 percent and an offsetting multifactor productivity adjustment of 0.4 percent;
- the suspension of the 2 percent Medicare sequestration from May 2020 through March 2021 due to the coronavirus PHE;
- an estimated case-mix growth of 0.5 percent in 2020 because of a higher acuity case mix in IRFs as a result of the PHE;
- an update of 2.4 percent in 2021 based on an IRF market basket increase of 2.4 percent, with no productivity adjustment; and
- changes to the high-cost outlier amount in 2021, which will increase payments by 0.4 percentage point.

This cumulative percentage increase is substantially higher than in prior years because of the expiration of statutory reductions in IRF updates required by the Affordable Care Act in each year from 2010 through 2019.

On the cost side, historically, cost growth in this sector has been at or below market basket levels, though cost growth exceeded the market basket between 2018 and 2019. We used a three-year historical average to estimate cost growth in 2020 and 2021.

Based on industry reports, we expect that COVID-19-related reductions in volume in the first half of 2020 will return to prepandemic levels and that increased costs for personal protective equipment and other COVID-19-related expenses will be more than offset by a concurrent increase in net revenue per discharge due to the temporary suspension of sequestration and a higher acuity case mix in IRFs as a result of the PHE. Considering these assumptions, we project an aggregate Medicare margin of 16 percent for IRFs in 2021.

For FY 2009 through FY 2017, the Commission recommended a 0 percent update to the IRF payment rate. For FY 2018 through FY 2020, however, as the payment adequacy indicators remained positive and the aggregate Medicare margin neared historic highs, the Commission recommended that the Congress reduce IRF payment rates by 5 percent. Because our recommendations were not enacted and because, in the absence of legislative action, CMS is required by statute to apply an adjusted market basket increase, payments have continued to rise. Aggregate Medicare margins for IRFs have remained above 13 percent since 2015. These high aggregate margins indicate that aggregate Medicare payments continue to substantially exceed the costs of caring for beneficiaries in IRFs. Absent congressional action, payments to IRFs will continue to increase in FY 2022, by an estimated 2.2 percent.

Reducing the payment rate for IRFs would better align Medicare payments with the costs of IRF care. The Commission also continues to believe that the high-cost outlier pool should be expanded, as previously recommended in 2016, to further redistribute payments within the IRF PPS and reduce the impact of potential misalignments between IRF payments and costs. As noted in our March 2016 report to the Congress, expanding the outlier pool could increase payments for providers who are less efficient and for providers whose patients' acuity is not well captured by the case-mix system.¹⁶

The Commission also reiterates its March 2016 recommendation that 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. With the recent shift to using the Quality Reporting Program functional measures to classify cases into case-mix groups, it is important that CMS conduct focused medical reviews to ensure consistency in reporting across providers using the new measures.

RECOMMENDATION 9

For fiscal year 2022, the Congress should reduce the 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

RATIONALE 9

The combination of low historical cost growth and increasing average payments has resulted in overpayments to IRFs. The high aggregate margin in 2019 and our projected margin for 2021 indicate that Medicare payments substantially exceed the costs of caring for beneficiaries. This excess contributes to Medicare's long-run sustainability challenges. For every fiscal year since 2009, the Commission has recommended that the update to the IRF payment rate be eliminated or that the payment rate be reduced. However, CMS has been required by statute to apply an adjusted market basket increase each year. Reducing the payment rate for IRFs by 5 percent for FY 2022 would better align Medicare payments with the costs of IRF care.

We do recognize that the coronavirus PHE will affect all payment adequacy indicators in 2020; however, we do not anticipate any long-term changes that will persist past the end of the PHE and therefore warrant inclusion in the annual update to IRF payments in 2022. Instead, to the extent that the coronavirus PHE continues into 2022, any needed additional financial support should be targeted to affected IRFs that are necessary for access.

Furthermore, in 2021, we expect currently positive IRF payment adequacy indicators to remain strong, driven by substantially higher annual updates to IRF payment rates in 2020 and 2021 with the expiration of statutory reductions in IRF updates required by the Affordable Care Act in each year from 2010 through 2019.

IMPLICATIONS 9

Spending

- Relative to current law, this recommendation would decrease Medicare spending by between \$750 million and \$2 billion in 2022 and by between \$5 billion and \$10 billion over five years.

Beneficiary and provider

- We do not expect this combination of recommendations to have an adverse effect on either Medicare beneficiaries' access to care or out-of-pocket spending. This recommendation could increase financial pressure on some providers. We expect relatively efficient providers will continue to be willing and able to care for Medicare beneficiaries. ■

Endnotes

- 1 More frequently, Medicare beneficiaries receive inpatient rehabilitation services in skilled nursing facilities (SNFs), in part because there are many more SNFs than IRFs nationwide.
- 2 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents to the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms but are designed to create different financial incentives.
- 3 More information about the prospective payment system for IRFs is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_irf_final_sec.pdf?sfvrsn=0.
- 4 During the public health emergency (PHE), CMS has waived some of Medicare’s IRF requirements to allow IRFs to work with acute care hospitals in their communities to ensure surge capacity. For example, CMS has allowed IRFs to exclude from the calculation used to determine the IRF compliance threshold any patient who has been admitted solely in response to the emergency (Centers for Medicare & Medicaid Services 2020). The IRF compliance threshold normally requires that no less than 60 percent of patients admitted to an IRF have as a primary diagnosis or comorbidity at least 1 of 13 specified conditions.
- 5 The 13 conditions are stroke; spinal cord injury; congenital deformity; amputation of a lower limb; major multiple trauma; hip fracture; brain injury; certain other neurological conditions (multiple sclerosis, Parkinson’s disease, cerebral palsy, and neuromuscular disorders); burns; 3 arthritis conditions for which appropriate, aggressive, and sustained outpatient therapy has failed; and hip or knee replacement when it is bilateral, the patient’s body mass index is greater than or equal to 50, or the patient is age 85 or older.
- 6 During the PHE, some exceptions have been made to Medicare coverage criteria to provide additional hospital beds for surge capacity in communities that need it. For example, the Secretary waived § 412.622(a)(3)(ii), commonly referred to as the “3-hour rule,” the criterion that patients treated in inpatient rehabilitation facilities generally receive at least 15 hours of therapy per week. CMS has specified that IRFs should strive to provide typical IRF levels of care for beneficiaries admitted during the coronavirus PHE who require and can benefit from the IRF levels of care (Centers for Medicare & Medicaid Services 2020).
- 7 CMS’s major revisions to the compliance threshold policy in 2004 were to (1) increase the number of conditions that count toward the threshold from 10 to 13 and (2) revise the qualifying criteria of major joint replacement—a condition that was commonly treated in IRFs at that time—such that only a certain subset of patients with that condition would count toward the compliance threshold.
- 8 Other orthopedic conditions, cardiac conditions, and debility are not among the 13 conditions that count toward the compliance threshold, but such cases may count if they have specified comorbidities.
- 9 This analysis of FFS IRF claims and assessment data from 2013 excluded cases that were not preceded by an acute care hospital stay within 30 days of the IRF admission.
- 10 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 11 If we approximate marginal cost as total Medicare cost minus fixed building and equipment cost, then:
$$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments}.$$
- 12 COVID-19 will also affect our ability to assess and compare quality of care for periods during the PHE. Next year, when we report on quality, it is likely that information for performance during the PHE may be incomplete for at least some portion of 2020 performance. CMS’s guidance on reporting requirements and how the PHE will affect quality payment programs is evolving. To date, CMS has stated it will exclude at least some of the 2020 experience in order to assist IRF providers while they direct their attention toward the health and safety of patients and staff during the pandemic.
- 13 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk

adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay.

14 In this analysis, Medicare margins were calculated as $(\text{Medicare payments} - \text{Medicare costs}) / \text{Medicare payments}$.

15 Standardized for wage index, case-mix index, and outliers.

16 The Commission estimates that reducing the payment rate for IRFs by 5 percent and expanding the outlier pool from 3 percent to 5 percent would decrease total payments to IRFs by 5 percent. We estimate the combined effect of reducing the payment rate for IRFs by 5 percent and expanding the outlier pool would decrease aggregate payments to freestanding IRFs by 6.2 percent, to hospital-based IRFs by 3.7 percent, to for-profit IRFs by 6.0 percent, and to nonprofit IRFs by 3.9 percent.

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CHAPTER 10

**Long-term care
hospital services**

R E C O M M E N D A T I O N

- 10** For fiscal year 2022, the Secretary should increase the 2021 Medicare base payment rate for long-term care hospitals by 2 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Long-term care hospital services

Chapter summary

Long-term care hospitals (LTCHs) provide care to beneficiaries who need hospital-level care for relatively extended periods of time. To qualify for Medicare payment as an LTCH, a facility must meet Medicare’s conditions of participation for acute care hospitals and have an average length of stay of more than 25 days for certain Medicare patients. In 2019, Medicare spent \$3.7 billion on care provided in LTCHs. That year, about 82,000 fee-for-service Medicare beneficiaries had about 91,000 LTCH stays, which accounted for about 56 percent of LTCH stays among all users.

CMS began a four-year phase-in of a dual payment-rate system for LTCHs in fiscal year 2016. When fully phased in, LTCHs will be paid the standard LTCH prospective payment system (PPS) rate for cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 and will be paid a lower “site-neutral” rate for cases that do not. While policies effective during the coronavirus public health emergency (PHE) have temporarily affected the complete transition to site-neutral rates for all LTCHs in 2021, ultimately, the extent to which LTCHs shift toward cases that qualify for the standard LTCH PPS rate will determine the industry’s financial performance under Medicare’s LTCH PPS. Our payment adequacy analysis must be interpreted in the context of the transition to the dual payment-rate system and its anticipated effects on our payment adequacy metrics. To assess the adequacy of standard payments under the LTCH PPS for cases meeting the LTCH criteria, some analyses in

In this chapter

- Are Medicare payments adequate in 2021?
- How should Medicare payments change in 2022?

this chapter focus on LTCHs treating a high share (more than 85 percent) of LTCH PPS-qualifying cases, consistent with the goals of the dual payment-rate system.

In this chapter, we recommend a payment-rate update for 2022. Because of standard data lags, the most recent complete data we have for most payment adequacy indicators is from 2019. Where relevant, we have considered the effects of the 2020 coronavirus PHE on our indicators and whether those effects are likely to be temporary or permanent. To the extent the effects of the PHE are temporary or vary significantly across LTCHs, they are best addressed through targeted temporary funding policies rather than a permanent change to all LTCHs' payment rates in 2022 and future years. Based on information available at the time of publication, we do not anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to long-term care hospital payments in 2022.

Assessment of payment adequacy

Beneficiaries' access to care—We consider the capacity and supply of LTCH providers and changes over time in the volume of services they furnish. We expect and have seen reductions in these metrics since the implementation of the dual payment-rate system that began to be phased in with cost reporting periods starting in fiscal year 2016.

- ***Capacity and supply of providers***—The number of LTCHs began to decrease in 2013, but the decline has been more rapid since the implementation of the dual payment-rate system. From 2018 through 2019, the number of LTCH facilities decreased by 3.5 percent, while the number of LTCH beds decreased by 3 percent. However, the average LTCH occupancy rate was 63 percent in 2019, suggesting that LTCHs have capacity in the markets they serve.
- ***Volume of services***—From 2016 to 2019, the total number of Medicare cases in all LTCHs decreased by an average of about 10 percent annually. This downward trend in volume predates the implementation of the dual payment-rate system but has become more pronounced since the phase-in of site-neutral rates under that system. However, controlling for changes in the size of the traditional Medicare population, volume decline for LTCH PPS qualifying cases during this period was just 1.7 percent annually.
- ***Marginal profit***—Marginal profit, an indicator of whether LTCHs with excess capacity have an incentive to admit Medicare patients, averaged about 15 percent across LTCHs in 2019, a 1 percentage point decrease from 2018 but still a positive indicator of access. For LTCHs with a high share of cases meeting the LTCH PPS criteria specified in the Pathway for SGR Reform Act

of 2013, marginal profit totaled 17 percent, less than 1 percentage point lower than 2018.

Quality of care—Aggregate risk-adjusted rates of successful discharge to the community have declined, and all-condition hospitalizations within a stay have been unchanged during the dual payment-rate phase-in period. Consistent with prior years, non-risk-adjusted mean rates of death in the LTCH and death within 30 days of discharge for all cases were stable.

Providers' access to capital—LTCHs continued to alter their cost structures and referral patterns in response to the dual payment-rate system. Continued phase-in of site-neutral rates for nonqualifying cases, 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—Aggregate LTCH margins have been variable and negative during the phase-in of the dual payment-rate system because costs grew more than payments in most years between 2016 and 2019. In 2017, the first full year that all LTCHs received the blended site-neutral rates under the transition to the dual payment-rate system, aggregate Medicare margins fell to –2.2 percent and then increased to –0.5 percent in 2018. In 2019, margins fell again to –1.6 percent. As they have since 2017, LTCHs with a high share of cases that met the criteria to be paid the standard LTCH rates in 2019 had positive margins, at 2.9 percent, a reduction of 1.8 percentage points from 2018. We expect continued changes in admission patterns and cost structures of LTCHs in response to the full implementation of the dual payment-rate system in 2020 and 2021, but the waiver of some site-neutral payment rules to create additional inpatient capacity during the PHE has delayed full implementation. We project that LTCHs' aggregate Medicare margin for facilities with more than 85 percent of Medicare discharges meeting the LTCH PPS criteria will be 2 percent in 2021.

How should payment rates change in 2022?

Based on payment adequacy indicators and in the context of ongoing changes to payment policy, the Commission recommends for fiscal year 2022 that the 2021 LTCH payment rate be increased by 2 percent. This update supports LTCHs in their provision of safe and effective care for Medicare beneficiaries meeting the LTCH PPS criteria for payment at the standard LTCH PPS rate. ■

Background

While most chronically critically ill (CCI) patients—those with profound debilitation of multiple systems, frequently with ongoing respiratory failure—are treated in acute care hospitals, some receive care in long-term care hospitals (LTCHs). LTCHs are primarily located in urban areas and are not distributed uniformly across the country, demonstrating that patients treated in LTCHs can be treated appropriately in other settings. To qualify as an LTCH for Medicare payment, a facility, which can be freestanding or colocated with other hospitals, must meet Medicare’s conditions of participation for short-term acute care hospitals (ACHs) and have an average length of stay of more than 25 days for certain Medicare patients.¹

In 2019, LTCHs had an average Medicare length of stay of 26.8 days. About 82,000 fee-for-service (FFS) Medicare beneficiaries had approximately 91,000 LTCH stays and accounted for 56 percent of LTCHs’ discharges covered by any payer in 2019.² That year, Medicare program payments to LTCHs, exclusive of beneficiary cost sharing, were about \$3.7 billion (Office of the Actuary 2020).

Under Medicare’s prospective payment system (PPS) for LTCHs, payments are adjusted for differences in expected resource use using the Medicare severity long-term care diagnosis related group (MS–LTC–DRG) patient classification system.³ MS–LTC–DRGs classify patients primarily according to diagnoses and procedures using the same groupings used in ACHs paid under the inpatient PPS (IPPS), but the MS–LTC–DRGs’ relative weights are specific to LTCH cases. The LTCH PPS makes high-cost outlier payments for cases that are extraordinarily costly and makes lower short-stay outlier payments for cases with shorter-than-average lengths of stay.⁴

Since 2016, Medicare has paid LTCHs according to a dual payment-rate system legislated in the Pathway for SGR Reform Act of 2013. (See text box, pp. 284–285, about the history of defining LTCH patient criteria, including previous Commission recommendations.) Under the law, the LTCH PPS standard payment rate applies only to qualifying LTCH stays that had an ACH stay immediately preceding LTCH admission and for which either:

- the ACH stay included at least 3 days in an intensive care unit (ICU) or

- the case was assigned to an MS–LTC–DRG based on the receipt of mechanical ventilation services in the LTCH for at least 96 hours.

These LTCH PPS–qualifying cases are referred to as “cases meeting the LTCH PPS criteria” or “qualifying cases.” All other LTCH stays, referred to as “site-neutral cases” or “nonqualifying cases,” do not meet the criteria, including stays assigned to psychiatric or rehabilitation MS–LTC–DRGs, regardless of intensive care unit use.

Site-neutral cases are paid the lower of an amount based on Medicare’s IPPS payments or 100 percent of the costs of the case.⁵ Starting in 2016 and continuing through 2019, nonqualifying cases received a blended payment of 50 percent of the standard LTCH PPS rate paid for qualifying cases and 50 percent of the site-neutral rate (Figure 10-1, p. 286).⁶ In fiscal year 2020, the full site-neutral rate was to have been phased in for each facility starting with the month their cost reporting year began. Given this phase-in period, site-neutral payments would not have been fully in effect for all LTCH facilities until fiscal year 2021. However, in response to the coronavirus public health emergency (PHE), the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 waived some of the provisions of the dual payment-rate system, as explained in the text box on LTCHs and the pandemic (pp. 288–289). Under current law, site-neutral rates will resume after the end of the PHE.⁷

To assess the adequacy of Medicare’s payments under the LTCH PPS, we focus some analyses in this chapter on LTCHs with a high share of cases that meet the LTCH PPS criteria. We define this subgroup of LTCHs as those with more than 85 percent of their Medicare cases meeting the LTCH PPS criteria.⁸ As shown in Figure 10-2 (p. 286), the number and share of LTCHs in this group have been increasing each year since 2016. In 2019, in 47 percent of LTCHs, more than 85 percent of cases met the LTCH PPS criteria. At the same time, the number of cases in facilities with a high share of qualifying cases also increased, as shown in Figure 10-3 (p. 287).

Are Medicare payments adequate in 2021?

To address whether LTCH PPS payments for 2021 are adequate to cover the costs that LTCHs incur in furnishing

History of defining long-term care hospital patient criteria

Given the variation in long-term care hospital (LTCH) use across the country and the cost of providing care to Medicare beneficiaries in LTCHs, researchers and policymakers have attempted to define the type of patient most appropriate for the LTCH setting. Building on this research and its own analysis published in March 2014, the Commission recommended that the LTCH payment system be reformed to better align payments for both chronically critically ill (CCI) cases and cases not meeting that definition across LTCH and acute care hospital (ACH) settings. A few months earlier, in December 2013, the Pathway for SGR Reform Act mandated limiting the higher standard LTCH prospective payment system (PPS) rate to cases that spent at least three days in an intensive care unit (ICU) during an immediately preceding ACH stay or to cases that received an LTCH principal diagnosis indicating prolonged mechanical ventilation. While the policy in the Pathway for SGR Reform Act of 2013 uses a three-day ICU stay in a referring ACH as the threshold to qualify for the standard LTCH PPS rate, rather than the eight-day stay the Commission recommended, both policies had the intent of reducing incentives for LTCHs to admit beneficiaries with lower severity conditions. As the dual payment-rate system has been phased in, the number of site-neutral cases has been steadily declining (see Table 10-2, p. 291).

Defining an LTCH patient: The research

A definition of the most medically complex patients appropriately treated in LTCHs has been elusive. Clinicians have described CCI patients requiring LTCH-level care as exhibiting metabolic, endocrine, physiologic, and immunologic abnormalities that result in profound debilitation and often ongoing respiratory failure (Nierman and Nelson 2002). While many of these conditions are not readily identifiable using administrative data, the research literature is consistent in describing such patients as having long ACH stays with heavy use of intensive care services. Another study defined LTCH-appropriate patients as ventilator dependent with major comorbidities, patients who have multiple organ failures, and patients with septicemia and other complex infections (Dalton et al. 2012).

Analysis of findings from the Post-Acute Care Payment Reform Demonstration, which tested the use of a standardized patient assessment tool in post-acute care settings, revealed meaningful differences in the intensity of nursing care and nutritional, rehabilitation, and physician services between LTCH users and other post-acute care (PAC) users. Length of time in an ICU during an immediately preceding ACH stay was a distinguishing characteristic of patients who used LTCHs as opposed to patients who used only skilled nursing facilities, inpatient rehabilitation facilities, or

(continued next page)

services to Medicare beneficiaries, we examine metrics of beneficiaries' access to care, including the capacity and supply of LTCH providers, changes over time in the volume of services furnished, and providers' willingness to admit Medicare beneficiaries; quality of care; providers' access to capital; and Medicare payments and providers' costs for LTCH PPS-qualifying cases. Our payment adequacy analysis for LTCHs must be interpreted in the context of the transition to the dual payment-rate system and its anticipated effects on our payment adequacy metrics. To focus our assessment of the adequacy of standard payments under the LTCH PPS, some analyses in

this chapter focus on LTCHs treating more than 85 percent of LTCH PPS qualifying cases in 2019. As shown earlier, the share of LTCHs in this group has grown, indicating that LTCHs are increasing their share of qualifying cases in response to the incentives of the LTCH PPS.

Beneficiaries' access to care: Expected reductions in supply and volume continue, without affecting access to care

As Medicare phased in the dual payment-rate system, signaling the types of cases to be paid the LTCH PPS standard rate, reductions in the overall capacity and supply

History of defining long-term care hospital patient criteria (cont.)

care provided by home health agencies. PAC episodes that had a preceding ACH ICU stay of seven days or more were found only among LTCH users (Gage et al. 2011).

Historically, LTCH care had also been commonly used for less acutely ill patients who may have required lengthy hospitalizations and subsequent PAC but did not have ongoing intensive nursing care needs (Centers for Medicare & Medicaid Services 2013). Research has shown that caring for lower acuity patients (defined as those with fewer than three days in an ICU and those without multiple system organ failure) in LTCHs increases Medicare expenditures without demonstrable improvements in quality of care or outcomes (Koenig et al. 2015).

Defining an LTCH patient: Commission recommendation

The Commission has long maintained that (1) LTCHs should serve only the most medically complex patients; (2) payments to providers should be properly aligned with patients' service needs; and (3) subject to risk differentials, payment for the same services should be comparable, regardless of where the services are provided. In keeping with these tenets, the Commission recommended in its March 2014 report that the Congress limit standard LTCH PPS payments to cases that spent eight or more days in an ICU during an

immediately preceding ACH stay (Medicare Payment Advisory Commission 2014). The Commission's analysis of inpatient prospective payment system (IPPS) claims data found that cases with eight or more days in an ICU accounted for about 6 percent of Medicare's IPPS stays and had a geometric mean cost per discharge that was four times that of IPPS cases with seven or fewer ICU days. These cases were concentrated in a small number of Medicare severity–diagnosis related groups that corresponded with critical care clinicians' descriptions of LTCH patients (Dalton et al. 2012).

Setting the ICU length-of-stay threshold for standard LTCH PPS payment at eight days captured a large share of LTCH cases requiring prolonged mechanical ventilation—a service specialty of many LTCHs. However, the Commission was concerned that LTCH care could be appropriate for some patients requiring mechanical ventilation even if they did not spend eight or more days in an ICU during an immediately preceding ACH stay. The Commission therefore recommended that cases requiring prolonged ventilation care qualify for the standard LTCH PPS payment rate. For LTCH cases that did not qualify for the LTCH PPS rate, the Commission recommended payment rates equal to those of ACHs and that savings from this policy be used to create additional inpatient outlier payments for CCI cases in IPPS hospitals. ■

of LTCHs and in the volume of services they furnish were expected as facilities adapted to the new payment incentives to treat higher acuity cases.

Capacity and supply of providers: Decrease in number of LTCHs began in 2013 and continued through 2019

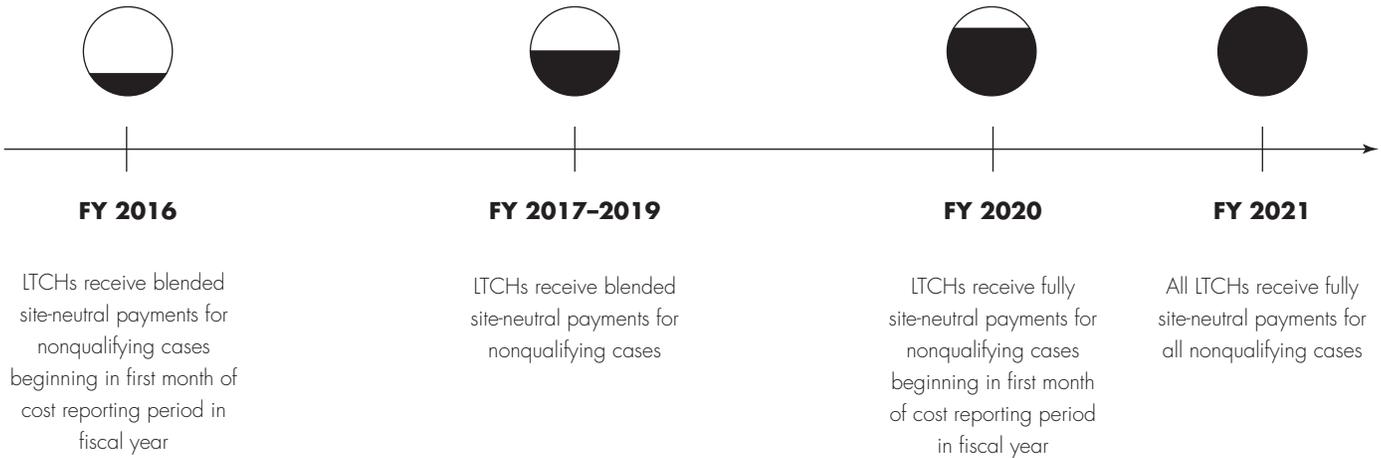
Because of concerns about appropriate use of LTCH-level care and spending on costly LTCH services, certain policies to constrain growth in the supply of LTCHs have been in place since the early 2000s. The Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA)

and subsequent legislation imposed a limited moratorium on new LTCHs and new beds in existing LTCHs from December 29, 2007, through December 28, 2012. During that time, new LTCHs were able to enter the Medicare program only if they met exceptions to the moratorium.⁹ The Pathway for SGR Reform Act of 2013 and subsequent legislation implemented a new moratorium from April 1, 2014, through September 30, 2017.¹⁰

Since peaking in 2012, the number of LTCHs in 2019 decreased by more than 14 percent, from 421 (not shown) to 361 (Table 10-1, p. 290).¹¹ In 2019, 80 percent of

FIGURE 10-1

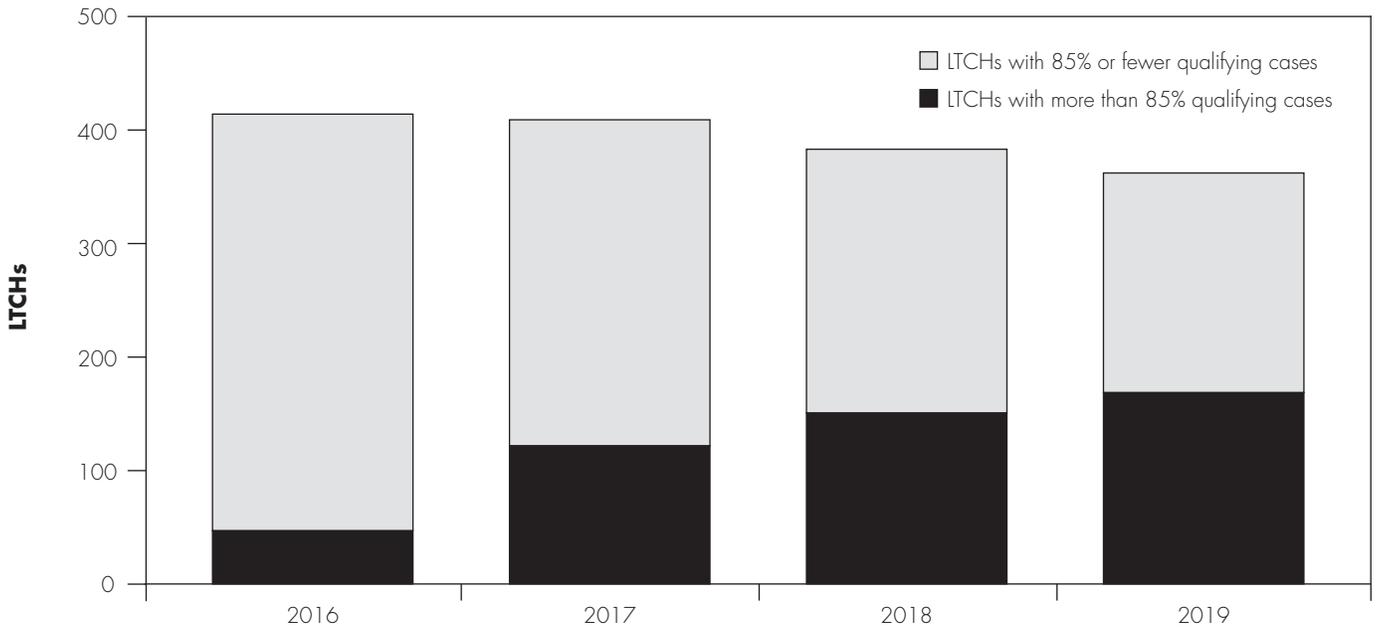
Dual payment-rate system phase-in began in fiscal year 2016 and was to have been fully in effect in fiscal year 2021, absent PHE-related waivers



Note: PHE (public health emergency, FY (fiscal year), LTCH (long-term care hospital). "Blended site-neutral payments" are 50 percent site-neutral rates and 50 percent standard LTCH prospective payment system (PPS) qualifying rates. "Nonqualifying cases" are Medicare cases that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS.

FIGURE 10-2

During the phase-in of the dual payment-rate system, the number and share of LTCHs with more than 85 percent of Medicare cases meeting the LTCH PPS criteria increased

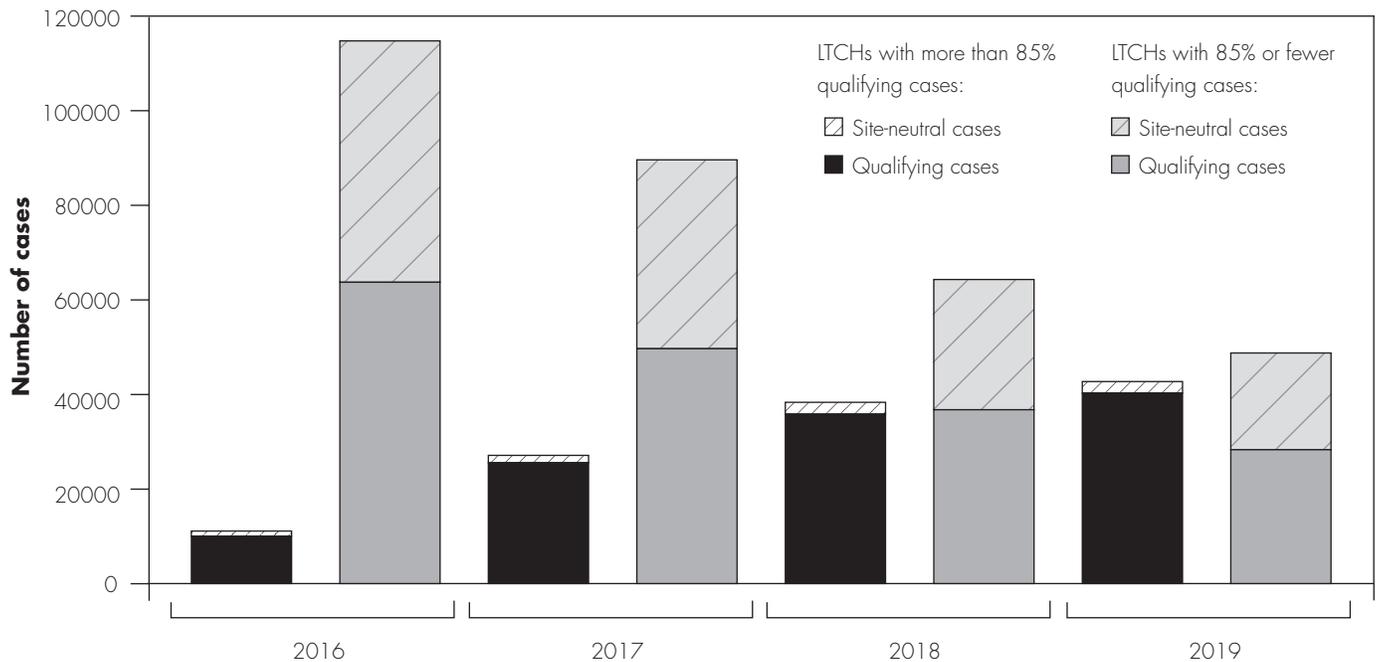


Note: LTCH (long-term care hospital), PPS (prospective payment system). "Meeting the LTCH PPS criteria" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS.

Source: MedPAC analysis of the LTCH Final Rule Impact files for fiscal years 2018, 2019, 2020, and 2021.

FIGURE 10-3

During the phase-in of the dual payment-rate system, the number of qualifying cases cared for in LTCHs with a high share of qualifying cases increased



Note: LTCH (long-term care hospital). “Qualifying cases” refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system.

Source: MedPAC analysis of the LTCH Final Rule Impact files for fiscal years 2018, 2019, 2020, and 2021.

LTCHs paid under the LTCH PPS were for profit (an increase from the historical trend), and 95 percent were in urban areas (consistent with historical trends). During the phase-in of the dual payment-rate system between 2016 and 2019, the number of LTCHs decreased by an average of 4.2 percent per year (Table 10-1, p. 290). From 2018 to 2019, the number of LTCHs decreased by 3.5 percent, and the number of beds decreased about 3 percent (data not shown).

Since the dual payment-rate system began through fiscal year 2020, 78 LTCHs have closed, representing over 15 percent of facilities and beds. The closures occurred primarily in market areas with multiple LTCHs: From October 2015 through September 2020, almost 80 percent of the MedPAC areas with an LTCH closure had at least one other LTCH in it.¹² In the remaining areas, the closest LTCH was within about two driving hours of the LTCH that closed.

Before the start of the dual payment-rate system, aggregate occupancy rates for LTCHs remained at about 66 percent for several years. In 2019, average occupancy was 63 percent for all LTCHs, the same as in 2018. LTCHs with more than 85 percent of Medicare cases meeting the LTCH PPS criteria had a higher aggregate occupancy rate (67 percent) than all LTCHs. These occupancy rates suggest that remaining LTCHs have capacity to treat additional patients.

We do not yet have a complete picture of the impact of the coronavirus PHE on occupancy or Medicare volume for all LTCHs in 2020. Information from the largest company providing LTCH services reported a 2 percentage point increase in year-over-year occupancy in its 100 facilities in 28 states from 2019 to 2020 through the end of the third quarter (Figure 10-5, p. 290) (Select Medical 2020). This company also reported increases in admissions and

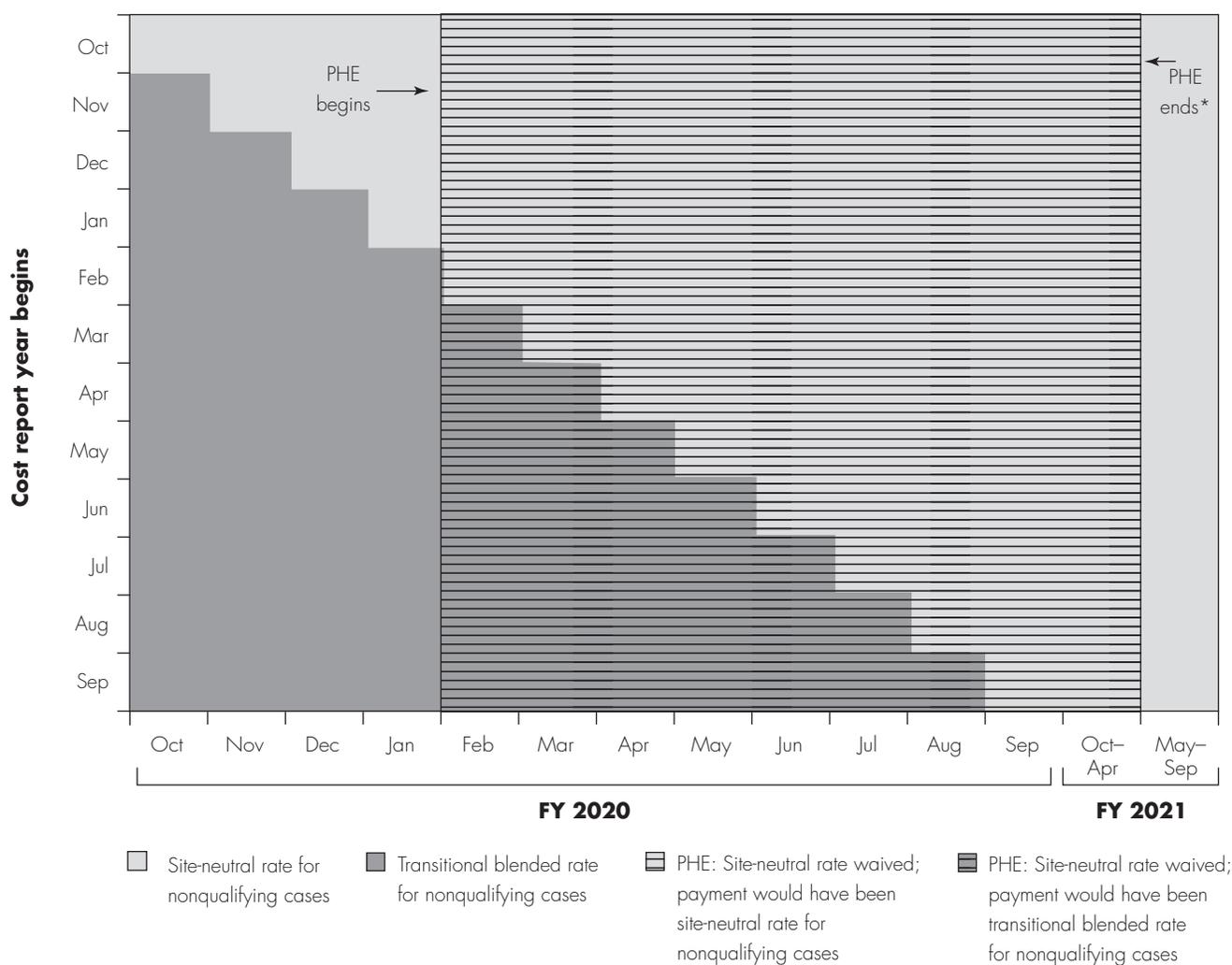
Long-term care hospitals and the coronavirus pandemic

Since early 2020, the ongoing coronavirus pandemic and associated public health emergency (PHE) have had tragic effects on beneficiaries. They also have affected providers' patient volume, revenues, and costs, but those effects have varied considerably by provider type and geography.

Federal grants and loans, as well as setting-specific payment policy changes, have blunted some of the financial impacts. For long-term care hospitals (LTCHs), the Coronavirus Aid, Relief, and Economic Security (CARES) Act of 2020 temporarily waived certain provisions relating to site-neutral payments

FIGURE 10-4

Waiver of site-neutral payments for LTCHs during the public health emergency interrupted full phase-in of dual payment-rate policy for LTCHs



Note: LTCH (long-term care hospital), PHE (public health emergency). "Nonqualifying cases" refers to Medicare cases that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system.

*As of this writing, the PHE is set to expire in April 2021.

(continued next page)

Long-term care hospitals and the coronavirus pandemic (cont.)

during the coronavirus PHE to allow for expansion of inpatient capacity (Centers for Medicare & Medicaid Services 2020). Effective for claims with an admission date on or after January 27, 2020, and continuing through the duration of the PHE, all cases admitted are paid the LTCH PPS standard federal rate and are counted as discharges paid the LTCH PPS rate for purposes of calculating an LTCH's discharge payment percentage, temporarily interrupting the completion of the transition to the site-neutral payments for nonqualifying cases.¹³

As shown in Figure 10-4, the number of months of full site-neutral payments that were overridden by the PHE waiver depends on the start date of an LTCH's cost reporting year. (For example, LTCHs with a cost reporting year that began October 2019 would have received fully site-neutral payments for nonqualifying cases through January until the PHE waiver took effect.) CMS also waived the 25-day average-length-of-stay requirement to participate in the LTCH PPS when an LTCH admits or discharges patients to meet the demands of the PHE. This requirement will resume with a hospital's first cost reporting period that does

not include the PHE waiver period. We will be able to observe the effects of these policy changes in claims and cost report data for 2020 and 2021.

In this chapter, we are recommending payment rate updates for 2022. Because of standard data lags, the most recent complete data we have is from 2019 for most payment adequacy indicators. As we do each year, we use these data as well as changes in payment policy in current law to project margins for 2021 and make payment recommendations for 2022. To the extent the coronavirus pandemic's effects are temporary or vary significantly across individual providers, they are best addressed through targeted, temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that also affect payments in future years. While the full effects of the pandemic on LTCH providers are not yet clear, available details about the impact of the coronavirus pandemic and associated policy changes on LTCHs can be found throughout this chapter. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2 of this report.) ■

patient days through the third quarter of 2020 compared with 2019 but did not attribute the increase to patients with COVID-19. Though we do not yet have complete data on Medicare beneficiaries' LTCH utilization during the PHE, relaxing Medicare's site-neutral payment policies and eliminating the length-of-stay requirements to expand inpatient capacity during the PHE may increase Medicare volume for many facilities in 2020 and 2021.

Volume of services: Number of LTCH users continued to decline through 2019

FFS Medicare beneficiaries' use of LTCHs decreased each year as the new dual payment-rate system was phased in. These decreases occurred, in part, because LTCHs changed their practices to admit fewer cases that did not

meet the LTCH PPS criteria (Medicare Payment Advisory Commission 2019). From 2016 to 2019, total LTCH cases per 10,000 beneficiaries dropped by about 10 percent annually, but for cases meeting the LTCH PPS criteria, that rate decreased just 1.7 percent per year over the same period (Table 10-2, p. 291). As volume declined, the share of cases meeting the criteria increased each year, reaching 75 percent in 2019, up from 58 percent in 2016, indicating success of the dual payment-rate system in reducing the number of site-neutral cases treated in LTCHs.

LTCH stays are increasingly concentrated in a small number of diagnosis groups In fiscal year 2019, the top 20 LTCH diagnoses made up 66 percent of LTCH stays. The most frequently occurring diagnosis was pulmonary

**TABLE
10-1**

The number of LTCHs continued to decrease in 2019

Type of LTCH	2016	2017	2018	2019	Average annual change 2016-2019
LTCHs paid under the LTCH PPS	411	394	374	361	-4.2%
LTCHs with valid cost reports	407	398	368	351	-4.8
Nonprofit	71	71	60	61	-4.9
For profit	320	312	294	271	-5.4
Government	16	15	14	19	5.9

Note: LTCH (long-term care hospital), PPS (prospective payment system). The Medicare, Medicaid, and SCHIP Extension Act of 2007 and subsequent legislation imposed a moratorium on new LTCHs and new LTCH beds in existing facilities from December 29, 2007, through December 29, 2012. The Pathway for SGR Reform Act of 2013 and subsequent legislation implemented a new moratorium from April 1, 2014, through September 30, 2017.

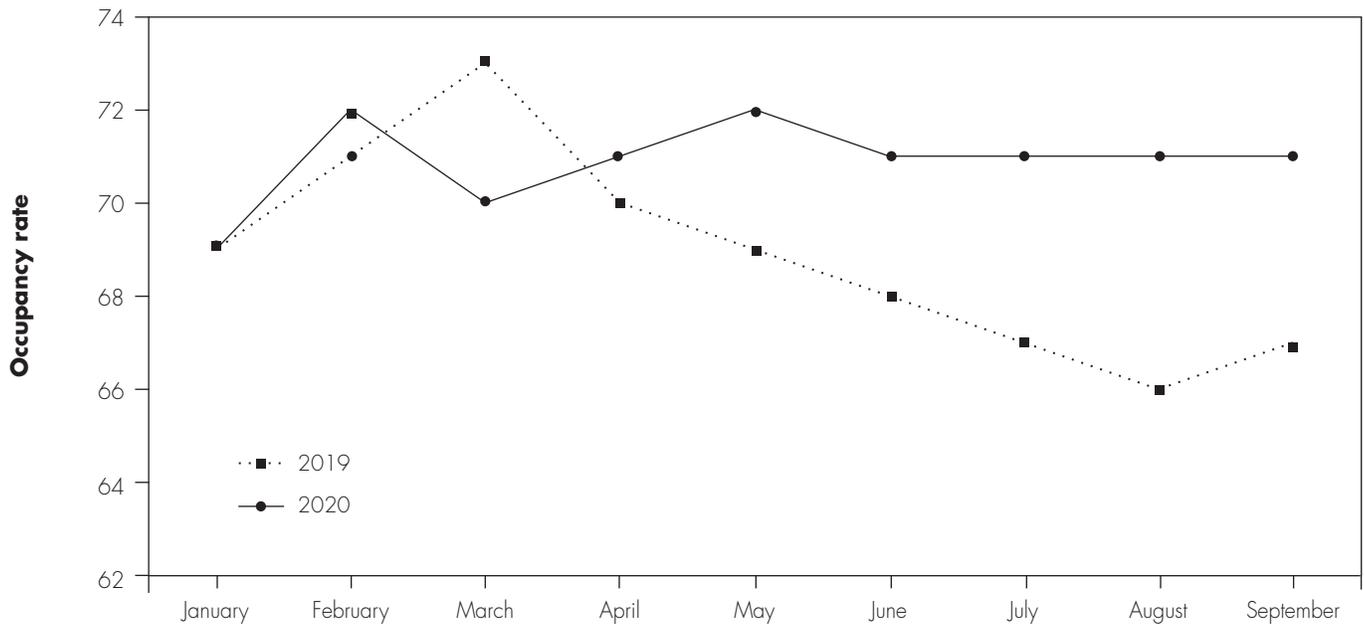
Source: Data for LTCHs paid under the LTCH PPS are from the Provider of Services file, based on the applicable fiscal year. Data for LTCHs with valid cost reports are from MedPAC analysis of cost report data (October 31, 2020 cut), based on the applicable fiscal year. The counts between the two sources differ due to the timing of the files and applicable data trims to the cost report files.

edema and respiratory failure (MS-LTC-DRG 189), accounting for 20 percent of stays. In 2019, 43 percent of LTCH cases were diagnoses that included respiratory conditions, an increase of 3 percentage points from 2018.¹⁴

Among the subset of LTCHs with a high share of cases (more than 85 percent) meeting the LTCH PPS criteria in 2019, LTCH stays are even more concentrated among a small number of diagnosis groups. For these LTCHs, the

**FIGURE
10-5**

Except for March, monthly occupancy rates for the largest company providing LTCH services were higher in 2020 than in 2019



Note: LTCH (long-term care hospital).

Source: Select Medical Holdings Corp Form 10-Q for the 3rd quarter of 2020.

**TABLE
10-2**

The number of LTCHs and Medicare FFS LTCH cases continued to decrease, while the share of cases meeting the LTCH criteria increased in 2019

	2016	2017	2018	2019	Average annual change 2016-2019
Cases					
All	125,586	116,424	102,288	91,147	-10.1%
Meeting criteria	72,318	74,666	71,916	67,987	-2.0
Share meeting criteria	58%	64%	70%	75%	8.6
Cases per 10,000 FFS beneficiaries					
All	32.5	30.1	26.5	23.8	-9.8
Meeting criteria	18.7	19.3	18.6	17.8	-1.7
Payment per case					
All	\$40,656	\$38,253	\$40,105	\$41,448	0.6
Meeting criteria	\$46,223	\$46,127	\$46,789	\$46,800	0.4
Average length of stay (in days)					
All	26.8	26.3	26.6	26.8	-0.1
Meeting criteria	27.9	27.9	28.0	28.0	0.1

Note: LTCH (long-term care hospital), FFS (fee-for-service). "Meeting criteria" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH prospective payment system. All counts are for stays covered by FFS Medicare and do not include those in private plans.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS and the annual reports of the Boards of Trustees of the Medicare trust funds.

top 20 diagnoses made up more than three-quarters of stays (Table 10-3, p. 292). Despite overall volume declines, the absolute number of cases with the top two diagnoses—pulmonary edema and respiratory failure and respiratory system diagnosis with ventilator support—increased between 2018 and 2019 and accounted for nearly 43 percent of stays in 2019. That year, 54 percent of cases in LTCHs with a high share of cases meeting the LTCH PPS criteria involved diagnoses that were respiratory conditions or involved prolonged mechanical ventilation. These shifts toward complex respiratory cases indicate continued responsiveness to payment incentives and are consistent with the goals of the dual payment-rate system.

Profile of Medicare LTCH users FFS Medicare beneficiaries have been a declining share of all LTCH users since 2012. In 2019, they accounted for 56 percent of LTCH stays and 45 percent of patient days in aggregate. Dual-eligible beneficiaries (enrolled in both Medicare and Medicaid) continued to use LTCHs disproportionately: About 44

percent of Medicare stays were dual-eligible beneficiaries in 2019. FFS Medicare beneficiaries who use LTCHs are also disproportionately male, under age 65, diagnosed with end-stage renal disease, and/or Black, compared with the overall population of FFS Medicare beneficiaries. The higher rate of LTCH use by Black beneficiaries could be due to the concentration of LTCHs in areas of the country with larger Black populations (Dalton et al. 2012, Kahn et al. 2010). Another contributing factor could be a greater incidence of critical illness in this population (Mayr et al. 2010) and a greater likelihood to opt for LTCH care since these individuals are less likely than White beneficiaries to elect hospice care (Medicare Payment Advisory Commission 2017a).

Financial incentives to serve Medicare beneficiaries across LTCHs

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat

**TABLE
10-3**

The top 20 MS-LTC-DRGs made up more than three-quarters of FFS Medicare stays at LTCHs with a high share of stays meeting the LTCH PPS criteria in 2019

MS-LTC-DRG	Description	Discharges	Share of cases
189	Pulmonary edema and respiratory failure	10,375	24.3%
207	Respiratory system diagnosis with ventilator support 96+ hours	7,873	18.4
871	Septicemia without ventilator support 96+ hours with MCC	2,440	5.7
208	Respiratory system diagnosis with ventilator support ≤96 hours	1,569	3.7
166	Other respiratory system OR procedures with MCC	1,038	2.4
949	Aftercare with CC/MCC	1,012	2.4
4	Tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth and neck without major OR procedure	891	2.1
177	Respiratory infections and inflammations with MCC	836	2.0
981	Extensive OR procedure unrelated to principal diagnosis with MCC	829	1.9
682	Renal failure with MCC	782	1.8
314	Other circulatory system diagnoses with MCC	630	1.5
291	Heart failure and shock with MCC	629	1.5
862	Postoperative and post-traumatic infections with MCC	566	1.3
539	Osteomyelitis with MCC	563	1.3
919	Complications of treatment with MCC	547	1.3
870	Septicemia with ventilator support 96+ hours with MCC	504	1.2
559	Aftercare, musculoskeletal system and connective tissue with MCC	460	1.1
592	Skin ulcers with MCC	440	1.0
853	Infectious and parasitic disease with OR procedure with MCC	361	0.8
637	Diabetes with MCC	329	0.8
Top 20 MS-LTC-DRGs		32,674	76.4

Note: MS-LTC-DRG (Medicare severity long-term care diagnosis related group), FFS (fee-for-service), LTCH (long-term care hospital), PPS (prospective payment system), MCC (major complication or comorbidity), OR (operating room), CC (complication or comorbidity). MS-LTC-DRGs are the case-mix system for LTCH facilities. Counts are for stays covered by FFS Medicare and do not include those in private plans. The sum of column components may not equal the stated total due to rounding. "Meeting the LTCH PPS criteria" refers to Medicare cases that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are greater than the marginal costs of treating an additional beneficiary, a provider with capacity has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.¹⁵

In 2019, the average LTCH marginal profit on Medicare cases was about 15 percent. Though down a percentage point from 2018, this value is a positive indicator of access because it suggests that LTCHs with available beds

continue to have a financial incentive to increase their occupancy with FFS Medicare beneficiaries who meet the LTCH PPS criteria. For LTCHs with a high share of Medicare cases meeting the LTCH PPS criteria, marginal profit in 2019 was even higher, 17 percent, less than 1 percentage point lower than in 2018.

Quality of care: Risk-adjusted measures are mixed; unadjusted mortality rates are stable during the dual payment-rate system transition

We evaluate the quality of LTCH care using two unadjusted mortality measures reported in previous years and two new measures: average risk-adjusted rates of

**TABLE
10-4**

Between 2015 and 2019, mean risk-adjusted rates of return to the community declined and hospital admissions and readmissions for LTCHs were stable

	2015	2016	2017	2018	2019	Average annual change	
						2018–2019	2015–2019
Hospitalizations (all LTCHs)	5.5%	5.4%	5.3%	5.2%	5.3%	1.7%	–0.7%
Successful discharge to the community (all LTCHs)	26.9	25.4	24.4	22.9	22.1	–3.7	–4.9

Note: LTCH (long-term care hospital). “Successful discharge to the community” includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk-adjusted across the four post-acute care settings. Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate.

Source: MedPAC analysis of Medicare Provider Analysis and Review data from CMS.

successful discharge to the community and all-condition hospitalizations within a stay.¹⁶ Successful discharge to the community includes beneficiaries discharged to the community (including those discharged to the same nursing home) who did not have an unplanned hospitalization or die in the 30 days after discharge. The hospitalization measure captures all unplanned hospital admissions and readmissions and outpatient observation stays that occur during the stay. Both measures are uniformly defined and risk-adjusted across the four post-acute care (PAC) settings (skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals).¹⁷ Providers with at least 60 stays in the year (the minimum count to meet a reliability of 0.7) were included in calculating the average facility rate.

Aggregate risk-adjusted rates of successful discharge to the community have declined and all-condition hospitalizations within a stay have been unchanged during the dual payment-rate phase-in period

In 2019, rates of acute care hospital admissions and readmissions during the LTCH stay were 5.3 percent (Table 10-4). This mean rate and the facility-level interquartile range of about 3 percent to 7 percent (not shown) were consistent with prior years of the dual payment-rate phase-in. Average rates of successful discharge to the community have gone down each year (higher rates are better) since 2015. In 2019, 22.1

percent of stays resulted in successful discharges to the community, a small decrease from 2018. During this period, patient acuity increased as a greater share of cases met the LTCH qualifying criteria and more facilities were treating a greater share of qualifying cases. While these cross-PAC measures are risk adjusted, to the extent that the risk adjustment does not account for certain patient characteristics, these changes could affect the rates of successful discharge.¹⁸ Because the risk adjustment model for these measures pools cases in all four PAC settings, it may work relatively worse for LTCH cases, given their small contribution to the overall combined-PAC case count.

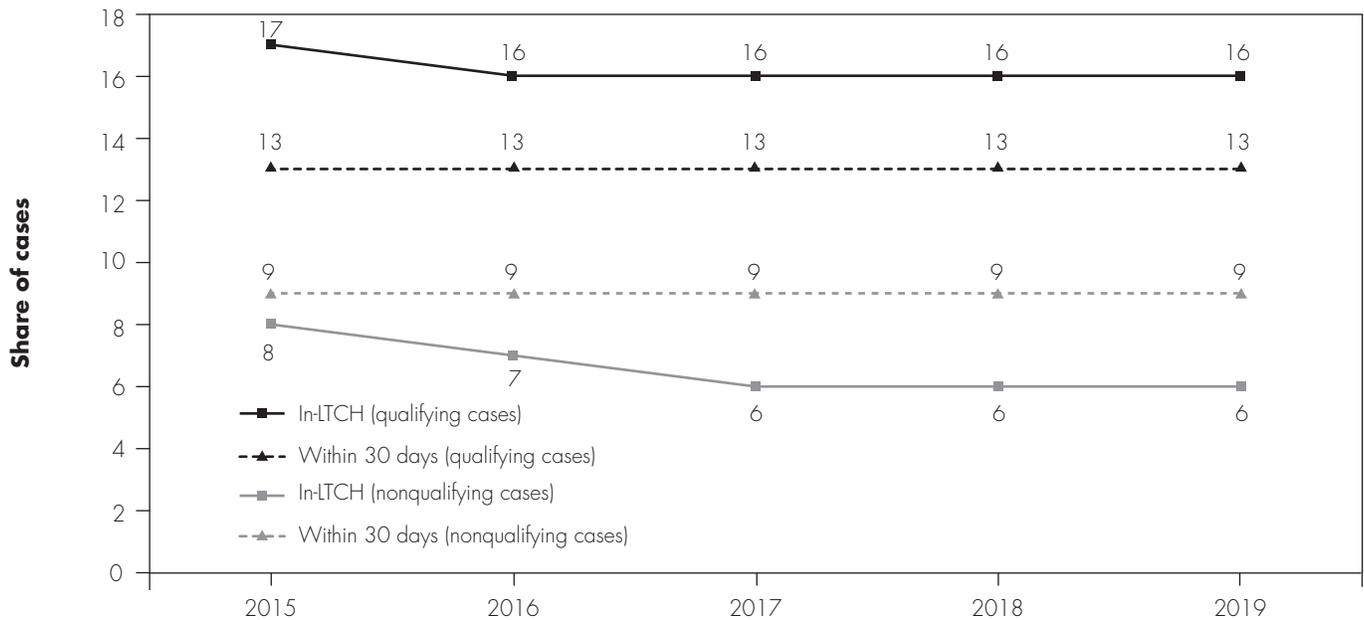
Aggregate unadjusted quality measures have remained stable

Unadjusted mortality rates in 2019 for FFS Medicare LTCH cases were generally unchanged from prior reported trends. However, because these measures are not risk adjusted, changes in patient severity may affect rates over time. Given differences in patient severity, unadjusted mortality rates (both in the facility and 30 days post discharge) varied depending on whether the case met the LTCH PPS criteria, but the rates were stable over time (Figure 10-6, p. 294).

For cases meeting the LTCH PPS criteria, unadjusted mortality rates varied based on which qualifying criteria the case met (Table 10-5, p 295). The approximately three-

FIGURE 10-6

Rates of unadjusted in-LTCH mortality and mortality within 30 days of discharge for FFS Medicare beneficiaries remain stable



Note: LTCH (long-term care hospital), FFS (fee-for-service). “Qualifying cases” refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 to qualify for payment under the LTCH PPS. “Nonqualifying cases” refers to Medicare stays that do not meet the criteria specified in the Pathway for SGR Reform Act of 2013. The share of qualifying cases is defined as having that share of cases in the reported year (e.g., 2018 rates are for providers with the designated share of cases in 2018), therefore the providers in those groups can vary each year.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

quarters of cases that qualified for LTCH PPS payment solely based on the 3-day ACH intensive care unit (ICU) stay criteria had lower rates of readmission and death than did the approximately one-quarter of cases that received mechanical ventilation services in the LTCH for 96 hours.

Unadjusted readmission and mortality also varied by respiratory diagnosis groups (Table 10-6). For example, among patients with a principal diagnosis of septicemia with prolonged ventilator support with major complication or comorbidity (MCC) (MS–LTC–DRG 870), 37 percent died in the LTCH and another 13 percent died within 30 days of discharge. By comparison, among patients with a primary diagnosis of chronic obstructive pulmonary disease with MCC (MS–LTC–DRG 190), 8 percent died in the LTCH and another 11 percent died within 30 days of discharge. Overall, 34

percent of patients meeting the LTCH PPS criteria with a diagnosis related to respiratory illness or prolonged use of mechanical ventilation died in the LTCH or within 30 days of discharge.

Providers’ access to capital: Implementation of LTCH dual payment-rate system slows investment

Access to capital allows LTCHs to maintain, modernize, and expand their facilities. If LTCHs were unable to access capital, it might reflect problems with the adequacy of Medicare payments since Medicare accounts for about half of LTCH total revenues. However, in prior years, the level of capital investment likely reflected more about uncertainty regarding changes to regulations and legislation governing LTCHs than about Medicare payment rates. Although the Pathway for SGR Reform Act

**TABLE
10-5****Among FFS Medicare LTCH cases meeting the LTCH PPS criteria, rates of unadjusted mortality varied by qualifying criteria, 2019**

Reason for LTCH qualifying stay	Number	In-LTCH mortality rate	30-day post discharge mortality rate	Total mortality (in-LTCH plus 30 days post discharge)
ACH stay included at least 3 days in ICU	51,651	13%	13%	26%
Receipt of mechanical ventilation in the LTCH for at least 96 hours	16,336	24	14	39

Note: FFS (fee-for-service), LTCH (long-term care hospital), PPS (prospective payment system), ACH (acute care hospital), ICU (intensive care unit). "Cases meeting the LTCH PPS criteria" refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform of 2013 for payment under the LTCH PPS. Components may not sum to total due to rounding. The 51,651 cases grouped in the "ACH stay included at least 3 days in the ICU" qualified solely on that criterion and did not receive mechanical ventilation in the LTCH for at least 96 hours. Of the 16,336 cases in the "receipt of mechanical ventilation in the LTCH for at least 96 hours" group, 15,943 also had an ACH stay that included at least 3 days in the ICU.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

of 2013 provided more long-term regulatory certainty for the industry compared with prior years, concerns about the industry's ability to comply with the new patient criteria have resulted in low levels of capital investment during the transition period.

The LTCH industry has been positioning itself for the changing payment environment by diversifying service lines and shifting portfolios over the last several years through closures and sales (Kindred Healthcare 2017, Kindred Healthcare 2015, Select Medical 2017, Select

**TABLE
10-6****Among FFS Medicare LTCH cases meeting the LTCH PPS criteria, rates of unadjusted mortality varied across diagnoses related to respiratory illness or using prolonged mechanical ventilation, 2019**

MS-LTC-DRG	Description	In-LTCH mortality rate	30-day post discharge mortality rate	Total mortality (in-LTCH plus 30 days post discharge)
4	Tracheostomy with ventilator support 96+ hrs or primary diagnosis except face, mouth and neck without major OR procedure	30%	14%	45%
166	Other respiratory system OR procedures with MCC	21	16	38
177	Respiratory infections and inflammations with MCC	14	12	26
189	Pulmonary edema and respiratory failure	15	14	29
190	Chronic obstructive pulmonary disease with MCC	8	11	20
207	Respiratory system diagnosis with ventilator support 96+ hours	22	14	36
208	Respiratory system diagnosis with ventilator support ≤96 hours	33	15	48
870	Septicemia with ventilator support 96+ hours with MCC	37	13	50
	Total diagnoses related to respiratory illness or prolonged use of mechanical ventilation	20	14	34

Note: FFS (fee-for-service), LTCH (long-term care hospital), PPS (prospective payment system), MS-LTC-DRG (Medicare severity long-term care diagnosis related group), OR (operating room), MCC (major complication or comorbidity). "Cases meeting the LTCH PPS criteria" refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. A higher rate of readmission and in-LTCH mortality is expected for cases grouped in MS-LTC-DRG 208 since it is defined in part by the length of time mechanical ventilation is received. Components may not sum to totals due to rounding.

Source: MedPAC analysis of Medicare Provider Analysis and Review and enrollment data from CMS.

Medical 2015). Many of these sales and closures occurred in markets with substantial competition from other LTCHs. In 2018, one of the two largest publicly traded LTCH chains, Kindred Healthcare, was acquired by two private equity firms (Kindred Healthcare 2018). In late 2018, a smaller LTCH chain, Promise Healthcare, filed for bankruptcy and has since sold or closed most of its LTCHs (Ellison 2018a). Three companies, including KPC Health (a for-profit health care venture), Select Medical (another LTCH chain), and Lexmark Holdings LLC, purchased the hospitals (Ellison 2018b, Kindred Healthcare 2019, Mosbrucker 2019).

The CARES Act, passed in March 2020 in response to the coronavirus pandemic, gave providers, including LTCHs, access to funds through several mechanisms, including the provider relief fund, to be used for preventing, preparing for, and responding to COVID-19 and for reimbursing providers for lost revenues and health care–related expenses that are attributable to the disease. Also included were a Medicare accelerated and advance payments program, employer payroll tax deferral, paycheck protection program, and elimination of the sequester. (These funding sources were in addition to pandemic-related payment policy changes discussed in the text box, pp. 288–289.) The largest company providing LTCH services reported accessing all these sources of funding (Select Medical 2020).

LTCHs’ access to capital largely depends on their total (all-payer) profitability, which has been variable but positive in the dual payment-rate phase-in period. Before the phase-in, from 2012 through 2015, the LTCH all-payer margin remained at about 4 percent. However, in 2016, as the dual payment-rate system phase-in began, LTCHs’ all-payer margin declined to 3.1 percent. In 2017, the first full year of the phase-in, the all-payer margin dropped to 0.2 percent and then increased to 2.3 percent in 2018. In 2019, as LTCHs shifted their mix of cases toward qualifying cases, the aggregate all-payer LTCH margin was 2 percent. During the phase-in period, between 2015 and 2019, the share of Medicare revenue fell, from almost 50 percent to about 37 percent of total LTCH revenue, largely due to a reduction in the number of Medicare cases, particularly site-neutral cases.

The coronavirus pandemic and PHE-related waivers of site-neutral payments have disrupted the phase-in of the dual payment-rate system in 2020 and 2021, deferring its full impacts, for which the industry has been adjusting its admissions patterns and cost structures for several years.

Nevertheless, the Commission expects continued industry consolidation, limited need for capital, and limited growth opportunities until after the LTCH dual payment-rate system becomes fully implemented and LTCHs adjust their admission patterns and cost structures to align with the payment incentives of the dual payment-rate system in 2021. Because, absent PHE-related waivers of site-neutral payment policies, Medicare pays less for certain cases, LTCHs with a higher share of cases meeting the LTCH PPS criteria should have stronger financial performance when the dual payment-rate policy is fully implemented. In 2019, LTCHs with more than 85 percent of their Medicare cases meeting the LTCH PPS criteria had an aggregate all-payer margin of 3.2 percent, down 1.2 percentage points from 2018. In the short-term (2020 and 2021), however, LTCHs that have not transitioned to treating higher shares of qualifying cases could see improvements in their total margins due to higher standard LTCH PPS Medicare payments during the PHE for relatively lower cost site-neutral cases. (See text box, p. 301, for a discussion of the interaction of PHE-related payment policy changes and margin projections.)

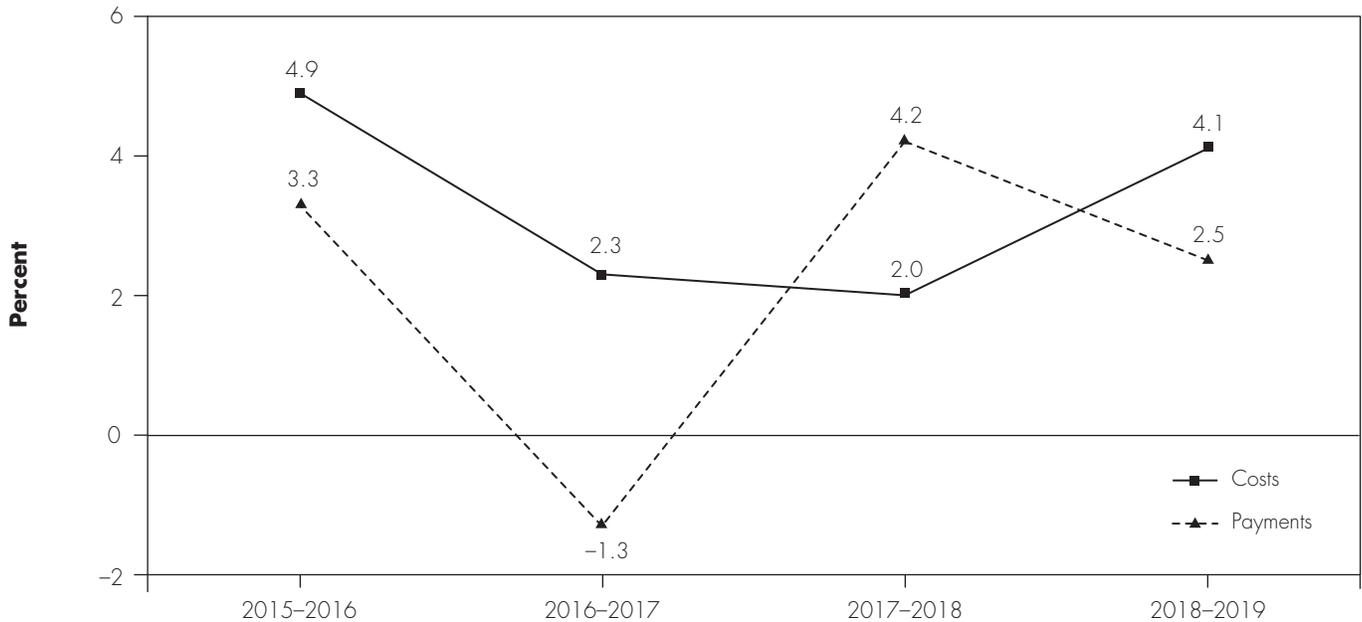
Medicare’s payments and providers’ costs: Cost growth exceeded payment growth in 2019

Fiscal year 2019 was the last full year of the dual payment-rate system transition period during which LTCHs received a blended payment of 50 percent of the site-neutral rate and 50 percent of the LTCH standard rate for cases that did not meet the LTCH criteria. In 2019, the aggregate Medicare margin for all LTCHs was –1.6 percent, a 1 percentage point reduction from 2018. Among LTCHs with more than 85 percent of LTCH PPS–qualifying cases in 2019, aggregate Medicare margins were 2.9 percent.

During the phase-in of the dual payment-rate system, growth in cost per case has outpaced payment increases for all LTCH cases

From 2016 to 2019, the share of all LTCH cases that met the LTCH PPS criteria increased from 58 percent to 75 percent. During this period of transition, aggregate cost growth was variable from year to year and generally outpaced payment growth as LTCHs adjusted their types of cases and received blended payments for cases that did not qualify for the standard LTCH PPS rate.

Changes in payments per Medicare stay CMS began to phase in the dual payment-rate system for cost-reporting periods beginning in 2016. As such, aggregate payment

FIGURE 10-7**Year-over-year changes in payments and cost per stay for LTCHs that had a high share of cases meeting the LTCH PPS criteria in 2019**

Note: LTCH (long-term care hospital), PPS (prospective payment system). "High share of cases meeting the LTCH PPS criteria" refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS.

Source: MedPAC analysis of cost report data from CMS.

changes for all LTCHs in this period reflect payments for site-neutral cases and cases qualifying for the LTCH PPS standard rate. From 2015 to 2016, growth in payments per stay was nearly flat. Between 2016 and 2017, the first full year of the dual payment-rate system phase-in for all LTCHs, average Medicare payment per stay declined by 6.8 percent, consistent with lower payments for all site-neutral cases. As the share of cases meeting the LTCH criteria increased, Medicare payment per LTCH stay increased 3.8 percent from 2017 to 2018 and 2.9 percent from 2018 to 2019. For facilities with a high share of LTCH PPS-qualifying stays in 2019, payments per stay increased 2.5 percent from 2018.

Changes in costs per Medicare stay As providers adjusted to the incentives of the site-neutral payments, growth in cost per stay between 2015 and 2016 slowed to 1.3 percent in aggregate, the slowest growth since 2011. In 2017, LTCHs reduced costs per stay by 0.9 percent in aggregate.

This reduction likely resulted from changes in LTCH cost structures for site-neutral cases under the dual payment-rate system. As the share of LTCH PPS-qualifying cases increased, costs per stay increased 2.9 percent in 2018 and 4.4 percent in 2019, reflecting declining volume and an increase in acuity associated with treating the higher severity cases meeting the LTCH PPS criteria.

For the cohort of facilities with a high share of LTCH PPS-qualifying stays in 2019, costs per stay increased by about 4 percent from 2018 (Figure 10-7). This rate of growth in cost per stay between 2018 and 2019, which was the final full year of the blended payments for nonqualifying cases, reflects declining case volume as more providers transitioned to greater shares of higher acuity LTCH PPS-qualifying cases. For this cohort of LTCHs, their aggregate share of cases meeting the LTCH criteria grew steadily between 2016 and 2019, from 71 percent to 94 percent.

**TABLE
10-7**

The aggregate LTCH Medicare margin decreased between 2018 and 2019

Type of LTCH	Share of stays, 2019	Medicare margin				
		2015	2016	2017	2018	2019
All	100%	4.7%	3.9%	-2.2%	-0.5%	-1.6%
Nonprofit	14	-5.9	-5.7	-13.0	-11.7	-12.2
For profit	84	6.5	5.5	-0.3	1.3	0.4

Note: LTCH (long-term care hospital). Nonprofit and for profit rows sum to 98 percent of stays because margins for government-owned facilities, which account for 2 percent of stays, are not shown.

Source: MedPAC analysis of Medicare cost report data from CMS.

Aggregate LTCH Medicare margins decreased in 2019

In 2019, the aggregate Medicare margin for LTCHs fell to -1.6 percent as providers’ costs grew more than Medicare payments. Consistent with prior years, financial performance of for-profit LTCHs (which accounted for 79 percent of all LTCHs (data not shown) in our cost report analysis and over 84 percent of LTCH stays) and nonprofit LTCHs varied in 2019 (Table 10-7). The aggregate margin for nonprofit LTCHs (which accounted for 17 percent of LTCHs (data not shown) in our cost report analysis and about 14 percent of LTCH stays) was -12.2 percent and the aggregate for-profit margin was 0.4 percent.

The aggregate Medicare margin for all LTCHs in Table 10-7 reflects the mix of site-neutral cases (paid the blended site-neutral rate in 2019) and LTCH PPS-qualifying cases paid the LTCH PPS standard rate each year. However, for purposes of determining the adequacy of the LTCH PPS, we are interested in cases that meet the LTCH criteria and are paid the standard LTCH PPS rate. (The payment rate for site-neutral cases is updated by means of the IPPS update.) In 2019, imputed case-level margins for cases meeting the LTCH PPS criteria were positive, over 3 percent, though down from about 6 percent in 2016 through 2018 (data not shown). To distinguish performance of providers under the LTCH PPS since 2017, we have examined margins for the subset of providers with a high share of qualifying cases in each year and found higher margins among these providers.

In 2019, this subset with a high share of qualifying cases (94 percent in aggregate) had an aggregate margin of 2.9 percent (Table 10-8). The 2019 margin for the subset of providers was lower than it had been in the previous two years, as membership in this group has grown over time to include more LTCHs. As we saw with the full sample of LTCHs, nonprofit providers have lower margins than for-profit providers among LTCHs with a high share of cases meeting the LTCH PPS criteria.

High-margin LTCHs focused on cases meeting the LTCH PPS criteria

Higher costs per stay and lower payments per stay drove differences in financial performance between LTCHs with the lowest (bottom quartile) and highest (top quartile) Medicare margins.¹⁹ High-margin LTCHs had a higher average case mix (1.22) than low-margin LTCHs (1.14) (Table 10-9, p. 300). This higher case mix index, in part, reflects the share of Medicare cases meeting the LTCH PPS criteria and has been increasing since the dual payment-rate system was implemented. In 2019, 80 percent of Medicare cases in high-margin LTCHs met the criteria, compared with 66 percent in low-margin LTCHs. Occupancy rates were also higher among high-margin LTCHs compared with low-margin LTCHs: 69 percent versus 55 percent.

After accounting for differences in case mix and local market input price levels, low-margin LTCHs had standardized costs per discharge that were over 40 percent higher than high-margin LTCHs (\$39,477 vs. \$27,819). Payments per discharge were substantially

lower for low-margin LTCHs. Outlier payments constituted a larger share of total payments to low-margin LTCHs compared with high-margin LTCHs. When these outlier payments were removed from total payments, standardized payment per discharge for low-margin LTCHs was \$33,599 compared with \$39,650 for high-margin LTCHs.

Given that low-margin LTCHs had relatively low occupancy, low share of stays meeting the LTCH PPS criteria, and relatively high costs in 2019, it may be difficult for many of these LTCHs to increase their occupancy rates and concurrently transition to a higher share of cases meeting the LTCH PPS criteria when the dual payment-rate system resumes after the end of the coronavirus PHE.

How should Medicare payments change in 2022?

To estimate LTCH payments, costs, and margins for 2021, we consider the experience of the subset of LTCHs with a high share of cases qualifying for the standard LTCH PPS rates in 2019. Starting with payments and costs information for 2019, we consider (1) expected changes to costs of caring for FFS Medicare beneficiaries between 2019 and 2021 and (2) Medicare payment changes in current law in 2020 and 2021 at the time of this writing. The payment changes that affect our estimate of the 2021 margin include:

- market basket increase of 2.9 percent for fiscal year 2020, less the required multifactor productivity adjustment of 0.4 percent, for a net update of 2.5 percent;
- market basket increase of 2.3 percent for fiscal year 2021, with no productivity adjustment, for a net update of 2.3 percent;
- budget-neutrality adjustments for the elimination of the 25 percent rule;²⁰
- budget-neutrality adjustments for changes to the area wage index;²¹
- CARES Act suspension of the 2 percent sequestration reduction to payments from May 1, 2020, through December 31, 2020, and subsequent extension of the suspension by the Consolidated Appropriations Act, 2021, through March 31, 2021.

TABLE 10-8

Aggregate Medicare margins were positive for LTCHs with a high share of LTCH PPS-qualifying cases in 2019

	Medicare margin		
	2017	2018	2019
All high-share LTCHs	4.6%	4.7%	2.9%
Nonprofit	-6.9	-5.6	-6.9
For profit	6.5	6.2	4.2

Note: LTCH (long-term care hospital), PPS (prospective payment system). The numbers of LTCHs are 117 for 2017, 141 for 2018, and 168 for 2019. "LTCHs with a high share of LTCH PPS-qualifying cases" refers to a cohort of LTCHs defined by their share of Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS each year.

Source: MedPAC analysis of LTCH Medicare Provider Analysis and Review and cost report data from CMS.

The net result is that from 2019 to 2021, payment rates will increase by about 3.9 percent for cases that meet the LTCH PPS criteria.

As more LTCHs have transitioned to treating higher shares of LTCH PPS-qualifying cases during the phase-in of the dual payment-rate system through 2019, we expected and have seen growth in costs per case associated with increased acuity of cases meeting the criteria and declining volume. In our interviews about transitioning to the dual payment-rate system in 2018, LTCH staff discussed operational and administrative changes to handle higher acuity patients, including adding services or increasing staff capabilities (Medicare Payment Advisory Commission 2019). LTCHs described adding ICU beds, bariatric beds, and telemetry services to accommodate the higher acuity of patients discharged from an ACH to the LTCH. To accommodate higher acuity patients, facilities had increased staff skill levels through additional training, including critical care training for registered nurses to ensure that ICU-level care could be provided. Facility staff also discussed increased training at all staff levels to facilitate more vigilant monitoring and earlier patient ambulation. In addition to training, facility staff also reported hiring more nurses to increase nurse-to-patient ratios. We observe that, by 2019, cost growth had not yet leveled off among providers with a high share of LTCH

**TABLE
10-9**

LTCHs in the top quartile of Medicare margins in 2019 had lower costs, higher payments, and a higher share of cases meeting LTCH PPS criteria

Characteristics	High-margin quartile	Low-margin quartile
Mean margin	15.5%	-29.2%
Mean total stays per facility (all payers)	459	405
Medicare patient share	63%	52%
Occupancy rate	69%	55%
Mean CMI	1.22	1.14
Mean per discharge:		
Standardized costs	\$27,819	\$39,477
Standard Medicare payment*	\$39,650	\$33,599
High-cost outlier payments	\$3,863	\$6,657
Share of:		
Cases meeting the LTCH PPS criteria	80%	66%
LTCHs that are for profit	85	70

Note: LTCH (long-term care hospital), PPS (prospective payment system), CMI (case-mix index). Figures presented include only established LTCHs—those that filed valid cost reports in both 2018 and 2019. High-margin-quartile LTCHs were in the top 25 percent of the distribution of Medicare margins. Low-margin-quartile LTCHs were in the bottom 25 percent of the distribution of Medicare margins. Standardized costs have been adjusted for differences in case mix and area wages. Case-mix indexes have been adjusted for differences in short-stay outliers across facilities. “Cases meeting the LTCH PPS criteria” refers to Medicare stays that meet the criteria specified in the Pathway for SGR Reform Act of 2013 for payment under the LTCH PPS. Government providers were excluded.
*Excludes outlier payments.

Source: MedPAC analysis of LTCH cost reports and Medicare Provider Analysis and Review data from CMS.

PPS-qualifying cases in that year, as we had anticipated in previous years.

As the industry continues to adapt and fully transition to caring for patients who qualify for LTCH PPS standard payments, we expect this historical rate of transitional-phase cost growth through 2021, particularly given that the coronavirus pandemic-related payment policies have protracted this transition. Based on payment changes in

current law and average cost growth from 2016 through 2019 (about 2.8 percent) for facilities that achieved this high share of qualifying cases by 2019, we project the aggregate margin among these providers will decrease to 2 percent in 2021. (See text box for a discussion of the interaction of PHE-related payment policy changes and margin projections.) Our projection is driven by an assumption of growth in cost per case, based on the historical average, which is higher than payment increases in the period, even with the additional payments resulting from the suspension of the sequester.

The 2022 payment update for cases meeting the LTCH PPS criteria is expected to equal the projected LTCH market basket of 2.5 percent, less an adjustment for productivity of 0.3 percent, but that may change by the time CMS calculates the final 2022 update. Absent coronavirus PHE-related payment policy changes, the phase-in of the dual payment-rate system would have been complete, and all LTCHs would have been paid the site neutral rate for cases not meeting the LTCH PPS criteria by 2021.²² However, as noted above, the CARES Act waiver of site-neutral policies disrupted this implementation to allow for expanded inpatient capacity.²³ As a result, the full site-neutral payments will not take effect until the PHE expires, absent any policy changes.

Based on these indicators, the Commission concludes that a positive payment update is necessary to support LTCHs focused on a high share of cases meeting the LTCH PPS criteria and to ensure that Medicare beneficiaries maintain access to safe and effective LTCH care.

RECOMMENDATION 10

For fiscal year 2022, the Secretary should increase the 2021 Medicare base payment rate for long-term care hospitals by 2 percent.

RATIONALE 10

Our payment adequacy measures for LTCHs are positive or reflect expected changes under the new dual payment-rate system. The aggregate Medicare margin for LTCHs with a high share of cases that meet the LTCH PPS criteria for 2019 was positive, indicating that LTCHs can operate under current payment rates. However, we estimate that the Medicare margin will decline from 2.9 percent to 2 percent for these facilities in 2021. While we continue to expect LTCHs to adapt to the new payment incentives, based on historical trends, we also expect to see cost

Coronavirus public health emergency waiver–related impacts on all long-term care hospital payments and costs in 2020 and 2021

As discussed in the text box (pp. 288–289), the Coronavirus Aid, Relief, and Economic Security Act temporarily waived certain provisions relating to site-neutral payments during the coronavirus public health emergency (PHE) to allow for expansion of inpatient capacity. Because it changed payments for site-neutral cases, this waiver does not affect projected margins for long-term care hospital (LTCH) prospective payment system (PPS)–qualifying cases. Under the fully implemented site-neutral policy, we would expect margins for LTCHs with high shares of LTCH PPS–qualifying cases to be higher than our projections and lower for LTCHs with higher shares of site-neutral cases in 2020 and 2021. However, with the waiver of site-neutral payments, LTCHs with a high

share of site-neutral cases could have higher margins in 2020 and 2021 than they would have otherwise because they will receive the higher LTCH PPS payment for lower-cost site-neutral cases. It is possible those margins could exceed margins for LTCHs with high shares of qualifying cases. It is also possible that LTCHs that have transitioned to caring for a high share of qualifying cases during the phase-in of the dual payment-rate system will care for more site-neutral cases due to the coronavirus pandemic or in response to payment incentives. We will be able to observe the effects of PHE–related policies on LTCHs’ payment and costs in cost-report data for 2020 and 2021 when available. ■

growth in 2020 and 2021 consistent with growth during the phase-in of the dual payment-rate system. Because of these factors, an update of 2 percent is appropriate given the shift in the industry toward higher acuity patients and the Commission’s desire to support LTCHs that have a high share of cases meeting the LTCH PPS criteria, while maintaining financial pressure on an industry that historically has been highly responsive to changes in payment policy.

IMPLICATIONS 10

Spending

- This recommendation would decrease federal program spending relative to the expected payment update by less than \$50 million in 2022 and by less than \$1 billion over five years.

Beneficiary and provider

- This recommendation is not expected to have adverse effects on Medicare beneficiaries’ access to care. This recommendation is not expected to affect providers’ willingness or ability to furnish care for cases that meet the LTCH PPS criteria. ■

Endnotes

- 1 The Medicare, Medicaid, and SCHIP Extension Act of 2007 also requires LTCHs to have a patient review process that screens patients to ensure appropriateness of admission and continued stay, daily physician on-site availability, and interdisciplinary treatment teams of health care professionals. The Pathway for SGR Reform Act of 2013 specifies that, beginning in fiscal year 2020, LTCHs are also required to maintain a certain share of beneficiaries who qualify to receive the standard LTCH prospective payment system rate.
- 2 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents of the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms but are designed to create different financial incentives.
- 3 More information on the prospective payment system for LTCHs is available at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ltch_final_sec.pdf?sfvrsn=0.
- 4 High-cost outlier cases are identified by comparing their costs with a threshold that is the MS–LTC–DRG payment for the case plus a fixed loss amount (\$27,124 in 2019). Medicare pays 80 percent of the LTCH’s costs above the threshold. In fiscal year 2019, high-cost outlier payments were made for about 15 percent of LTCH cases. The prevalence of high-cost outlier cases varied by LTCH ownership. About 14 percent of cases in for-profit LTCHs were high-cost outliers compared with 22 percent of cases in nonprofit LTCHs.
- 5 The Bipartisan Budget Act of 2018 specified that the IPPS-comparable amount would be reduced by 4.6 percent for fiscal years 2018 through 2026.
- 6 Not all LTCHs’ cost reporting start dates are the same; implementation of the dual payment-rate system began for LTCHs over the course of fiscal year 2016.
- 7 Under section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 8 The 85 percent threshold originated from conversations with industry representatives and stakeholders as a reasonable goal for financial stability under Medicare. We update this cohort annually to reflect changes in the industry over time; therefore, some time series analyses presented for this cohort are not necessarily comparable across reports.
- 9 MMSEA and subsequent legislation allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before December 29, 2007; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before December 29, 2007; (3) entities that had obtained a state certificate of need on or before December 29, 2007; (4) existing LTCHs that had obtained a certificate of need for an increase in beds issued on or after April 1, 2005, and before December 29, 2007; and (5) LTCHs that were in a state with only one other LTCH and that sought to increase beds after the closure or decrease in the number of beds of the state’s other LTCH.
- 10 The Pathway for SGR Reform Act of 2013, as amended by the Protecting Access to Medicare Act of 2014, allowed exceptions to the moratorium for (1) LTCHs that began their qualifying period (demonstrating an average Medicare length of stay greater than 25 days) on or before April 1, 2014; (2) entities that had a binding or written agreement with an unrelated party for the construction, renovation, lease, or demolition of an LTCH, with at least 10 percent of the estimated cost of the project already expended on or before April 1, 2014; and (3) entities that had obtained a state certificate of need on or before April 1, 2014.
- 11 The Medicare Provider of Services (POS) file is one data source for determining LTCH supply. The POS file includes a larger number of facilities than is found in the cost report file. The cost report file provides a more conservative count because some LTCHs may not yet have filed a cost report for the applicable year when we completed our analysis, while others may have been exempt from filing cost reports because of low Medicare volume or because they were paid under an all-inclusive rate. However, POS data can overstate the total number of LTCHs because some facilities that close are not immediately removed from the file.

- 12 We define MedPAC areas as metropolitan statistical areas within a state or rest-of-state nonmetropolitan areas, depending on where beneficiaries reside (Medicare Payment Advisory Commission 2017b).
- 13 Section 3711(b)(2) of the CARES Act provides a waiver of the application of the site-neutral payment rate under Section 1886(m)(6)(A)(i) of the Act for those LTCH admissions that are in response to the PHE and occur during the coronavirus PHE period. Under this provision, all LTCH cases admitted during the PHE period will be paid the relatively higher LTCH PPS standard federal rate (Centers for Medicare & Medicaid Services 2020). For cost reporting periods beginning on or after October 1, 2019, an LTCH that has not maintained the required discharge payment percentage (DPP) is paid an amount comparable to the amount paid for a similar stay under the acute care hospital PPS until its DPP reaches 50 percent or higher; however, section 3711(b)(1) of the CARES Act waives the payment adjustment under section 1886(m)(6)(C)(ii) of the Act for LTCHs that do not have a DPP for the period that is at least 50 percent during the coronavirus public health emergency period. (An LTCH's DPP is its ratio of fee-for-service discharges that qualify for the LTCH PPS rate to the LTCHs' total number of Medicare discharges.)
- 14 The following MS–LTC–DRGs are considered related to respiratory illness or prolonged use of mechanical ventilation: MS–LTC–DRG 4, tracheostomy with ventilator support 96+ hours or primary diagnosis except face, mouth, and neck without major operating room (OR) procedure; MS–LTC–DRG 166, other respiratory system OR procedures with major complication or comorbidity (MCC); MS–LTC–DRG 177, respiratory infections and inflammations with MCC; MS–LTC–DRG 189, pulmonary edema and respiratory failure; MS–LTC–DRG 207, respiratory system diagnosis with ventilator support 96+ hours; MS–LTC–DRG 208, respiratory system diagnosis with ventilator support ≤ 96 hours; MS–LTC–DRG 870, septicemia with prolonged ventilator support with MCC.
- 15 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:
- (payments for Medicare services – (total Medicare costs – fixed building and equipment costs)) / Medicare payments.
- This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 16 This year we have dropped standardized infection ratios of hospital-onset infections—including rates of catheter-associated urinary tract infection, central line–associated blood stream infection, methicillin-resistant staphylococcus aureus (MRSA) infection, clostridium difficile infection—published by CMS on its LTCH Compare website. We previously reported that these rates continued to be lower than expected after adjusting for certain risk factors, but we cautioned against interpreting the ratios and changes over time because of variation in LTCHs' reporting of these infections. Data available for three of these measures (MRSA is no longer reported) shows continued decline (indicating improvement compared to fiscal year 2018) for fiscal year 2019.
- 17 The risk adjustment for the successful discharge to the community measure includes age and sex of the beneficiary, end-stage renal disease (ESRD) and disability status for entitlement, principal diagnosis, comorbidities, the length of stay of the preceding hospital stay (if there was one), and a count of the hospitalizations during the preceding year. Risk adjusters for the hospitalization measure include primary diagnosis, comorbidities and severity of illness, special conditions (severe wounds, difficulty swallowing, and bowel incontinence), age and sex, disability and ESRD status, hospitalization in the previous month, days in the intensive care unit during a preceding hospitalization (if there was one), a count of the hospitalizations during the preceding year, and the provision of ventilator care during the PAC stay.
- 18 The risk adjustment model for these measures pools cases across all four PAC settings.
- 19 Many new LTCHs operate at a loss for a period after opening. For this analysis of high-margin and low-margin LTCHs, we examined only LTCHs that submitted valid cost reports in both 2018 and 2019. We excluded government-owned LTCHs because they operate in a different financial context than other LTCHs, making their financial performance not comparable.
- 20 CMS established the “25 percent threshold rule” to set a limit on the share of cases that can be admitted to an LTCH from certain referring ACHs and reduce payment for some LTCHs with cases that exceed the threshold. Although the policy was intended to create disincentives for LTCHs to admit a large share of their patients from a single ACH, it was never fully implemented. In its final 2019 payment rule, CMS eliminated the 25 percent threshold rule. The 2020 standard federal rate included a temporary, one-time budget-neutrality adjustment of 0.999858 in connection with the elimination of the 25 percent rule. The 2021 standard federal rate included a permanent, one-time budget-neutrality adjustment of 1.000517 for the elimination of the 25 percent threshold rule.

- 21 The 2020 standard federal rate included an area wage budget-neutrality factor of 1.0020203. The 2021 standard federal rate included an area wage budget-neutrality factor of 1.0016837.
- 22 CMS estimated that LTCH PPS payments for cases that complete the statutory transition to the lower payment rates under the dual rate system would decrease by approximately 24 percent in 2021. This estimate accounts for the LTCH site-neutral payment rate cases that will no longer be paid a blended rate at the end of the statutory transition period, cases that represent approximately 25 percent of all LTCH cases and 10 percent of all LTCH PPS payments.
- 23 The CARES Act also temporarily waived the requirement that, on or after October 1, 2019, to be paid the LTCH PPS rate, a facility must have maintained a discharge payment percentage (DPP) of at least 50 percent.

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CHAPTER

11

Hospice services

R E C O M M E N D A T I O N

- 11** For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for hospice and wage adjust and reduce the hospice aggregate cap by 20 percent.

COMMISSIONER VOTES: YES 17 • NO 0 • NOT VOTING 0 • ABSENT 0

Hospice services

Chapter summary

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 2019, more than 1.6 million Medicare beneficiaries (including more than half of decedents) received hospice services from 4,840 providers, and Medicare hospice expenditures totaled \$20.9 billion.

In this chapter, we make a recommendation concerning the payment rate update for 2022. Because of standard data lags, the most recent complete data we have is from 2019 for hospice utilization and 2018 for provider costs and margins. Where relevant, we have considered the effects of the 2020 coronavirus public health emergency (PHE) on our indicators and whether those effects are likely to be temporary or permanent. To the extent the PHE effects are temporary or vary significantly across hospice providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all hospice payment rates in 2022 and future years. Based on information available at the time of publication, we do not

In this chapter

- Are Medicare payments adequate in 2021?
.....
- How should Medicare payments change in 2022?
.....

anticipate any long-term PHE-related effects that would warrant inclusion in the annual update to hospice payments in 2022.

Assessment of payment adequacy

The indicators of payment adequacy for hospices—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers’ costs—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. In 2019, hospice use increased across all demographic and beneficiary groups examined. However, rates of hospice use remained higher for White beneficiaries than for other beneficiaries.

- **Capacity and supply of providers**—In 2019, the number of hospice providers increased by 4.3 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.
- **Volume of services**—In 2019, the proportion of beneficiaries using hospice services at the end of life continued to grow, and length of stay among decedents increased. Between 2018 and 2019, the share of Medicare decedents who used hospice rose from 50.6 percent to 51.6 percent, the average length of stay among decedents rose from 90.3 days to 92.6 days, and the median length of stay was stable at 18 days.
- **Marginal profit**—In 2018, Medicare payments to hospice providers exceeded marginal costs by roughly 16 percent. This rate of marginal profit suggests that providers have a strong incentive to treat Medicare patients and is a positive indicator of patient access.

Quality of care—Limited quality data are available for hospice providers. Scores on a composite measure of seven processes of care at hospice admission are very high, and the composite measure is nearly “topped out”; that is, scores are so high and unvarying that meaningful distinctions and improvement in performance can no longer be made. Performance on a measure of visits in the last three days of life improved slightly. Scores on the Hospice Consumer Assessment of Healthcare Providers and Systems[®] were stable. 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—Hospices are not as capital intensive as other provider types because they do not require extensive physical infrastructure. Continued

growth in the number of for-profit providers (6.3 percent increase in 2019) and reports of strong investor interest in the sector suggest 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—The aggregate 2018 Medicare margin, which is an indicator of the adequacy of Medicare payments relative to providers' costs, was 12.4 percent, similar to the 2017 margin of 12.5 percent. The projected 2021 margin is 13 percent.

In addition to indicators of hospice payment adequacy, this chapter also discusses the hospice aggregate cap. The cap limits the total payments a hospice provider can receive in a year in aggregate. If a provider's total payments exceed the number of patients treated multiplied by the cap amount, the provider must repay the excess to the Medicare program.

The aggregate cap functions as a mechanism that reduces payments to hospices with long stays and high margins. In 2018, about 16 percent of hospices exceeded the cap; their aggregate Medicare margin was about 22 percent before and 10 percent after application of the cap. These above-cap hospices had high average lengths of stay and high live-discharge rates and were disproportionately for profit, freestanding, urban, small, and new entrants to the Medicare program. Unlike wage-adjusted Medicare payments, the hospice aggregate cap is not wage adjusted, resulting in an aggregate cap that is stricter in some areas of the country than in others.

How should Medicare payments change in 2022?

Based on positive indicators of payment adequacy and strong margins, the Commission has concluded that, in aggregate, payments are more than sufficient to cover providers' costs. The Commission recommends that the hospice payment rates in 2022 be held at their 2021 levels. In addition, the Commission recommends that the hospice aggregate cap be wage adjusted and reduced by 20 percent, which would focus payment reductions on providers with disproportionately long stays and high margins. ■

Background

Medicare began offering the hospice benefit in 1983, pursuant to the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The benefit covers palliative and support services for beneficiaries who are terminally ill with a medical prognosis indicating that the individual's life expectancy is six months or less if the illness runs its normal course. A broad set of services is included, such as nursing care; physician services; counseling and social worker services; hospice aide (also referred to as home health aide) and homemaker services; short-term hospice inpatient care (including respite care); drugs and biologics for symptom control; supplies; home medical equipment; physical, occupational, and speech therapy; bereavement services for the patient's family; and other services for palliation of the terminal illness and related conditions. Most commonly, hospice care is provided in patients' homes, but hospice services are also provided in nursing facilities, assisted living facilities, hospice facilities, and hospitals. In 2019, more than 1.6 million Medicare beneficiaries received hospice services, and Medicare expenditures totaled about \$20.9 billion.

Beneficiaries receive the Medicare hospice benefit only if they choose to; if they do, they agree to forgo Medicare coverage for conventional treatment of the terminal illness and related conditions. Medicare continues to cover items and services unrelated to the terminal illness and its related conditions. For each person admitted to a hospice program, a written plan of care must be established and maintained by an interdisciplinary group (which must include a hospice physician, registered nurse, social worker, and pastoral or other counselor) in consultation with the patient's attending physician, if there is one. The plan of care must identify the services to be provided (including management of discomfort and symptom relief) and describe the scope and frequency of services needed to meet the patient's and family's needs.

Beneficiaries elect hospice for defined benefit periods. The first hospice benefit period is 90 days. For a beneficiary to elect hospice initially, two physicians—a hospice physician and the beneficiary's attending physician—are generally required to certify that the beneficiary has a life expectancy of six months or less if the illness runs its normal course.¹ If the patient's

terminal illness continues to engender the likelihood of death within 6 months, the hospice physician can recertify the patient for another 90 days and for an unlimited number of 60-day periods after that, as long as he or she remains eligible.² Beneficiaries can disenroll from hospice at any time (referred to as "revoking hospice") and can reelect hospice for a subsequent period as long as the beneficiary meets the eligibility criteria.

Over the last decade, hospice spending has grown substantially. Between 2010 and 2019, Medicare spending on hospice care grew at an average annual rate of 5.5 percent, increasing from \$12.9 billion to \$20.9 billion. Specifically, between 2010 and 2012, Medicare hospice spending rose rapidly from \$12.9 billion to \$15.1 billion, remained flat between 2012 and 2014 (reflecting in part the implementation of the sequester), and increased after 2014. Between 2018 and 2019, Medicare hospice spending increased 8.5 percent, reflecting an increase in the number of beneficiaries using hospice care and in hospice length of stay, plus a 1.8 percent update in hospice base payment rates in 2019. Medicare is the largest payer of hospice services, covering nearly 92 percent of hospice patient days in 2018.

Medicare payment for hospice services

The Medicare program pays a daily rate to hospice providers. The hospice provider assumes all financial risk for costs and services associated with care for the patient's terminal illness and related conditions. The hospice provider receives payment for every day a patient is enrolled, regardless of whether the hospice staff visits the patient or otherwise provides a service each day. This payment design is intended to encompass not only the cost of visits but also other costs a hospice incurs for palliation and management of the terminal condition and related conditions, such as on-call services, care planning, drugs, medical equipment, supplies, patient transportation between sites of care that are specified in the plan of care, and short-term hospice inpatient care.

Payments are made according to a fee schedule that has four levels of care: routine home care (RHC), general inpatient care (GIP), continuous home care (CHC), and inpatient respite care (IRC). The four levels are distinguished by the location and intensity of the services provided. RHC is the most common level of hospice care, accounting for more than 98 percent of Medicare-covered

hospice days in 2019. The other levels of care are available to manage needs in certain situations. GIP is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. CHC is intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. IRC is care in a facility for up to five days to provide a break for an informal caregiver. Unless a hospice provides CHC, IRC, or GIP on any given day, it is paid at the RHC rate. The level of care can vary throughout a patient's hospice stay as the patient's needs change.

Beginning in January 2016, Medicare pays two per diem rates for RHC—a higher rate for the first 60 days of a hospice episode and a lower rate for days 61 and beyond (\$199 and \$157 per day, respectively, in 2021). (Previously, RHC was paid a single, uniform daily rate.) Medicare also makes additional payments (\$60 per hour in 2021 for up to four hours per day) for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC.

The change to the RHC payment structure was intended to better align payments with the costs of providing hospice care, which tend to be higher at the beginning and end of an episode and lower in the middle. Because of this u-shaped pattern of hospice visits, long stays in hospice have historically been profitable. The change CMS made to the RHC payment structure in 2016 has modestly reduced the variability in profitability by length of stay. Additional policies could be explored to address the profitability of long stays and concerns about aberrant utilization patterns among some providers (see text box on potential directions for payment policy, pp. 341–344).

Beginning fiscal year 2020, CMS rebased the payment rates for the three higher intensity, less frequently provided levels of hospice care (CHC, IRC, GIP). To better align payments with the costs for these three levels of care, CMS increased the CHC payment rate 40 percent, the IRC rate 156 percent, and the GIP rate 35 percent. To offset the projected increase in spending, the payment rates for RHC in fiscal year 2020 were reduced slightly (by 2.7 percent, which, when offset by the annual payment update, resulted in a net reduction of less than 1 percent). Although CMS estimated that the payment rates for RHC in 2019 exceeded costs by 18 percent to 19 percent, the statute requires that any rebalancing of the payment rates be budget neutral. Because RHC accounts for about 98 percent of hospice days, only a small decline in the RHC

rates was needed to offset the increases for the three less frequent levels of care. As of fiscal year 2021, CMS pays \$1,046 per day for GIP, \$461 per day for IRC, and \$60 per hour for CHC.

Hospice payment rates are updated annually by the hospital market basket. The market basket index is reduced by a productivity adjustment. Hospices that do not report quality data receive a 2 percentage point reduction in their annual payment update, and beginning fiscal year 2024 this penalty will increase to 4 percentage points (in accord with the Consolidated Appropriations Act, 2021).

Beneficiary cost sharing for hospice services is minimal. Hospices can, but are not required to, charge coinsurance of 5 percent for each prescription provided outside the inpatient setting (not to exceed \$5) and for inpatient respite care (not to exceed the inpatient hospital deductible). (For a more complete description of the hospice payment system, see http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_hospice_final_sec.pdf?sfvrsn=0.)

Medicare hospice payment limits (“caps”)

The Medicare hospice benefit was designed to give beneficiaries a choice in their end-of-life care, allowing them to forgo conventional treatment (often in inpatient settings) and die at home, with family, according to their personal preferences.

The inclusion of the Medicare hospice benefit in TEFRA was based in large part on the premise that the new benefit would be a less costly alternative to conventional end-of-life care (Government Accountability Office 2004, Hoyer 2007). Studies show that beneficiaries who elect hospice incur less Medicare spending in the last one or two months of life than comparable beneficiaries who do not, but also that Medicare spending for beneficiaries is higher for hospice enrollees than for nonenrollees in the earlier months before death. In essence, a hospice's net reduction in Medicare spending decreases the longer the patient is enrolled, and beneficiaries with long hospice stays tend to incur higher Medicare spending than those who do not elect hospice (Medicare Payment Advisory Commission 2008). Studies have been mixed on whether hospice has saved the Medicare program money in the aggregate compared with conventional care.³ Research by a Commission contractor examined the literature and conducted a new market-level analysis of hospices' effect

on Medicare expenditures. That study found that while hospice produces savings for some beneficiaries, such as those with cancer, overall, hospice has not reduced net Medicare program spending and may have even increased net spending because of very long stays among some hospice enrollees (Direct Research 2015).

When the Congress established the hospice benefit, it included two limitations, or “caps,” on payments to hospices in an effort to make cost savings more likely. The first cap limits the share of inpatient care days that a hospice can provide to 20 percent of its total Medicare patient care days. This cap is rarely exceeded; any inpatient days provided in excess of the cap are paid at the RHC payment rate.

The second, more visible cap limits the aggregate Medicare payments that an individual hospice can receive. This aggregate cap was established in statute when the hospice benefit was created and was intended to ensure that the benefit would generate savings compared with conventional care. The cap was initially pegged at 40 percent of the estimated cost of conventional care for cancer patients in the last six months of life. In the first year, the cap was set at \$6,500, and it has been increased annually by a measure of inflation.⁴ The hospice cap is the only significant fiscal constraint on the growth of program expenditures for hospice care (Hoyer 2007).

Under the cap, if a hospice’s total Medicare payments exceed its total number of Medicare beneficiaries served multiplied by the cap amount (\$30,684 in 2021), it must repay the excess to the program.⁵ Beneficiaries who receive hospice care in multiple cap years or from multiple hospice providers are reflected in the beneficiary count of the cap calculation for a particular cap year and hospice provider in a prorated manner.⁶ This cap is not applied individually to the payments received for each beneficiary, but rather to the total payments across all Medicare patients served by the hospice in the cap year. It is important to note that the cap is not a limit on Medicare’s coverage of hospice services for patients. Rather, it limits how much Medicare will pay a hospice provider in the aggregate for its patient population. After the year ends, Medicare totals all its payments to the provider, and if that amount exceeds the number of beneficiaries multiplied by the aggregate cap amount, Medicare requires the hospice to repay the excess to the Medicare program.⁷ We estimate the share of hospices that exceeded the cap in 2018 was about 16 percent.

Are Medicare payments adequate in 2021?

To address whether payments in 2021 are adequate to cover the costs of the efficient delivery of care and how much providers’ payments should change in the coming year (2022), we examine several indicators of payment adequacy. Specifically, we assess beneficiaries’ access to care by examining the capacity and supply of hospice providers, changes over time in the volume of services provided, quality of care, providers’ access to capital, and the relationship between Medicare’s payments and providers’ costs.

While impossible to predict the future with any certainty given the evolving coronavirus pandemic, we anticipate hospice payment adequacy indicators will remain positive in 2021. (For a description of how the coronavirus pandemic has been incorporated into our payment adequacy framework, see the text box, p. 316.)

Beneficiaries’ access to care: Indicators continue to be favorable

Our analysis of access indicators—including trends in the supply of providers, utilization of hospice services, and marginal profit—shows that beneficiaries’ access to care in 2019 was favorable.

Capacity and supply of providers: Supply of hospices continued to grow, driven by growth in for-profit providers

In 2019, 4,840 hospices provided care to Medicare beneficiaries, a 4.3 percent increase from the prior year (Table 11-1, p. 317). For-profit hospices accounted for most of the net increase in the number of hospices. Between 2018 and 2019, the number of for-profit hospices increased by 6.3 percent, while the number of nonprofit hospices increased by 0.2 percent, and government-owned hospices declined by 5.7 percent. As of 2019, about 71 percent of hospices were for profit, 26 percent were nonprofit, and 3 percent were government owned. Because for-profit providers tend to be smaller on average than nonprofits, for-profit providers account for just over half (51 percent) of hospice patients while nonprofit and government providers account for 45 percent and 4 percent, respectively (data not shown).

Growth in the number of freestanding hospices accounted for almost all of the net growth in the number

The coronavirus public health emergency and the Commission's payment adequacy framework

The coronavirus pandemic and associated public health emergency (PHE) had tragic effects on beneficiaries' health in 2020.⁸ Since the onset of the PHE, many beneficiaries have died from COVID-19 and many have died from causes unrelated to the pandemic. For beneficiaries facing the end of life and their families, the social isolation associated with the pandemic and its emotional effects has added to the human tragedy.

COVID-19 has also had material effects on providers' patient volume, revenues, and costs. The impact of COVID-19 has varied considerably both geographically and over time, and it is not clear when or whether the pandemic's full effects will end. With respect to hospice providers, information from publicly traded hospice companies indicates that patient volumes declined initially but generally rebounded within a few months to near and in some cases above pre-pandemic levels. Site of care appears to have shifted, as hospice providers reported fewer nursing facility and assisted living facility patients (as many facilities have restricted access) while referral from other sources such as community physicians has increased. Hospice providers have faced some additional costs associated with the pandemic (e.g., costs related to personal protective equipment, testing, and telehealth

equipment), while federal grants and loans received by some hospice providers and temporary policy changes (e.g., flexibility to use telehealth visits and suspension of some training and supervision requirements) have helped ease the PHE's impact.

In this chapter we recommend payment rate updates for 2022. Because of standard data lags, the most recent complete data we have are from 2019 for hospice utilization and 2018 for provider costs and margins. As always, we use the best available data and changes in payment policy to project margins for 2021 and make payment recommendations for 2022. To the extent the COVID-19 effects are temporary or vary significantly across individual providers, they are best addressed through targeted temporary funding policies rather than a permanent change to all providers' payment rates in 2022 that will also affect payments in future years. For each payment adequacy indicator in this chapter, we discuss whether the effects of COVID-19 on those indicators will most likely be temporary or permanent. Only permanent effects of the pandemic will be factored into recommended permanent changes in Medicare payment rates. (For an overview of how our payment adequacy analysis takes account of the PHE, see Chapter 2.) ■

of hospice providers in 2019 and throughout this decade (Table 11-1). Between 2018 and 2019, the number of freestanding providers increased by 6.3 percent, while the number of hospital-based and home health-based hospices declined by 4.6 percent and 1.7 percent, respectively.⁹ The number of skilled nursing facility (SNF)-based hospices is very small and declined in 2019. As of 2019, about 81 percent of hospices were freestanding, 9 percent were hospital based, 9 percent were home health based, and less than 1 percent were SNF based.

The number of rural hospices has declined since 2010, falling about 1.5 percent between 2018 and 2019

(Table 11-1). As of 2019, 82 percent of hospices were in urban areas and 18 percent were in rural areas. The number of hospices in rural areas is not necessarily reflective of hospice access for rural beneficiaries for several reasons. A count of the number of rural hospices does not capture the size of those hospice providers, their capacity to serve patients, or the size of their service area. Furthermore, a count of rural hospices does not take into account hospices with offices in urban areas that also provide services in rural areas. While the number of rural hospices has declined in the last several years, the share of rural decedents using hospice has grown (Table 11-2, p. 318).

**TABLE
11-1**

Increase in total number of hospices driven by growth in for-profit providers

Category	2010	2016	2017	2018	2019	Average annual percent change 2010–2018	Percent change 2018–2019
All hospices	3,498	4,382	4,488	4,639	4,840	3.6%	4.3%
For profit	1,958	2,943	3,101	3,233	3,437	6.5	6.3
Nonprofit	1,316	1,272	1,226	1,246	1,248	-0.7	0.2
Government	224	167	161	159	150	-4.2	-5.7
Freestanding	2,401	3,376	3,525	3,699	3,932	5.6	6.3
Hospital based	609	499	470	454	433	-3.6	-4.6
Home health based	465	482	471	464	456	0.0	-1.7
SNF based	23	25	22	22	19	-0.6	-13.6
Urban	2,485	3,474	3,603	3,760	3,952	5.3	5.1
Rural	950	901	879	872	859	-1.0	-1.5

Note: SNF (skilled nursing facility). Some categories do not sum to total because of missing data for some providers. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare cost reports, Medicare Provider of Services file, and the 100 percent hospice claims standard analytical file from CMS.

Most of the growth in the number of hospices in 2019 was concentrated in two states—California and Texas. Between 2018 and 2019, California gained 118 hospices and Texas gained 53 hospices, continuing the trend in recent years of substantial market entry by hospice providers in these two states. From 2014 to 2019, California averaged gains of about 108 hospices each year, and Texas has gained 38 hospices each year. In addition to California and Texas, Arizona and Georgia gained a substantial number of hospice providers in 2019 (a net increase of 12 providers in each state). In 2019, some states saw the number of hospice providers decline, although these changes were generally modest. The three states (Maine, Missouri, and Oklahoma) with the largest decline in the number of providers in 2019 nevertheless experienced stable or increased hospice use rates among decedents.

Patterns of care among new hospices in California and Texas suggest additional oversight is warranted, particularly given the rapid entry of new providers in these states. To understand more about the characteristics of new hospices in California and Texas, we analyzed

new hospices in those states that began treating Medicare patients in 2015 and followed them through 2018. Of the 104 hospices in California and 39 hospices in Texas that began treating Medicare patients in 2015, about 90 percent were still treating Medicare patients as of 2018. Nearly all of the new providers had for-profit ownership, and they tended to be small, treating about half the number of patients in 2018 treated by other hospices in the state, on average. Compared with providers that had been operating longer, a larger share of new providers in both states did not provide any IRC in 2018, and in Texas a larger share of new providers did not furnish any GIP. However, new providers in these two states were more likely to provide CHC to at least one patient in 2018 than other providers in the state, on average. A substantial share of new hospices (58 percent in California and 34 percent in Texas) exceeded the aggregate cap in 2018. These hospices had a high average length of stay (216 days in California and 259 days in Texas) and high live-discharge rates (37 percent in California and 32 percent in Texas) that year. In addition, a separate analysis of quality reporting data across states finds that California and Texas are the two

**TABLE
11-2**

Hospice use among decedents continues to increase

Share of Medicare decedents who used hospice

	2010	2017	2018	2019	Average annual percentage point change 2010–2018	Percentage point change 2018–2019
All decedent beneficiaries	43.8%	49.8%	50.6%	51.6%	0.9	1.0
FFS beneficiaries	42.8	48.9	49.7	50.7	0.9	1.0
MA beneficiaries	47.2	51.6	52.3	53.2	0.6	0.9
Dual eligibles	41.5	47.0	47.5	49.2	0.8	1.7
Medicare only	44.5	50.6	51.5	52.3	0.9	0.8
Age						
<65	25.7	28.3	28.8	29.4	0.4	0.6
65–74	38.0	40.3	40.6	41.0	0.3	0.4
75–84	44.8	50.5	51.2	52.2	0.8	1.0
85+	50.2	59.7	61.1	62.7	1.4	1.6
Race/ethnicity						
White	45.5	51.8	52.7	53.8	0.9	1.1
Black	34.2	39.5	39.7	40.8	0.7	1.1
Hispanic	36.7	41.5	42.5	42.7	0.7	0.2
Asian American	30.0	37.7	38.8	39.8	1.1	1.0
American Indian/Alaska Native	31.0	36.6	37.8	38.5	0.9	0.7
Sex						
Male	40.1	45.1	45.9	46.7	0.7	0.8
Female	47.0	54.1	55.0	56.2	1.0	1.2
Beneficiary county						
Urban	45.6	51.1	51.8	52.7	0.8	0.9
Micropolitan	39.2	47.1	48.2	49.7	1.1	1.5
Rural, adjacent to urban	39.0	46.9	47.9	49.5	1.1	1.5
Rural, nonadjacent to urban	33.8	41.2	42.4	43.8	1.2	1.4
Frontier	29.2	33.4	35.3	36.2	1.1	1.6

Note: FFS (fee-for-service), MA (Medicare Advantage). Beneficiary location reflects the beneficiary’s county of residence in one of four categories (urban, micropolitan, rural adjacent to urban, or rural nonadjacent to urban) based on an aggregation of the Urban Influence Codes (UICs). This chart uses the 2013 UIC definition. The frontier category is defined as population density equal to or less than six people per square mile and overlaps with the beneficiary county of residence categories. Yearly figures presented in the table are rounded, but figures in the percentage point change columns were calculated using unrounded data. The estimates in this table may differ from those published in prior reports because this analysis uses the data from the Common Medicare Enrollment file instead of the denominator file (which was used in past years) and because we have made some refinements to our methodology (e.g., beneficiaries residing in U.S. territories are included in this table, whereas they were not in prior reports).

Source: MedPAC analysis of data from the Common Medicare Enrollment file and hospice claims data from CMS.

states with the highest share of providers that are not meeting the requirement to report quality data to CMS (and that are not exempt from the reporting requirement).

The number of hospice providers is not necessarily an indicator of beneficiary access to hospice. The supply of providers—as measured by the number of hospices per 10,000 Medicare decedents—varies substantially across states. In the past, we have concluded that there is no

relationship between the supply of hospice providers and the rate of hospice use across states (Medicare Payment Advisory Commission 2010). A new analysis of 2019 data yields similar findings: Variation in hospice use rates across states appears unrelated to the number of hospice providers per 10,000 beneficiaries in state.

Share of decedents using hospice continues to increase

In 2019, hospice use among Medicare beneficiaries increased, continuing the trend of a growing proportion of beneficiaries using hospice services at the end of life.¹⁰ Of the Medicare beneficiaries who died that year, 51.6 percent used hospice, up from 50.6 percent in 2018 (Table 11-2). Over the last two decades—from 2000 to 2019—hospice use rates among decedents more than doubled, increasing from less than 25 percent to more than 50 percent of decedents (data for 2000 not shown). Hospice use varied in 2019 by beneficiary characteristics—enrollment in fee-for-service (FFS) Medicare or Medicare Advantage (MA); Medicare-only beneficiaries and beneficiaries dually eligible for Medicare and Medicaid; age, race, and sex; and urban or rural residence—but increased in all of these groups.¹¹

Hospice use is slightly higher among decedents in MA than in FFS. In 2019, about 51 percent of Medicare FFS decedents and 53 percent of MA decedents used hospice. MA plans do not provide hospice services. Once a beneficiary in an MA plan elects hospice care, the beneficiary receives hospice services through a provider paid by Medicare FFS. In March 2014, the Commission urged that this policy be changed, recommending that hospice be included in the MA benefits package (Medicare Payment Advisory Commission 2014). In January 2021, as part of its value-based insurance design (VBID) models in MA, CMS's Center for Medicare & Medicaid Innovation (CMMI) launched a demonstration permitting 9 MA organizations (which comprise 53 plan benefit packages) to provide hospice and palliative care services for their enrollees to test the effects of adding the hospice benefit to MA (Centers for Medicare & Medicaid Services 2020b).

Hospice use varies by other beneficiary characteristics. In 2019, a smaller proportion of Medicare decedents who were dually eligible for Medicare and Medicaid used hospice compared with the rest of Medicare decedents (49 percent vs. 52 percent). Hospice use was least prevalent among Medicare decedents under age 65 (who are also

likely to be dually eligible) and most prevalent among those age 85 and older (about 29 percent vs. 63 percent). Female beneficiaries were also more likely than male beneficiaries to use hospice, which partly reflects the longer average life span for women and greater hospice use among older beneficiaries. Hospice use is higher for urban than for rural beneficiaries, although use has grown across all area categories (Table 11-2).

Hospice use also varies by racial and ethnic group (Table 11-2). As of 2019, Medicare hospice use was highest among White decedents, followed by Hispanic, Black, Asian American, and American Indian/Alaska Native decedents, in that order. Hospice use grew across all these groups between 2018 and 2019, but differences in use rates persisted. The reasons for these differences are not fully understood. Researchers have cited a number of possible factors, such as cultural or religious beliefs, preferences for end-of-life care, disparities in access to care or information about hospice, socioeconomic factors, and mistrust of the medical system (Barnato et al. 2009, Cohen 2008, Crawley et al. 2000, LoPresti et al. 2016, Martin et al. 2011).

One driver of increased hospice use over the past decades has been growing use by patients with noncancer diagnoses, owing to increased recognition that hospice can care for such patients. Beneficiaries with any diagnosis where the life expectancy is six months or less are eligible to receive hospice services under Medicare. At the same time, beneficiaries with these terminal conditions tend to have longer hospice stays, which have historically been more profitable than shorter stays under Medicare's hospice payment system. In 2019, 75 percent of Medicare beneficiaries who used hospice had a noncancer diagnosis, a slight increase from 74 percent in 2018 and up from 48 percent in 2000 (data not shown).

Volume of services: Hospice use and length of stay increased in 2019

In 2019, the number of Medicare beneficiaries receiving hospice services continued to increase. About 1.61 million beneficiaries used hospice services, up 3.7 percent from about 1.55 million in 2018 (Table 11-3, p. 320). Between 2018 and 2019, the number of hospice days furnished to Medicare beneficiaries also increased 7.3 percent, from about 114 million days to about 122 million days. During that period, the mix of hospice days by level of care shifted slightly, with the share of days accounted for by RHC edging upward (data not shown).¹²

**TABLE
11-3**

Hospice expenditures and use increased in 2019

Category	2010	2017	2018	2019	Average annual change, 2000-2017	Change, 2017-2018	Change, 2018-2019
Total spending (in billions)	\$12.9	\$17.9	\$19.2	\$20.9	4.8%	7.4%	8.5%
Number of hospice users (in millions)	1.15	1.49	1.55	1.61	3.8%	3.9%	3.7%
Number of hospice days for all hospice beneficiaries (in millions)	81.6	106.3	113.5	121.8	3.9%	6.8%	7.3%
Average length of stay among decedents (in days)	87.0	89.3	90.3	92.6	0.4%	1.1%	2.5%
Median length of stay among decedents (in days)	18	18	18	18	0 days	0 days	0 days

Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime. Total spending, number of hospice users, number of hospice days, and average length of stay displayed in the table are rounded; the percentage change for number of users and total spending is calculated using unrounded data. The length-of-stay estimates in this table may differ from those published in prior reports because this analysis uses the data from the Common Medicare Enrollment file instead of the denominator file (which was used in past years) and because we have made some refinements to our methodology (e.g., beneficiaries residing in U.S. territories are included in this table, whereas they were not in prior reports).

Source: MedPAC analysis of the Common Medicare Enrollment file and the Medicare Beneficiary Database from CMS.

Most hospice decedents have short stays, but some have very long stays (Figure 11-1). In 2019, one-quarter of hospice decedents had stays of 5 days or less, half had stays of 18 days or less, and three-quarters had stays of 85 days or less. At the same time, 10 percent of hospice decedents had stays of more than 266 days. Between 2018 and 2019, hospice average length of stay among decedents increased from 90.3 days to 92.6 days and median length of stay was stable at 18 days (Table 11-3). Length of stay for the shortest stays remained stable (two days at the 10th percentile and five days at the 25th percentile), while it increased for longer stays (from 82 days to 85 days at the 75th percentile and from 255 days to 266 days at the 90th percentile) (Figure 11-1 shows 2019 data).

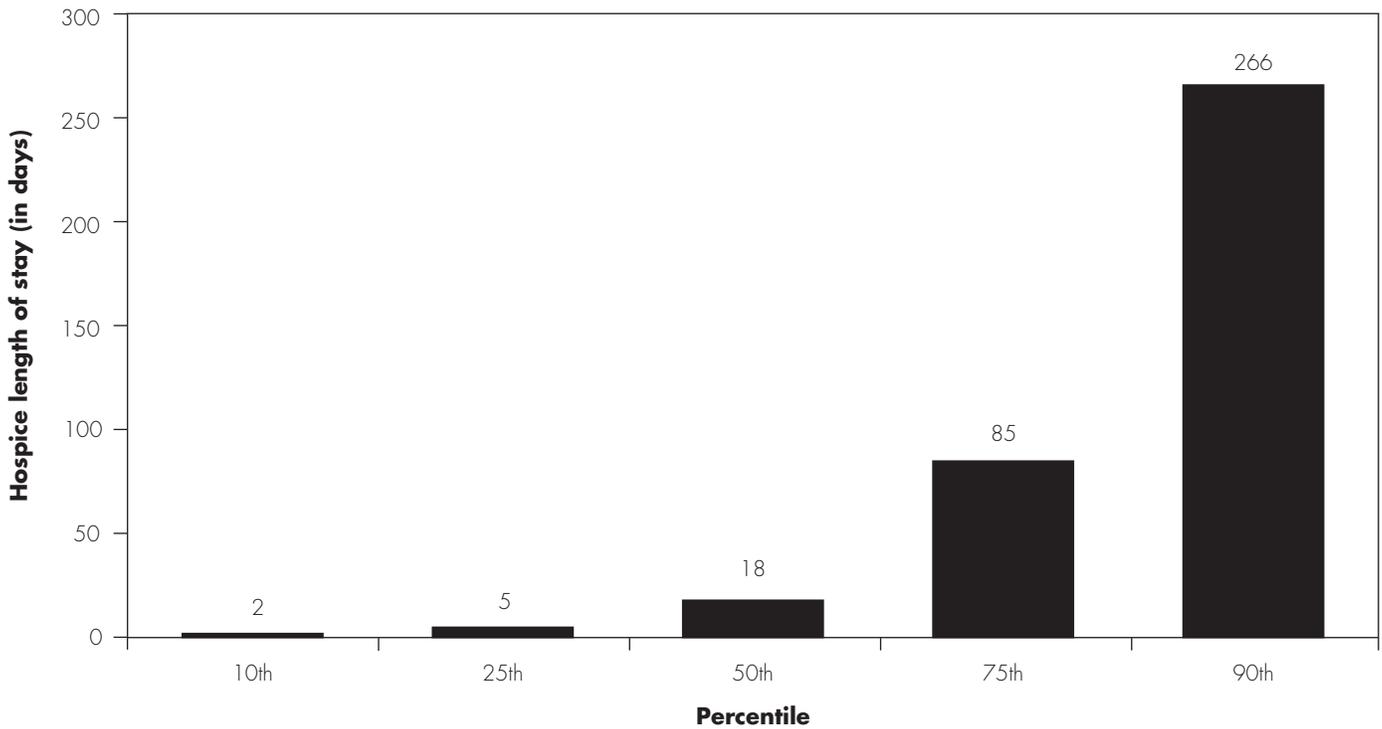
Hospice length of stay is generally similar for hospice decedents in FFS Medicare and MA. Average length of stay for decedents in 2019 was 93.1 days for FFS beneficiaries and 91.7 days for MA beneficiaries (data not shown). The most significant difference is that very long stays in hospice are slightly shorter for beneficiaries in MA than for those in FFS (263 days for MA beneficiaries

compared with 268 days for FFS beneficiaries at the 90th percentile of stays in 2019). Among beneficiaries with short stays, MA beneficiaries had slightly longer stays than FFS beneficiaries (median length of stay of 19 days and 18 days, respectively) (data not shown).

With the growing use of hospice, rates of patients dying in the hospital have declined, but evidence is mixed on the extent to which the decline has been accompanied by a reduction in the overall intensity of care in the last months of life. Teno and colleagues (2018) found that between 2000 and 2015, the share of Medicare FFS decedents ages 65 and older dying in the hospital declined (from 32.6 percent to 19.8 percent). In addition, some indicators of intensity of care rose at the beginning of the 2000 to 2015 window but fell in later years, with a net overall decrease by 2015. For example, between 2000 and 2015, the share of beneficiaries with 3 or more hospitalizations in the last 90 days of life and the share with multiple hospitalizations for infections or dehydration in the last 120 days of life declined. At the same time, the study found that other indicators of intensity of care have increased. For

**FIGURE
11-1**

Most hospice decedents in 2019 had relatively short stays, but some had very long stays



Note: Lifetime length of stay is calculated for decedents who were using hospice at the time of death or before death and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime.

Source: MedPAC analysis of the Common Medicare Enrollment file and the Medicare beneficiary database from CMS.

example, the share of beneficiaries receiving treatment in an intensive care unit during the last month of life increased between 2000 and 2009 (from 24.3 percent to 29.2 percent) and has changed little between 2009 and 2015. The share of beneficiaries with a hospitalization in the last 90 days of life increased between 2000 and 2005; it has declined since then but remained higher in 2015 than in 2000. This increase in the intensity of some aspects of end-of-life care may in part reflect referrals to hospice occurring in only the last few days of life for some beneficiaries.

The Commission has previously expressed concern about very short hospice stays. More than one-quarter of hospice decedents enroll in hospice only in the last week of life, a length of stay that is commonly thought

to be of less benefit to patients than enrolling somewhat earlier. Very short hospice stays occur across a wide range of diagnoses (Table 11-4, p. 322). These very short stays stem largely from factors unrelated to the Medicare hospice payment system: Some physicians are reluctant to have conversations about hospice or tend to delay such discussions until death is imminent; some patients and families have difficulty accepting a terminal prognosis; and financial incentives in the FFS system encourage increased volume of clinical services (compared with palliative care provided by hospice providers) (Medicare Payment Advisory Commission 2009). In addition, some analysts point to the requirement that beneficiaries forgo intensive conventional care to enroll in hospice as a factor that contributes to deferring hospice care, resulting in short hospice stays.

**TABLE
11-4**

Hospice length of stay among decedents by beneficiary and hospice characteristics, 2019

Characteristic	Average length of stay (in days)	Percentile of length of stay				
		10th	25th	50th	75th	90th
Beneficiary						
Diagnosis						
Cancer	52	3	6	17	51	129
Neurological conditions	155	4	9	40	182	459
Heart/circulatory	99	2	5	18	94	297
COPD	124	2	6	30	140	362
Other	57	2	3	8	38	158
Main location of care						
Home	95	4	9	27	91	257
Nursing facility	109	3	6	22	105	324
Assisted living facility	161	5	14	56	199	457
Hospice						
Hospice ownership						
For profit	112	3	6	24	107	332
Nonprofit	71	2	5	14	60	195
Type of hospice						
Freestanding	95	2	5	19	86	275
Home health based	72	2	5	15	64	199
Hospital based	59	2	4	12	51	163

Note: COPD (chronic obstructive pulmonary disease). Length of stay is calculated for Medicare beneficiaries who died in 2019 and used hospice that year and reflects the total number of days the decedent was enrolled in the Medicare hospice benefit during his or her lifetime. This year, we made some refinements to our methodology (e.g., beneficiaries residing in U.S. territories are included in this table, whereas they were not in prior reports), which makes the numbers not fully comparable with those in past reports. The location categories reflect where the beneficiary spent the largest share of his or her days while enrolled in hospice. "Diagnosis" reflects primary diagnosis on the beneficiary's last hospice claim.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file, the Common Medicare Enrollment file, the Medicare Beneficiary Database, Medicare hospice cost reports, and Provider of Services file from CMS.

A number of initiatives seek to address concerns about potentially late hospice enrollments and the quality of end-of-life care more generally. Since 2016, under the physician fee schedule, Medicare has paid for advance care planning conversations between a beneficiary and his or her physician or advanced practice registered nurse or physician assistant care. In 2016, CMS also launched a demonstration program (called the Medicare Care Choices Model (MCCM)) that permits certain FFS beneficiaries who are eligible for hospice (but not enrolled in the

Medicare hospice benefit) to enroll in the demonstration and receive palliative and supportive care from a hospice provider while continuing to receive "curative" care from other providers.¹³ An evaluation of the first three years of experience with the MCCM reported that demonstration participants were more likely to enroll in hospice before death and to do so about a week earlier than comparison group decedents, and the estimated net savings from the demonstration were reported at about \$21 million due to lower acute care costs at the end-of-life among participants (Harris et al. 2020).

In March 2014, the Commission recommended that hospice be included in the MA benefits package, which would give plans greater incentives to develop and test new models aimed at improving end-of-life care and care for beneficiaries with advanced illnesses (Medicare Payment Advisory Commission 2014). As noted earlier, CMMI launched a VBID demonstration in January 2021 that tests, for MA plans participating in the demonstration, the inclusion of hospice services in the MA benefit. MA plans participating in the demonstration may also offer palliative care outside the hospice benefit, transitional concurrent hospice and curative care, and hospice supplemental benefits (e.g., meals, transportation, or additional in-home caregiver support) to enrollees under certain circumstances.

In addition to MA plans, accountable care organizations (ACOs)—which are accountable for a defined Medicare population’s total spending, including end-of-life care and hospice—are entities that could also provide hospice care and potentially reduce costs by implementing policies that would facilitate beneficiaries’ use of end-of-life care in a way that is consistent with their preferences. Research examining the effect of ACOs on patterns of end-of-life care and hospice use are nascent, but findings to date suggest the effects are modest (Gilstrap et al. 2018).

The Commission has also expressed concern about very long hospice stays. In 2019, Medicare spent about \$12.3 billion, nearly 60 percent of hospice spending that year, on patients with stays exceeding 180 days (Table 11-5). About \$4.3 billion of that spending was on additional hospice care for patients who had already received at least one year of hospice services. Although the 2016 changes to the payment structure for RHC reduced payments for long stays and increased payments for short stays to some extent, patients with long stays continue to account for a large share of hospice spending.

Hospice lengths of stay vary by observable patient characteristics, such as patient diagnosis and location, which permits providers to identify and enroll patients likely to have long (more profitable) stays if they believe it is financially advantageous to do so (Table 11-4). For example, Medicare decedents in 2019 with neurological conditions and chronic obstructive pulmonary disease had substantially higher average lengths of stay (155 days and 124 days, respectively) compared with decedents with cancer (52 days). In addition, length of stay varies by the setting in which care is provided. In 2019, average length

**TABLE
11-5**

Nearly 60 percent of Medicare hospice spending in 2019 was for patients with stays exceeding 180 days

	Medicare hospice spending, 2019 (in billions)
All hospice users in 2019	\$20.9
Beneficiaries with LOS >180 days	12.3
Days 1–180	4.1
Days 181–365	3.8
Days 366+	4.3
Beneficiaries with LOS ≤ 180 days	8.6

Note: LOS (length of stay). LOS reflects the beneficiary’s lifetime LOS as of the end of 2019 (or at the time of discharge in 2019 if the beneficiary was not enrolled in hospice at the end of 2019). All spending reflected in the chart occurred only in 2019. Breakout groups do not sum to totals because of rounding.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file and an Acumen LLC data file on hospice lifetime length of stay (which is based on an analysis of historic claims data).

of stay was higher among Medicare decedents whose main care setting was an assisted living facility (ALF) (161 days) or a nursing facility (109 days) compared with home (95 days) (Table 11-4). In particular, hospice patients in ALFs had markedly longer stays compared with other settings, even for the same diagnosis, which warrants further monitoring and investigation in CMS’s medical review efforts. These patterns of differences in length of stay by diagnosis and location of care have persisted over many years.

Lengths of stay vary by type of provider ownership as well as by patient characteristics (Table 11-4). In 2019, average length of stay was substantially longer among for-profit hospices than among nonprofit hospices (112 days compared with 71 days). The reason for longer length of stay among for-profit hospices has two components: (1) for-profit hospices have more patients with diagnoses that tend to have longer stays, and (2) for-profit hospice beneficiaries have longer stays for all diagnoses than beneficiaries who receive care from nonprofit hospices

**TABLE
11-6****Hospices that exceeded Medicare's annual payment cap, 2014-2018**

	2014	2015	2016	2017	2018
Estimated share of hospices exceeding the cap	12.1%	12.3%	12.7%	14.0%	16.3%
Average payments over the cap per hospice exceeding it (in thousands)	\$370	\$316	\$295	\$273	\$334
Payments over the cap as share of overall Medicare hospice spending	1.2%	1.0%	1.0%	1.0%	1.3%
Total Medicare hospice spending in the cap year* (in billions)	\$15.0	\$15.7	\$16.7	\$16.2	\$18.9

Note: The aggregate cap statistics reflect the Commission's estimates and may differ from the CMS claims processing contractors.

*Spending in cap year 2017 reflects an 11-month period from November 1, 2016, to September 30, 2017. For years before 2017, the cap year was defined as the period beginning November 1 and ending October 31 of the following year. Beginning 2018, the cap year is aligned with the federal fiscal year (October 1 to September 30 of the following year).

Source: MedPAC analysis of 100 percent hospice claims standard analytical file, Medicare hospice cost reports, and Medicare Provider of Services file from CMS. Data on total spending are from the CMS Office of the Actuary or MedPAC estimates.

(data not shown). For example, among decedents with a neurological diagnosis, average length of stay was 181 days in for-profit hospices and 121 days in nonprofits. Underlying this difference between for-profit and nonprofit hospices' average length of stay for neurological decedents is variation in length of stay for patients with the longest stays. For example, the 90th percentile length of stay for neurological decedents was substantially higher in for-profit hospices (530 days) compared with nonprofits (362 days).

Several factors contribute to some providers treating more patients with very long stays than other providers. Given the uncertainty associated with predicting life expectancy, some differences across providers in length of stay are expected due to random variation across providers; however, persistent differences in length of stay over time for individual providers suggest additional factors are at work. Since long stays in hospice are more profitable than short stays, financial incentives likely play a role in why some providers treat more patients with very long stays than do other providers. The sources from which providers seek referral may also contribute to length of stay differences. For example, beneficiaries who reside in assisted living facilities tend to have longer stays than beneficiaries residing in other settings, even for the same diagnosis. It is also possible that some providers' interpretations of the hospice eligibility criteria differ from others' interpretations, resulting in some providers

admitting patients for hospice care before other providers would consider them eligible.

Among the hospices with very long stays are those that exceed the hospice aggregate cap. In 2018, we estimate about 16.3 percent of hospices exceeded the aggregate payment cap, an increase from the prior year (14.0 percent in 2017) (Table 11-6).¹⁴ On average, above-cap hospices exceeded the cap by about \$334,000 in 2018, reversing a downward trend in recent years.

Above-cap hospices have fewer patients per year, on average, than below-cap hospices and are more likely to be for-profit, freestanding, recent entrants to the Medicare program and located in urban areas (Table 11-7). Above-cap hospices have substantially longer stays than below-cap hospices, even for patients with similar diagnoses. Above-cap hospices also have substantially higher rates of discharging patients alive than other hospices. As the Commission has noted in past reports, these length-of-stay and live-discharge patterns suggest that above-cap hospices are admitting patients who do not meet the hospice eligibility criteria, which merits further investigation by the Office of Inspector General and CMS.

With the variation in practice patterns across hospices and concerns about potential for some hospices to focus on patients likely to have long stays and high profitability, the Commission has advocated over the years for a targeted

**TABLE
11-7**

Characteristics of above-cap and below-cap hospices, 2018

	Above-cap hospices	Below-cap hospices
Average number of patients per year	120	396
Share of hospices by:		
Date of entry into Medicare program		
Pre-2000	5%	39%
2000–2009	17%	27%
2010 onward	78%	34%
Provider characteristics		
Urban	95%	78%
For profit	98%	64%
Freestanding	97%	76%
Share of patients by diagnosis		
Cancer	15%	26%
Neurological	33%	23%
Heart/circulatory	36%	29%
COPD	6%	5%
Other	10%	17%
Average lifetime length of stay for patients through 2018 (in days; all patients—not limited to decedents)		
Cancer	131	74
Neurological	360	228
Heart/circulatory	274	156
COPD	293	184
Other	197	92
Share of patients discharged alive	39%	16%

Note: COPD (chronic obstructive pulmonary disease). Data on average length of stay reflect lifetime length of stay as of the end of cap year 2018 for all patients who received care during 2018, including patients who were discharged deceased, discharged alive, or remained a patient.

Source: MedPAC analysis of hospice claims file, Medicare hospice cost reports, Medicare Provider of Services file from CMS, and an Acumen LLC data file on hospice lifetime length (which is based on an analysis of historic claims data).

approach to auditing hospice providers, focusing the most resources on providers for which such scrutiny is warranted. In March 2009, the Commission recommended that CMS conduct medical reviews of all hospice stays exceeding 180 days among those hospice providers for which these long stays exceeded a specified share of the provider’s caseload. Similarly, in this report and prior reports, the Commission has expressed concern about very long hospice stays in ALFs among some hospice providers and long stays and high live-discharge rates among above-

cap hospices. The Commission has suggested that more program integrity scrutiny is warranted in those areas.

A targeted auditing approach that shows promise is to focus on providers that receive a high share of their payments for hospice patients before the last year of life. As discussed in detail in our March 2017 report, the share of payments hospice providers receive for a beneficiary’s care before the last year of life varies across providers. A provider with an unusually high share of payments derived

**TABLE
11-8**

Provision of nurse and social worker visits during the last seven days of life has been stable

	2015	2017	2018	2019
Nurse visits in last 7 days of life				
Average number of visits per day	0.59	0.63	0.64	0.66
Average length of each visit (in 15-minute increments)	5.00	4.66	4.56	4.44
Average visit time per day (in 15-minute increments)	2.96	2.92	2.94	2.94
Social worker visits in last 7 days of life				
Average number of visits per day	0.09	0.10	0.10	0.10
Average length of visits (in 15-minute increments)	4.22	4.00	4.02	4.01
Average visit time per day (in 15-minute increments)	0.37	0.40	0.41	0.42

Note: Nurse visits include both registered nurse (RN) and licensed practical nurse (LPN) visits. Although the new payment system makes additional payments only for RN (not LPN) visits in the last days of life, we have included both types of visits in this chart because data specific to RNs are not available for 2015.

Source: MedPAC analysis of 100 percent hospice claims standard analytical file data from CMS.

from care furnished to patients earlier in the disease trajectory—for example, before the last year of life—could signal questionable admitting practices and warrant further program integrity scrutiny of those providers (Medicare Payment Advisory Commission 2017). The recently enacted Consolidated Appropriations Act, 2021, includes additional hospice program integrity provisions that will require additional scrutiny for some hospice providers.

In addition to targeted auditing, other measures could address providers’ aberrant utilization patterns. For example, a compliance threshold policy—similar to the inpatient rehabilitation facility 60 percent rule and long-term care hospital 50 percent rule—could be considered for hospice providers as a way to limit the potential for a subset of providers to profit by pursuing outlier admitting and discharge practices (see text box, pp. 341–344). Furthermore, there may be a role for educational efforts that give physicians information on how the timing of their hospice referrals compares with other physicians. The benefits of such an educational effort could be two-fold, educating physicians about both early and late referrals to hospice.

Visits in the last days of life

One feature of the 2016 hospice payment system modifications is that it provides additional payment for certain visits in the last days of life. The purpose of these additional payments is to compensate hospices for the

higher patient need and visit intensity in the last days of life. The hospice provider is eligible for additional payments for registered nurse and social worker visits that occur during the last seven days of life for patients receiving RHC. These payments are in addition to the base payment that the hospice receives for each day of care. These visits are paid at an hourly rate (up to four hours per day) as a means of targeting the payments toward those hospices that provide more visits in the last days of life.

We estimate that, in calendar year 2019, Medicare paid hospice providers roughly \$167 million for registered nurse and social worker visits in the last seven days of life. We examined the frequency and length of visits that occurred in the last days of life between 2015 and 2019 to see whether they changed over the first three years of the payment system changes. The prevalence and length of visits in the last days of life changed very modestly between 2015 and 2019 (Table 11-8). In that period, overall, a modest increase in nurse visit frequency offset a modest decrease in the length of these visits, with the average visit time per day remaining about 44 minutes (2.94 fifteen-minute increments). Social worker visits in the last days of life were less frequent and changed minimally during this period. Overall, these data continue to suggest that the additional payments for certain visits during the last seven days of life have led to little change in the overall amount of time spent furnishing visits to patients at the end of life.

Marginal profit as a measure of access

Another measure of access is whether providers have a financial incentive to expand the number of Medicare beneficiaries they serve. In considering whether to treat a patient, a provider with excess capacity compares the marginal revenue it will receive (i.e., the Medicare payment) with its marginal costs—that is, the costs that vary with volume. If Medicare payments are larger than the marginal costs of treating an additional beneficiary, a provider has a financial incentive to increase its volume of Medicare patients. In contrast, if payments do not cover the marginal costs, the provider could have a disincentive to care for Medicare beneficiaries.¹⁵ For hospice providers, we find that Medicare payments in 2018 exceeded marginal costs by roughly 16 percent, suggesting that providers with the capacity to do so had a strong incentive to treat Medicare patients. This profit margin is thus a positive indicator of patient access.

Our preceding analysis of access to care relies on data through 2018 and 2019. Only limited information is available on hospice access to care during the 2020 pandemic, mostly from reports of publicly traded hospice companies. These companies report that hospice patient volumes, which were initially down in 2020, have rebounded to near or in some cases above prepandemic levels. Hospice providers report that some nursing facilities and assisted living facilities are restricting access to their facility, which has led to lower patient volume in those settings, while hospice referrals from other sources have increased. Companies report modest, varied effects of the pandemic on hospice length of stay as of third quarter 2020. The effect of the pandemic on the amount of hospice visits received by patients is currently unknown. CMS has permitted hospice providers flexibility during the public health emergency (PHE) to do telehealth visits to supplement in-person visits or substitute for them when there are barriers to in-person visits; providers have generally reported that these flexibilities have been helpful in maintaining access. While there will continue to be effects of the pandemic in 2021, we anticipate that indicators of hospice access to care will remain positive in 2021.

Quality of care: Data on hospice quality are limited

CMS has had a hospice quality reporting program underway for several years, but data on hospice quality are limited. Scores on a composite measure of seven processes of care at hospice admission are very high and scores on

the seven individual process measures are topped out. In the most recent period, providers' performance on a measure of visits in the last three days of life improved slightly, and scores on the Hospice Consumer Assessment of Healthcare Providers and Systems[®] (CAHPS[®]) were stable. It is notable, however, that an Office of Inspector General (OIG) 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.

Hospice performance on process measures

Hospices are required to report data on seven process measures that address important aspects of care for patients newly admitted to hospice. These measures focus on pain screening, pain assessment, dyspnea screening, dyspnea treatment, documentation of treatment preferences, addressing beliefs and values if desired by the patient, and provision of a bowel regimen for patients treated with an opioid. CMS also has a composite measure that reflects the share of admitted patients for whom the hospice performed all seven activities appropriately (or appropriately performed all the activities relevant to the patient).

Hospices' scores on these seven measures related to processes of care at hospice admission are very high. In 2019, median performance ranged from 98.0 percent to 100 percent across the seven individual measures. Performance on the composite measure—reflecting the share of patients for whom all 7 measures were appropriately performed—was slightly lower (93.8 percent) and ranged from 85.6 percent at the 25th percentile to 97.8 percent at the 75th percentile (Table 11-9, p. 328). Although the high scores on these quality measures are encouraging, the Commission has several concerns about these measures. Because they are process measures, it is uncertain how much they affect quality from the perspective of patients and families. The seven individual measures are “topped out,” which CMS defines as scores so high and unvarying that meaningful distinctions and improvement in performance can no longer be made, and the composite measure is nearly topped out. According to the Commission's principles, Medicare quality programs should include population-based measures, such as outcomes, patient experience, and value, and quality measurement should not be unduly burdensome for providers. Therefore, in our view, CMS should retire process measures that are topped out and

**TABLE
11-9**

Scores on the seven hospice process measures are mostly topped out, 2019

Measures of processes of care at admission	Provider percentiles scores on process measures		
	25th	50th	75th
Composite measure of seven processes of care at admission	85.6%	93.8%	97.8%
Seven individual measures			
Treatment preferences	99.8	100.0	100.0
Beliefs and values	98.2	99.7	100.0
Dyspnea screening	98.8	99.8	100.0
Dyspnea treatment	96.6	98.8	100.0
Pain screening	97.2	99.2	100.0
Pain assessment	93.1	98.0	100.0
Bowel regimen	97.2	99.6	100.0
Visits in the last three days of life	81.6	90.2	95.2

Note: For the seven process measures related to care at admission, the numbers in the chart refer to the share of times a hospice appropriately performed a process measure at admission (among patients for whom the process measure was relevant). The composite of all seven process measures represents the share of patients for whom the hospice appropriately performed all seven process measures (or all of the subset of process measures relevant to the patient) at admission.

Source: MedPAC analysis of Hospice Item Set data from CMS.

weakly correlated with health outcomes of importance to beneficiaries and the program.

The quality reporting program also includes a measure of the share of hospice decedents who received at least one registered nurse, physician, nurse practitioner, or physician assistant visit in the last three days of life. Providers’ performance on this measure shows some variation and potential room for improvement among some providers. In 2019, providers’ scores at the 25th, 50th, and 90th percentiles ranged from 81.6 percent, to 90.2 percent, to 95.2 percent, respectively (Table 11-9). Performance on this measure at each of these percentiles has increased slightly (less than a percentage point) since the prior measurement period (January 2018 to December 2018) (data not shown).

Hospice performance on the CAHPS hospice survey

The Hospice Quality Reporting Program requires hospice providers (except new providers and, if they request an exemption, very small providers) to participate in a CAHPS hospice survey. The survey gathers information from the patient’s informal caregiver (typically a family

member) after the patient’s death.¹⁶ The survey addresses aspects of hospice care that are thought to be important to patients and for which informal caregivers are positioned to provide information. In particular, the survey collects information on how the hospice performed in the following areas: communicating, providing timely care, treating patients with respect, providing emotional support, providing help for symptom management, providing information on medication side effects, and training family or other informal caregivers in the home setting.

In the aggregate, hospices’ performance on the CAHPS survey was stable in the most recent period (January 2018 to December 2019) compared with the prior period (January 2017 to December 2018).¹⁷ CAHPS scores were highest on measures related to providing emotional support and treating patients with respect (on average, 90 percent to 91 percent of caregivers chose the most positive response in those areas) (Table 11-10). Scores were lowest in the areas of providing help for pain and symptoms, providing timely care, and training caregivers (on average 75 percent to 78 percent of caregivers chose the most positive response in those areas). In terms of an overall

**TABLE
11-10**

Scores on hospice CAHPS® quality measures, January 2018 to December 2019

	National average	25th percentile	50th percentile	75th percentile
Providing emotional support	90	88	91	93
Caregiver rates hospice 9 or 10	81	77	82	85
Caregiver recommends hospice	84	80	85	89
Treating patients with respect	91	89	91	93
Help for pain and symptoms	75	71	75	79
Hospice team communication	81	77	81	84
Providing timely help	78	74	78	83
Caregiver training	76	72	76	80

Note: CAHPS® (Consumer Assessment of Healthcare Providers and Systems®). These scores reflect the share of respondents who reported the “top-box” — meaning the most positive survey response. The national average score is across providers. The percentile scores reflect provider-level performance data.

Source: MedPAC analysis of Hospice CAHPS data from CMS for period January 2018–December 2019.

assessment of the hospice provider, about 81 percent of caregivers rated the hospice a 9 or 10 on a 10-point scale, and about 84 percent would definitely recommend the hospice to others on average. While average hospice CAHPS scores have been steady, we lack an absolute benchmark for performance on these measures to judge how much potential room for improvement remains. Although 100 percent is theoretically a benchmark for performance, we would not necessarily expect a provider furnishing high-quality care to receive positive scores from 100 percent of caregivers. Nonetheless, with some measures showing average performance in the mid-70 percent range and with some variation in performance across providers, opportunities for improvement likely exist.

A recent Government Accountability Office (GAO) study examined hospices’ performance on the hospice item set process measures and the CAHPS survey, focusing on differences by type of ownership (Government Accountability Office 2019). In general, GAO found that average scores were similar for for-profit and nonprofit providers. However, GAO analyzed the 10 percent of providers with the lowest scores on these quality measures and found that for-profit providers accounted for a disproportionate share of the lowest scoring decile.

Another source of information on quality comes from an OIG report examining data from state survey agencies and accrediting organizations on deficiencies of and complaints about hospice providers (Office of Inspector General 2019). OIG found serious deficiencies or severe complaints among a small group of providers and more common deficiencies in compliance with regulatory requirements among a broader set of providers. Over the five years from 2012 to 2016, OIG found that 80 percent of hospices had at least one deficiency, and 20 percent of hospices had at least one serious deficiency. Most common deficiencies were failure to meet certain care planning requirements, lack of timely aide supervision, and deficiencies related to patient assessments. OIG also found that one-third of hospice providers had at least one complaint filed against them over the five-year period (including complaints that were and were not substantiated). OIG identified a group of 313 hospice providers as poor performers in 2016, defined as providers that had at least one serious deficiency or one substantiated severe complaint that year. Most of the 313 poor performers had prior deficiencies or complaints, and 40 of these providers had at least one prior serious deficiency or substantiated severe complaint.

With quality measurement in general, the Commission consistently maintains that outcome measures are preferable to process measures. Although outcome

**TABLE
11-11**

Rates of hospice live discharge and reported reason for discharge, 2017-2019

Category	2017	2018	2019
Live discharges as a share of all discharges, by reason for live discharge			
All live discharges	16.7%	17.0%	17.4%
No longer terminally ill	6.5	6.3	6.5
Beneficiary revocation	6.4	6.6	6.5
Transferred hospice providers	2.1	2.2	2.3
Moved out of service area	1.4	1.6	1.7
Discharged for cause	0.3	0.3	0.3
Providers' overall rate of live discharge as a share of all discharges, by percentile (for providers with more than 30 discharges)			
10th percentile	8.5%	8.5%	8.6%
25th percentile	12.2	12.0	12.3
50th percentile	18.1	17.9	18.9
75th percentile	27.1	27.8	29.5
90th percentile	41.4	42.5	46.6

Note: Percentages may not sum to total due to rounding. "All discharges" includes patients discharged alive or deceased.

Source: MedPAC analysis of the 100 percent hospice claims standard analytical file, Medicare hospice cost reports, and Medicare Provider of Services file from CMS.

measures for hospice are particularly challenging, the Commission believes outcome measures such as patient-reported pain and other symptom-management measures merit further exploration. CMS is currently developing a new patient assessment instrument for hospice, the Hospice Outcomes & Patient Evaluation (HOPE) instrument. An interim report by CMS's contractor Abt Associates indicates that the instrument will be designed to collect information on patients' and families' needs at different points throughout an episode (not just at admission and discharge) and is intended to support the development of outcome measures related to symptoms such as pain (Abt Associates 2020).

CMS is also considering use of a claims-based quality measure, referred to as the Hospice Care Index, that would identify hospice providers with unusual patterns of care (Centers for Medicare & Medicaid Services 2020a). The measure would use claims data in several domains to identify hospice providers with outlier utilization and provision of services compared with other hospice

providers. In January 2021, CMS presented a specification to the National Quality Forum Measure Applications Partnership for the hospice care index that would identify outlier utilization patterns across 10 indicators: 4 related to the provision of visits (i.e., weekend skilled nurse visits, gaps in nurse visits, amount of nurse visit minutes, visits near the of life), 4 related to live discharges and burdensome transitions, 1 related to per beneficiary spending, and 1 related to provision of high acuity care (i.e., continuous home care and general inpatient care) (National Quality Forum 2021). At this time, it is unknown whether CMS will pursue adoption of this measure.

The Commission has over the years raised concern about hospice providers with unusually high live discharge rates compared with other hospice providers. Hospice providers are expected to have some live discharges because some patients change their mind about using the hospice benefit and disenroll from hospice or their condition improves and they no longer meet the hospice eligibility criteria.

However, claims data showing providers with substantially higher rates of live discharge than their peers could signal a problem with quality of care or program integrity, such as a hospice provider not meeting the needs of patients and families or admitting patients who do not meet the eligibility criteria.

In 2019, the aggregate rate of live discharge (that is, live discharges as a share of all discharges) was 17.4 percent (Table 11-11) and has been on a slight upward trend since 2017. In 2019, hospice claims data show “beneficiary revocation” and “beneficiary not terminally ill” as the most common reasons for live discharge, each accounting for 6.5 percent of all discharges that year.

Live-discharge rates vary by patient diagnosis. In 2019, the rate was higher for hospice beneficiaries with chronic obstructive pulmonary disease (26 percent), neurological conditions (21 percent), and heart and circulatory conditions (20 percent) than for those with cancer (12 percent) or other diagnoses (14 percent) (data not shown). The diagnoses that tend to have higher live-discharge rates are the same diagnoses that tend to have longer stays (lengths of stay by diagnosis are shown in Table 11-4, p. 322).

Some providers have unusually high live-discharge rates. In 2019, among providers with more than 30 discharges, the median live-discharge rate was about 19 percent, but 10 percent of providers had live-discharge rates in excess of 46 percent (Table 11-11). Hospices with very high live-discharge rates were disproportionately for-profit and recent entrants to the Medicare program (entered in 2010 or after) and had an above-average rate of exceeding the aggregate payment cap (data not shown). Small hospices as a group also had substantially higher than average live-discharge rates—45 percent for hospices with 30 or fewer discharges compared with 17 percent for hospices of all sizes.

Our analysis focuses on the broadest measure of live discharges, including live discharges initiated by the hospice (because the beneficiary is no longer terminally ill or because the beneficiary is discharged for cause) and live discharges initiated by the beneficiary (because the beneficiary revokes his or her hospice enrollment, transfers hospice providers, or moves out of the area). Some stakeholders argue that live discharges initiated by the beneficiary—such as revocation of his or her hospice enrollment—should not be included in a live-discharge measure because, some stakeholders assert, these discharges reflect beneficiary preferences and are

not in the hospice’s control. Because beneficiaries may choose to revoke hospice for a variety of reasons, which in some cases are related to the hospice provider’s business practices or quality of care, we include revocations in our analysis. A CMS contractor, Abt Associates, found that rates of live discharge—due to beneficiary revocations and discharges because beneficiaries are no longer terminally ill—increase as hospice providers approach or surpass the aggregate cap (Plotzke et al. 2015). The contractor report suggested this pattern could reflect hospice-encouraged revocations or inappropriate live discharges and merit further investigation.

Providers’ access to capital: Hospices have good access to capital

Hospices in general are not as capital intensive as other provider types because they do not require extensive physical infrastructure (although some hospices have built their own inpatient units, which require significant capital). Overall, access to capital for hospices appears adequate, given the continued entry of for-profit providers in the Medicare program.

In 2019, the number of for-profit providers grew by about 6.3 percent, indicating that capital has been accessible to these providers. Although the pandemic affected hospice providers’ operations in a number of ways, financial reports from publicly traded hospice companies for the third quarter of 2020 were generally favorable: These companies reported revenue growth, favorable margins, or both. After an initial decline in patient volume at the outset of the pandemic, publicly traded firms also reported that hospice patient admissions, average daily census, or both had returned to near, similar, or above prepandemic levels. Reports from publicly traded companies that have multiple lines of business suggest that the pandemic generally had less of an effect on volume for their hospice providers than for some other types of providers. According to financial reports, at the end of 2020, the hospice sector continued to garner investment interest and is expected to continue to do so in 2021. Several publicly traded hospice firms expressed interest in acquiring additional hospice providers. According to an executive of one publicly traded company, the hospice sector offers growth opportunities and margin levels that are favorable compared with the health care sector overall (Amedisys 2020). It is also notable that CMS’s changes to the hospice payment system in 2016 have generally been viewed as modest.

**TABLE
11-12****Total hospice costs per day varied
by type of provider, 2018**

	Average total cost per day
All hospices	\$148
Freestanding	142
Home health based	159
Hospital based	213
For profit	130
Nonprofit	175
Above cap	134
Below cap	150
Urban	150
Rural	136

Note: Data reflect aggregate costs per day for all types of hospice care combined (routine home care, continuous home care, general inpatient care, and inpatient respite care) for all payers. "Days" reflects the total number of days for which the hospice is responsible for care of its patients, regardless of whether the patient received a visit on a particular day. Data are not adjusted for differences in case mix or wages across hospices.

Source: MedPAC analysis of Medicare hospice cost reports and Medicare Provider of Services file from CMS.

Among nonprofit freestanding providers, less is known about access to capital, which may be limited. Hospital-based and home health-based nonprofit hospices have access to capital through their parent providers, which currently appear to have adequate access to capital in both sectors.

A provider's total margin—which reflects how its total revenues compare with its total costs for all lines of business and all payers—can influence a provider's ability to obtain capital. Irregularities in how some hospices report data on their total revenues and total expenses on their cost reports prevent us from calculating a reliable estimate of total margins for hospices. Among hospice payers, however, Medicare accounts for about 90 percent of hospice days, and hospices' Medicare margins are strong.

Medicare payments and providers' costs

As part of our assessment of payment adequacy, we examine the relationship between Medicare payments

and providers' costs by considering whether current costs approximate what providers are expected to spend on the efficient delivery of high-quality care. Medicare margins illuminate the relationship between Medicare payments and providers' costs. Specifically, we examined margins through the 2018 cost reporting year, the latest period for which complete cost report and claims data were available.¹⁸ To understand the variation in margins across providers, we also examined the variation in costs per day across providers.

Hospice costs

Hospice costs per day vary substantially by type of provider (Table 11-12), which is one reason for differences in hospice margins across provider types. In 2018, hospice costs per day across all hospice providers averaged about \$148, about the same as the previous year's average. The flat average cost per day between 2017 and 2018 is partly accounted for by a shift in the mix of hospice days, with the share of days accounted for by RHC (the lowest cost level of care) increasing in 2018.^{19,20} Freestanding hospices had lower costs per day than provider-based hospices (i.e., home health-based hospices and hospital-based hospices). For-profit, above-cap, and rural hospices also had lower average costs per day than their respective counterparts.

Many factors contribute to variation in hospice costs across providers. One factor is length of stay. Hospices with longer stays have lower cost per day on average. Freestanding and for-profit hospices have substantially longer stays than other hospices and as a result have lower costs per day (Table 11-4, p. 322). Another factor relates to overhead costs. Included in the costs of provider-based hospices are overhead costs allocated from the parent provider, which contributes to provider-based hospices' higher costs compared with freestanding providers. The Commission maintains that payment policy should focus on the efficient delivery of services and that if freestanding hospices are able to provide high-quality care at a lower cost than provider-based hospices, payment rates should be set accordingly; the higher costs of provider-based hospices should not be a reason for increasing Medicare payment rates.

Table 11-13 presents estimates of hospice costs by level of care for freestanding and provider-based hospices in 2018. In that year, the payment rates by level of care (routine home, continuous home, general inpatient, and

**TABLE
11-13**

Hospice costs and payment rates by level of care, 2018

Category	2018 cost per day*				FY 2018 payment rate per day*	Share of days 2018
	Average	25th percentile	50th percentile	75th percentile		
Routine home care	\$132	\$110	\$131	\$159	\$164	98.2%
General inpatient care	915	525	808	1,195	744	1.2
Inpatient respite care	530	219	298	510	173	0.3
Continuous home care* (dollars per hour)	48	19	47	81	41	0.2

Note: FY (fiscal year). Medicare payment rates and costs are rounded to the nearest dollar.

*Cost estimates and payment rates reflect dollars per day except for continuous home care, which is dollars per hour.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims data, and Provider of Services file from CMS.

inpatient respite care) were out of balance relative to estimated costs. The costs for RHC, which account for the vast majority of days in hospice, averaged \$132 per day, while the payment rate averaged \$164. Medicare’s payment rate for the other three less frequently provided levels of care was lower than the average and median costs per day for freestanding providers. For example, in 2018, the estimated cost per day for general inpatient care was \$915 on average and \$808 at the median, compared with a payment rate of \$744. The fiscal year 2020 rebasing raised the payment rates for CHC, IRC, and GIP substantially to address the gap between estimated costs and payment rates seen in Table 11-13. The fiscal year 2020 payment rate for RHC was reduced slightly (2.72 percent) to maintain budget neutrality, but it remains substantially above estimated cost.

Hospice margins

In 2018, the aggregate Medicare margin for hospice providers was 12.4 percent, similar to 2017 (12.5 percent) (Table 11-14, p. 334).²¹ Medicare margins varied widely across individual hospice providers: –5.0 percent at the 25th percentile, 11.7 percent at the 50th percentile, and 25.3 percent at the 75th percentile (data not shown). Our estimates of Medicare margins exclude overpayments to above-cap hospices and are calculated based on Medicare-allowable, reimbursable costs consistent with our approach in other Medicare sectors.²²

We excluded nonreimbursable bereavement costs from our margin calculations. The statute requires that hospices

offer bereavement services to family members of their deceased Medicare patients (Section 1861(dd)(2)(A)(i) of the Social Security Act); however, the statute prohibits Medicare payment for these services (Section 1814(i)(1)(A)). Hospices report the costs associated with bereavement services on the Medicare cost report in a nonreimbursable cost center. If we included bereavement costs from the cost report in our margin estimate, it would reduce the 2018 aggregate Medicare margin by at most 1.3 percentage points. This figure likely overestimates the bereavement costs associated with Medicare hospice patients because, in addition to bereavement costs associated with hospice patients, the estimate could include the costs of community bereavement services offered to the family and friends of decedents who were not enrolled in hospice. Also, some hospices fund bereavement services through donations. Hospice revenues from donations are not included in our margin calculations.

We also exclude nonreimbursable volunteer costs from our margin calculations. As discussed in our March 2012 report, the statute requires Medicare hospice providers to use some volunteers in the provision of hospice care. Costs associated with recruiting and training volunteers are generally included in our margin calculations because they are reported in reimbursable cost centers. The only volunteer costs that would be excluded from our margins are those associated with nonreimbursable cost centers. It is unknown what costs are included in the volunteer

**TABLE
11-14**

Hospice Medicare margins by selected characteristics, 2014–2018

Category	Share of hospices 2018	2014	2015	2016	2017	2018
All	100%	8.2%	9.9%	10.9%	12.5%	12.4%
Freestanding	80	11.6	13.8	14.0	15.3	15.1
Home health based	10	3.5	3.3	6.2	8.1	8.4
Hospital based	10	-20.8	-23.8	-16.7	-13.8	-16.5
For profit	70	15.3	17.7	17.9	20.0	19.0
Nonprofit	27	-0.4	0.1	2.2	2.5	3.8
Urban	81	8.7	10.4	11.4	12.9	12.6
Rural	19	3.3	4.8	6.3	8.9	10.3
Patient volume (quintile)						
Lowest	20	-4.9	-5.3	-3.1	-1.1	-3.1
Second	20	2.0	4.3	6.2	6.7	5.6
Third	20	9.8	10.7	11.2	13.8	13.8
Fourth	20	9.9	13.0	13.1	15.2	14.0
Highest	20	8.4	9.9	11.1	12.5	12.7
Below cap	83.7	8.4	9.9	10.7	12.6	12.5
Above cap (excluding cap overpayments)	16.3	6.0	9.8	12.6	12.1	10.1
Above cap (including cap overpayments)	16.3	18.8	21.4	20.2	21.9	21.8

Note: Margins for all provider categories exclude overpayments to above-cap hospices, except where specifically indicated. Margins are calculated based on Medicare-allowable, reimbursable costs. Margin by hospice ownership status is based on hospices' ownership designation from the Medicare cost report. The rural and urban definitions used in this chart are based on updated definitions of the core-based statistical areas (which rely on data from the 2010 census).

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytical file, and Medicare Provider of Services file from CMS.

nonreimbursable cost center. If nonreimbursable volunteer costs were included in our margin calculation, it would reduce the aggregate Medicare margin by 0.4 percentage point.

Hospice margins vary by provider characteristics, such as type of hospice (freestanding or provider based), type of ownership (for profit or nonprofit), patient volume, and urban or rural location (Table 11-14). In 2018, freestanding hospices had higher margins (15.1 percent) than home health–based or hospital-based hospices (8.4 percent and -16.5 percent, respectively) (Table 11-14). Provider-based hospices typically have lower margins than freestanding hospices for several reasons, including their shorter stays and the allocation of overhead costs from the parent provider to the provider-based hospice. In 2018,

the aggregate Medicare margin was considerably higher for for-profit hospices (19.0 percent) than for nonprofit hospices (3.8 percent). The margin for freestanding nonprofit hospices was higher (7.6 percent) than the margin for nonprofit hospices overall (data not shown). Generally, hospices' margins vary by the provider's volume—hospices with more patients have higher margins on average. Hospices in urban areas have a slightly higher overall aggregate Medicare margin (12.6 percent) than those in rural areas (10.3 percent).

In 2018, above-cap hospices had favorable margins even after the return of overpayments. Above-cap hospices had a margin of about 21.8 percent before the return of overpayments but had a margin of 10.1 percent after

the return of overpayments. The margin for below-cap hospices was 12.5 percent.

Hospice profitability is closely related to length of stay. Hospices with longer stays have higher margins. For example, in an analysis of hospice providers based on the share of their patients' stays exceeding 180 days, the average margin ranged from -3.0 percent for hospices in the lowest quintile to 21.7 percent for hospices in the second highest quintile (Table 11-15). Hospices in the quintile with the greatest share of their patients exceeding 180 days had a 15.5 percent average margin after the return of cap overpayments, but without the hospice aggregate cap, these providers' margins would have averaged 21.7 percent (latter figure not shown in table).

Hospices with a large share of patients in nursing facilities and assisted living facilities (ALFs) also have higher margins than other hospices (Table 11-16, p. 336). For example, in 2018, the 50 percent of hospices with the highest share of patients residing in nursing facilities had a margin of about 15 percent compared with a roughly 9 percent margin for providers with fewer nursing facility patients. For the half of providers with the largest share of patients residing in ALFs, the margin was about 15 percent, compared with a margin of about 8 percent for other hospices. Some of the difference in margins among hospices with different concentrations of nursing facility and ALF patients was driven by differences in their patients' diagnostic profile and length of stay. However, hospices may find caring for patients in facilities more profitable than caring for patients at home for reasons in addition to length of stay. As discussed in our June 2013 report, there may be efficiencies in treating hospice patients in a centralized location in terms of mileage costs and staff travel time, as well as facilities serving as referral sources for new patients. Nursing facilities can also be a more efficient setting for hospices to provide care because of the overlap in responsibilities between the hospice and the nursing facility. Analyses in our June 2013 report suggest that a reduction to the RHC payment rate for patients in nursing facilities is warranted because of this overlap (Medicare Payment Advisory Commission 2013).

Our 2018 margin estimates reflect hospices' financial performance in the third year of the new RHC payment structure, which began in January 2016. CMS's payment reforms—which move away from a single base rate for RHC to a two-tiered base rate and provide additional

**TABLE
11-15**

**Hospice Medicare margins
by length of stay, 2018**

Hospice characteristic	Medicare margin
Average length of stay	
Lowest quintile	-2.8%
Second quintile	8.5
Third quintile	16.8
Fourth quintile	20.8
Highest quintile	17.6
Share of stays >180 days	
Lowest quintile	-3.0
Second quintile	7.5
Third quintile	18.4
Fourth quintile	21.7
Highest quintile	15.5

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports, Common Medicare Enrollment file, 100 percent hospice claims standard analytical file, and Medicare Provider of Services file from CMS.

payments for certain visits in the last seven days of life—were expected to modestly reduce the variation in profitability across hospices. In fact, the variation across providers by length of stay initially narrowed, but widened in 2018. When providers were grouped based on the share of their patients' stays exceeding 180 days, in 2015 (the year before the payment changes) the spread in margins between the lowest length-of-stay quintile (-8.9 percent) and the second highest length-of-stay quintile (20.4 percent) was over 29 percentage points. By 2017, the difference in margins across those length-of-stay quintiles had narrowed to 22 percentage points (as shown in our March 2020 report). However, in 2018, the difference in margins across those quintiles increased to about 26 percentage points, nearing the variation in margins that existed before the payment system changes.

Projecting margins for 2021

To project the aggregate Medicare margin for 2021, we model the policy changes that went into effect between

**TABLE
11-16**

Hospice Medicare margins by providers' share of patients residing in facilities, 2018

Hospice characteristic	Medicare margin
Share of patients in nursing facilities	
Lowest half	9.3%
Highest half	14.8
Share of patients in assisted living facilities	
Lowest half	7.7
Highest half	15.2

Note: Margins for all provider categories exclude overpayments to above-cap hospices. Margins are calculated based on Medicare-allowable, reimbursable costs.

Source: MedPAC analysis of Medicare hospice cost reports, 100 percent hospice claims standard analytical file, and Medicare Provider of Services file from CMS.

2018 (the year of our most recent margin estimates) and 2021. The policies include annual payment updates in 2019, 2020, and 2021 of 1.8 percent, 2.6 percent, and 2.4 percent, respectively. The updates for these years reflect the market basket update, a productivity adjustment, and, for 2019, an additional legislated adjustment of -0.3 percentage point. In addition, in response to the coronavirus PHE, the Congress suspended the 2 percent sequester from May 2020 to March 2021, which effectively increased Medicare payment rates by 2 percentage points for the first half of fiscal year 2021. An area of uncertainty stemming from the pandemic is providers' cost growth. While hospice providers are likely to face some additional costs related to the pandemic (e.g., costs of personal protective equipment, testing, and telehealth equipment), certain regulatory flexibilities granted during the PHE (e.g., greater use of telehealth and suspension of some training and supervision requirements) may yield some offsetting cost savings. Overall, we do not anticipate a substantial shift in hospices' cost structure as a result of the pandemic. For our 2021 margin projection, we assume a rate of cost growth equal to the projected growth in the market basket (which is slightly higher than hospice cost growth in recent years). Taking these factors into account, for 2021, we project an aggregate

Medicare margin for hospices of 13 percent. This margin projection excludes nonreimbursable costs associated with bereavement services and volunteers (which, if included, would reduce the aggregate margin by at most 1.3 percentage points and 0.4 percentage point, respectively).

Policy to modify the hospice aggregate cap

Last year, in the March 2020 report, the Commission determined that the aggregate level of hospice payments exceeded the amount necessary to provide high-quality care and that payments could be reduced in 2021. Rather than recommend an across-the-board reduction, the Commission recommended payments in fiscal year 2021 be frozen at the fiscal year 2020 levels and that the aggregate level of payments be reduced through a policy to modify the cap.

The Commission recommended that the aggregate cap be wage adjusted and reduced by 20 percent (Medicare Payment Advisory Commission 2020). Because the hospice payments are wage adjusted but the aggregate cap is not, the cap is stricter in some areas of the country than others. Wage adjusting the cap would make it equitable across all providers.²³ The Commission also recommended that the aggregate cap be reduced by 20 percent. This reduction to the cap would focus payment reductions on providers with disproportionately long stays and high margins, while leaving the majority of providers unaffected by the cap reduction. The Congress has yet to act on the Commission's recommendation to modify the aggregate cap.

Given that our findings are similar this year with regard to payment adequacy (e.g., a strong aggregate Medicare margin but wide variation in profitability by length of stay), the rationale for the Commission's March 2020 cap recommendation stands. Last year, we simulated the effect of the cap recommendation using historical data (2017). We have repeated that simulation with the most recently available data (2018) to provide an updated sense of its impact. An important caveat to our simulations of the hospice cap policy is that the simulation is based on historical data and makes no projections or behavioral assumptions.

Under the Commission's cap recommendation, we estimate the share of hospices exceeding the cap would increase, while many providers would remain well under the cap. In our simulation, the estimated share of hospices exceeding the cap in 2018 would change from

**TABLE
11-17**

Simulated share of providers exceeding the aggregate cap in 2018 under rebasing and a policy to modify the aggregate cap

	Share of providers exceeding the cap	
	2018 actual	2018 simulated with rebasing and modified cap
All	16%	28%
Freestanding	20	34
Home health based	5	11
Hospital based	0	1
For profit	23	39
Nonprofit	1	5
Urban	19	32
Rural	4	14

Note: This analysis simulates the effect of rebasing and the policy to wage adjust and reduce the cap by 20 percent using 2018 data. The simulation assumes no changes in utilization in response to the policy.

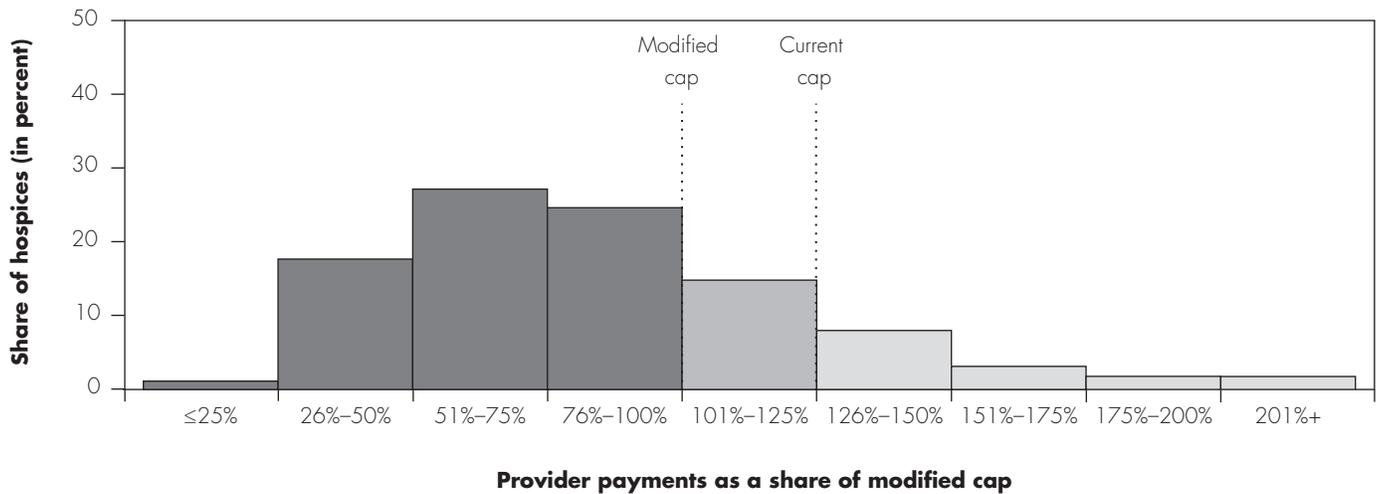
Source: MedPAC analysis of Medicare claims data for hospice providers.

16 percent (the estimated actual rate) to 28 percent under the policy to wage adjust and reduce the cap (Table 11-17).²⁴ The additional providers estimated to exceed the cap under the proposed policy are predominantly for profit (92 percent) and freestanding (94 percent), with a long average length of stay (249 days) and a high 2018 aggregate Medicare margin (22 percent) (data not shown). Despite the estimated increase in the share of hospices exceeding the cap, a sizable share of providers would remain substantially below the cap (Figure 11-2, p. 338). Under the modified cap policy, if a provider’s payments as a share of the modified cap is less than 100 percent, the provider remains below the cap. Across all providers, our simulation finds that nearly half (46 percent) of hospices would be at least 25 percent below the cap under this policy (i.e., payments as a share of the modified cap would be less than or equal to 75 percent). As described in detail in our March 2020 report, a greater share of rural hospices, nonprofit hospices, and provider-based hospices would be substantially below the cap than the overall share of hospices nationally.

We estimate the cap policy would have reduced aggregate Medicare program payments in 2018 by about 3.2 percent (assuming no changes in utilization). The reductions

in payments would occur among a subset of providers with disproportionately long stays and high margins. For example, our simulation finds that the cap policy change would reduce payments for hospices in the top two length-of-stay quintiles (by about 5 percent in the fourth quintile and about 15 percent in the fifth (highest) quintile), while payments for other hospices would remain largely unchanged (Table 11-18, p. 339). The effects of the cap policy by category of hospice provider depends on the prevalence of providers in each category with disproportionately long stays. Per category, for-profit and freestanding hospices are estimated to have reduced payments under the policy to modify the cap, while payments to nonprofit and hospital-based providers (the two groups with the lowest margins) would be largely unaffected.

Under the modified cap policy, we expect that beneficiaries will continue to have good access to hospice care. As we discussed in our March 2020 report, the current aggregate cap in 2020 is equivalent to the amount that Medicare pays for a routine home care stay of about 179 days (assuming a wage index of 1.0). Because the cap is applied in the aggregate across the provider’s entire

**FIGURE
11-2****Many hospices would remain substantially below the cap under the modified cap policy**

Note: The figure simulates the amount that providers would have been above or below the cap in 2018 under rebasing and the policy to wage adjust and reduce the aggregate cap by 20 percent. This simulation assumes no changes in utilization in response to the policy changes. New providers that enter Medicare after the start of the cap year do not have cap overpayments calculated and are not included in this chart.

Source: MedPAC analysis of Medicare claims data for hospice providers.

patient population (including both short and long stays) and not at the individual level, a hospice provider can provide a substantial amount of long stays and remain under the cap. For example, consider a hypothetical hospice with a wage index of 1.0 whose patients received only RHC. Under the current cap, in cap year 2020, if half of the hospice's patients each had a length of stay of 30 days, the other half could have an average length of stay of up to 335 days before that provider would exceed the 2020 cap.²⁵ The length-of-stay patterns in this hypothetical example are much longer than typical for the hospice population (both for patients with short and long stays), demonstrating the extent to which hospices that exceed the current cap have outlier utilization patterns. In the hypothetical example, if the hospice cap were reduced by 20 percent, the hospice provider could have half of its patients with 30-day stays and the other half with an average stay of 257 days before the provider would exceed the reduced aggregate cap amount.

There is evidence suggesting that some hospices are inappropriately using live discharges as a way to limit their

cap liabilities. CMS and the Office of Inspector General should monitor this type of behavior under current policy and any changes under a policy to reduce the cap. In addition, there could be merit in considering a payment penalty for hospices with unusually high rates of live discharges. For example, live-discharge rates could be included in a compliance threshold policy as discussed in the text box on potential directions for payment policy, pp. 341–344.

In aggregate, both urban and rural providers are estimated to experience reduced payments under the cap policy modification; however, these payment reductions would occur among the subset of urban and rural providers with disproportionately long stays and high margins. For example, both urban and rural providers in the two highest length-of-stay quintiles had substantial profit margins in 2018, with payment-to-cost ratios ranging from 1.19 to 1.30; they would experience payment declines under the cap policy modification, as seen in Table 11-19 (p. 340). Table 11-19 also shows that rural providers with fewer long-stay patients and lower margins (e.g., providers in the

**TABLE
11-18**

Simulated effect on hospice payments of the policy to modify the aggregate cap

**Percent change in Medicare payments based on simulation of cap policy:
Wage adjust and reduce the cap by 20%**

All	-3.2%
Freestanding	-3.7
Home health based	-1.2
Hospital based	0.0
For profit	-5.3
Nonprofit	-0.4
Urban	-3.2
Rural	-3.8
Share of stays >180 days	
Lowest quintile	0.0
Second quintile	0.0
Third quintile	-0.1
Fourth quintile	-4.7
Highest quintile	-14.5

Note: This analysis, using 2018 data, simulates the policy to wage adjust and reduce the cap by 20 percent. The simulation assumes no changes in utilization in response to the policy. The figures reported here by ownership are based on the hospice ownership designation in the Medicare cost report.

Source: MedPAC analysis of Medicare claims and cost report data for hospice providers from CMS and an Acumen LLC data file on hospice lifetime length (which is based on an analysis of historic claims data).

two lowest length-of-stay quintiles) would see no change in their payments under the policy to modify the cap.

How should Medicare payments change in 2022?

The indicators of payment adequacy for hospices—beneficiary access to care, quality of care, provider access to capital, and Medicare payments relative to providers’ costs—are positive. The Commission has concluded that aggregate payments are more than sufficient to cover providers’ costs and that the payment rates in 2022 should be held at their 2021 levels. In addition, the Commission has concluded that aggregate payments should be reduced

by wage adjusting and reducing the hospice aggregate cap, an approach that focuses payment reductions on providers with the longest stay and high margins.

RECOMMENDATION 11

For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for hospice and wage adjust and reduce the hospice aggregate cap by 20 percent.

RATIONALE 11

Our indicators of access to care are positive, and there are signs that the aggregate level of payment for hospice care exceeds the level needed to furnish high-quality care to beneficiaries. The number of providers, number of beneficiaries enrolled in hospice, days of hospice care,

**TABLE
11-19**

Simulated effect of rebasing and policy to modify the aggregate cap on 2018 payment-to-cost ratios for urban and rural hospices

2018 payment-to-cost ratios

Providers grouped by share of stays greater than 180 days	All providers		Urban providers		Rural providers	
	Actual	Simulated with rebasing and policy to wage adjust and reduce cap	Actual	Simulated with rebasing and policy to wage adjust and reduce cap	Actual	Simulated with rebasing and policy to wage adjust and reduce cap
Lowest quintile	0.97	0.99	0.98	1.00	0.92	0.93
Second quintile	1.07	1.08	1.07	1.09	1.04	1.04
Third quintile	1.21	1.20	1.21	1.20	1.17	1.16
Fourth quintile	1.28	1.21	1.27	1.20	1.30	1.27
Highest quintile	1.20	1.01	1.19	1.02	1.29	1.00

Note: This analysis, using 2018 data, simulates the effect of rebasing and policy to wage adjust and reduce the cap by 20 percent. The simulation assumes no changes in utilization in response to the policy.

Source: MedPAC analysis of Medicare claims and cost report data for hospice providers.

and average length of stay increased in 2019. In 2018, the rate of marginal profit was 16 percent. As the number of for-profit providers increased by 6.3 percent, access to capital appears strong. The aggregate Medicare margin in 2018 was 12.4 percent, nearly the same as the prior year. The projected 2021 margin is 13 percent. Given the margin in the industry and our other positive payment adequacy indicators, we anticipate that the aggregate level of payments could be reduced and would still be sufficient to cover providers' costs. In light of the differential financial performance across providers, the Commission's recommendation would keep the payment rates unchanged in 2022 at the 2021 levels for all providers and would also restate the Commission's March 2020 recommendation to modify the hospice aggregate cap to focus payment reductions on providers with disproportionately long stays and high margins. Our recommendation would bring aggregate payments closer to costs, would lead to savings for beneficiaries and taxpayers, and would be consistent with the Commission's principle that it is incumbent on Medicare to maintain financial pressure on providers to constrain costs.

IMPLICATIONS 11

Spending

- Under current law, hospices are projected to receive an update in fiscal year 2022 equal to 2.4 percent (based on a projected market basket of 2.7 percent and a projected productivity adjustment of 0.3 percent). Our recommendation would decrease federal program spending relative to the statutory update by \$750 million to \$2 billion in one year and between \$5 billion and \$10 billion over five years.

Beneficiary and provider

- We do not expect this recommendation to have an adverse effect on beneficiaries' access to care. This recommendation is not expected to affect providers' willingness or ability to care for Medicare beneficiaries. ■

Potential hospice payment policy directions

CMS has taken steps to improve payment accuracy in the hospice payment system but concerns remain about distortions in the system that favor long stays, wide variability in profitability by length of stay, and aberrant utilization patterns among some hospice providers. Several policy directions could be considered in the future to address these issues, including adjustments to the routine home care (RHC) payment levels, episode-based payment, and compliance threshold policies.

RHC payment levels and u-shaped curve

In January 2016, CMS implemented reforms to the hospice payment system that represented the first changes to the payment structure since the benefit's inception in 1983. CMS moved from paying a single, uniform, daily rate for RHC to two per diem rates for days 1 to 60 and 61 and beyond (\$199 and \$157 per day, respectively, in 2021). Medicare also pays an additional amount (\$60 per hour in 2021) for registered nurse and social worker visits that occur during the last seven days of life (up to four hours per day) for patients receiving RHC.

These modifications to the RHC payment structure were intended to better align payments with the costs of providing hospice care throughout an episode. Because hospices tend to provide more services at the beginning and end of an episode and fewer in the middle, long stays were more profitable than short stays under a flat per diem payment rate. In March 2009, the Commission recommended that Medicare move away from the flat per diem to one that is higher at the beginning and end of an episode and lower in the intervening period. The RHC payment structure that CMS implemented in 2016 moves in this direction and has modestly reduced the variability in profitability by length of stay.

Opportunities exist to refine the RHC payment structure to more closely resemble the u-shaped cost structure reflected in hospice visit patterns throughout an episode. Such changes could be a step toward improving payment accuracy and could modestly reduce payments for long stays, but would not be expected to substantially alter incentives under the hospice payment system for long hospice stays.

CMS established the two RHC payment rates using Medicare claims data on hospice visit minutes throughout patient episodes. CMS estimated the labor costs associated with these visit minutes using data on wages and benefits for the different types of staff furnishing the visits. Taking a similar approach, Figure 11-3 (p. 342) shows our estimate of the average labor cost associated with visits throughout an episode using 2018 data. The labor cost estimates reflect only time spent with the patient (and do not reflect travel time, phone calls (except for social worker phone calls), or care coordination or care management that occurs outside of the presence of the patient).

Labor costs associated with visits for patients receiving RHC are highest in the first few days of the episode and decline over the next few days and weeks of the episode, until flattening out at about 60 days (Figure 11-3, p. 342).²⁶ Under the current RHC payment structure, hospice providers are paid the same rate for days 1 to 60, even though costs decline over the course of the first 60 days of the episode. The RHC payment rates could be honed to include finer payment categories that reflect the different levels of visit intensity early in the episode.

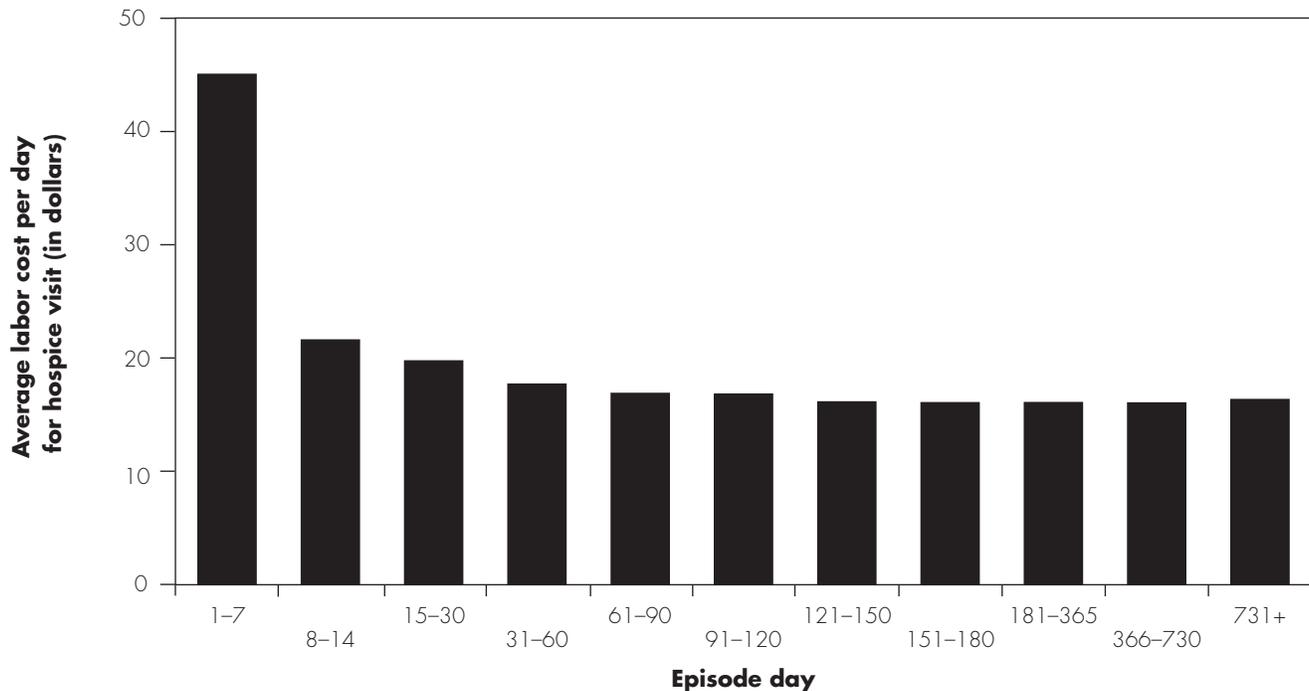
For example, five per diem payment rates could be established to more closely mirror costs in the visit data: days 1–7, days 8–14, days 15–30, days 31–60, and days 61+. As illustrated in Table 11-20 (p. 343), under this alternative payment structure, the relative payment weight and the resulting hospice payment daily payment rate would increase for the first 7 days of a hospice episode and would decrease for days 8–60, while the rate for days 61 and beyond would not change. This latter category accounts for more than two-thirds of RHC days. Compared with net payments under the current payment system, net payments under the alternative approach would increase for stays of roughly 30 days or less and decrease for stays of 31 days and longer. Payments for very long stays would be reduced, but the overall percentage reduction in total payments for long stays would be modest because the payment rate for days 61 and beyond would be unchanged. Thus, we expect this approach would provide some

(continued next page)

Potential hospice payment policy directions (cont.)

**FIGURE
11-3**

Average labor cost per day for hospice visits by episode day for routine home care, 2018



Note: The figure reflects only days when patients received routine home care. "Episode day" reflects the day within the hospice episode (and does not represent final length of stay). The last seven days of life are included in the chart within whichever episode-day category they fall and are not broken out separately. The average labor cost per day for hospice visits is calculated by taking the amount of visit minutes reported on hospice claims multiplied by an estimate of the national average wage rate (including benefits) for the type of practitioner performing the visit. For social workers, we include in this estimate time spent on both visits and phone calls, which are each reported on the claims.

Source: MedPAC analysis of Medicare hospice 100 percent standard analytic file and Acumen LLC lifetime length of stay file.

improvement in payment accuracy, especially for short stays, and would modestly reduce payments for long stays, but would not be expected to substantially alter the incentives for long stays. A potential concern with this approach is that the higher payment rate for days 1–7 might spur some providers to seek out patients in the last days of life rather than earlier in the disease trajectory when hospice could potentially offer patients more benefits.

Reduction in the daily payment rate for long hospice stays

Although a small share of hospice patients have long stays, these patients account of the majority of hospice

spending. In 2019, patients with stays exceeding 180 days accounted for nearly 60 percent of total hospice spending. Among decedents in 2019 who received hospice care, 10 percent had a hospice lifetime length of stay of 266 or more days. Hospices' profitability increases as its share of cases with long stays increases (until the provider exceeds the aggregate cap).

For patients with long stays, hospice may be substituting for other types of care such as custodial home care, which is generally financed out-of-pocket or by Medicaid or Medicare-covered home health care. As hospice length of stay increases, hospice aide

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Potential hospice payment policy directions (cont.)

**TABLE
11-20**

Comparison of average labor cost per day and relative payment weights for different RHC payment rate structures

Episode days	Alternate payment structure: 5 levels of payment		Current payment system with two rates: Days 1-60 and days 61+	
	Average labor cost per day	Relative weight	Average labor cost per day	Relative weight
1-7	\$45.08	2.4	\$24.10	1.3
8-14	21.62	1.2	24.10	1.3
15-30	19.77	1.1	24.10	1.3
31-60	17.72	1.0	24.10	1.3
61+	16.29	0.9	16.29	0.9

Note: RHC (routine home care).

Source: MedPAC analysis of Medicare hospice 100 percent standard analytic file and the common Medicare enrollment file from CMS.

minutes make up an increasingly larger portion of total visit minutes while nurse minutes decline. The greater share of hospice time devoted to aide visits among patients with the longest stays suggests that hospice is performing some of the same functions as custodial care. With long stays in hospice, a larger portion of care is occurring earlier in the disease trajectory, so patients are likely to be stable for longer periods of time, compared with patients with shorter stays who are nearer to the end of life and typically experience increased needs for hospice nursing and psychosocial supports.

Although there are important differences between hospice, custodial home care, and Medicare-covered home health care, there may be merit in considering a payment adjustment for very long hospice stays that brings the hospice payments for long stays closer to the payment rate for these other types of care. For example, a reduction to the hospice daily payment rate could be considered when a hospice stay exceeds a specified day threshold (e.g., for days 181 and beyond). A number of factors could be considered in establishing a payment rate for hospice days above the threshold, including

the type and frequency of visits that hospices typically provide, payment rates for these types of practitioner visits when furnished by other providers such as home health agencies, and the types of other services and supports beyond visits that hospice providers furnish and the costs associated with these services.

Episode payment For hospice, Medicare pays a daily rate for each day a beneficiary is enrolled in hospice. As an alternative to a per diem payment system, we could explore the use of an episode payment system for hospice. Because of the substantial variation in hospice length of stay across patients, it would be important to have episodes that are of a short duration. Short episodes (e.g., 30 days) could reduce the potential for systematic overpayments or underpayments or lessen the incentives for patient selection. In the Center for Medicare & Medicaid Innovation's value-based insurance design model that includes hospice in Medicare Advantage (MA), CMS has developed a 30-day episode payment to pay MA plans for hospice beneficiaries (with the payment rate for the first 30 days adjusted based on number of days of care provided

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Potential hospice payment policy directions (cont.)

(1–6 days, 7–15 days, 16+ days) to account for very short stays). As part of exploring an episode payment approach for fee-for-service hospice providers, we could consider whether episode payment rates should decline over time when patients have multiple episodes (an increase in payment for care in the last days of life). Such a structure could be considered to address variation in profitability by length of stay.

Compliance threshold The Commission has found that some hospice providers have outlier utilization patterns, such as unusually long stays and high live-discharge rates. These providers could be focusing on patients likely to have long, profitable stays who may not meet the eligibility criteria. High live-discharge rates are also a concern as they could signal a hospice’s poor admitting practices or quality of care, or an approach on the part of some hospices to discharge patients as the hospice approaches the aggregate cap.

An argument could be made that the care provided by hospices with unusually long stays and high live discharge rates is different in comprehensiveness and intensity compared with the end-of-life care furnished by other hospice providers. For example, unusually high live discharge rates seem inconsistent with the

core mission of hospice, which is to support patients through the last days of life, a time when symptom burden and the need for supports is often greatest. Hospices treating a mix of patients with very long stays are providing a larger share of the care they furnish earlier in the disease trajectory when patients may be more stable and have less-intense care needs.

Compliance thresholds such as the 60-percent rule for inpatient rehabilitation facilities and the 50-percent rule for long-term care hospitals are examples of how Medicare has sought to counter incentives for patient selection in payment systems in other sectors and to encourage providers to focus on patients most appropriate for that level of care. We could consider this type of approach for hospice providers. For example, a policy could be developed under which hospice providers whose live-discharge rate or length of stay for its patient population exceeds a specified threshold would in subsequent years receive a reduced payment rate for all patients. Having such a policy in place could help reduce the potential for patient selection under the hospice payment system and reduce the incentive for hospice business models to focus on revenue-generating strategies. ■

Endnotes

- 1 If a beneficiary does not have an attending physician, he or she can initially elect hospice based on the certification of the hospice physician alone.
- 2 When first established under TEFRA, the Medicare hospice benefit limited coverage to 210 days of hospice care. The Medicare Catastrophic Coverage Repeal Act of 1989 and the Balanced Budget Act of 1997 eased this limit.
- 3 Some studies have found large cost savings due to hospice, while others have found little or no savings overall. A contractor report sponsored by the Commission examined the difference in the methodologies used in the literature (Direct Research 2015). The report found that large hospice cost savings found by some studies are likely an artifact of the methodology used rather than a reflection of the effect of hospice on Medicare spending. In particular, the report reviewed the methodology used by six studies. Four studies that looked at a fixed time period before death (e.g., last year or half-year) showed small costs or small savings for hospice users, depending on time period and population studied. By contrast, two studies that looked only at the period of hospice enrollment (and compare it with a “pseudo”-enrollment period created for non-hospice decedents) showed very large (e.g., 24 percent) cost savings for hospice decedents. Because the date of enrollment/pseudo-enrollment will influence the calculated savings or costs, the report suggests that issues with the assignment of a pseudo-enrollment date to non-hospice enrollees make this methodology biased to find savings.
- 4 The aggregate cap increased annually by the rate of growth in the consumer price index for all urban consumers for medical care through 2016. In accord with the Improving Medicare Post-Acute Care Transformation Act of 2014 and the Consolidated Appropriations Act, 2021, the aggregate cap is updated annually by the same factor as the hospice payment rates (market basket net of productivity and other adjustments) from 2017 through 2030.
- 5 The 2021 cap year is aligned with the federal fiscal year (October 1, 2020, to September 30, 2021). Payments for the cap year reflect the sum of payments to a provider for services furnished in that year.
- 6 The beneficiary count starts with the number of beneficiaries treated by the hospice in the cap year. If a beneficiary receives care from more than one hospice, in more than one cap year, or both, that beneficiary is generally represented as a fraction in the beneficiary count of the cap calculation. In general, the fraction is calculated based on a proportional methodology and reflects the number of days of hospice care in a cap year the beneficiary received from that hospice as a share of all days of hospice care received by that beneficiary from all hospices in all years. Because the fraction a beneficiary represents in a prior year’s cap calculation can change going forward as that beneficiary continues to receive hospice care in subsequent cap years, CMS claims processing contractors can revisit the cap calculation for up to three years to update the beneficiary count and collect additional overpayments. Some hospices have elected an alternative methodology for handling the beneficiary count when a patient receives care in more than one cap year—called the streamlined methodology. For a detailed description of the two methodologies for the beneficiary count and when they are applicable, see our March 2012 report (Medicare Payment Advisory Commission 2012).
- 7 When the CMS claims processing contractor calculates cap overpayments for the most recent cap year, the contractor can also reopen the cap calculation for a hospice provider for up to three prior years to adjust the prior years’ beneficiary count to more accurately take into account beneficiaries who continued to receive hospice beyond the end of that cap year (as described in more detail in note 5).
- 8 Under section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a public health emergency (PHE) or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exist. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE has been renewed four times, most recently on January 7, 2021.
- 9 Type of hospice reflects the type of cost report filed (a hospice files a freestanding hospice cost report or is included in the cost report of a hospital, home health agency, or skilled nursing facility). The type of cost report does not necessarily reflect where patients receive care. For example, all hospice types may serve some nursing facility patients.
- 10 Statistics on hospice use rates and length of stay for 2017 through 2019 may differ from estimates in prior reports because they are based on different data sources and incorporate some refinements to our methodology. However, these differences do not change the conclusion that hospice use among decedents and average lifetime length of stay continue to increase. We have moved from using the Medicare Denominator File to the Common Medicare Enrollment to identify decedents and beneficiary characteristics. These statistics include U.S. territories whereas previously they had not.

- 11 Throughout this chapter, we use the term “FFS Medicare” or “traditional Medicare” as equivalents for the CMS term “Original Medicare.” Collectively, we distinguish the payment model represented by these terms from other models such as Medicare Advantage or advanced alternative payment models that may use FFS mechanisms but are designed to create different financial incentives.
- 12 Between 2018 and 2019, the share of days accounted for by RHC increased slightly from 98.2 percent to 98.4 percent because the number of RHC days increased 7 percent, while the number of GIP and CHC days declined (2 percent and 4 percent, respectively). The number of IRC days also increased about 8 percent, but IRC is an infrequently used level of care, so it remained about 0.3 percent of days in 2019.
- 13 The term *curative care* is often used interchangeably with *conventional care* to describe treatments intended to be disease modifying.
- 14 The estimates of hospices over the cap are based on the Commission’s analysis. While the estimates are intended to approximate those of the CMS claims processing contractors, differences in available data and methodology have the potential to lead to different estimates. An additional difference between our estimates and those of the CMS contractors relates to the alternative cap methodology that CMS established in the hospice final rule for 2012 (Centers for Medicare & Medicaid Services 2011). Based on that regulation, for cap years before 2012, hospices that challenged the cap methodology in court or made an administrative appeal had their cap payments calculated from the challenged year going forward using a new, alternative methodology. For cap years from 2012 onward, all hospices have their cap liability calculated using the alternative methodology unless they elect to remain with the original method. For estimation purposes, we assume that the CMS contractors used the alternative methodology for cap year 2012 onward.
- 15 If we approximate marginal cost as total Medicare costs minus fixed building and equipment costs, then marginal profit can be calculated as follows:
- $$\text{Marginal profit} = (\text{payments for Medicare services} - (\text{total Medicare costs} - \text{fixed building and equipment costs})) / \text{Medicare payments.}$$
- This comparison is a lower bound on the marginal profit because we do not consider any potential labor costs that are fixed.
- 16 The response rate for hospice CAHPS in the most recent period was 32 percent (<https://www.hospicecahpsurvey.org/en/scoring-and-analysis>).
- 17 Hospice CAHPS data are available for rolling two-year periods.
- 18 We present margins for 2018 because our margin estimates exclude cap overpayments to providers. To calculate this exclusion accurately, we need the next year’s claims data (i.e., the 2018 cap overpayment calculation requires 2019 claims data).
- 19 Between 2017 and 2018, the share of days accounted for by RHC rose slightly from 98.1 percent to 98.2 percent, while the share of days accounted for by GIP and CHC dropped from 1.6 percent to 1.5 percent. Because there are substantial cost differences between the lower cost RHC and the higher cost GIP and CHC levels of care, these small shifts in the mix of days contributed to the flat cost per day between 2017 and 2018.
- 20 Several other factors could have also contributed to the flat average cost per day between 2017 and 2018, such as the increase in average length of stay and the increase in the share of revenues accounted for by freestanding providers (which have lower costs than provider-based hospices).
- 21 The aggregate Medicare margin is calculated as follows:
- $$((\text{sum of total Medicare payments to all providers}) - (\text{sum of total Medicare costs of all providers})) / (\text{sum of total Medicare payments to all providers}).$$
- Estimates of total Medicare costs come from providers’ cost reports. Estimates of Medicare payments and cap overpayments are based on Medicare claims data.
- 22 Hospices that exceed the Medicare aggregate cap are required to repay the excess to Medicare. We do not consider the overpayments to be part of hospice revenues in our margin calculation.
- 23 As discussed in our March 2020 report, the hospice cap could be wage adjusted in the following manner. For each provider, Medicare could calculate the provider’s wage index ratio and adjust the aggregate cap accordingly. Wage index ratio = Provider’s actual payments in cap year / amount that provider’s payments would have been without wage adjustment. Wage-adjusted cap for a particular provider = National cap × wage index ratio for the provider. The cap calculation would otherwise work the same as it does today. If the provider’s payments in the cap year exceeded the wage-adjusted cap multiplied by the number of beneficiaries served, the provider would repay the excess to the government
- 24 These estimates are based on constant 2018 utilization data. Although we are not able to incorporate potential behavioral changes in our simulation, it is possible that some providers

might respond to cap changes by adjusting their admissions practices to remain under the cap.

25 This hypothetical example involves a hospice that provided only RHC to its patients. The aggregate cap equates to a smaller number of days for the other, more intense, higher paid levels of care. However, the three other levels of care are typically furnished only for a short period, so the general principle that providers have room within the cap to furnish very long stays to some patients without exceeding the cap applies to providers that furnish the three higher intensity levels of care as well. In addition, this example involves beneficiaries who receive hospice care entirely within a cap

year. When beneficiaries receive hospice care across multiple cap years, methodologies exist to apportion the hospice cap amount for the beneficiary across cap years. In that situation, the average length of stay that results in a hospice exceeding the cap varies and depends on several factors, such as how many beneficiaries receive care entirely within the cap year versus multiple cap years and what share of a beneficiary's hospice days occur in only the cap year versus within other cap years.

26 Although not broken out separately in Figure 11-3 (p. 342), the labor cost of visits increases in the last seven days of life.

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CHAPTER

12

**The Medicare Advantage
program: Status report**

The Medicare Advantage program: Status report

Chapter summary

Each year, the Commission provides a status report on the Medicare Advantage (MA) program. In 2020, the MA program included over 4,000 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with both Part A and Part B coverage), and paid MA plans an estimated \$317 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 fee-for-service (FFS) Medicare beneficiaries. We also provide updates on risk adjustment, risk coding practices, and the current state of quality reporting 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 among Medicare coverage options, including the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Because Medicare pays private plans a predetermined rate—risk adjusted per enrollee—rather than a per service rate, plans have greater incentives than FFS providers to innovate and use care-management techniques to deliver more efficient care.

In this chapter

- Increasingly robust MA enrollment, plan availability, and rebates financed by higher payments relative to FFS spending
- Medicare Advantage risk adjustment and coding intensity
- Quality in Medicare Advantage is difficult to evaluate
- Payment and access for enrollees with end-stage renal disease
- Future direction of MA payment policy

The Commission has emphasized the importance of encouraging 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 substantially above FFS rates. The phase-in of MA payment policies from the Affordable Care Act reduced the difference in Medicare spending between MA and FFS on a national average basis. However, aggregate plan payments under the ACA were similar to FFS levels for only one year before rising above FFS due to higher risk coding, an increasing share of MA enrollees in areas with payments above FFS spending, and quality bonus rules. Notwithstanding, over the past few years, plan bids 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. The clear, strong trend suggests an opportunity for the Medicare program to share in MA efficiencies.

Enrollment—Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 24.4 million enrollees. About 43 percent of Medicare beneficiaries with Part A and Part B coverage (39 percent of all Medicare beneficiaries) were enrolled in MA plans in 2020, up from 40 percent with Part A and Part B coverage in 2019. Among plan types, HMOs continued to enroll the most beneficiaries (15 million), with 24 percent of all Medicare beneficiaries in HMOs in 2020. During this period, enrollment in local preferred provider organizations (PPOs) grew by 15 percent, regional PPO enrollment decreased by 7 percent, and private fee-for-service enrollment decreased by 27 percent. Special needs plan enrollment grew by 14 percent, and employer group enrollment grew by 5 percent.

Plan availability—Access to MA plans remains high in 2021, with 99 percent of Medicare beneficiaries having access to at least one plan. Almost all beneficiaries have had access to some type of MA plan since 2006, and HMOs and local PPOs have become more widely available in the past few years. Nearly all Medicare beneficiaries (98 percent) have an HMO or local PPO plan operating in their county of residence. Regional PPOs are available to 72 percent of beneficiaries. The average beneficiary in 2021 has 32 available plans sponsored by 7 different parent organizations.

Plan rebates—In 2021, rebates used to provide additional benefits to enrollees are at a historic high of \$140 per enrollee per month. The average total rebates are 14 percent higher than in 2020 (\$17 higher per enrollee per month). Plans can devote the rebate (including plans' allocation of administrative costs and profit) to lower

cost sharing, lower premiums, or supplemental benefits. In 2021, a smaller share of projected plan rebates—46 percent compared with 49 percent in 2020—was allocated for lower cost sharing.

Plan payments—In 2021, plan payments remain higher than FFS spending levels. Total Medicare payments to MA plans (including rebates that finance extra benefits) average an estimated 104 percent of FFS spending, an increase of 1 to 2 percentage points compared with 2020. The 2021 estimate incorporates about 3 percentage points of uncorrected coding intensity. Relative to FFS spending for Part A and Part B benefits, quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021. Using plan bid data for 2021, and ignoring the impact of coding intensity, we estimate that MA payments would be 101 percent of FFS spending. Bid data also show that MA benchmarks—the maximum amount Medicare will pay an MA plan to provide Part A and Part B benefits—are slightly higher relative to FFS than they were in recent years. MA benchmarks in 2021 averaged an estimated 108 percent of FFS spending (including quality bonuses), compared with 107 percent in 2020. Bids slightly decreased to 87 percent of FFS, a record low.

Risk adjustment and coding intensity—Medicare payments to MA plans are enrollee specific, based on a plan’s payment rate and an enrollee’s risk score. Risk scores account for differences in expected medical expenditures and are based in part on diagnoses that providers code. 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 providing a service. In contrast, MA plans have 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 2019 shows that higher diagnosis coding intensity resulted in MA risk scores that were more than 9 percent higher than scores for similar FFS beneficiaries. This estimate is higher than the prior year due to faster MA risk score growth relative to FFS risk score growth, which, except for 2016 and 2017, has been the norm since 2007. By law, CMS makes an across-the-board reduction to MA risk scores to make them more consistent with FFS coding, and although CMS has the authority to impose a larger reduction than the minimum required by law, the agency has never done so. In 2019, the adjustment reduced MA risk scores by 5.9 percent, resulting in MA risk scores and payments that were more than 3 percent higher than they would have been if MA enrollees had been treated in FFS Medicare. The minimum adjustment for coding intensity will remain at 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. This year we highlight the impact of MA plans' use of medical chart reviews to increase risk scores (a coding practice that does not exist in FFS). Recent reports from the Office of Inspector General indicate that the majority of MA coding intensity may be due to chart reviews and health risk assessments.

Quality in MA—The Commission has previously reported its concerns with the MA star rating system and 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 43 percent of eligible Medicare beneficiaries 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 necessary for proper evaluation. 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 and is costly to Medicare, in its June 2020 report the Commission recommended a new value incentive program for MA that would replace the current quality bonus program.

Future direction of MA payment policy—As in the past several years, many indicators continue to point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and historically high extra benefits. However, some policies are deeply flawed and are in need of immediate improvement. The Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program.

Despite the relative efficiency of MA plans in providing Part A and Part B benefits, aggregate MA payments (including rebates that finance extra benefits) are about 4 percent higher than expected FFS expenditures for similar beneficiaries, an increase of more than 1 percentage point from last year. In setting payment policy in the FFS sector, the Commission consistently strives to encourage providers to deliver care efficiently while maintaining beneficiary access to good quality care. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS Medicare, which are compounded by Medigap's effect of insulating beneficiaries from true health care costs, and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare in

1982, in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, Medicare may be able to share in some of those efficiencies. ■

Background

The Medicare Advantage (MA) program allows Medicare beneficiaries enrolled in both Part A and Part B to receive benefits from private plans rather than from the traditional fee-for-service (FFS) program. In 2020, the MA program included 4,234 plan options offered by 185 organizations, enrolled over 24 million beneficiaries (43 percent of all Medicare beneficiaries with Part A and Part B coverage), and paid MA plans an estimated \$317 billion (not including Part D drug plan payments). The Commission supports including private plans in the Medicare program because they allow beneficiaries to choose between FFS Medicare and the alternative delivery systems that private plans can provide. Plans often have flexibility in payment methods, including the ability to negotiate with individual providers, use care-management techniques that fill potential gaps in care delivery (e.g., programs focused on preventing avoidable hospital readmissions), and develop robust information systems that can potentially provide timely feedback to providers. Plans also can provide incentives for beneficiaries to seek care from more efficient providers and give beneficiaries more predictable cost sharing; one trade-off is that the choice of providers in plan networks is more limited than in FFS Medicare.

By contrast, traditional FFS Medicare has lower administrative costs and offers beneficiaries an unconstrained choice of health care providers, but it often lacks incentives to coordinate care and is limited in its ability to make care delivery more efficient. Because private plans and traditional FFS Medicare have structural aspects that appeal to different segments of the Medicare population, we favor providing a choice between private MA plans and traditional FFS Medicare that does not unduly favor one program component over the other through Medicare's payment systems or its monitoring and enforcement efforts.

Efficient MA plans can capitalize on their administrative flexibility to provide better value to beneficiaries who enroll in those plans by providing extra benefits without exceeding FFS spending levels. However, in some parts of the country, MA plans offer higher levels of extra benefits to their enrollees because they receive payments that are higher relative to what would have been paid under FFS Medicare for similar beneficiaries. Thus, some of those benefits are subsidized by higher government spending and higher beneficiary Part B premiums (including the premiums for enrollees in traditional FFS Medicare) at

a time when Medicare and its beneficiaries are under increasing financial stress. To encourage efficiency and innovation, MA plans need to face appropriate financial pressure similar to what the Commission recommends for providers in the traditional FFS program. One method of achieving equal financial pressure is to link private plans' payments more closely to FFS Medicare costs within the same market. The Commission will continue to monitor plan payments and performance and begin to develop policies to further improve the efficiencies of MA.

Each year, the Commission provides a status report on the MA program. 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 the current state of quality in MA.

Types of MA plans

Our analysis of the MA program uses the most recent data available and reports results by plan type. The analysis does not cover non-MA private plan options that may be available to some beneficiaries, such as cost plans. The MA plan types are:

- **HMOs and local preferred provider organizations (PPOs)**—These plans have provider networks and, if they choose, can use tools such as selective contracting and utilization management to coordinate and manage care and control service use. They can choose individual counties to serve and can vary their premiums and benefits across counties. These two plan types are classified as coordinated care plans (CCPs).
- **Regional PPOs**—These plans are required to offer a uniform benefit package and premium across CMS-designated regions made up of one or more states. Regional PPOs have more flexible provider network requirements than local PPOs. Regional PPOs are also classified as CCPs.
- **Private FFS (PFFS) plans**—These plans may or may not use provider networks, depending on where they operate. The Medicare Improvements for Patients and Providers Act of 2008 mandated that, in areas with two or more network MA plans, PFFS plans have provider networks. Therefore, PFFS plans have to either locate in areas with fewer than two network

plans or operate as network-based PFFS plans. The Congress anticipated that the legislation would reduce the availability of and enrollment in these plans that did not manage care as efficiently as their HMO and PPO competitors. In 2020, only about 80,000 beneficiaries were enrolled in PFFS plans.

- **Medicare Savings Account (MSA) plans**—MSA plans are a combination of a high-deductible plan and a medical savings account. The plan is paid the full MA benchmark and places a deposit into the member’s account that the member can use to help meet the plan deductible on Medicare services. In 2020, they were available in 25 states with a total enrollment of about 8,000 beneficiaries. However, we do not include MSA plans in our analyses because their enrollment has been limited, beneficiaries dually eligible for Medicare and Medicaid are not eligible to enroll in MSA plans, and these plans do not bid.

Two additional plan classifications cut across plan types: special needs plans (SNPs) and employer group plans. SNPs offer benefit packages tailored to specific populations (those beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions). SNPs must be CCPs. Employer group plans are available only to Medicare beneficiaries who are members of employer or union groups that contract with those plans. SNPs are included in our plan data, with the exception of plan availability figures because these plans are not available to all beneficiaries. (See the Commission’s March 2013 report to the Congress, available at <http://www.medpac.gov>, for more detailed information on SNPs.) As we recommended in an earlier report, employer plans no longer submit bids (since 2017). Therefore, they are not included in our access and payment analyses. (See the Commission’s March 2015 report to the Congress for more detailed information on employer plans.)

How Medicare pays MA plans

In contrast to traditional FFS Medicare’s fixed rates per service paid to providers, Medicare pays MA plans a fixed rate for each beneficiary who has chosen to enroll. Plan payment rates are determined by the MA plan bid—which represents the dollar amount that the plan estimates will cover the Part A and Part B benefit package for a beneficiary of average health status—and the benchmark for the county in which the beneficiary resides, which is

the maximum amount of Medicare payment set by law for an MA plan to provide Part A and Part B benefits.¹ (Medicare also pays plans for providing the Part D drug benefit, but Medicare’s Part D payments are determined through the Part D bidding process, and not all plans include the Part D benefit.) Plans with higher quality ratings are rewarded with a higher benchmark. If a plan’s normalized bid is above the normalized benchmark (that is, a benchmark for a person of average risk), the plan’s MA base payment rate is set at the benchmark and enrollees have to pay a premium (in addition to the usual Part B premium) equal to the difference. If a plan’s bid is below the benchmark, its payment rate is its bid plus a share (between 50 percent and 70 percent, depending on a plan’s quality ratings) of the difference between the plan’s bid and the benchmark. For this computation, the comparison is between an individual plan’s actual bid for its expected enrolled population and a plan-specific risk-adjusted average benchmark, weighted by the plan’s projected enrollment from counties in its service area. The beneficiary pays no additional premium to the plan for Part A and Part B benefits (but continues to be responsible for payment of the Medicare Part B premium and may pay premiums to the plan for additional benefits). The added payment based on the difference between the bid and the benchmark is referred to as the rebate. Plans must use the rebate to provide additional benefits to enrollees in the form of lower cost sharing, lower premiums, or supplemental benefits. Plans can also devote some of the rebate to administration costs and margins. Plans may also choose to include additional supplemental benefits that are not financed by the rebate in their packages and charge premiums to cover those additional benefits.² (A more detailed description of the MA program payment system can be found at http://medpac.gov/docs/default-source/payment-basics/medpac_payment_basics_20_ma_final_sec.pdf?sfvrsn=0.)

How Medicare calculates MA benchmarks

Under the Affordable Care Act (ACA), each county’s benchmark, excluding quality bonuses, equals a certain share (ranging from 95 percent to 115 percent, subject to caps) of the projected average per capita FFS Medicare spending for the county’s beneficiaries.³ Each county’s benchmark is determined by organizing the counties into quartiles based on their FFS spending. Each quartile contains 785 or 786 counties. Low-FFS-spending counties have benchmarks higher than their county’s FFS spending

level to help attract plans, and high-FFS-spending counties have benchmarks lower than FFS to generate Medicare savings, given the history of very low bids in such counties that reflect high FFS service use. Counties (excluding the territories) are assigned to quartiles based on average FFS spending; the highest spending quartile of counties has benchmarks set at 95 percent of local FFS spending. The next highest spending quartile of counties has benchmarks set at 100 percent of FFS spending, followed by the third-highest quartile set at 107.5 percent of FFS spending. The lowest spending quartile has benchmarks set at 115 percent of local FFS spending. (U.S. territories are treated like counties in this low-spending quartile.) Counties can move among quartiles from year to year and in doing so receive a blended quartile factor; for example, a county moving from the 100 percent quartile in 2019 to the 107.5 percent quartile in 2020 would have a blended rate of 103.75 percent.

By statute, plans awarded quality bonuses have benchmarks that are 5 percent higher than the standard county benchmarks (subject to benchmark growth caps); in certain counties, plans can receive a double bonus, and the benchmarks for plans awarded quality bonuses are 10 percent higher than the standard benchmarks.⁴ Unlike nearly all of Medicare’s FFS quality incentive programs, these quality bonuses are not budget neutral but are instead financed by added program dollars. The Commission’s original conception of a quality incentive program for MA plans was a system that would be budget neutral and financed with a small share of plan payments (Medicare Payment Advisory Commission 2012b, Medicare Payment Advisory Commission 2004). A budget-neutral system is consistent with the Commission’s principle of providing a level playing field between private MA plans and traditional FFS Medicare and reflects the Commission’s recommendation to the Congress in June 2020 (Medicare Payment Advisory Commission 2020c, Medicare Payment Advisory Commission 2019a).

Increasingly robust MA enrollment, plan availability, and rebates financed by higher payments relative to FFS spending

Substantial growth in MA plan enrollment, availability, and rebates indicates an increasingly robust MA program, financed by MA payments that continue to be above

FFS levels. For the second consecutive year, MA plan enrollment in 2020 grew by 10 percent; 43 percent of all eligible Medicare beneficiaries are now in MA plans, compared with 40 percent in 2019. The increasing share of MA enrollees in some geographic areas raises questions about the long-term feasibility of using the local FFS population to calculate MA payment benchmarks. For 2021, the average beneficiary now has access to 32 plans sponsored by 7 organizations, and rebates that finance extra benefits are the highest in the program’s history. However, the robust growth and availability of MA plans has occurred without overall savings to the Medicare program. In 2021, MA bids average 87 percent of FFS spending, but payment benchmarks average 108 percent of FFS—resulting in MA payments that are 101 percent of FFS and an estimated 104 percent of FFS spending after accounting for differences in coding practices between MA and FFS.⁵

Ten percent growth in MA plan enrollment in 2020; MA enrollment now 43 percent of all eligible Medicare beneficiaries

Between July 2019 and July 2020, enrollment in MA plans grew by 10 percent—or 2.1 million enrollees—to 24.4 million enrollees (compared with a 2 percent growth in the same period for the total Medicare population and about a 2 percent decline in FFS enrollment). The 10 percent growth is among the highest in the last 10 years, equaling the 10 percent growth in 2012 and 2019. During this period, MA enrollment rose from 36 percent (data not shown) to 39 percent of all Medicare beneficiaries (Table 12-1, p. 362).⁶ Beneficiary eligibility to join an MA plan requires enrollment in both Part A and Part B. Because 9 percent of Medicare beneficiaries do not meet this requirement, we also examined MA enrollment as a share of the Medicare population with both Part A and Part B coverage. Between July 2019 and July 2020, MA enrollment increased from 40 percent to 43 percent of all Medicare beneficiaries with Part A and Part B coverage. (See the text box, pp. 363, for an explanation of updates to our enrollment methodology.) Enrollment in MA has more than doubled since 2010 (Figure 12-2, p. 364). MA has increasingly become attractive to beneficiaries because of MA plans’ coverage of cost-sharing reductions at little to no premium and a mandatory cap on out-of-pocket expenses. Many beneficiaries with care needs that are met within plan networks will likely have lower financial liability (premiums and cost sharing) compared

**TABLE
12-1**

MA plan enrollment continued rapid growth in 2020

	MA enrollment (in millions)		Percent change in enrollment	2020 MA enrollment as a share of total Medicare
	July 2019	July 2020		
Total	22.2	24.4	10%	39%
Plan type				
CCP	22.1	24.3	10	39
HMO	13.8	15.0	8	24
Local PPO	7.0	8.1	15	13
Regional PPO	1.2	1.1	-7	2
PFFS	0.1	0.1	-27	<1
Restricted availability plans included in totals above				
SNPs*	3.1	3.5	14	6
Employer group*	4.5	4.7	5	8
Urban/rural				Share of Medicare population in MA
Urban	17.5	19.0	8	42
Rural	4.7	5.4	14	31

Note: MA (Medicare Advantage), CCP (coordinated care plan), HMO (health maintenance organization), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). CCPs include HMO, local PPO, and regional PPO plans. The total Medicare population used to calculate enrollment shares in this table includes the 9 percent of beneficiaries who are not eligible to enroll in an MA plan because they do not have both Part A and Part B coverage. In 2020, 43 percent of eligible beneficiaries were enrolled in an MA plan. Urban/rural designations use the Urban Influence Codes delineated by the Office of Management and Budget (OMB). These codes were last updated in 2013 and are updated every 10 years. Urban areas are those designated as metropolitan by OMB. Rural areas include counties designated as micropolitan and counties that are neither metropolitan nor micropolitan. The sum of column components may not equal the stated total due to rounding.

*SNPs and employer group plans have restricted availability. Their enrollment is included in the statistics by plan type and location. We present them separately to provide a more complete picture of the MA program.

Source: MedPAC analysis of CMS enrollment files.

with beneficiaries who stay in FFS and purchase the most comprehensive supplemental coverage.⁷

Among plan types, although enrollment grew more slowly in HMOs (8 percent) than in local PPOs (15 percent), HMOs continued to enroll the most beneficiaries (15 million) in 2020, with 24 percent of all Medicare beneficiaries in HMOs (Table 12-1). Between 2019 and 2020, enrollment in regional PPOs and PFFS plans dropped by 7 percent and 27 percent, respectively. In 2020, SNP enrollment grew by 14 percent, and employer group enrollment grew by 5 percent.

Enrollment patterns differ in urban and rural areas. Over 40 percent of urban beneficiaries are enrolled in MA compared with less than one-third of beneficiaries

residing in rural counties. In 2020, 41 percent of rural MA enrollees were in HMO plans compared with about 67 percent of urban enrollees (not shown in Table 12-1). By contrast, 48 percent of rural enrollees were in local PPOs compared with 29 percent of urban enrollees.

The increasing share of MA enrollees in some geographic areas raises questions about the long-term feasibility of using the local FFS population to calculate MA payment benchmarks. In fact, many areas now have a majority of their Medicare beneficiaries enrolled in MA.⁸ In three states (Florida, Hawaii, and Oregon) and Puerto Rico, more than half of the MA-eligible population enrolled in MA plans in 2020. In some metropolitan areas (e.g., Miami, FL; Pittsburgh, PA; Rochester, NY; Grand Rapids, MI; Portland, OR; El Paso, TX), 60 percent or

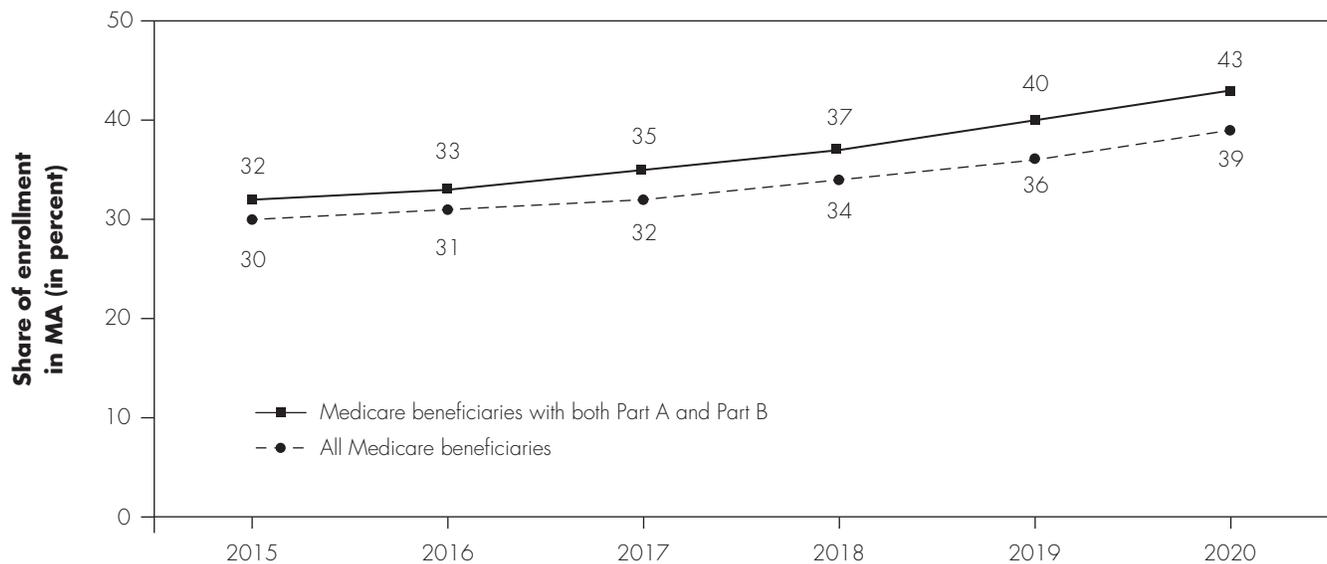
The share of Medicare beneficiaries enrolled in MA

Historically, the Commission has used information on “Medicare-eligible individuals” from CMS’s Medicare Advantage (MA) penetration files as the denominator in calculating the share of Medicare beneficiaries enrolled in MA. However, “Medicare-eligible individuals” include people previously, but no longer, covered by Medicare and people within 5 months of their 65th birthday. In addition, CMS has identified an issue with the Medicare-eligible individuals number in recent years, in which the program double counted fee-for-service beneficiaries with multiple addresses. We now have data from the CMS enrollment dashboard that allows us to calculate MA enrollment as a share of Medicare beneficiaries with either Part A or Part B coverage and thus can calculate a more accurate MA

enrollment percentage. At the national level, these data also allow the Commission to calculate MA enrollment as a share of the Medicare population with both Part A and Part B coverage. Because having both Part A and Part B coverage is required for MA enrollment, this information is particularly valuable. Furthermore, we now report enrollment as of July since it is the month most representative of average annual (and person-year) enrollment. The percentages published here for the years shown supersede all of the Commission’s prior estimates of the share of Medicare beneficiaries enrolled in MA. That share has increased rapidly in recent years (Figure 12-1). Between 2015 and 2020, MA enrollment increased from 32 percent to 43 percent of all Medicare beneficiaries with Part A and Part B coverage. ■

FIGURE 12-1

Rapid increase in the share of eligible Medicare beneficiaries enrolled in MA, 2015–2020

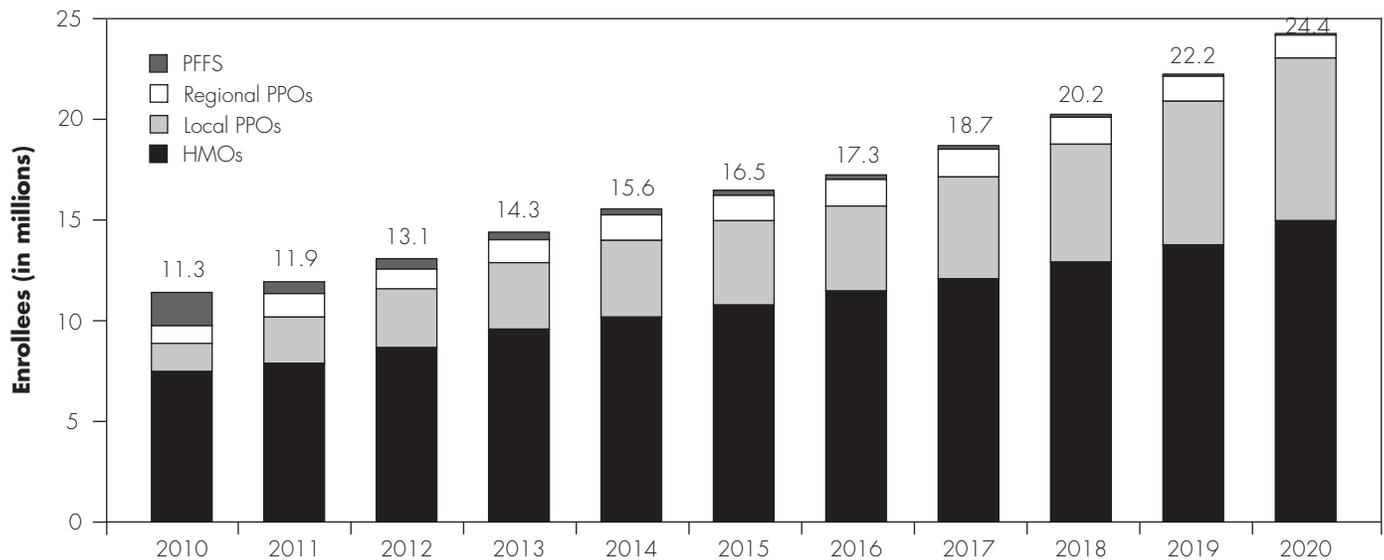


Note: MA (Medicare Advantage). Medicare beneficiaries must have both Part A and Part B coverage to enroll in an MA plan. In 2020, 9 percent of Medicare beneficiaries were not eligible to enroll in an MA plan because they did not have both Part A and Part B coverage.

Source: MedPAC analysis of CMS enrollment files, July 2015–2020.

more of all Medicare beneficiaries enrolled in MA plans. MA benchmarks are computed at the county level, and an increasing number of counties had most Medicare beneficiaries enrolled in MA plans. In all counties in

Puerto Rico and an additional 241 counties across 29 states, more than half of all Medicare beneficiaries enrolled in MA plans. Thus, as the share of FFS beneficiaries in these counties decreases, benchmarks can

**FIGURE
12-2****Medicare Advantage enrollment, 2010–2020**

Note: PFFS (private fee-for-service), PPO (preferred provider organization), HMO (health maintenance organization).

Source: MedPAC analysis of CMS enrollment files, July 2010–2020.

become biased if the FFS population is not representative of Medicare beneficiaries overall. When this disparity arises, the risk adjustment model is less likely to capture differences between the local FFS and MA populations. For example, a disproportionate number of a county's FFS beneficiaries may have comprehensive supplemental coverage, which is unavailable in MA and induces higher demand for service use. In addition, a larger share of beneficiaries remaining in FFS may rely on care from volume-inducing providers who are outside of most MA plan networks.⁹

Access to MA plans remains high in 2021

Every year, we assess plan availability and projected enrollment for the coming year based on the bid data that plans submit to CMS. We find that access to MA plans remains high in 2021, with most Medicare beneficiaries having access to many plans. Some measures of availability have improved for 2021. While almost all beneficiaries have had access to some type of MA plan since 2006, local CCPs have become more widely available in the past few years (Table 12-2). In 2021, 98

percent of Medicare beneficiaries have an HMO or local PPO plan (both are considered local CCPs) operating in their county of residence, the same as in 2020. Regional PPOs are available to 72 percent of beneficiaries in 2021, nearly the same as in 2020. Access to PFFS plans in 2021 is lower, available to 34 percent of beneficiaries, down from 36 percent in 2020. Overall, 99 percent of Medicare beneficiaries have access to an MA plan, and 99 percent have access to a CCP (total CCP data not shown in Table 12-2), similar to 2020.

The availability of SNPs improved across types of special needs population served. In 2021, 92 percent of beneficiaries reside in areas where SNPs serve beneficiaries who are dually eligible for Medicare and Medicaid (up from 90 percent in 2020), 57 percent live where SNPs serve beneficiaries with chronic conditions (up from 52 percent in 2020), and 72 percent live where SNPs serve institutionalized beneficiaries (up from 67 percent in 2020). Overall, 96 percent of beneficiaries reside in counties served by at least one type of SNP (data not shown).

**TABLE
12-2****Access to Medicare Advantage plans remains high****Share of Medicare beneficiaries with access to at least one MA plan, by type**

Type of plan	2017	2018	2019	2020	2021
Any MA plan	99%	99%	99%	99%	99%
Local CCP	95	96	97	98	98
Regional PPO	74	74	74	73	72
PFFS	45	41	38	36	34
Special needs plans					
Dual eligible	86	86	89	90	92
Chronic condition	44	47	47	52	57
Institutional	52	56	63	67	72
Zero-premium plan with drug coverage	81	84	90	93	96
Average number of choices					
County weighted	10	10	13	15	18
Beneficiary weighted	18	20	23	27	32
Average monthly rebate for nonemployer, non-SNP plans	\$89	\$95	\$107	\$122	\$140

Note: MA (Medicare Advantage), CCP (coordinated care plan), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). "Local CCPs" includes HMO and local PPO plans. These figures exclude employer-only plans. Special needs plans are included in the three special needs plan rows but excluded from all other rows. "Share of Medicare beneficiaries" includes beneficiaries that do not have both Part A and Part B coverage (i.e., all Medicare beneficiaries). A zero-premium plan with drug coverage includes Part D coverage and has no premium (including the Part D premium) beyond the Part B premium. "County weighted" means that each county is weighted the same and the measure is the average number of choices per county. "Beneficiary weighted" means that each county is weighted by the number of beneficiaries in the county. The plan rebate is the per beneficiary per month amount that the plan is offering as premium-free extra benefits and excludes plans that do not offer Part D coverage.

Source: MedPAC analysis of CMS bid and enrollment data.

In 2021, 96 percent of Medicare beneficiaries (compared with 93 percent in 2020) have access to at least one nonemployer, non-SNP MA plan that includes Part D drug coverage and charges no Part C or Part D premium (beyond the Medicare Part B premium) (Table 12-2). About 64 percent of nonemployer, non-SNP MA enrollment is projected to be in these zero-premium plans (data not shown). Also in 2021, 89 percent of beneficiaries (compared with 79 percent in 2020) have access to plans that offer some reduction in the Part B premium, but only 4 percent of 2021 enrollment was projected to be in these premium-reduction plans (data not shown).

In most counties, a large number of MA plans sponsored by a robust number of organizations are available to beneficiaries. In 2021, the average number of plans

available in a county increased. On average, 18 plans (vs. 15 plans in 2020) are available in each county in 2021 (Table 12-2). Plan availability can also be calculated by weighting the number of beneficiaries living in the county to give a sense of the number of plan choices available to the average beneficiary. Under that calculation, the average beneficiary in 2021 has 32 available plans, an increase from 27 plans in 2020. The average beneficiary in 2021 can choose from plans sponsored by seven organizations (data not shown). In 2021, 95 percent of beneficiaries will have available MA plans sponsored by at least three different organizations. In 2021, beneficiaries in 70 counties can choose from at least 20 plans offered by at least 10 distinct organizations. These counties include the major markets of Atlanta, Chicago, Cincinnati, Cleveland, Dallas, Houston, Los Angeles, Miami, New York City, and

**TABLE
12-3**

Share of Medicare Advantage enrollment by parent organization, July 2020

Urban areas		Rural areas	
Parent organization	Share of total MA enrollment in urban counties	Parent organization	Share of total MA enrollment in rural counties
UnitedHealth Group Inc.	26%	UnitedHealth Group Inc.	27%
Humana Inc.	17	Humana Inc.	25
CVS Health Corporation	11	CVS Health Corporation	10
Kaiser Foundation Health Plan Inc.	9	Anthem Inc.	5
Anthem Inc.	6	Blue Cross Blue Shield of Michigan	4
Centene Corporation	4	Centene Corporation	3
CIGNA	2	Highmark Health	1
Blue Cross Blue Shield of Michigan	2	CIGNA	1
SCAN Health Plan	1	Spectrum Health System	1
Summit Master Company LLC	1	BlueCross BlueShield of Tennessee	1
Total, top 10 organizations	78	Total, top 10 organizations	79

Note: MA (Medicare Advantage). Includes only Medicare Advantage plans (coordinated care, private fee-for-service, and medical savings account plans). Excluded are cost-reimbursed plans and Medicare–Medicaid demonstration plans. Urban/rural designations use the Urban Influence Codes delineated by the Office of Management and Budget (OMB). These codes were last updated in 2013 and are updated every 10 years. Urban areas are those designated as metropolitan by OMB. Rural areas include counties designated as micropolitan and counties that are neither metropolitan nor micropolitan. Totals may not sum due to rounding.

Source: MedPAC analysis of CMS July 2020 enrollment data and OMB Urban Influence Codes.

Phoenix. At the other end of the spectrum, 211 counties, representing 1 percent of beneficiaries, have no MA plans available (medical savings account plans and SNPs are not included in general availability measures); however, some of these beneficiaries have the option of joining cost plans (another managed care option under Medicare).¹⁰

Largest organizations slightly increase MA market share

The national MA market has become slightly more concentrated in recent years, and that trend continued in 2020. In 2020, the top 3 organizations had 56 percent of enrollment (vs. 55 percent in 2019; data not shown), and the top 10 organizations had 78 percent of total enrollment (vs. 76 percent in 2019; data not shown). Market concentration differed between urban areas (19.0 million MA enrollees) and rural areas (5.4 million enrollees) (Table 12-3). In urban areas in 2020, the top three organizations had 53 percent of the MA enrollees residing in these areas (unchanged from 2019; 2019 data

not shown). In rural areas, the top three organizations accounted for 62 percent of the MA enrollees residing in these areas (unchanged from 2019; 2019 data not shown).

Another way of looking at the market structure in the MA program is to examine market competition at the county level. Excluding employer plans and SNPs, in 2020, 69 percent of MA enrollees (down from 71 percent in 2019) resided in a highly concentrated county as measured by the Herfindahl–Hirschman Index.¹¹ In 2020, enrollment in the top organization in each county accounted for 45 percent of all MA enrollment (down from 47 percent in 2019). Enrollment in the top two organizations in each county accounted for 69 percent of all MA enrollment (down from 71 percent in 2019). Thus, although the MA market is highly concentrated, the level of concentration is not increasing locally. In tandem, national MA market concentration modestly rose, but local MA market concentration modestly fell, suggesting that the largest national plans are slightly gaining MA market share in areas where they do not have a large presence. Nevertheless, as

**TABLE
12-4**

A smaller share of plan rebates are allocated to cost sharing in 2021

	Rebate (per member per month)		2021 percent change	Share of total rebate	
	2020	2021		2020	2021
Total	\$122	\$140	14%	100%	100%
Extra benefit type					
Cost sharing	60	64	5	49	46
Non-Medicare supplemental	22	29	33	18	21
Part D supplemental	22	24	9	18	17
Part D premium	16	20	26	13	15
Part B premium	2	2	12	2	2

Note: Employer group plans, special needs plans, and plans that do not offer Part D coverage are not included. Amounts for cost sharing and supplemental benefits include plan costs for administration and profit. Totals, differences, and rebate shares may not sum due to rounding.

Source: MedPAC analysis of data from CMS on plan bids.

illustrated in the section on plan availability in 2021 (pp. 364–365), the average beneficiary has access to many MA plans offered by a robust number of organizations.

MA rebates in 2021 are a record high \$140 per enrollee per month

For 2021, rebates for nonemployer, non-SNP plans average \$140 per enrollee per month (nearly \$1,700 annually per enrollee) and are the highest in the program’s history (accounting for 14 percent of plan payment). The average total rebates are 14 percent higher than in 2020 (\$17 higher per enrollee per month) (Table 12-4). Plans can devote the rebate (including administrative costs and profit) to lower cost sharing, lower premiums, or supplemental benefits. In 2021, the share of plan rebates allocated toward cost-sharing reductions are projected to fall. Plans project that \$64 per enrollee per month (46 percent) of rebates go toward reductions in cost sharing for Medicare services, a 5 percent increase relative to 2020 but a decrease in the share of rebate (49 percent).^{12,13} The growth rate of cost-sharing reductions is similar to CMS’s projected growth rate of all Part A and Part B expenditures (5.6 percent), suggesting that many MA plans do not need or want to devote additional rebate dollars to this benefit beyond medical inflation. Indeed, plans may find that additional rebate allocations toward reductions in cost sharing may induce greater service use, such as the induced service use that occurs in FFS when beneficiaries

have first-dollar Medigap coverage (Medicare Payment Advisory Commission 2012a). Plans project that \$29 per enrollee per month (21 percent) of rebates will be used for non-Medicare-covered supplemental benefits, which often include coverage for some vision, fitness, hearing, or dental services.¹⁴ On a more limited basis, some plans have started using rebates for supplemental benefits intended to help address social determinants of health.¹⁵ Two other uses of rebate dollars are for reductions in Part D premiums (15 percent of projected rebates), Part D supplemental benefits (17 percent of projected rebates), and reductions in Part B premiums (2 percent of projected rebates). MA plans cannot allocate administrative expenses or margin to these three categories of benefits.¹⁶

Plans bid at record low levels in 2021, but payments remain above FFS spending

In 2021, MA plan payments (including rebates that finance extra benefits) remained above what Medicare would have paid for similar beneficiaries in FFS, continuing the trend of higher levels of payment throughout the history of Medicare managed care (see text box on Medicare payments to MA plans, p. 371). Payments to MA plans are determined using a plan’s bid—which represents the dollar amount that the plan estimates it will need to cover the Medicare benefit package for a beneficiary—and the benchmark for the county in which the beneficiary resides, which is based on local FFS spending and is

**TABLE
12-5**

Overall plan bids at record low levels in 2021, but payments remain above FFS spending

Share of FFS spending in 2021

Plan type	Benchmarks	Bids	Payments
All MA plans	108%*	87%*	101%*
HMO	108	86	100
Local PPO	109	92	103
Regional PPO	99	87	94
PFFS	107	100	104
Restricted availability plans (SNPs) included in totals above	107	90	101

***Values would be about 3 percentage points higher when coding intensity is reflected fully using our most recent estimate (e.g., payments for all MA plans average 104 percent of FFS spending if coding differences were fully reflected).**

Note: FFS (fee-for-service), MA (Medicare Advantage), PPO (preferred provider organization), PFFS (private fee-for-service), SNP (special needs plan). Benchmarks are the maximum Medicare program payments for MA plans and incorporate plan quality bonuses. We estimate FFS spending by county using the 2021 MA rate book. We removed spending related to the remaining double payment for indirect medical education payments made to teaching hospitals. The estimate of regional PPO benchmarks relative to FFS corrects the methodology from prior years that used an imputed benchmark amount rather than the benchmark in plan bid data. This correction has no effect on bids or payments for regional PPOs and has no substantive effect on overall benchmark estimates relative to FFS. The FFS spending denominator used in the table includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. For 2017, the Commission estimated that FFS spending for enrollees with both Part A and B was about 1 percent higher than spending for all FFS enrollees. Comparing benchmarks, bids, and payments with spending for FFS enrollees with both Part A and Part B would decrease the overall values for all MA plans in the table by about 1 percentage point. *All numbers in this table have been risk adjusted and reflect quality bonuses, but they have not been adjusted for coding intensity differences between MA and FFS that exceed the statutory minimum adjustment.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and fee-for-service expenditures.

the maximum Medicare payment amount set by law for an MA plan to provide Part A and Part B benefits for beneficiaries in that county. In the early years of MA, benchmarks were set high in order to attract plan participation. In 2010, MA benchmarks averaged 112 percent of FFS spending, bids averaged 100 percent of FFS, and payments averaged 109 percent of FFS. After implementation of the ACA, reductions in benchmarks began lowering Medicare payments to plans. However, with ACA policies fully implemented and in place since 2017, benchmarks have slightly increased and payments remain above FFS spending levels. We estimate that in 2021, MA benchmarks (including quality bonuses) average 108 percent of FFS spending (before adjusting fully for coding intensity; see below) (Table 12-5). In contrast, benchmarks in 2020 averaged 107 percent of FFS (data not shown). In 2021, MA plans bid at record low levels. Overall plan bids average an estimated 87 percent of FFS spending in 2021, down from 88 percent of FFS in 2020 (latter data not shown). 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. Overall, we estimate that Medicare payments to MA plans would average 101 percent of FFS spending in 2021; however, uncorrected coding intensity increases payments to 104 percent of FFS spending. An estimated 2 percentage points to 3 percentage points of MA payments relative to FFS spending are due to quality bonuses. MA payments relative to FFS increased by 1 percentage point to 2 percentage points compared with 2020.

MA benchmarks relative to FFS rose by 1 percentage point compared with 2020, but bids fell by 1 percentage point relative to FFS—resulting in overall payments that increased by 1 percentage point relative to FFS (before accounting for coding differences). The small increase in benchmarks and payments relative to FFS spending partially reflects a larger share of projected MA enrollment in counties with benchmarks that are 115 percent of FFS spending. In 2021, 28 percent of projected MA enrollment was in these high-benchmark counties, up from 26 percent in 2020.

**TABLE
12-6**

Distribution of 2021 MA bids relative to FFS

Bids as a percent of FFS spending	Share of bids	Share of projected MA enrollment
Less than 70%	5%	4%
At least 70%, less than 80%	15	20
At least 80%, less than 90%	32	34
At least 90%, less than 100%	35	33
At least 100%, less than 110%	11	7
110% or more	3	1

Note: MA (Medicare Advantage), FFS (fee-for-service). Employer group plans and special needs plans are not included. Percentages do not account for unaddressed coding intensity differences. Totals may not sum to 100 percent due to rounding.

Source: MedPAC analysis of data from CMS on plan bids, enrollment, benchmarks, and FFS expenditures.

Our estimates of the benchmarks relative to projected FFS spending, the bids relative to projected FFS spending, and the resulting payments to MA plans relative to projected FFS spending are calculated using plans’ bid projections to compare projected MA spending with projected FFS spending on a like set of FFS beneficiaries. Benchmarks are set each April for the following year. Plans submit their bids in June and incorporate the recently released benchmarks. Benchmarks reflect FFS spending estimates for 2021 made by CMS actuaries at the time the benchmarks were published in April 2020. (See the text box about the effect of the coronavirus pandemic on our 2021 estimates, p. 372.) The bid data mask the impact of differences in MA and FFS diagnostic coding. Accounting for these differences would increase overall bids, benchmarks, and payments to MA plans by about 3 percentage points. However, using the bid data allows for subgroup comparisons, such as by MA plan type, shown in Table 12-3 (see p. 366).

The ratio of MA plan payments to FFS spending for 2021 varies by plan type (Table 12-5). For example, HMOs as a group bid an average of 86 percent of FFS spending, yet payments for HMO enrollees are estimated to average 100 percent of FFS spending because of benchmarks averaging 108 percent of FFS spending. Local PPOs’ bids average 92 percent of FFS spending, and PFFS plans have average bids of 100 percent of FFS spending. As a result, payments for local PPO and PFFS enrollees are estimated to be 103 percent and 104 percent of FFS spending, respectively. Payments for beneficiaries enrolled in regional PPOs’ average 94 percent of FFS because of the regional PPOs’

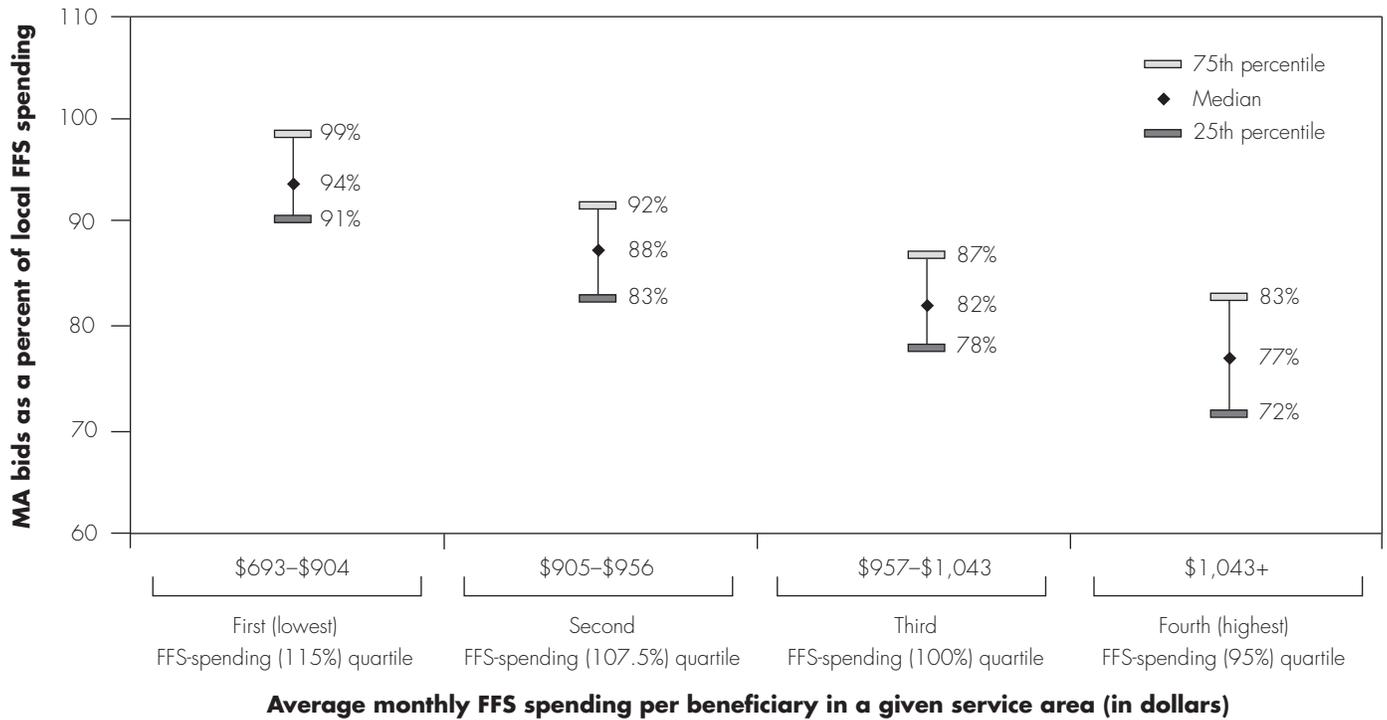
relatively low benchmarks (which are a blend of regional plans’ bids and FFS spending).

We analyzed bids and payments to SNPs separately because these plans are available only to subpopulations of Medicare beneficiaries, and bidding behavior can differ from that of other plan types. In the past, SNPs’ bids and payments tended to be slightly higher (relative to FFS spending) than payments to the other nonemployer MA plans. In the three most recent years in aggregate, although SNP bids are slightly higher than other MA plans’ bids, their payments are similar to the average plan.

In the past, we recommended that CMS pay employer plans differently because the employer bids were not usually submitted for a competitive purpose, while the bids for other plans are submitted to compete for enrollment. (For more details on employer plans and our recommendation, see our March 2014 report to the Congress, available at <http://www.medpac.gov>.) As we recommended, CMS no longer pays the employer plans based on their bids. In 2017, CMS began paying employer plans based on the bidding behavior of nonemployer plans. As a result, we expect that payments to employer plans will look somewhat like the payments to the plans in our analysis. We will continue to monitor MA payments to employer plans.

Variation in 2021 MA bids and payments

Almost all plans (about 87 percent) bid to provide Part A and Part B benefits for less than what the FFS Medicare program would spend to provide these benefits (Table 12-6). These plans are projected to enroll about 91

FIGURE 12-3**Medicare Advantage bids in relation to FFS spending levels, 2021**

Note: FFS (fee-for-service), MA (Medicare Advantage). This figure is based on 3,797 plan bids and excludes employer group plans, special needs plans, and plans in the territories. Percentages do not account for unaddressed coding intensity differences. The FFS spending denominator used in the figure includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. Comparing bids with spending for FFS enrollees with both Part A and Part B would decrease overall MA bids relative to FFS spending by about 1 percentage point.

Source: MedPAC analysis of data from CMS on plan bids and FFS expenditures.

percent of MA enrollees, excluding those in employer group and special needs plans. About 4 percent of MA enrollees are projected to enroll in plans that bid lower than 70 percent of FFS spending; 1 percent are projected to enroll in plans that bid more than 110 percent of FFS spending.

Although plan bids average less than FFS spending, payments for these plans' enrollees can exceed FFS spending because the benchmarks (including the quality bonuses) can be high relative to their area's FFS spending. Figure 12-3 shows how plans bid relative to FFS for service areas with different ranges of FFS spending. Each of the four FFS ranges covers the bids of at least 432 plans that include at least 2.9 million projected enrollees. As expected, plans bid higher (relative to FFS) in areas

with relatively low FFS spending and bid lower (relative to FFS) where FFS spending is relatively high. However, even in service areas with the lowest FFS spending, less than \$905 per month on average, most plans bid less than the FFS spending level for 2021 (Figure 12-3). In plan service areas averaging \$905 or more per month in FFS spending, most plans are likely to bid far below the FFS level. This finding suggests that, geographically, plan costs do not vary as much as FFS spending. After the ACA began lowering benchmarks in 2012, plans serving areas with benchmarks set at 115 percent of FFS spending (the lowest spending quartile, corresponding to areas with benchmarks below \$905 per month in 2021) began bidding below FFS far more frequently. The median bid for areas in this quartile declined between 2013 and 2021 from 111 percent to 94 percent of FFS. However, the

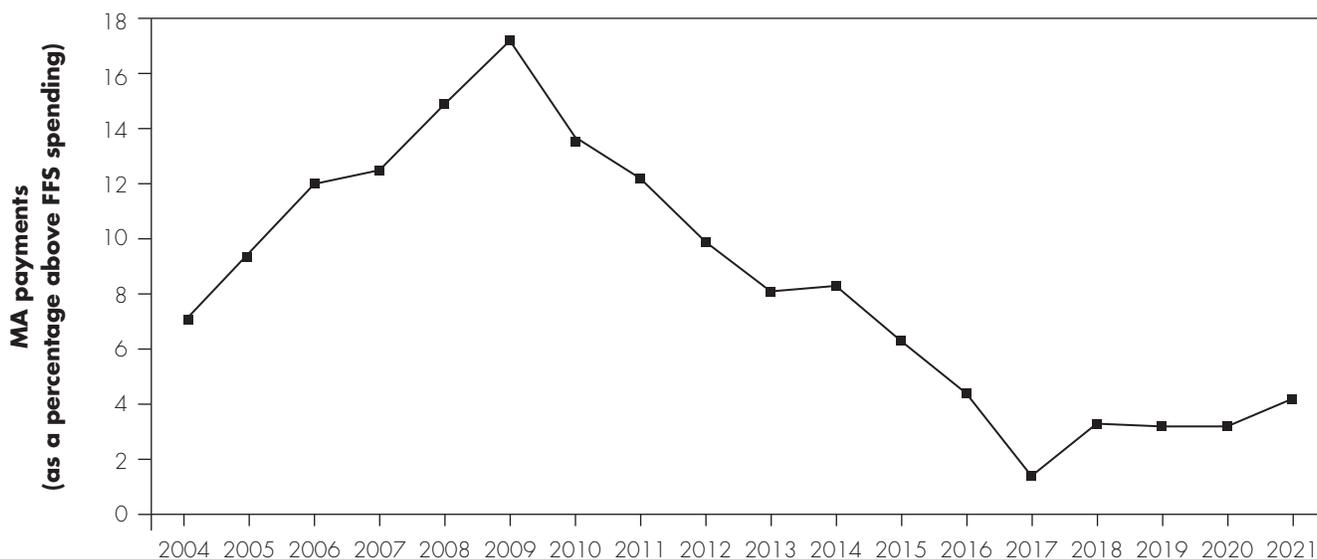
Aggregate Medicare payments to Medicare Advantage plans have never been lower than FFS Medicare spending

Our review of private plan payments suggests that over a 35-year history, the many iterations of full-risk contracting with private plans have never yielded aggregate savings for the Medicare program. Throughout the history of Medicare managed care, the program has paid more—sometimes much more—than it would have paid for beneficiaries to have remained in fee-for-service (FFS) Medicare. Evaluations of private plan payment rates under Medicare demonstrations occurring before 1985 found that payment rates were 15 percent to 33 percent higher than FFS

Medicare (Langwell and Hadley 1990). Between 1985 and 2004, risk adjustment was inadequate and led to private plan payments that were higher than FFS Medicare (5 percent to 7 percent higher in the late 1980s and through the mid-1990s) (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996). Figure 12-4 shows that since 2004, payments to Medicare Advantage plans have been above the amount FFS Medicare would have spent for the same beneficiaries. ■

FIGURE 12-4

Medicare has paid more to MA plans than FFS Medicare spending would have been for the same enrollees, 2004–2021



Note: MA (Medicare Advantage), FFS (fee-for-service). Benchmark increases under the quality bonus demonstration applied from 2012 through 2014 and under the quality bonus program applied starting in 2015. The figure reflects the Commission's estimates of the impact of coding intensity, beginning in 2007. In the figure, we conservatively assume that the coding intensity impact for 2020 and 2021 is the same as for 2019 (the most recent year of data available). Alternatively, assuming a coding intensity impact based on historical trend would increase MA payments by 1 percentage point in 2020 and by 2 percentage points in 2021. The FFS spending denominator in the figure includes all Part A and Part B spending. MA enrollees must be enrolled in both Part A and Part B. For 2017, we estimated that FFS spending for enrollees with both Part A and B was about 1 percentage point higher than spending for all FFS enrollees. Comparing payments to MA plans with spending for FFS enrollees with both Part A and B would shift the line in the graph down about 1 percentage point.

Source: MedPAC reports to the Congress 2006 through 2020, MedPAC analysis of 2021 data from CMS on plan bids and FFS expenditures.

The impact of the coronavirus pandemic on 2021 benchmarks, bids, and payments relative to FFS spending

Since early 2020, the ongoing coronavirus pandemic and associated public health emergency (PHE) have had tragic effects on beneficiaries. They have also affected providers' patient volume and costs. Overall utilization of health care services dropped sharply beginning in March 2020, though by summer had returned to near-normal levels for many types of services. Although the pandemic's impact on utilization has varied by type of service and geographic region, the aggregate reduction in utilization due to delaying or forgoing the more common treatments has been only partially offset by use of health care services related to treatment of COVID-19. For Medicare Advantage (MA) plans and other payers of medical services, the pandemic has lowered overall medical expenditures. In financial reports, public MA insurers reported medical expenses as a share of revenue (or medical loss ratios (MLRs)) at or near record lows during the second quarter of 2020 (April through June). In the third quarter of 2020, most MA insurers reported MLRs that were closer to, but still below normal, third quarter levels.¹⁷ Meanwhile, because Medicare payments to MA plans are established before the start of each calendar year based on prior year data, plan revenues in 2020 have remained at normal levels. As a result, plan profitability has increased during the pandemic, with one study of 2018 to 2020 financial data from the National Association of Insurance Commissioners finding that MA plans were more profitable during the first three quarters of 2020 compared with the first three quarters of 2018 and 2019 (McDermott et al. 2020). Although insurers remain concerned about delayed care rebounding as the pandemic ebbs, boosting future

medical expenses above normal levels, that scenario had not borne out as of publication of this report. In response to the coronavirus PHE, CMS allowed plans to change their benefit package in mid-2020. Many plans used the opportunity to reduce premiums or cost sharing, reflecting plans' lower medical expenditures.¹⁸

Our estimates of plan payments do not take into account the impact of the coronavirus pandemic, but given the prospective nature of MA payments, we do not anticipate the pandemic having a substantial impact on MA payments in 2021. We use CMS's estimate of 2021 fee-for-service (FFS) spending, which uses data through 2019 as the basis for 2021 MA benchmarks, bids, and payments. This estimate also represents the FFS spending levels assumed by plans when they submitted bids for 2021 in June of 2020. We do not yet know the full effect of the pandemic on beneficiary spending in 2021 and 2021 risk scores based on services in 2020. However, the record level of plan rebates in 2021 and the wider availability of zero-premium plans indicate that plans anticipate continued ability to offer bids far below payment benchmarks. We also note that MA coding intensity increased 2019 MA risk scores and payments by more than 3 percentage points and continues to increase MA risk scores and payments by 1 percentage point per year. At the start of 2021, many plans are at a financial advantage due to coding intensity before accounting for any potential negative impact on 2021 risk scores due to the pandemic. We will continue to monitor the impact of the coronavirus pandemic on plan availability and MA payments. ■

increasing efficiency demonstrated by plan bids in these areas, which were presumed to be the most challenging for MA plans to compete in, have not translated to Medicare savings. For 2021, Medicare is still paying an average of 109 percent of FFS spending in these areas because the benchmarks average 116 percent of FFS when quality bonuses are included.

MA margins

The continued growth in MA enrollment, the ability of MA plans to bid well below FFS expenditure levels, and plans' ability to provide generous extra benefits point to continued strong financial health in the MA sector. Margins for MA sponsors have remained stable. The most recent data available, from 2019, show that MA

plans reported margins that averaged 4.5 percent.¹⁹ This figure excludes Part D—for which we do not have 2019 data—and the following plan categories that do not submit bids: employer group plans, the Medicare–Medicaid demonstration plans, cost-reimbursed plans, Program of All-Inclusive Care for the Elderly, and medical savings account plans. In addition, the ownership of plans and providers under the same organization may overestimate plan medical expenses and underestimate plan margins. The degree to which provider revenues are shared with plans under these arrangements is unknown.

We estimate that including Part D drug margins would raise the average MA plan margin by approximately 0.5 percent; and if employer plan data were available, the margin levels would likely be higher. The absence of data on employer plans—20 percent of MA enrollment in 2019—limits our ability to determine the average margin in the MA sector. In prior years, when employer plan bids were included in the bid data, we found that employer plan margins were higher than the margins of other MA plans (Medicare Payment Advisory Commission 2016).

Margins vary by plan tax status. In the 2019 data, nonprofit plans reported a margin of 0.9 percent; for-profit entities reported a pretax margin of 5.4 percent. As noted in our March 2018 report to the Congress, the large difference in margins (4.5 percentage points) between for-profit and nonprofit entities could be because the bid data do not include employer group plans (Medicare Payment Advisory Commission 2018b). Given the relatively high margins of employer group plans in prior years, including these plans would at least modestly increase MA margins for nonprofit plans whose overall MA business is disproportionately more reliant on employer group plans. In addition, many nonprofit plans are sponsored by providers, and this relationship may obscure plan margins. Further, for-profit entities' MA plan margins were slightly higher in 2019 because MA plans were subject to payment of the ACA insurer fees in 2018 but not 2019.²⁰ In 2018, the insurer fees represented about 1.5 percent of total revenue.

All categories of SNPs had positive margins in 2019. Dual-eligible SNPs (D–SNPs), for Medicare–Medicaid dual-eligible beneficiaries, had margins of 7.8 percent. SNPs for enrollees with certain chronic conditions (C–SNPs) had margins of 10.7 percent. Institutional SNPs (I–SNPs) had margins of 12.1 percent. The 2019 profit margin among nonprofit D–SNPs was 2.5 percent.

Medicare Advantage risk adjustment and coding intensity

Medicare payments to MA plans are adjusted to account for differences in expected beneficiary medical costs. The purpose of risk adjustment is to ensure that plans are adequately and fairly compensated for treating all categories of enrollees—those with high medical costs as well as other enrollees with less health care utilization. If the risk adjustment system is flawed, misaligned incentives could result in “favorable selection,” in which plans have an incentive to attract certain types of beneficiaries and avoid enrolling others. Plans can achieve unwarranted profits if the risk adjustment system overpays for some enrollees and underpays for other enrollees.

Medicare payments to private plans in the early years of the program were not sufficiently risk adjusted. By avoiding counties with high hospital spending and by marketing to healthy beneficiaries, plans were able to disproportionately attract profitable enrollees. Other factors contributed to favorable selection for plans: Beneficiaries could choose to enroll in or disenroll from a plan on a monthly basis, and sicker beneficiaries preferred FFS Medicare (Medicare Payment Advisory Commission 2000, Newhouse et al. 1989). Research demonstrated that favorable selection of enrollees led to Medicare spending on private plans that was 5.7 percent higher in 1989 and 7 percent higher in the mid-1990s than spending would have been under FFS Medicare (Brown et al. 1993, Medicare Payment Advisory Commission 1998, Newhouse 2002, Riley et al. 1996).

The Balanced Budget Act of 1997 required Medicare to improve risk adjustment for private plan payments and mandated the collection of diagnoses from inpatient claims. Initially, a small share of payment to plans was based on a new risk adjustment model using principal inpatient diagnoses. The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 expanded risk adjustment to include the use of diagnoses from ambulatory settings. From 2004 through 2006, Medicare phased in the CMS hierarchical condition category (CMS–HCC) model, which uses diagnoses collected from hospital visits (both inpatient and outpatient) and physician office visits in addition to beneficiary demographic information.

The CMS–HCC risk adjustment model, coupled with policies requiring plans to enroll all eligible Medicare

beneficiaries who elect a plan and locking in MA enrollees for the calendar year (with limited exceptions), has generally reduced favorable selection for MA plans. However, some favorable selection may persist as beneficiaries who use more services may be wary of plans' limits on provider choice and thus may be less likely to enroll in MA; if they do enroll, they may be more likely to disenroll and return to FFS than beneficiaries who use fewer services (Jacobson et al. 2019, McWilliams et al. 2012, Newhouse et al. 2012).

Although favorable selection has been reduced, the CMS–HCC model's reliance on diagnosis codes creates a financial incentive for MA plans to document diagnosis codes more thoroughly than in FFS Medicare. In 2019, differences in diagnostic coding caused Medicare to pay MA plans \$9 billion more than it would have spent if the same beneficiaries had been enrolled in FFS Medicare.

The CMS–HCC risk adjustment model

The risk adjustment model uses demographic information (e.g., age, sex, Medicaid enrollment, and disability status) and certain diagnoses grouped into HCCs to calculate a risk score for each enrollee. HCCs are medical conditions or groups of related conditions with similar treatment costs. Higher risk scores generate higher payments because beneficiaries with high risk scores are expected to have higher expenditures and vice versa. CMS designed this risk adjustment model to maximize its ability to predict annual medical expenditures for Medicare beneficiaries, with some constraints. In developing the model, CMS used statistical analyses to select certain HCCs for inclusion in the model based on an HCC's ability to predict annual Medicare expenditures, ensuring that the diagnostic categories included in the model were clinically meaningful and specific enough to minimize opportunities for gaming or discretionary coding (Pope et al. 2004). CMS applies additional criteria to ensure the validity and reliability of the model's diagnostic data. To be used in determining payment to MA plans, (1) diagnoses must appear on a claim from a hospital inpatient stay, a hospital outpatient visit, or a face-to-face visit with a physician or other health care professional (including real-time audio and video telehealth visits), and (2) diagnoses must be supported by evidence in the patient's medical record.²¹ Diagnoses resulting from telehealth services meet the face-to-face requirement when the services are provided using interactive audio telecommunication simultaneously with

video telecommunication to permit real-time interactive communication with the beneficiary.

Diagnostic data in the CMS–HCC model are used prospectively, meaning that diagnoses collected during one calendar year are used to predict Medicare costs for the following calendar year. HCCs are counted toward an enrollee's risk score if any of the underlying diagnosis codes are submitted on a hospital or physician claim at any time during the data collection year. Multiple submissions of the same diagnosis code and submissions of different diagnosis codes that are grouped in the same HCC do not affect an enrollee's risk score.

MA plans submit diagnostic information to CMS in two ways: (1) through the Risk Adjustment Processing System (RAPS), to which plans submit the minimum information necessary to identify which HCCs apply to each enrollee, and (2) through the encounter data system (EDS), to which MA plans submit detailed information about each Medicare-covered encounter an enrollee has with a health care provider and each Medicare-covered item provided to the enrollee. CMS initially used RAPS to calculate risk scores, but in 2016, it began a transition to use encounters as the source of diagnostic information by generating two risk scores, one based on RAPS data and one based on EDS data.²² Figure 12-5 shows the use of encounter data for risk adjustment since 2016. In that year, payment was based on a blend of the RAPS risk score (90 percent) and the EDS risk score (10 percent). In 2017, CMS increased the portion of the payment based on EDS risk scores to 25 percent. Facing opposition from plans, CMS reduced the portion of the payment based on EDS risk scores to 15 percent in 2018, and in 2019 began pooling EDS data with inpatient RAPS data and basing the remainder of risk scores on RAPS data alone.²³

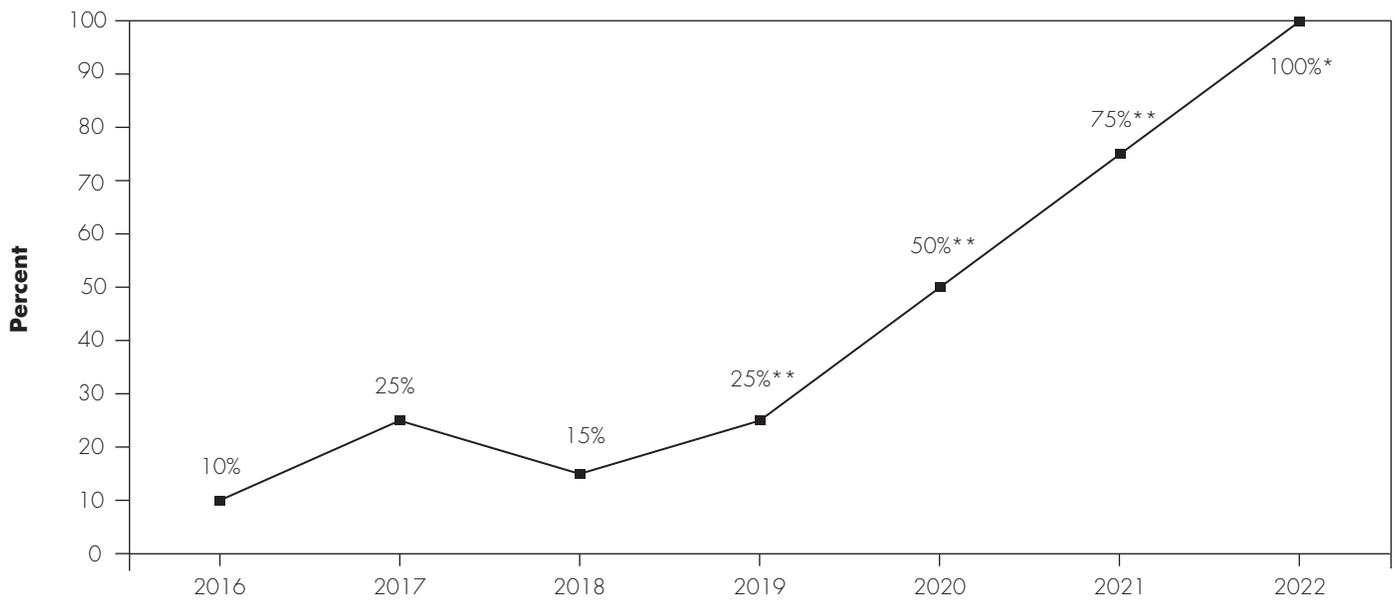
The share of risk scores based on pooled EDS and inpatient RAPS data increased to 50 percent in 2020 and 75 percent in 2021; for 2022, CMS will base risk scores entirely on encounter data with no use of RAPS data.²⁴ The Commission has strongly supported basing MA risk scores entirely on encounter data.

The incentive to code diagnoses more thoroughly in MA

Documenting additional diagnosis codes increases enrollees' risk scores, which both increases the monthly payment amount a plan receives and increases the rebate amount a plan uses to provide extra benefits to enrollees.

**FIGURE
12-5**

Use of encounter data for MA risk scores, 2016–2022



Note: MA (Medicare Advantage).

*Proposed for 2022.

**For 2019, 2020, and 2021, CMS added inpatient Risk Adjustment Processing System data to encounter data, making the true proportion of risk scores based on encounter data less than the percentage noted in the figure.

Source: CMS announcement of MA rates for 2016 through 2022.

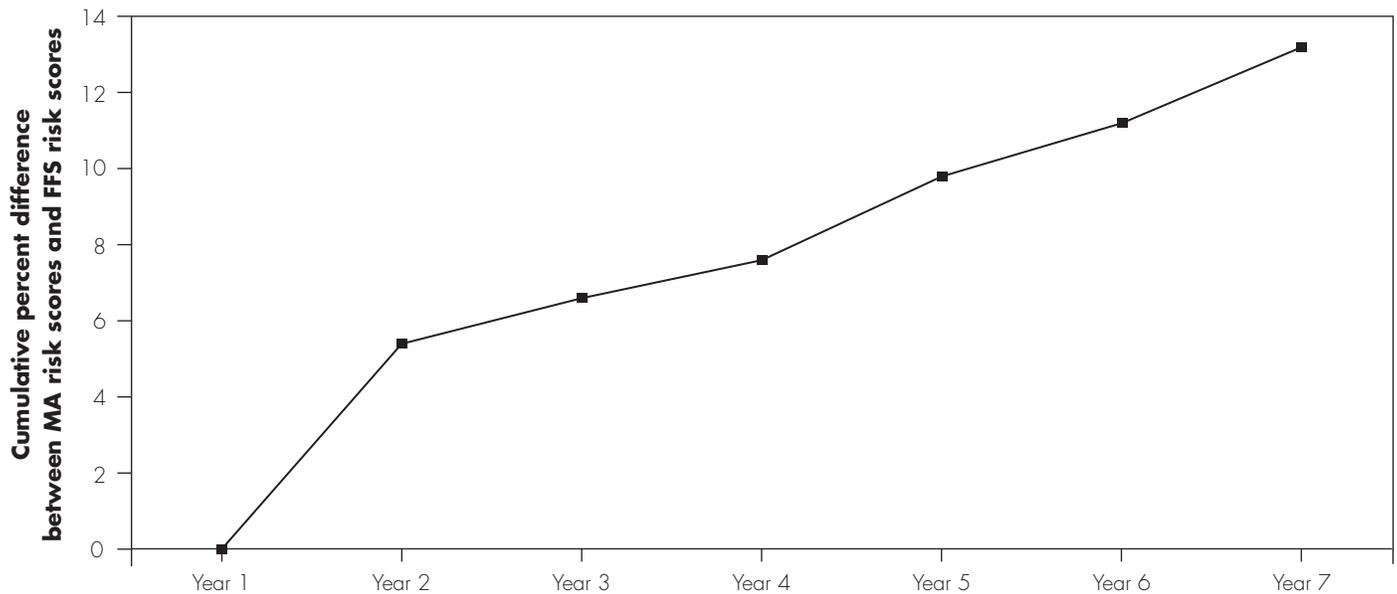
Each demographic and HCC component in the risk adjustment model has a coefficient that represents the expected medical expenditures associated with that component. These coefficients are estimated using FFS Medicare claims data such that all Medicare spending in a year is distributed among the model components. Medicare payment for an MA enrollee is approximately equal to the sum of the dollar-value coefficients for all components identified for that enrollee. Although the actual dollar amount a plan will receive for newly identifying an HCC depends on several additional factors, we consider a simplified example using average FFS Medicare spending to show how coding additional HCCs increases payment to a plan.²⁵ To illustrate, the annual Medicare payment to the MA organization in 2018 for an 84-year-old male who was not eligible for Medicaid (demographic component valued at \$5,707) with diabetes without complication (HCC 19, valued at \$1,058) would have been \$6,765, the sum of the two model components.

Documenting each additional HCC for an enrollee can significantly increase the Medicare payment. If the same 84-year-old male with diabetes were also found to have vascular disease (HCC 108, valued at \$3,031), the Medicare payment to the MA organization would increase from \$6,765 to \$9,796. The payment per MA enrollee for most HCCs is between \$1,000 and \$5,000, although some HCCs increase payment by \$10,000 or more.

Because the CMS–HCC model is based on FFS Medicare claims data to estimate the size of the model coefficients, the model calculates an expected spending amount based on FFS Medicare costs and diagnostic coding patterns. Most diagnoses are reported through physician and outpatient claims, which in FFS Medicare tend to be paid based on procedure codes and provide little incentive to document diagnoses for FFS beneficiaries.²⁶ If certain diagnoses are not reported on FFS claims, the cost of treating those conditions is attributed to other components in the model, causing the coefficients overall to be inflated

**FIGURE
12-6**

Average MA risk scores grew fastest relative to average FFS risk scores in the first cohort year, for all enrollment cohorts 2007 through 2013



Note: MA (Medicare Advantage), FFS (fee-for-service). Analysis includes six MA and FFS cohort pairs ending in 2013 and starting in 2007 through 2012.

Source: MedPAC analysis of CMS enrollment and risk score files.

above the value they would have if the diagnoses had been reported. It is necessary for MA payment accuracy that diagnoses be coded with the same intensity in FFS Medicare and MA, meaning that if all diagnoses reported in one program would also be reported in the other program, coefficients would produce accurate payments and would not be inflated. However, when MA plans submit more diagnoses for a beneficiary than would have been documented in FFS Medicare, the program spends more for that beneficiary in MA than it would have if the beneficiary were in FFS. We have found that because of the financial incentives for MA plans to code as many diagnoses as possible, coding intensity is higher in MA than in FFS Medicare, whose structure lacks such incentives, and payments to MA plans are thus higher than intended.

We used data from 2007 through 2013 to test whether beneficiary risk scores grew faster in MA than in FFS. We built cohorts of beneficiaries who spent their first full calendar year of Medicare enrollment and all subsequent

years through 2013 in the same program, either FFS or MA. For example, one cohort pair consisted of those beneficiaries who joined FFS Medicare during 2006 and then either (1) remained exclusively in FFS through 2013 or (2) switched into MA in January 2007 and remained in MA through 2013. We also examined five similar pairs of cohorts for beneficiaries whose first full years in Medicare were 2008 through 2012. Beneficiaries were assessed starting with their first full year of Medicare enrollment so that the subsequent differences in the risk score growth between the cohort pairs could be attributed to differences in coding.

Figure 12-6 shows how average MA risk scores changed relative to the change in average FFS risk scores for all pairs of cohorts. From year 1 to year 2, average MA risk scores increased by about 6 percent more than FFS across all cohorts. For each subsequent year, average MA risk scores continued to increase more than FFS scores by about 1.5 percent across all cohorts.

**TABLE
12-7**

Illustrative example: Differences in plan risk scores affect the level of extra benefits

Plan	Bid: Monthly cost of care for expected population	Risk score of expected population	MA benchmark for the county for an average-risk population (+5% for bonus plan)	Risk-adjusted benchmark for this plan (benchmark multiplied by risk score)	Rebate base (risk-adjusted benchmark less cost of care)	Share of base for rebates	Value of extra benefits (rebate amount)
Nonbonus plans							
Plan A (3.5 stars)	\$900	0.97	\$952	\$924	\$24	65%	\$15
Plan B (3.5 stars)	900	1.03	952	981	81	65	53
Bonus plan							
Plan Z (4 stars)	900	0.97	1,000	970	70	65	46

Note: MA (Medicare Advantage). An average-risk population has a risk score of 1.0. This example assumes that the actual cost of care for the expected population is \$900 for each of the three plans and that Plan B's risk score of 1.03 is inflated due to greater diagnostic coding effort.

Higher payments to MA plans due to differences in coding intensity in MA and FFS Medicare are the result of a failure in risk adjustment policy, violating the assumption that diagnoses are documented with the same intensity in FFS Medicare (where less incentive exists) and in MA (where significant incentive exists). MA plans that document additional diagnoses for their enrollees (relative to FFS Medicare) are reacting to incentives when those diagnoses are accurate and properly supported by medical evidence. MA plans that report inaccurate diagnoses for the purpose of receiving unwarranted payments risk financial penalty if inaccurate diagnoses are discovered during risk adjustment data validation audits.

In addition to the direct increase in payment rates, greater diagnostic coding can allow a plan to offer more extra benefits and potentially attract more enrollees. The first step in the bidding process determines whether a normalized plan bid (for a person of average risk, or a 1.0 risk score) is at or above the plan's normalized benchmark (for the plan's service area). For plans that bid below the plan's benchmark, the second step of the bidding process determines the rebate amount available for extra benefits by comparing a plan's bid for its expected composition of enrollment (that is, it is not normalized to 1.0) and the area benchmark adjusted by the plan's expected average risk score. The size of the rebate (or the value of extra benefits) is a share of the difference between the bid and

risk-adjusted benchmark. Plans that put more effort into documenting all diagnosis codes, increasing their average risk score relative to other plans, can inflate the dollar value difference between the plan's bid and risk-adjusted benchmark, leading to greater value of extra benefits for the plan.

Table 12-7 illustrates this effect, using three hypothetical plans that cover the same set of hypothetical enrollees and therefore have the same cost of care, at \$900 per member per month. Although all three plans have actual costs of \$900 per member per month, Plans A and Z have an expected risk score below 1.0 (at 0.97), and Plan B has an expected risk score of 1.03 due to more aggressive diagnostic coding. All three plans have bids below the risk-adjusted benchmark and must provide extra benefits funded by rebates. Because Plan B has a higher risk score, its rebate is larger than Plan A's rebate and it can offer enrollees more benefits: \$38 per month more in extra benefits (\$53 minus \$15). Because Plan B's aggressive diagnostic coding effort has inflated its risk score (its risk score otherwise would be the same as that of Plan A and Plan Z), Plan B will have an unfair competitive advantage. The higher risk score also gives Plan B, which has only 3.5 stars, an advantage over bonus-level Plan Z; Plan B has a higher total rebate amount: \$7 more. Thus, by increasing its risk score from 0.97 to 1.03, Plan B will be able to offer a level of extra benefits that is of more value than

that provided through quality bonuses. Thus, differences in coding practices can more than offset the effect of MA quality bonuses and can have significant consequences for MA payment policy.

The plans illustrated in Table 12-7 (p. 377) have a risk score difference of 6 percentage points that reflects only coding practices. The Commission's analysis of MA coding practices suggests that there is a far wider range of coding variation, with several contracts having risk scores inflated by 15 percent or 20 percent above FFS due to coding practices (see Figure 12-8, p. 382).

Mechanisms of coding more diagnoses in MA

MA plans use several mechanisms that do not exist in FFS Medicare to document diagnoses for their enrollees. Diagnoses documented through these mechanisms generate higher coding intensity compared with FFS Medicare and contribute to higher MA payments.

MA plans often identify enrollees with missing HCCs by using an enrollee's historical information (e.g., electronic health records, claims, or risk score data) when it is available, or by identifying likely diagnoses in data that are not used in MA risk adjustment, such as prescription drug data (e.g., a prescription for insulin likely indicates a diabetes diagnosis). Plans then need to ensure that all diagnoses are appropriately documented in the current year to count toward MA payment. This documentation can be facilitated by greater sharing of diagnostic information. For example, providers can give plans access to electronic medical records and, under capitated arrangements, pay physicians a risk-adjusted sum per enrollee, thereby passing the coding incentives on to physicians with direct access to medical records and diagnostic information. In addition, plans actively collect diagnoses through health risk assessments, chart reviews of earlier provider encounters, and pay-for-coding programs, which pay doctors to complete patient assessment forms that confirm diagnoses that have not yet been documented. While these efforts can be used to improve care management, some companies offering services to collect diagnostic information use language that targets enrollees based on a lack of documentation rather than a clinical need. Our March 2018 report to the Congress describes the mechanisms that we believe contribute to higher rates of diagnosis documentation in MA, resulting in higher payments (Medicare Payment Advisory Commission 2018b).

Our prior work closely examined MA plans' use of health risk assessments to document additional diagnosis codes (Medicare Payment Advisory Commission 2016). Some MA plans spend significant resources calling enrollees, offering incentives to have them participate in health risk assessments, and sending nurses to enrollees' homes to conduct health risk assessments. We calculated that diagnoses supported only by a health risk assessment—where no treatment was provided during the year—accounted for about 1 percentage point to 2 percentage points of overall MA coding intensity impact. The Office of Inspector General (OIG) found that in 2017, diagnoses supported only by a health risk assessment—80 percent of which were the result of in-home health risk assessments—accounted for payments to MA plans of \$2.6 billion (Office of Inspector General 2020). We note that this amount is about 1.2 percent of payments to MA plans in 2017. Medicare should not reimburse MA plans for medical conditions that were not treated. At least one plan sponsor is alleged to have used its health risk assessment program to submit invalid and unsupported diagnosis codes to CMS with the knowledge of plan officials (United States of America ex rel. Robert A. Cutler v. Cigna Corp. 2020).

MA plans' use of chart reviews to increase diagnosis coding

Some MA plans devote significant effort to chart reviews to increase MA payments. Because chart reviews are not used in FFS Medicare, all diagnoses based on chart reviews contribute to differences in FFS and MA diagnostic coding and contribute to overpayments to MA plans. Chart reviews document the diagnoses made during hospital and physician encounters in which medical services were provided. MA plans use chart reviews to identify diagnoses not captured through the usual means of reporting diagnoses (e.g., claims data and encounter data): Sometimes the diagnoses are not reported on the provider's claim that is sent to the MA plan, and sometimes the MA plan does not submit a record of the encounter to CMS. Because Medicare requires each HCC to be supported by diagnostic evidence in a patient's medical record, medical record reviews are a logical way for plans to identify diagnoses not captured through provider claims or on plan encounter data. However, chart review programs are used exclusively in MA (there is no incentive to undertake chart reviews in FFS Medicare) and thereby exacerbate Medicare's failure to sufficiently account for differences in MA and FFS diagnostic coding.

Some MA plans treat chart review programs as an independent revenue stream that yields a positive return on investment (ROI) by generating additional Medicare payments from newly documented diagnoses that exceed the costs of paying nurses and medical assistants to review medical charts.²⁷ Ongoing lawsuits allege that MA plans use chart reviews to identify new diagnosis codes, but not to verify the accuracy of already submitted codes, even when the plan sponsor is aware that some diagnoses that have been submitted are not supported by the chart review (violating Medicare’s rule that diagnoses must be supported by a medical record, and a code already submitted should be deleted if the plan finds no evidence in the medical record to support the diagnosis). Documentation from these whistleblower lawsuits sheds light on the profitability of chart reviews. During 2005 and 2006, just one year after the CMS–HCC model began to be phased in, one plan sponsor contracted with a chart review vendor to conduct three batches of chart reviews, yielding ROIs ranging from 22:1 to 30:1 (United States of America ex rel. James M. Swoben v. Secure Horizons 2017). Between 2010 and 2015, a large insurer obtained over \$3 billion in additional MA payments from its chart review program (United States of America ex rel. Benjamin Poehling v. UnitedHealth Group 2016). In 2015, a different MA plan sponsor spent about \$19 million conducting over 500,000 chart reviews and was able to net over \$94 million in profits, yielding an ROI of 6:1 (United States of America v. Anthem 2020). Some plans and vendors appear to selectively review charts with a higher likelihood of increasing revenue and are using artificial intelligence to more accurately identify likely revenue-producing charts (Optum 2020). One vendor claims that its clients have received ROIs between 6:1 and 12:1 (Blue Health Intelligence 2020). Although the financial return is clearly worth plan sponsors’ effort and financial investment, chart review programs offer questionable benefits for plan enrollees and are detrimental for the taxpayers funding the Medicare program.

Medicare accepts chart reviews as evidence of a diagnosis for risk adjustment. In RAPS data, plans do not identify the source of the information—provider claims or chart reviews—submitted for risk adjustment. For encounter data, plans submit records of chart reviews along with records of encounters with health care providers. Some chart review records are linked to a specific provider encounter, but CMS also allows plans to submit “unlinked chart review records,” where the provider encounter that is the subject of the chart review is not specified. Some chart

review records provide evidence of provider encounters for which the plan has not submitted an encounter record. For use in risk adjustment, CMS uses both encounter records and chart review records from hospital and physician visits as the source of diagnostic data.

OIG analyzed 2016 encounter data and found that 80 percent of MA contracts submitted at least one chart review and that plans submitted a total of 52.6 million chart reviews during the year (Office of Inspector General 2019). Of those chart reviews, 17 million contained diagnoses that were not documented on any health care encounter record. Although plans can use chart reviews to add or delete diagnoses from encounters, OIG found that less than 1 percent of chart reviews were used to delete diagnoses, decreasing payments by \$196.5 million. Chart reviews adding diagnoses increased payments to MA plans by \$6.9 billion (resulting in a net payment increase of \$6.7 billion, which we note is about 3.2 percent of payments to MA plans in 2017). Chart reviews that were not linked to a specific provider encounter accounted for \$2.7 billion of the increased payments. Although chart reviews are common in MA, the use of chart reviews varied across contracts or plan sponsors. OIG found that 10 MA contracts accounted for one-third of the additional payments, and that 10 out of 137 parent organizations accounted for 79 percent of the increased payments to MA plans.

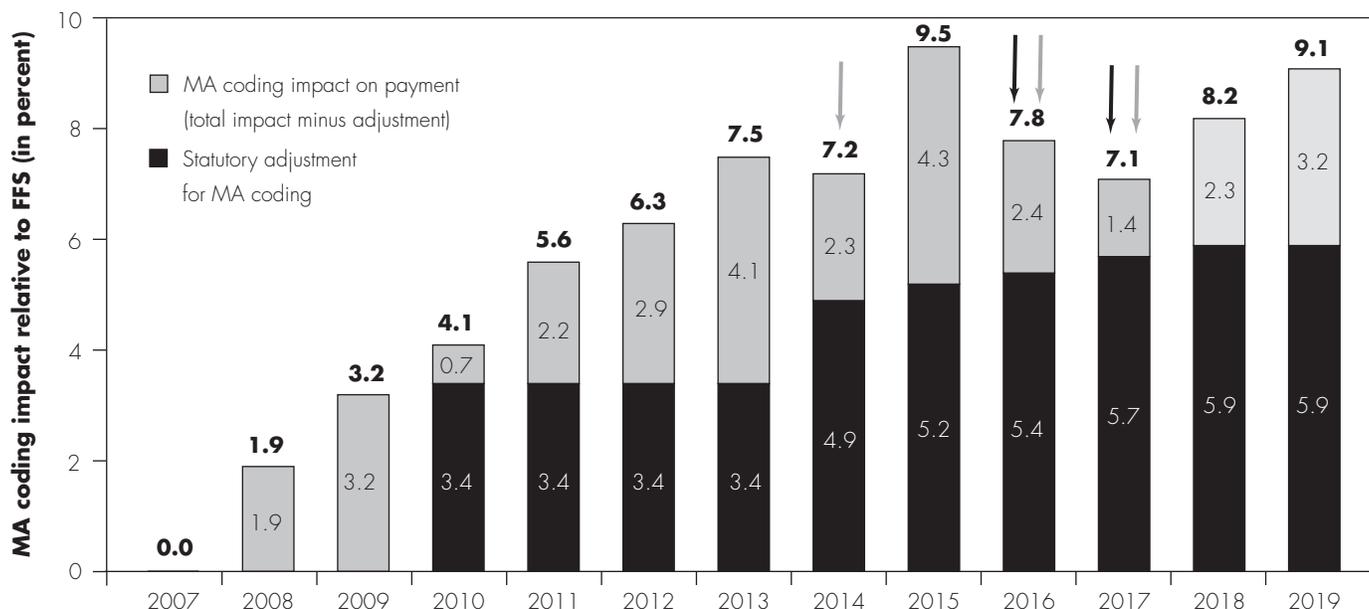
For 2017, we estimated that MA risk scores were about 7.1 percent higher than FFS risk scores before applying the mandatory coding adjustment. Based on OIG’s findings that in 2017 health risk assessments accounted for \$2.6 billion (or 1.2 percent of total payments to plans) and chart reviews accounted for \$6.7 billion (or 3.2 percent of total payments to plans), we estimate that health risk assessments and chart reviews were responsible for more than 60 percent of MA coding intensity in 2017.

Policies to address the impact of coding differences

A series of congressional mandates has required CMS to reduce MA risk scores to address the impact of coding differences between MA and FFS. Because of these mandates, CMS reduced MA risk scores by 3.41 percent in each year from 2010 through 2013. Starting in 2014, legislation specified a minimum reduction of about 4.9 percent, which increased gradually to about 5.9 percent in 2018, where it will remain until CMS estimates a risk adjustment model using MA cost and

**FIGURE
12-7**

Impact of coding intensity on MA risk scores was larger than coding adjustment, 2007–2019



MA coding intensity increased MA risk scores by 1 percentage point or more annually, but was offset by new risk adjustment model versions in 2014, 2016, and 2017 (gray arrows) and by increased FFS coding in 2016 and 2017 (black arrows).

Note: MA (Medicare Advantage), FFS (fee-for-service). All estimates account for any differences in age and sex between MA and FFS populations. Annual adjustment for MA coding began in 2010.

Source: MedPAC analysis of CMS enrollment and risk score files.

use data. CMS reduced MA risk scores by the minimum amount required by law for 2014 through 2021 and has proposed the minimum adjustment amount for 2022, although larger reductions would have been allowed. CMS took an additional step to help control MA’s increased coding intensity by phasing in a new CMS–HCC model that removed some diagnoses suspected of being more aggressively coded by MA plans (e.g., lower severity kidney disease and polyneuropathy). Our analysis suggests that the new CMS–HCC model made MA risk scores more similar to FFS scores by reducing them 2 percentage points to 2.5 percentage points relative to the old model. The new model was phased in during 2014 and 2015, and MA payments were based entirely on the new model starting in 2016.

Before 2017, the HCC model accounted for dual enrollment in Medicare and Medicaid with a set of

variables that increased payment for such enrollees. This approach treated MA enrollees who qualify for full Medicaid benefits and those who qualify for partial Medicaid benefits as a single group even though enrollees with full Medicaid benefits have significantly higher Medicare spending than enrollees with partial Medicaid benefits. As a result, risk scores under the old model were systematically too low for full-benefit dual enrollees and too high for partial-benefit dual enrollees.²⁸ Partial-benefit dual enrollees make up a larger share of dual enrollees in MA than in FFS Medicare, causing the overall risk scores for MA enrollees with Medicaid benefits to be inflated under the old model. CMS began differentiating between MA enrollees with full Medicaid and partial Medicaid benefits in 2017 by using separate models that more accurately determined the risk scores of these two groups.²⁹ We found that the model introduced in 2017

reduced MA risk scores by almost 1 percentage point by more accurately determining risk scores for full-benefit and partial-benefit dual enrollees, among other subgroups.

Coding differences increased payments to MA plans by nearly \$9 billion in 2019

To assess the overall impact of coding differences on payments to MA plans, we built retrospective cohorts of beneficiaries enrolled in either FFS or MA for all of 2019. We tracked each beneficiary backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007, the first year that payment to MA plans was based entirely on CMS–HCC-model risk scores. Our analysis calculated differences in risk score growth by comparing FFS and MA cohorts with the same years of enrollment (e.g., 2007 through 2019, 2008 through 2019), adjusting for differences in age and sex.

Figure 12-7 shows the impact of differences in coding intensity on MA risk scores relative to FFS and the size of the coding intensity adjustment (the amount by which CMS reduced MA risk scores to account for coding intensity) for payment years 2007 through 2019. The figure shows that coding intensity consistently increased MA risk scores by about 1 percentage point or more annually; however, the underlying trend was offset in 2014, 2016, and 2017 by the introduction of new versions of the risk adjustment model and increased FFS coding. The coding intensity adjustment has never accounted for the full impact of coding intensity, resulting in additional spending relative to the amount Medicare would have spent if the same beneficiaries had been enrolled in FFS Medicare.

For 2019, MA risk scores were 9.1 percent above FFS risk scores, and this difference was only partially offset by the coding intensity adjustment that reduced MA risk scores by 5.9 percent. The net effect was a 3.2 percent increase in MA risk scores, leading to nearly \$9 billion in excess payments to MA plans. The magnitude of these findings is consistent with other research showing that the impact of coding differences on MA risk scores is larger than CMS’s adjustment for coding (Congressional Budget Office 2017, Geruso and Layton 2015, Government Accountability Office 2013, Hayford and Burns 2018, Kronick and Welch 2014).

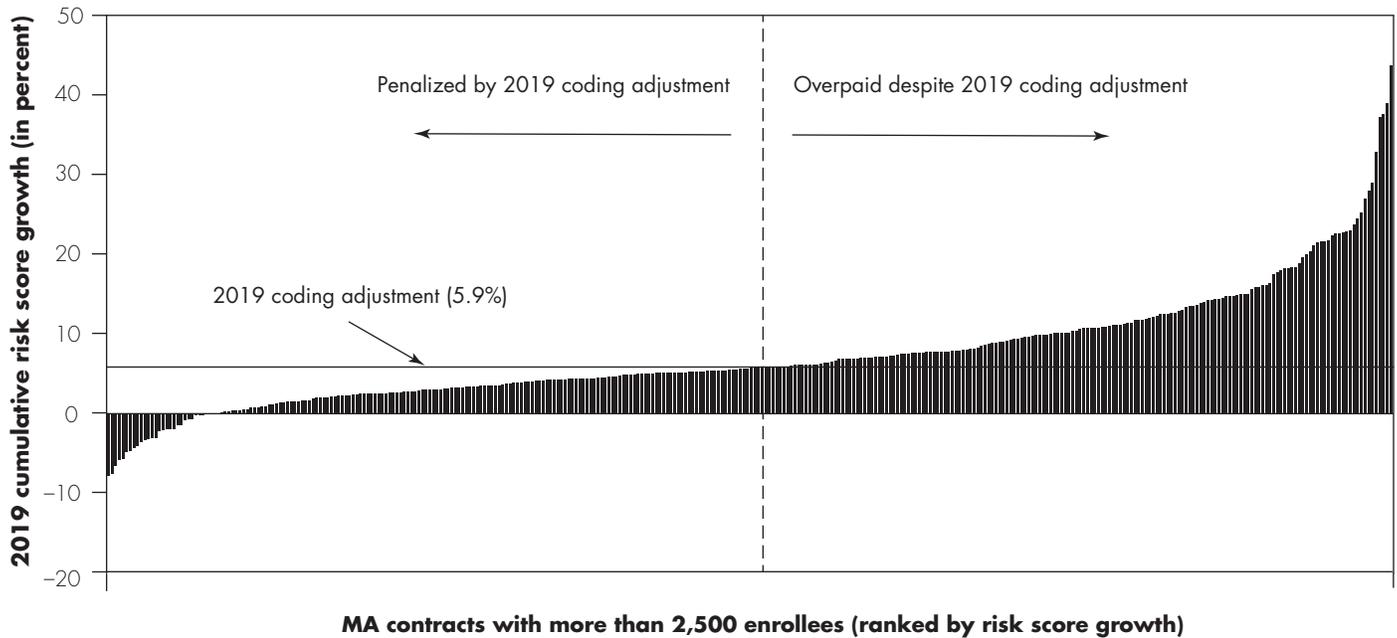
In addition to the 1 percentage point annual increase in MA risk scores, we tracked the influence of three factors affecting the overall impact of coding intensity: changes in the risk adjustment model, changes in the relative growth rates of FFS and MA risk scores, and changes in the use

of encounter data as a source of diagnoses for MA risk adjustment.

Changes in the risk adjustment model—Our analysis found that two newer versions of the CMS–HCC model have been less susceptible to diagnostic coding differences between MA and FFS. These model versions reduced risk scores in 2014, 2016, and 2017, noted in Figure 12-7.

- One new model version, phased in between 2014 and 2016, removed certain diagnoses with large differences in MA and FFS coding rates, thereby reducing the impact of coding differences by 2 percentage points to 2.5 percentage points when fully phased in. Figure 12-7 shows the impact of phasing in this model in 2014 and in 2016. In 2014, the model was the basis for 75 percent of MA risk scores, but in 2015 the model accounted for only 33 percent of MA risk scores and in 2016, accounted for 100 percent of MA risk scores.
- In 2017, CMS introduced a different version of the model, adding separate aged/disabled and Medicaid enrollment status segments. This model reduced the impact of coding differences by almost 1 percentage point.
- No changes to the risk adjustment model were implemented in 2018. In 2019, a new version of the model that added five HCCs to the 2017 model version had a relatively minor effect on the overall coding differences.

Relative growth rates for FFS and MA risk scores—Our analysis shows that, between 2007 and 2015, MA risk score growth outpaced FFS risk score growth in every year, increasing the overall impact of coding intensity on MA risk scores by an average of more than 1 percentage point in each year. Changes in FFS risk scores are offset by the normalization factor, which is applied to all risk scores and keeps the average FFS risk score at 1.0. MA risk score growth above the normalization factor contributes to excess payments to MA plans. Between 2015 and 2017, MA risk scores continued to increase at about the same rate as in prior years, but FFS risk scores grew at a faster rate.³⁰ The faster growth in FFS risk scores increased the normalization factor and thereby helped to reduce the impact of MA coding intensity in 2016 and 2017, shown in Figure 12-7. Between 2017 and 2019, MA risk score growth again reflected the underlying trend of MA risk scores outpacing FFS risk score growth by about 1 percentage point per year.

**FIGURE
12-8****Cumulative MA risk score growth varied across contracts relative to local FFS, 2019**

Note: MA (Medicare Advantage), FFS (fee-for-service). Excludes MA contracts with enrollment below 2,500 (representing less than 1 percent of total MA enrollment), contracts for the Program of All-Inclusive Care for the Elderly, and special needs plans. Analysis is based on retrospective cohorts of 2019 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007.

Source: MedPAC analysis of CMS enrollment and risk score files.

Encounter data as a source of diagnostic information—

Starting in 2016, CMS blended risk scores based on encounter data with risk scores based on RAPS data. Encounter-based risk scores were initially lower than RAPS-based risk scores, causing concern among plans that the transition to using encounter data would decrease payments. Our analysis found that encounter-based and RAPS-based risk scores were the same for about 92 percent of MA enrollees in 2016, 93 percent in 2017, and 95 percent in 2018.³¹ For enrollees with different encounter-based and RAPS-based risk scores, we also found that the average difference between the two has converged over time. Average encounter-based risk scores were about 2 percent lower than RAPS-based risk scores in 2016 and about 1 percent lower in 2018. For 2019, RAPS data were the basis for risk scores using the 2017 model, but CMS used encounter data pooled with inpatient RAPS data as the basis for risk scores calculated with a new model. The 2019 model adds five HCCs to the 2017

model. Therefore, we do not have a direct RAPS-based to encounter-based risk score comparison, but we found that the 2019 model risk scores with pooled data are 0.3 percent larger than the 2017 model risk scores based on RAPS data.

Considering the impact of encounter data on MA risk scores, we noted that in 2018, using encounter data reduced MA risk scores by about 0.2 percent relative to using only RAPS data (i.e., in 2018, encounter-based risk scores accounted for 15 percent of payments and were about 1 percent less than RAPS-based risk scores). For 2019, CMS applied a 25 percent weight to risk scores using the 2019 model with pooled data, resulting in an increase of about 0.1 percent to overall MA risk scores relative to using only RAPS data (i.e., in 2019, risk scores under the 2019 model with pooled data accounted for 25 percent of payments and were about 0.3 percent larger than RAPS-based risk scores).³²

Variation in coding intensity across MA contracts

For 2019, we continued to find that nearly all MA contracts had risk scores that were higher than FFS scores and that the impact of coding intensity across MA contracts varied widely. This finding is based on a similar analysis we conducted of average coding differences (using retrospective cohorts of 2019 enrollees, tracked backward for as long as they were continuously enrolled in the same program (FFS or MA) or as far back as 2007, the first year that payment to MA plans was based entirely on CMS–HCC-model risk scores), but the change in risk score for each MA beneficiary was attributed to the contract (excluding contracts in the Program of All-Inclusive Care for the Elderly and SNPs) in which the beneficiary was enrolled in 2019, thereby capturing the coding impact for each contract’s 2019 payments. Figure 12-8 illustrates the variation across contracts with more than 2,500 enrollees in 2019 relative to FFS in their local service area.³³

Our finding that coding intensity varies across MA contracts is consistent with other research (Geruso and Layton 2015, Kronick and Welch 2014). Given this variation, CMS’s across-the-board adjustment for coding intensity, which reduces all MA risk scores by the same amount, generates inequity across contracts by disadvantaging plans with lower coding intensity and allowing other plans to retain a significant amount of revenue from higher coding intensity.

The Commission’s prior recommendation on coding intensity

The Commission’s long-standing position is that Medicare payment policies should not unduly favor MA or FFS Medicare. Excess payments to MA plans may benefit enrollees in the MA program (when used to increase the value of extra benefits offered rather than increase profits) but cost taxpayers more than if these enrollees were covered in FFS Medicare. Further, excess payments to MA plans increase fiscal pressure on the Hospital Insurance (Part A) Trust Fund as well as on the taxpayers, beneficiaries, and state Medicaid programs who pay premiums to finance the Part B program.

In our March 2016 report to the Congress, the Commission recommended a multipronged approach that would fully account for the impact of coding differences and would improve the equity of the adjustment across MA contracts. The recommendation,

which would replace the existing mandatory minimum coding intensity adjustment (which was 5.9 percent in 2019), has three parts:

- Develop a risk adjustment model that uses two years of FFS and MA diagnostic data.
- Exclude diagnoses that are documented only on health risk assessments from either FFS or MA.
- Then apply a coding adjustment that fully accounts for the remaining differences in coding between FFS Medicare and MA plans.

Using two years of diagnostic data would improve the accuracy of both FFS and MA diagnostic information and would reduce year-to-year variation in documentation. The 21st Century Cures Act (the Cures Act) codifies the Secretary’s authority to use two years of diagnostic data in MA risk adjustment, stating that, for 2019 and subsequent years, “the Secretary may use at least two years of diagnosis data.” However, CMS did not take this step in any of the rulemaking to implement provisions of the Cures Act. Removing diagnoses documented through only health risk assessments would mean that a diagnosis, to be counted in risk adjustment calculations, would have to have been the subject of medical treatment. Diagnoses that were both documented on an assessment and associated with medical treatment would continue to count toward risk adjustment. However, about 30 percent of the HCCs documented through health risk assessments for MA enrollees were not treated during the year, compared with about 6 percent of diagnoses that were documented through these assessments for FFS enrollees.

Implementing the first two policies—using two years of diagnostic data and excluding diagnoses documented through health risk assessments alone—would result in a more equitable, targeted adjustment to MA contracts than the current across-the-board adjustment. We estimated that these policies’ combined effect would reduce MA risk scores by roughly 3 percentage points to 5 percentage points relative to FFS Medicare and thus would address roughly half of the impact of coding differences.

Adjusting for any remaining coding intensity differences could also improve equity across MA contracts. Under one approach, contracts would be grouped into tiers of high, medium, and low coding intensity, and a coding intensity adjustment would be applied based on each tier’s average level of coding intensity. CMS has used a similar

approach to select MA contracts for risk adjustment data validation (RADV) audits.³⁴ While this policy would leave some unevenness within each group of contracts, overall inequity would be reduced relative to an across-the-board adjustment. CMS could consider using a greater number of tiers to further refine the equity of the overall adjustment.

The Commission's recommendation does not address the use of chart reviews to increase MA risk scores and payments since data were not available in 2016. Recent analysis from OIG indicates that chart reviews are a significant driver of MA and FFS coding differences. The Commission's approach to addressing MA coding intensity has been to tackle the underlying causes (e.g., remove health risk assessments and reduce year-to-year coding variations) and then address remaining differences with either an across-the-board or tiered adjustment. Eliminating chart reviews as a source of diagnoses for risk adjustment is consistent with the Commission's approach and would reduce the need for an across-the-board or tiered adjustment.

Risk adjustment data validation

Medicare payments to MA plans are based, in part, on diagnostic data that plans submit to CMS. Program rules state that, to be used for payment, diagnoses submitted for risk adjustment must result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional; diagnoses also must be supported by evidence in the patient's medical record. For both RAPS and encounter data, MA plan leadership signs an attestation that risk adjustment criteria are applied correctly and submitted data are accurate. However, only for encounter data does CMS independently verify that diagnoses result from a hospital inpatient stay, hospital outpatient visit, or a face-to-face visit with a physician or other health care professional. The use of encounter data significantly improves oversight of payment data and offers the opportunity to ensure their validity before payments are made to MA plans. CMS must conduct RADV audits of both encounter and RAPS data to ensure that diagnoses are supported by the medical record, but RADV audits of RAPS data must also check whether diagnoses are made during an encounter with an appropriate type of provider.

RADV audits determine whether an MA plan was overpaid due to invalid data and are the basis for calculating an overpayment amount to recover from the

plan. CMS audits roughly 5 percent of MA contracts per year (about 30 contracts in early audit years) and, for each contract, uses a sample of 201 enrollees who had at least 1 HCC reported and met certain other criteria.³⁵ The sample includes 67 randomly selected enrollees from each of three strata of beneficiaries' risk scores (low, medium, and high). For each beneficiary, the audit calculates a payment error rate, defined as the portion of the beneficiary's HCC-based payment that was not based on valid data. Beneficiary payment error rates can be offset if any additional HCCs are found that were not submitted for payment but were supported by the beneficiary's medical record.³⁶ For the initial round of audits of 2007 data, CMS recovered overpayments only for beneficiaries in the sample of 201 enrollees. For subsequent audits, in 2018 CMS proposed recovering overpayments for the entire contract (of eligible enrollees) by extrapolating from the payment error rates for the sampled enrollees.³⁷

RADV audits of MA contracts have been limited so far. Audits of 2007 RAPS data identified diagnoses that did not meet risk adjustment criteria and determined that average overpayment rates were well over 10 percent for most contracts under audit (Schulte 2016). CMS recovered \$13.7 million in overpayments from audits of 37 contracts, based on overpayments only for the 7,437 beneficiaries included in the sample of beneficiaries for the contracts under audit (Centers for Medicare & Medicaid Services 2017). No audits were conducted for payment years 2008 through 2010. For audits of 2011, 2012, and 2013 payment years, CMS stated that it expects to recoup about \$650 million in overpayments based on the extrapolation method (Centers for Medicare & Medicaid Services 2018). However, CMS will not release the results of those audits until its extrapolation method is finalized (Centers for Medicare & Medicaid Services 2019). CMS has proposed additional RADV audits focused on specific HCCs rather than whole contracts; however, CMS has not identified the scope of such audits or stated when they would begin. Audits of 2014 and 2015 data are in progress.

In reviewing the RADV audit process, the Government Accountability Office noted that RADV audits are tasked with recouping billions of dollars in improper payments to MA plans based on RAPS data, but found a number of shortcomings with the audits and recommended targeting them at contracts with a higher likelihood of overpayments (Government Accountability Office 2016).

Increase the use of encounter data for risk adjustment

To ensure payment accuracy for the MA population, the importance of collecting complete and accurate encounter data from MA plans cannot be overstated. So far, the main use of encounter data has been as a source of diagnoses for risk adjustment. Given the more robust review process upon submission of encounter data, the return of hundreds of millions of dollars in overpayments resulting from unsupported diagnoses in RAPS data, and the continued convergence of RAPS and encounter-based risk scores, we believe CMS should move as soon as possible to discontinue the collection of RAPS data and rely only on encounter data for risk adjustment.

For 2021, CMS will use encounter data along with inpatient RAPS data as the source of diagnoses for a new version of the risk adjustment model, which will be the basis for 75 percent of MA payments. For 2022, CMS will use encounter data as the sole basis for risk adjustment. The Commission supports increasing incentives for plans to submit complete encounter data, which could serve multiple purposes.³⁸ For example, using encounter data as the basis for measuring MA plan quality would allow for more consistent quality measurement between MA and FFS and would provide an additional incentive for MA plans to submit complete encounter data.

Quality in Medicare Advantage is difficult to evaluate

The law established, beginning in 2012, a quality bonus program (QBP) that ranks MA plans based on a 5-star system and provides bonuses to plans rated 4 stars or higher. The 5-star system, which predates the QBP, is also the basis of information that beneficiaries receive about MA plan quality through the Medicare.gov Plan Finder website. Over the years, the Commission has discussed the flaws in the 5-star system and the QBP and the continuing erosion of the reliability of data on the quality of MA plans (Medicare Payment Advisory Commission 2019a, Medicare Payment Advisory Commission 2018a). The current state of quality reporting is such that the Commission's yearly updates can no longer provide an accurate description of the quality of care in MA. The Commission's March 2019 report to the Congress contains a detailed discussion of the difficulty of evaluating the quality of care within the MA sector and changes in MA

quality from one year to the next (Medicare Payment Advisory Commission 2019b).

With 43 percent of eligible Medicare beneficiaries enrolled in MA plans, good information on the quality of care MA enrollees receive and how that quality compares with quality in FFS Medicare, including in accountable care organizations (ACOs), is necessary for proper evaluation. MA plans have a number of management tools that are not available in FFS but permit plans to improve the quality of care for their enrollees—tools such as selective contracting, care management, information systems shared across providers, and utilization management that can prevent overutilization of potentially harmful care. These tools provide MA the potential to improve quality relative to FFS, but a lack of sufficient data severely limits any definitive comparisons. Comparative assessments could help in evaluating MA performance and changes in performance over time, in evaluating payment policy in MA, and in determining the adequacy and appropriateness of the standards applied to MA plans (for example, by using quality results as an indirect measure of network adequacy in MA plans). The ability to compare MA and FFS quality, and to compare quality across MA plans, is also important for beneficiaries. Choosing between MA and FFS is a threshold choice that beneficiaries make before getting to the step of deciding among available MA plans.

A new MA value incentive program

In our June 2019 report to the Congress, the Commission discussed ways to apply the Commission's quality principles to the MA program through a value incentive program (Medicare Payment Advisory Commission 2019a). In the June 2020 report to the Congress, the Commission recommended replacing the quality bonus program with a value incentive program that incorporates the following key features:

- Use of a small set of population-based outcome and patient/enrollee experience measures that, where practical, should align across all Medicare-accountable entities and providers, including MA plans and ACOs. To avoid undue burden on providers, measures should be calculated or administered largely by CMS, preferably with data that are already being reported, such as claims and encounter data.
- Evaluation of quality at the local market level to provide beneficiaries with information about the quality of care in their local area and provide MA

plans with incentives to improve the quality of care provided in every geographic area.

- Quality measurement against a continuous scale of performance that clearly provides the incentive to improve quality at every level.
- Accounting for differences in enrollees' social risk factors by stratifying plan enrollment into groups of beneficiaries with similar social risk factors so that plans with higher shares of enrollees with social risk factors are not disadvantaged in their ability to receive quality-based payments, while actual differences in the quality of care are not masked.
- Application of budget-neutral financing so that the MA quality system is more consistent with Medicare's FFS quality payment programs, which are either budget neutral (financed by reducing payments per unit of service) or produce program savings because they involve penalties (Medicare Payment Advisory Commission 2020c).

Payment and access for enrollees with end-stage renal disease

Individuals with end-stage renal disease (ESRD) require regular dialysis treatments to remove waste from the blood stream. Medicare beneficiaries with ESRD have significantly higher Medicare spending than other beneficiaries. CMS projects that in 2021, spending for beneficiaries with ESRD in FFS Medicare will be over eight times higher than spending for FFS beneficiaries without ESRD (Centers for Medicare & Medicaid Services 2020e). About 31 percent of Medicare spending for FFS beneficiaries with ESRD is for dialysis treatments; 28 percent for inpatient hospital care; 12 percent for Part D prescription drugs; and the rest for other Medicare services (United States Renal Data System 2019). Given greater medical spending, beneficiaries with ESRD face significantly higher cost-sharing liability, averaging roughly \$13,000 per year for FFS beneficiaries with ESRD (Health Management Associates 2020). About 47 percent of FFS beneficiaries with ESRD are also eligible for Medicaid and have Medicaid assistance with cost-sharing coverage. Other ESRD beneficiaries in FFS Medicare can obtain cost-sharing coverage through an employer-sponsored plan or a Medigap plan.

But Medigap plans are not available to all ESRD beneficiaries. Medicare beneficiaries have guaranteed-issue rights for Medigap plans—meaning that a plan must be offered—when they turn 65. However, about half of individuals with ESRD become eligible for Medicare before reaching age 65, and federal guaranteed-issue rights do not extend to those beneficiaries. As of 2020, 33 states required insurers to offer at least one Medigap plan to beneficiaries under age 65, but only 30 states require insurers to offer a plan to those entitled to Medicare due to ESRD rather than because of disability (American Kidney Fund 2019b, Centers for Medicare & Medicaid Services 2020b). Even though a plan must be offered in these states, the insurer can charge a higher premium based on age, sex, or existing health conditions, depending on state insurance rating rules. Medigap plans can be expensive (when they are available to ESRD beneficiaries), and some patients get assistance paying plan premiums through the American Kidney Fund.³⁹

Alternatively, beneficiaries with ESRD can enroll in an MA plan to reduce their cost-sharing liability. MA plans generally offer reduced cost sharing for most services relative to FFS Medicare and are required to offer a maximum out-of-pocket (MOOP) limit on total cost-sharing expenditures in a year. Medicare requires MA plans to offer the same levels of cost sharing (including MOOP limit) to all plan enrollees, although different services may have different levels of cost-sharing coverage.⁴⁰

Historically, individuals with ESRD were prohibited from joining an MA plan during open enrollment unless the plan was specifically designed for ESRD enrollees.⁴¹ Under the prohibition, MA plan access was limited to (1) individuals with ESRD in an employer-sponsored health plan, who could enroll in an MA plan offered by the same insurer if one was available when initially enrolling in Medicare; (2) Medicare beneficiaries already enrolled in an MA plan, who could remain in that plan after developing ESRD; or (3) Medicare beneficiaries who could enroll in an ESRD chronic condition special needs plan (C-SNP) and certain other SNPs.⁴² As of January 2020, the availability of ESRD C-SNPs was limited to only a few states, and ESRD C-SNP enrollment represented less than 5 percent of ESRD enrollees in MA.⁴³

Even under the enrollment limitations, the share of ESRD beneficiaries in MA has been increasing; CMS estimates that about 131,000 enrollees with ESRD were in private

Medicare plans in 2019, about 25 percent of the 532,000 Medicare beneficiaries with ESRD (Centers for Medicare & Medicaid Services 2020e). By comparison, about 36 percent of all Medicare beneficiaries were enrolled in MA plans in 2019.

The 21st Century Cures Act established complete access to MA plans for beneficiaries with ESRD

Beginning with the 2021 plan (calendar) year, the Cures Act allows Medicare beneficiaries with ESRD to enroll directly in an MA plan.⁴⁴ The Cures Act also relieved MA plans from coverage of organ acquisition costs, authorizing coverage of those costs for MA enrollees through FFS Medicare and removing them from MA benchmarks. Some observers believe the Cures Act's changes will significantly increase MA enrollment among beneficiaries with ESRD as beneficiaries seek to reduce their cost-sharing liability. Because of Cures Act changes, CMS expects that an additional 83,000 beneficiaries will enroll in an MA plan between 2021 and 2026, making the share of ESRD beneficiaries enrolled in MA roughly equal to that of non-ESRD beneficiaries (Centers for Medicare & Medicaid Services 2020e).

In 2004, the Commission recommended that the Congress allow all beneficiaries with ESRD to enroll in private plans. The accompanying report noted that a new risk adjustment system would be implemented to improve payments to private plans for ESRD enrollees in the following year. The Commission also reported that a study evaluating a Medicare ESRD demonstration showed that the quality of care and outcomes of most plan participants were equal to or better than those for ESRD patients enrolled in FFS Medicare (Medicare Payment Advisory Commission 2004).

The Commission strongly supports beneficiaries' ability to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans provide. Some ESRD beneficiaries may find MA plan coverage to be superior to traditional Medicare, given the substantial extra benefits that plans offer (accounting for 14 percent of Medicare's payments to plans in 2021) and the care coordination and cost-control tools they employ. Extra benefits can reduce Part B and Part D premiums; reduce cost sharing for basic Medicare and Part D benefits; cover additional services such as dental, hearing, and vision; or offer assistance with transportation. The requirement that all MA plans have an out-of-pocket cap on cost sharing for

the basic Medicare benefit is likely to be a valuable benefit for enrollees with ESRD.

Many indicators point to an increasingly robust MA program, including growth in enrollment, increased plan offerings, and a historically high level of extra benefits. The 21st Century Cures Act provides ESRD beneficiaries with the same access to Medicare coverage through an MA plan as other Medicare beneficiaries. The requirement that MA plans make all items and services available and accessible to each individual electing a plan guarantees that plan benefits are equally available to all plan enrollees. The Commission reiterates its support for the ability of all beneficiaries, including those with ESRD, to choose between traditional Medicare coverage or coverage through an MA plan.

Ensuring appropriate payments to MA plans for enrollees with ESRD

To assess whether ESRD beneficiaries have access to MA plans equal to that of other Medicare beneficiaries, we evaluated Medicare payments to MA plans for ESRD enrollees. We examined how MA plans are paid for ESRD and non-ESRD enrollees, how MA plan revenues for ESRD enrollees compare with MA plan costs for coverage of ESRD enrollees, and plan advocates' concerns about the adequacy of Medicare payments to MA plans for ESRD enrollees.

Medicare payments to MA plans differ for ESRD and non-ESRD enrollees

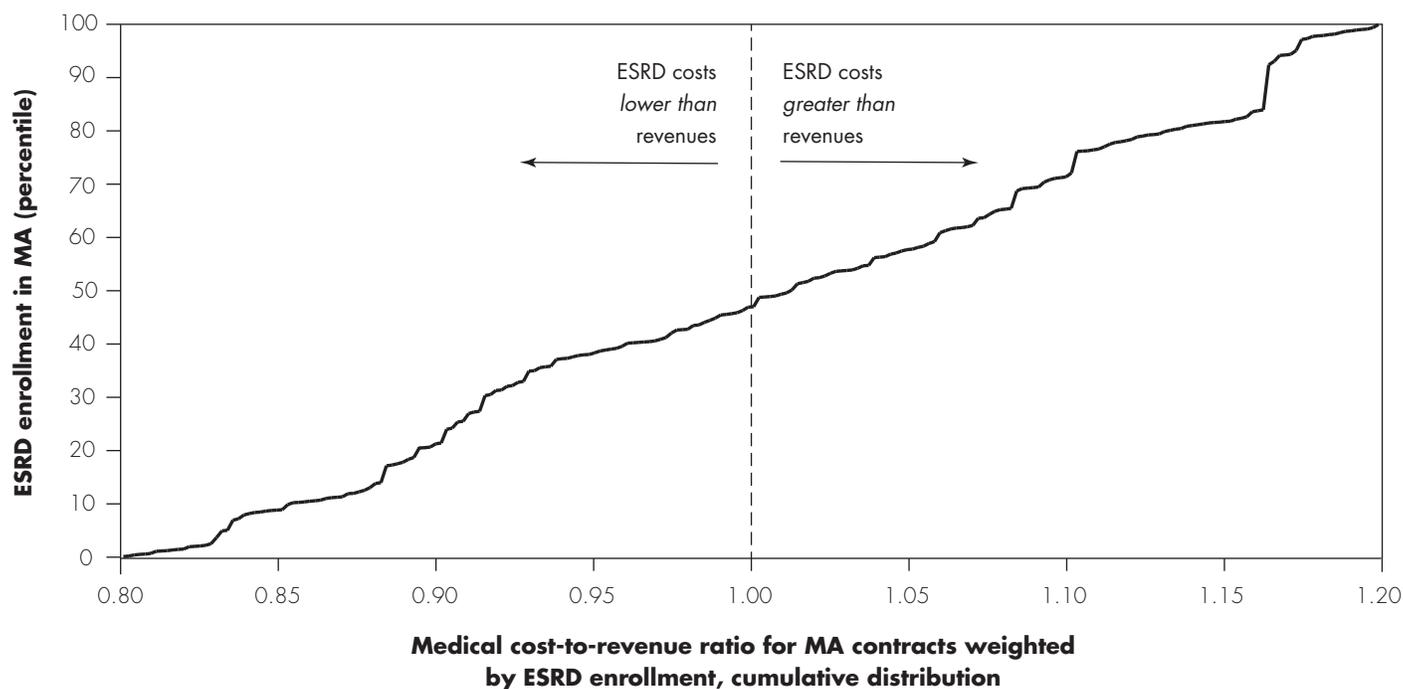
CMS pays MA plans a monthly amount for each enrollee that is the product of a base payment rate and a risk score; however, calculation of the base rate and risk scores differ for non-ESRD and ESRD enrollees.

In setting base payment rates for an MA payment area, CMS uses local FFS spending. For ESRD enrollees, a base rate is established for each state—called the “ESRD state rate”—and is equal to the average FFS spending for ESRD beneficiaries in that state. MA payment for an ESRD enrollee is the ESRD state rate based on where the enrollee resides, adjusted by the enrollee's ESRD risk score. The ESRD risk model is based on FFS beneficiaries with ESRD.⁴⁵

Because plans bid only for non-ESRD enrollees (ESRD state rates are calculated entirely by CMS), a plan's funding for extra benefits (i.e., the rebate) is based only on non-ESRD enrollees. However, all MA plan enrollees

**FIGURE
12-9**

MA ESRD revenues cover medical costs on average, but contracts' costs relative to revenue for ESRD enrollees varies widely, 2018



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The figure excludes ESRD chronic condition special needs plans, which submit bids through a specialized bid tool, and employer group waiver plans, which do not submit bids. About 1 percent of MA ESRD beneficiaries are enrolled in a contract with a medical cost-to-revenue ratio below 0.80, and about 6 percent are enrolled in a contract with a ratio above 1.20. The cost to administer an MA contract is not included in this analysis because administrative costs are not identified separately for ESRD enrollees in the bid payment tool data.

Source: MA 2020 bid payment tool data including 2018 cost and revenue information.

receive the same benefit package, including receipt of extra benefits or a requirement to pay a plan premium. CMS offers plans the option to reconcile financing for ESRD enrollees with the plan's rebate using the "ESRD subsidy."⁴⁶ For plans with ESRD payments that do not cover plan ESRD costs, the ESRD subsidy allows plans to cover the net ESRD costs by drawing down rebate funding and reducing the level of extra benefits. Conversely, for plans with ESRD payments that are greater than plan ESRD costs, the ESRD subsidy allows plans to add net ESRD revenues to their rebate funding and increase the level of extra benefits.

Medicare payments to MA plans cover medical costs for ESRD enrollees on average

To assess whether Medicare payments to MA plans for ESRD enrollees cover plan costs, we analyzed plan-submitted data for the 2020 plan year. The bid pricing tool

(BPT) includes information about a plan's 2018 financial experience for both non-ESRD enrollees and ESRD enrollees. The 2020 BPT data include 2018 plan costs and revenues for the vast majority of ESRD enrollees.⁴⁷ We aggregated plan-level BPT data to the MA contract level in our analysis and separately analyzed data for ESRD C-SNPs.⁴⁸

We found that ESRD enrollees' average medical costs of \$6,752 per member per month (PMPM) were slightly below the average plan revenue of \$6,769 PMPM—a medical cost-to-revenue ratio of 0.997. However, we found a wide range of ESRD medical cost-to-revenue ratios across MA contracts as shown by the cumulative distribution in Figure 12-9. MA contracts with lower ESRD medical costs than revenues have a cost-to-revenue ratio below 1.0 and include about 56 percent of MA ESRD enrollees. Contracts with higher ESRD medical costs than revenues have a ratio higher than 1.0 and include about

44 percent of MA ESRD enrollees. The cost to administer an MA contract is not included in this analysis because administrative costs are not identified separately for ESRD enrollees in the BPT data.

Although Figure 12-9 shows that Medicare payments adequately cover plan medical costs for ESRD enrollees for most MA contracts and most MA enrollees with ESRD, CMS estimates that plans have nonbenefit expenses of about \$350 PMPM for plan administration of benefits for ESRD enrollees (Centers for Medicare & Medicaid Services 2020f). Adding administrative expenses to average medical costs of \$6,752 means that the average plan revenue of \$6,769 PMPM does not cover total plan costs of about \$7,102 per ESRD enrollee, equating to a total cost-to-revenue ratio of about 1.05 for ESRD enrollees (not shown in Figure 12-9) (that is, total costs including administration were 5 percent higher than revenues, on average). We found that in 2018, plan revenues covered total plan costs for about 46 percent of ESRD enrollees.

In contrast, we found that Medicare payments adequately covered total plan costs for ESRD C–SNPs, which enroll only beneficiaries with ESRD. We separately analyzed costs and revenues for ESRD C–SNPs because those plans submit bid information through a specialized BPT, which for 2020 covers the vast majority of 2018 ESRD C–SNP enrollees. We found that, for C–SNPs in 2018, average ESRD enrollee medical costs (\$7,231) and revenues (\$7,678) were higher than for other MA plans, in large part because more than 70 percent of ESRD C–SNP enrollment in 2018 was in California, which had the third-highest ESRD state rate of \$7,748.72 monthly. The medical cost-to-revenue ratio for ESRD C–SNP enrollees was 0.942 (that is, costs excluding administration were 6 percent lower than revenues, on average). This ratio is about 5.5 percentage points lower than the average medical cost-to-revenue ratio for ESRD enrollees across all MA plans (0.997, noted above). The ESRD C–SNP BPT data also showed average administrative costs of \$302 PMPM for a total (medical plus administrative) cost-to-revenue ratio of 0.981 (that is, total costs including administrative costs were almost 2 percent lower than revenues, on average), indicating that ESRD C–SNPs have been profitable.

Most MA plans pay facilities more than FFS rates for dialysis services

Although Medicare payments to MA plans appear to cover medical costs for most ESRD enrollees, some plans have net costs for ESRD enrollees. One reason is that some

plans pay a higher price for dialysis services relative to FFS Medicare. The number of dialysis treatments a patient receives in a year does not vary much across beneficiaries, meaning that any variation in plan spending for dialysis services is primarily driven by differences in price rather than number of treatments. In FFS Medicare, dialysis spending accounts for about 31 percent of total spending for ESRD beneficiaries (United States Renal Data System 2019). If MA plans are unable to negotiate dialysis prices similar to (or lower than) FFS Medicare payment rates for dialysis, plans have to offset higher dialysis spending by reducing costs for other services provided to these enrollees (e.g., care coordination to reduce inpatient hospital and emergency room visits) or risk losses on ESRD enrollees.

We analyzed dialysis services reported in 2018 MA encounter data for the 50 states and the District of Columbia to estimate the price MA plans paid for dialysis. Although we previously found encounter data to be insufficiently complete to analyze MA service utilization (where missing encounter data introduce bias in utilization estimates toward lower utilization), an analysis of dialysis prices is not necessarily biased by incomplete data. To better understand the potential for bias due to incomplete encounter data, we evaluated the completeness of dialysis treatments reported in MA encounter data by calculating the number of dialysis treatments we would expect to observe and comparing that with the number of MA dialysis treatments included in our analysis (see text box on completeness of MA encounter data, p. 390).

In FFS Medicare, payments to dialysis providers are adjusted by facility-level factors (wage index, low-volume adjustment, and rural adjustment) and patient-level factors (age, body size, onset (first four months of dialysis treatment), and comorbidities). The MA encounter data did not include sufficient information to replicate the complete FFS payment calculation, but we were able to adjust MA plan payments to facilities by the two factors we consider having the greatest importance: wage index and age. We do not expect differences in the other factors to significantly affect the comparison of dialysis prices.

Accounting for age and wage index differences (geographic location), we found that in 2018, the prices MA plans paid for dialysis services averaged about 14 percent higher than FFS Medicare rates. The average price paid by MA contracts varied widely, suggesting that some MA plan sponsors negotiated rates similar to those in FFS Medicare, while most plan sponsors paid

Evaluating the completeness of MA encounter data for estimating dialysis prices paid by MA plans

To evaluate Medicare Advantage (MA) encounter data for use in estimating dialysis prices paid by MA plans, we calculated the share of dialysis treatments in fee-for-service (FFS) claims relative to the maximum number of possible treatments if all FFS beneficiaries in dialysis status received complete dialysis treatments (3 treatments per week × 52 weeks = 156 treatments per year). There are several reasons why the number of dialysis treatments provided is lower than the “maximum number possible.” First, dialysis patients do not always receive three treatments per week due to hospitalizations or missed treatments when transportation is not available, for example. Second, the number of individuals in dialysis status likely overestimates the number of current dialysis patients because patients who choose to end dialysis treatment without receiving a transplant may continue to be reported as in dialysis status.⁴⁹

In 2018, if the maximum possible treatments were provided to FFS beneficiaries in dialysis status, about 53.2 million dialysis treatments would have been provided. Our analysis of FFS claims data for 2018 found about 44.3 million dialysis treatments, or roughly 83 percent of the maximum possible treatments.

Using this FFS share of maximum possible treatments, we expected to find about 12.9 million dialysis treatments in MA encounter data based on the number of MA enrollees in dialysis status. Our analysis of 2018 MA encounter data identified about 10.1 million

dialysis treatments, or roughly 79 percent of the dialysis treatments we would expect to observe. Thus, we conclude that the available dialysis treatments in MA encounter data are a sufficient basis for estimating dialysis prices paid by MA plans without meaningful bias.

The discrepancy between dialysis treatments included in our analysis and the number of treatments we expected to find in MA encounter data could be due to missing dialysis treatment encounters or due to exclusions we applied to ensure accurate calculation of dialysis prices. MA encounter data are not adjudicated claims and have not been processed and verified by a Medicare administrative contractor, allowing some variables used to calculate dialysis payment in FFS Medicare to be missing or inaccurate in encounter data. We excluded encounters for dialysis treatments that did not have complete data or likely showed inaccurate reporting for one or more variables used to calculate price per dialysis treatment.⁵⁰ Some MA plans have capitated arrangements with dialysis facilities. MA plans are not required to report provider payment amounts for capitated encounters. Therefore, capitated encounters were likely excluded from our analysis because missing provider payment data would have caused such encounters to be excluded by our criteria. After applying exclusion criteria, we included the remaining encounters for dialysis treatments in our estimate of MA payment rates. ■

more than FFS Medicare rates for dialysis treatment. Specifically, 26 percent of MA contracts (covering about 18 percent of MA dialysis treatments) paid less than FFS rates, and 15 percent of MA contracts (accounting for less than 5 percent of MA dialysis treatments) paid rates at or above 40 percent of FFS rates. Figure 12-10 shows the distribution of MA-to-FFS dialysis payment ratios for MA contracts purchasing dialysis services.

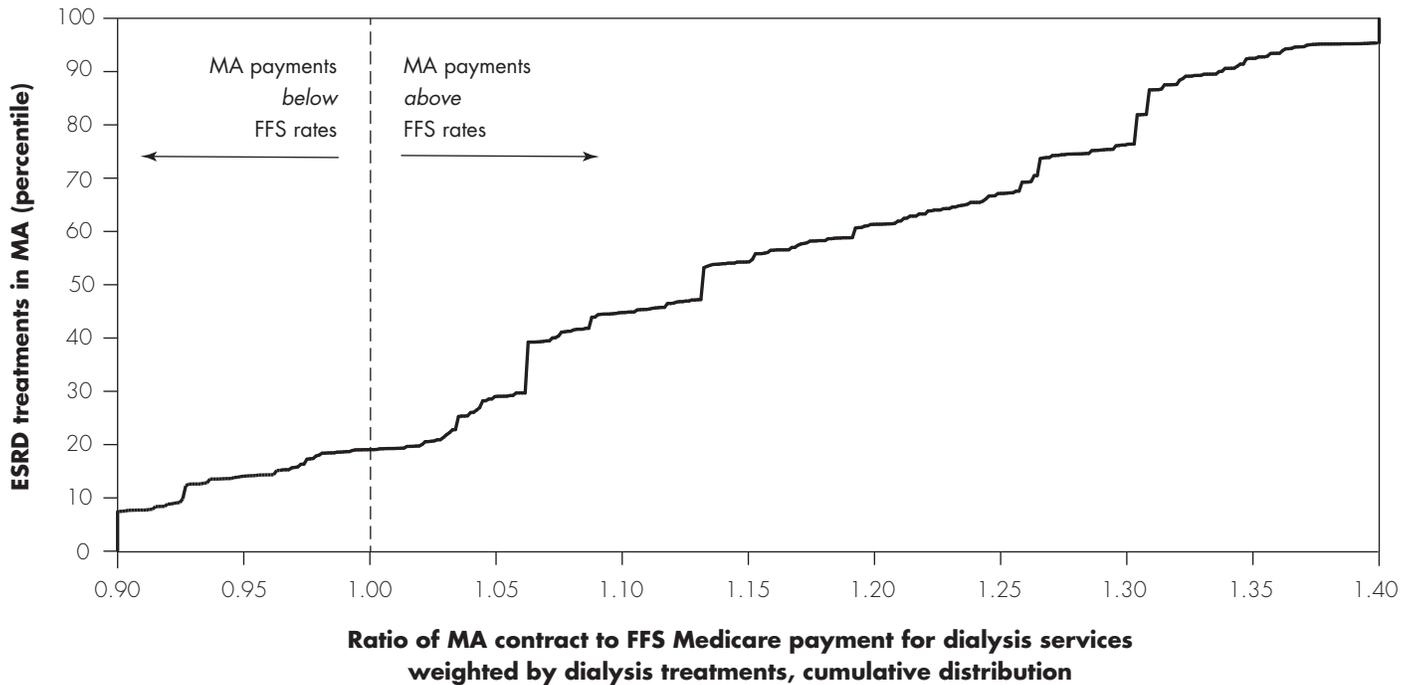
One reason that MA plans pay more for dialysis than FFS Medicare could be the high level of consolidation

in outpatient dialysis facilities. In 2018, two companies, DaVita and Fresenius, operated 74 percent of dialysis facilities, so MA plans are likely to be negotiating with these companies. In some counties, either DaVita or Fresenius is the sole operator of the county’s dialysis facilities.

Given that 2021 is the first year ESRD beneficiaries are able to enroll in any MA plan and that the number of MA ESRD enrollees is expected to increase, the balance of negotiating leverage between MA plans and dialysis

**FIGURE
12-10**

MA contracts frequently paid more per dialysis treatment than FFS Medicare rates, 2018



Note: MA (Medicare Advantage), FFS (fee-for-service), ESRD (end-stage renal disease). About 7 percent of dialysis treatments were covered by a contract with a payment ratio less than 0.9, and less than 5 percent of dialysis treatments were covered by a contract with a payment ratio greater than 1.4. Dialysis encounters that did not have complete data or likely showed inaccurate reporting for one or more variables used in our analysis were excluded (endnote 50 identifies the exclusions for this analysis). The analysis accounts for differences in age and geographic location (wage index) between MA and FFS treatments, but does not account for differences in other factors that affect FFS payment rates: low-volume facility status or rural location, patient body size, dialysis onset status (first four months of dialysis treatment), or comorbidities.

Source: MA encounter and FFS Medicare claims data, 2018.

providers could shift in the coming years. We will continue to monitor dialysis prices paid by MA plans and consider whether high dialysis prices provide an incentive for plans to design benefit packages and networks that may deter ESRD beneficiaries from enrolling in MA.

Medicare payment rates based on statewide average spending could overpay or underpay plans

ESRD state rates are currently based on average FFS spending for ESRD beneficiaries in each state; however, the Secretary has the authority to set ESRD payment rates using another geographic unit.⁵¹ The choice of geographic unit is limited by the number of ESRD FFS beneficiaries that serve as the basis for calculating ESRD payment rates in MA. To maximize accuracy, payments should

be based on the smallest geographic unit with enough ESRD FFS beneficiaries to attain stable payment rates in each payment area over time, thereby balancing the goal of stable payments with the goal of limiting the extent of FFS ESRD spending variation within each payment area. Under the current ESRD state rates, Medicare payments for ESRD enrollees can be too high if a plan's enrollment is concentrated in parts of the state with local FFS ESRD spending that is lower than the state average and vice versa.

One industry-sponsored analysis of this issue identified 15 metropolitan statistical areas (MSAs) and compared their average FFS spending for ESRD enrollees with the state's ESRD rates. The analysis found that the state rate was less than local FFS spending for 10 of the MSAs, ranging from 2 percent to 12 percent lower. For the other five MSAs,

the state rate was greater than local FFS expenditures by 1 percent to 9 percent (Avalere 2019). A separate industry analysis compared Medicare spending for FFS beneficiaries with ESRD in several large metropolitan areas in California, Florida, Ohio, and Texas. The analysis tracked ESRD FFS spending in each metropolitan area from 2015 to 2017 and found that spending in the metropolitan areas ranged from about 15 percent above or below the state average spending in each state. Spending in many metropolitan areas, however, was much closer to the state average (Health Management Associates 2020).⁵² These analyses suggest that there is room to improve MA payment accuracy for ESRD enrollees by establishing payment areas with less variation in ESRD spending than in states.

Ensuring equal access to MA plans for beneficiaries with ESRD

The 21st Century Cures Act sought to create access to MA plans for ESRD beneficiaries that is equal to that of other Medicare beneficiaries. Although the law eliminated enrollment barriers, some MA plans report ESRD losses and may seek to limit plan access for ESRD beneficiaries within the bounds of Medicare rules. One strategy is to impose high out-of-pocket spending for ESRD enrollees, diminishing ESRD beneficiaries' incentive to enroll in an MA plan to reduce their cost-sharing liability. A second strategy is for plans to restrict their dialysis facility networks to discourage ESRD beneficiaries from enrolling.

Cost-sharing coverage for ESRD enrollees in MA

MA plans can require enrollees to pay cost sharing up to the amount charged in FFS Medicare. Given the level of dialysis cost sharing in FFS Medicare (20 percent coinsurance) and the frequency of dialysis services (three treatments per week), ESRD beneficiaries enrolled in MA can face cost-sharing liability of about \$52 per dialysis treatment, or about \$8,068 per year (assuming FFS rates for dialysis and a complete set of annual treatments). We found that in 2018, 47 percent of ESRD beneficiaries in FFS Medicare had dialysis cost-sharing assistance through Medicaid, compared with 38 percent of ESRD beneficiaries in MA. MA enrollees generally do not have a Medigap plan as it is illegal for anyone to sell a Medigap policy to an MA enrollee, and Medigap policies cannot be used to pay MA cost sharing or premiums.

MA plans choose to reduce beneficiary cost sharing for most services (an extra benefit financed by plan rebates)

and are required to offer a MOOP limit. Each plan's benefits for cost sharing and limits on out-of-pocket spending must be the same for all enrollees; however, the level of cost-sharing coverage can differ across service categories.

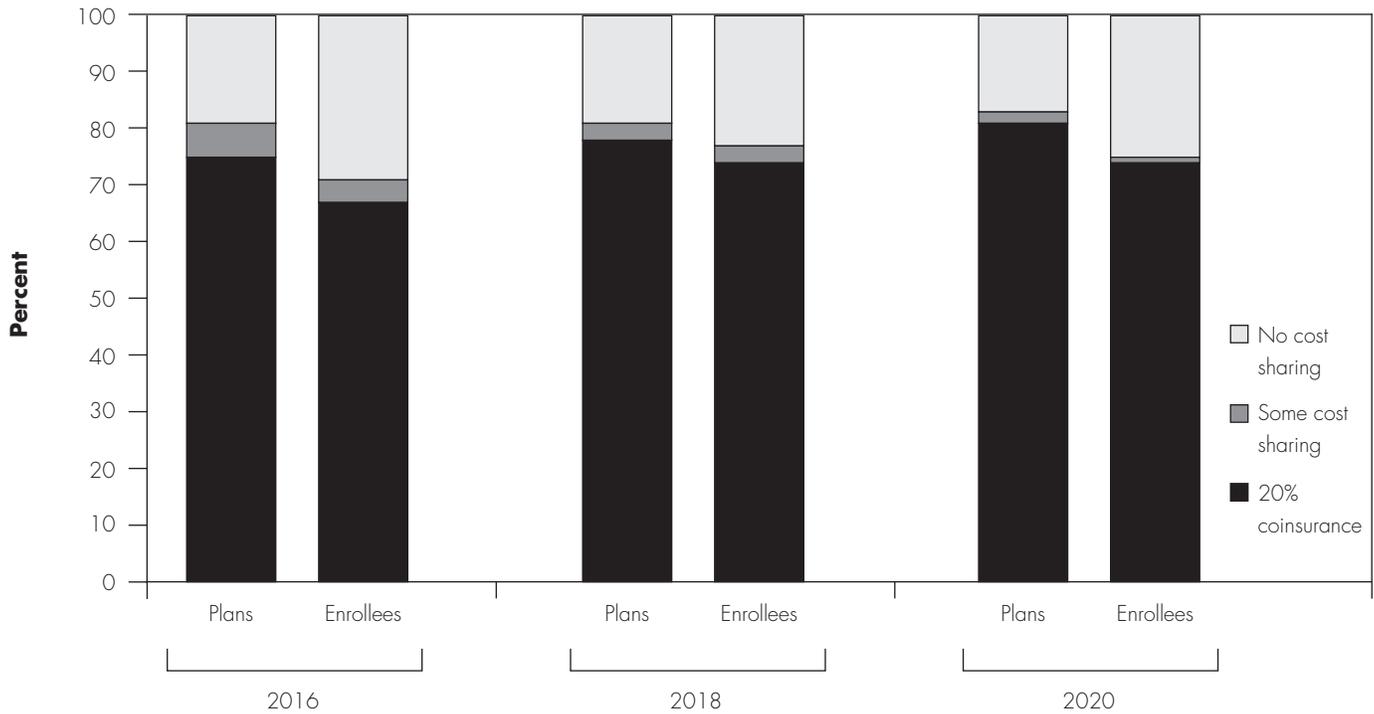
As shown in Figure 12-11, about three-quarters of MA plans had the maximum allowable cost sharing for dialysis services in 2016, prior to the passing of the Cures Act, affecting about two-thirds of ESRD enrollees. Setting cost sharing for dialysis services at the maximum allowable amount allows plans to redistribute rebate funding to other extra benefits, which can be beneficial for enrollees whose dialysis cost sharing is covered through other sources, such as Medicaid or employer-sponsored coverage. But setting cost sharing for dialysis at the maximum allowable amount may discourage beneficiaries without other sources of coverage from enrolling in the MA plan.

Since the Cures Act was passed, the share of MA plans with 20 percent coinsurance rose from 75 percent to 81 percent between 2016 and 2020, and the share of ESRD enrollees with 20 percent coinsurance rose from 67 percent to 74 percent between 2016 and 2018 (the most recent year of ESRD enrollment data). The share of plans and ESRD enrollees with some cost sharing, but less than the maximum allowable 20 percent coinsurance, fell between 2016 and 2020. For ESRD C-SNPs in 2020 (included in Figure 12-11), most plans and about 67 percent of enrollees had 20 percent coinsurance for dialysis services, while the remaining plans and their enrollees had no cost sharing. Although 20 percent coinsurance is the maximum allowable dialysis cost sharing for any Medicare beneficiary, it is possible for MA enrollees to pay a higher dollar value for dialysis cost sharing than is allowable in FFS Medicare, particularly in MA plans that charge 20 percent dialysis coinsurance and that pay dialysis prices well above FFS Medicare rates.

Despite most MA plans charging the maximum allowable cost sharing for dialysis services, the MOOP constrains total out-of-pocket spending for ESRD enrollees. Prior to 2021, the mandatory MOOP limit was set at the 95th percentile of beneficiary cost-sharing expenditures for FFS beneficiaries *without* ESRD, and the voluntary MOOP limit was set at the 85th percentile. In response to the Cures Act changes, CMS will begin to incorporate beneficiary cost sharing for FFS beneficiaries with ESRD when estimating MOOP limits (i.e., when calculating the 85th and 95th percentiles of out-of-pocket expenditures).

FIGURE 12-11

Large share of MA plans and MA ESRD enrollees with 20 percent coinsurance for dialysis services in 2016 increased modestly through 2020



Note: MA (Medicare Advantage), ESRD (end-stage renal disease). The maximum allowable cost sharing for dialysis services is 20 percent coinsurance. Plan enrollment in 2020 is assumed to be the same as in 2018, the most recent year of ESRD enrollment data.

Source: MedPAC analysis of plan benefit package data, 2016, 2018, and 2020.

Calculating the mandatory limit using cost-sharing data for all FFS beneficiaries (including those with ESRD) would increase the 2021 limit for all beneficiaries by about \$1,000. To limit the impact of the change in calculation method, CMS includes 40 percent of the difference in 2021, increasing the mandatory limit from \$7,175 (using the old method) to \$7,550 (rounded to nearest \$50 increment). A transition will continue to add 20 percent of the difference each year until 2024, when MOOP limits will be based on all FFS beneficiaries (Centers for Medicare & Medicaid Services 2020c).

Some plans may use high cost sharing to deter overuse of a particular service by steering enrollees to lower cost sites for care, such as steering patients away from the emergency department when an urgent care clinic or physician visit would suffice and is available. Frequent dialysis treatments, on the other hand, are necessary to

sustain the lives of ESRD patients. High cost sharing for dialysis services is not in the interest of ESRD patients and can be used to discourage ESRD beneficiaries without supplemental cost-sharing coverage from enrolling in an MA plan. Given the substantial out-of-pocket spending that ESRD beneficiaries face overall, the mandatory MOOP limit is essential for maintaining ESRD beneficiary access to MA plans and limits the impact of most plans charging the maximum allowable cost sharing for dialysis services.

Network adequacy for dialysis facilities

MA plans are required to maintain an adequate network of providers for all Medicare services. Network adequacy is enforced through two requirements that set a specific minimum or standard for each physician specialty and facility type. For facilities, plans must first maintain a minimum number of facilities per county and, second,

maintain access to facilities that is consistent with the prevailing community pattern of health care delivery. The second requirement uses travel time and distance standards that vary by county population and density.

In recent rulemaking, CMS eliminated both network adequacy requirements for outpatient dialysis facilities starting in 2021 and instead requires plans to attest to maintaining an adequate network of dialysis facilities (Centers for Medicare & Medicaid Services 2020d). CMS did not eliminate or propose to eliminate network adequacy standards for any other facility type. The Commission strongly opposed the elimination of time and distance standards for dialysis facilities because:

- CMS did not articulate the goal it was trying to achieve by eliminating the network adequacy standards (although the agency acknowledged concerns from stakeholders that network adequacy standards were leveraged by dialysis providers to obtain higher payments from plans);
- MA coverage should be the same for ESRD beneficiaries as for all Medicare beneficiaries, and if plans were allowed to construct networks with a lesser degree of coverage for dialysis facilities than for other provider types, it could allow plans some ability to discriminate against ESRD beneficiaries wishing to enroll in MA;
- proximity to a dialysis facility is important for dialysis care, and greater travel time has a negative correlation with health outcomes; and
- home dialysis is not a substitute for in-center dialysis for some beneficiaries due to home limitations, caregiver access and burnout, and the need to visit a facility for home dialysis training and for nephrologist visits at least one out of every three months. (CMS proposed one option allowing exceptions to dialysis facility time and distance standards for plans covering home dialysis for all enrollees, and in another context encouraged plans to exercise all options to access medically necessary dialysis care (Medicare Payment Advisory Commission 2020a).⁵³)

Despite our comments, CMS finalized the proposal to eliminate network adequacy requirements for dialysis facilities, potentially compromising access to MA plans for beneficiaries with ESRD. CMS argued that the new regulation did not diminish network adequacy

requirements for dialysis facilities. Under the new regulation, MA plans must attest to maintaining an adequate dialysis network, and other regulations also require plans to maintain an adequate network (including a requirement for plans to arrange for services outside of the plan's provider network when network providers are unavailable or inadequate). At the same time, CMS argued that the change in requirements for outpatient dialysis facilities would encourage competition and bring down high reimbursement costs for dialysis treatment. The two arguments appear to be contradictory. Although a plan's negotiating position would be improved by removing, or credibly threatening to remove, a dialysis provider from its provider network, it is unclear how a plan could use this new leverage and leave access to dialysis in the plan's network unchanged. Either the network adequacy requirements are unchanged and plans cannot achieve greater leverage by removing a facility from its network, or network adequacy requirements are relaxed, giving plans greater leverage when negotiating with facilities. If a plan removes a dialysis facility from its network for an upcoming plan year, dialysis patients receiving treatment from that facility are unlikely to remain in the MA plan or to join the plan. A plan's attestation that it will ensure access to dialysis is not readily apparent to dialysis patients when choosing Medicare coverage, and there is no clear means to convey such information to beneficiaries.

Commission plans for ensuring appropriate payment and access for MA enrollees with ESRD

The 21st Century Cures Act gave Medicare beneficiaries with ESRD full access to MA plans equal to other Medicare beneficiaries. However, this access may be compromised by regulatory decisions, plans' cost-sharing arrangements, and other plan behavior (which may, in some cases, be motivated by dialysis facilities' demands for payment above FFS rates). To the extent MA plans seek to discourage enrollment by beneficiaries with ESRD in order to reduce potential ESRD losses, access to MA plans and the care coordination and extra benefits they offer are diminished. MA plans bear full risk for Medicare expenditures, and given the tools available to them to control costs and improve efficiency, MA plans should see an opportunity to improve care and reduce the significant medical costs for ESRD enrollees. The Commission will continue to review issues with payments to MA plans and network adequacy to ensure equal access to MA plans for beneficiaries with ESRD.

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 second consecutive year, MA enrollment has grown by 10 percent while enrollment in traditional FFS Medicare has declined. If the trend continues, MA is likely to become the most common form of Medicare coverage within the next several years. The MA payment system relies on FFS Medicare data for establishing benchmarks and calibrating the risk adjustment model, so the enrollment trend continues to increase the importance of using FFS data appropriately to set MA payment rates. The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide; however, some policies are deeply flawed and in need of immediate improvement.

The Commission is currently discussing changes to MA benchmark policy that would improve equity and efficiency in the MA program. The discussion incorporates the Commission's prior recommendations on MA benchmark policy.⁵⁴ The Commission also has standing recommendations to (1) account for continued coding differences between MA and FFS and address those differences in a complete and equitable way (Medicare Payment Advisory Commission 2016) and (2) ensure the completeness and accuracy of encounter data as a means to improve the MA payment system, to serve as a source of quality data, and to facilitate comparisons with FFS (Medicare Payment Advisory Commission 2019a). Through reforms to the MA payment system, the Commission aims to better focus the program on the beneficiaries it serves and on ways to harness plan efficiency to improve Medicare's long-term financial sustainability.

In setting payment policy in the FFS sector, the Commission consistently applies a level of fiscal pressure on providers to promote the efficient provision of care while maintaining beneficiary access to high-quality care. FFS payment policies of that nature can affect MA payments through the benchmarks, which are based on FFS expenditure levels. Relying on fiscal pressure only in the FFS sector means that savings to the program that come from MA can be generated only indirectly through FFS spending reductions. The ACA-instituted payment reforms reduced MA program payments, causing some concern about whether MA would continue to grow and attract Medicare beneficiaries. However, this substantial fiscal pressure did not have the negative effect that some had predicted. Instead, bids have fallen in relation to FFS spending—even in areas where sponsors might have found it challenging to operate successful plans, such as in low-FFS-spending areas where MA benchmarks are at 115 percent of FFS. Further, the value of extra benefits offered to MA enrollees—now equal to approximately \$1,700 annually per enrollee, or 14 percent of the basic benefit—has reached a historical high for the fourth consecutive year.

Aggregate MA payments are 4 percent higher than FFS expenditure levels. However, given the level of overutilization in FFS and other factors not discussed in this chapter—such as the volume-inducing effects of traditional FFS, Medigap's effect of insulating beneficiaries from the financial impact of their utilization, and inappropriate spending owing to fraud and waste—using payment parity between MA and FFS Medicare as a benchmark prevents policymakers from using any efficiencies generated by the MA program to reduce program spending. Consistent with the original incorporation of full-risk private plans in Medicare (through the Tax Equity and Fiscal Responsibility Act of 1982), in which private plan payments were set at 95 percent of FFS payments, we expect plans to be more efficient than FFS. In the future, Medicare may be able to share in some of those efficiencies. ■

Endnotes

- 1 This section describes payments for enrollees without end-stage renal disease (ESRD), representing the vast majority of MA enrollees. How Medicare pays MA plans for enrollees with ESRD is described in the “Medicare payments to MA plans differ for ESRD and non-ESRD enrollees” section (see pp. 387–388).
- 2 Plans are not permitted to apply rebate dollars toward optional supplemental benefits. In addition, optional supplemental benefits cannot include reduced cost sharing for Medicare Part A and Part B services.
- 3 Benchmarks are calculated using FFS spending for all Medicare beneficiaries, including those with both Part A and Part B coverage and those with only Part A or Part B. In our March 2017 report to the Congress, we recommended that CMS change the calculation to include FFS spending for only those beneficiaries with both Part A and Part B (that is, expenditures for only those beneficiaries eligible to enroll in MA plans) (Medicare Payment Advisory Commission 2017).
- 4 ACA payment formulations include an administratively determined cap on each county’s benchmark. The law included a provision that caps any county’s benchmark at the higher of (1) its pre-ACA level, projected into the future with a legislatively modified national growth factor or (2) 100 percent of its estimated FFS spending in the current year. Our March 2016 report to the Congress provides more detail on double-bonus counties and benchmark growth caps. In that report, we recommended eliminating the double bonuses as well as the benchmark growth caps, which limited the benchmarks in many counties (Medicare Payment Advisory Commission 2016).
- 5 To account for coding differences in 2021, we conservatively assume that the impact of coding intensity in 2021 is the same as in 2019. The coding intensity trend from 2017 to 2019 suggests that the impact in 2021 may be higher than in 2019. We will continue to evaluate this trend. Our estimate of MA payments relative to FFS spending does not account for other potential factors that we cannot measure with certainty, including the adjustment of CMS’s estimate of FFS spending for beneficiaries with both Part A and Part B, potential favorable selection of beneficiaries that choose to either switch from FFS to MA or exit MA, potential spillover of provider behavior that may occur from large increases in MA market share into FFS or potential spillover from FFS alternative payment models into MA, and any effect of retrospective MA and FFS improper payment remittances.
- 6 The Commission’s previous work suggests that, although some beneficiaries enroll in MA immediately upon becoming eligible, most MA enrollees initially enroll in FFS Medicare and subsequently move to MA. For more on enrollment patterns, see our March 2015 report (Medicare Payment Advisory Commission 2015).
- 7 In 2018, most beneficiaries who purchased Medigap supplemental insurance chose the most comprehensive supplemental coverage options, which generally have the highest premiums. For more information on Medigap enrollment, see our July 2020 data book (Medicare Payment Advisory Commission 2020b).
- 8 By contrast, in some metropolitan areas, less than 1 percent of Medicare beneficiaries were enrolled in MA plans. For example, in Anchorage, AK, where only employer group plans are available, 1 percent of beneficiaries were enrolled in MA.
- 9 For example, the Commission has found that the risk adjustment model tends to underpredict spending for beneficiaries with no medical conditions (Medicare Payment Advisory Commission 2020c). If a disproportionate share of a county’s FFS beneficiaries had no medical conditions, the risk-adjusted average FFS spending estimate would be too high.
- 10 Beneficiaries in some parts of the country have access to Section 1876 cost-reimbursed HMOs. Such plans arrange for the full range of Medicare services. They receive reasonable cost reimbursement for Part B physician and supplier services, but the Medicare program directly pays providers for inpatient and outpatient institutional services. Enrollees of cost plans are not locked into the plan and can receive any out-of-network services and have them paid by the Medicare program. The statute calls for the phasing out of cost plans in areas in which there are at least two competing MA CCPs that meet a minimum enrollment requirement. The cost plans are expected to transition to MA plans, and some have already begun the transition.
- 11 Market concentration is traditionally computed using the Herfindahl–Hirschman Index. The index is calculated by squaring the market share of each entity competing in the market and summing the results. The index approaches zero when a market is occupied by a large number of firms of relatively equal size and reaches its maximum of 10,000 points when a market is controlled by a single firm. The index rises both as the number of firms in the market drops and as the disparity in size among those firms increases. Using Department of Justice guidelines, markets with an index

- below 1,500 are considered unconcentrated; those with an index between 1,500 and 2,500 are considered moderately concentrated; and those above 2,500 are considered highly concentrated (Department of Justice and the Federal Trade Commission 2010).
- 12 Plans estimate administrative expenses and margins separately for cost-sharing reductions. The allocated \$64 per enrollee per month for cost sharing includes administrative expenses of 10 percent and a margin of 2 percent.
 - 13 CMS estimates that the 2020 monthly actuarial value of Medicare deductibles and coinsurance for a beneficiary without end-stage renal disease is \$169.92 (Centers for Medicare & Medicaid Services 2020a). The Commission has previously summarized the evidence on the effects of cost sharing on Medicare spending and recommended an additional charge on supplemental insurance (Medicare Payment Advisory Commission 2012a) and commissioned a study finding higher Medicare spending for beneficiaries with Medigap coverage (Hogan 2009).
 - 14 Plans estimate administrative expenses and margins separately for supplemental benefits. The allocated \$29 per enrollee per month for supplemental benefits includes administrative expenses of 11 percent and a margin of 4 percent.
 - 15 Beginning in 2019, CMS relaxed one of the criteria for eligible supplemental benefits—that the benefit be primarily health related—to include items and services that are used to diagnose, compensate for physical impairments, ameliorate the functional/psychological impact of injuries or health conditions, or reduce avoidable emergency and health care utilization. A supplemental benefit is not primarily health related if it is an item or service that is solely or primarily used for cosmetic, comfort, or general use purposes or to address social determinants of health. The degree of projected spending for new types of supplemental benefits is not available in plan bid data.
 - 16 When submitting Part D bids, plans may allocate administrative expenses and margin toward the Part D revenue that results from projected Part C rebates.
 - 17 MA plans annually report their MLRs to CMS. Plans may include quality improvement and fraud reduction activities as medical expenses when submitting their MLRs. Plans are subject to financial and other penalties for failure to meet the statutory requirement that they have an MLR of at least 85 percent. For contract year 2020, plans submit MLRs to CMS in December of 2021, and CMS would begin subtracting remittances from regular monthly plan payment in July of 2022 to recoup any revenue difference between a plan’s actual MLR and the minimum MLR of 85 percent.
 - 18 Under Section 319 of the Public Health Service Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of a coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
 - 19 Margins are calculated as the remainder of payments to the plan after accounting for all other costs, including all medical expenses, salaries, bonuses, beneficiary incentive payments, and all administrative costs. We removed 19 outlier contracts (accounting for 6 percent of reported plan revenues) that reported greater medical expenses than their stated plan revenues for that year (i.e., contracts reporting insufficient revenue to cover benefits and no revenue to cover administrative expenses). We identified outliers at the contract level to account for plans that may be subsidized by other plans (i.e., product pairing) within the same service area. Most of the outlier contracts we identified reported negative margins in the bid data for consecutive years. These contracts are likely atypical because CMS requires MA plans with negative margins to submit a business plan to achieve profitability and expects MA plans to meet or exceed the year-by-year margin targets in the business plan.
 - 20 The ACA insurer fee was in effect in 2020 but is entirely repealed in all subsequent years.
 - 21 Other possible sources of diagnostic information—such as encounters for home health services, skilled nursing, ambulatory surgery, durable medical equipment, lab and imaging tests, and hospice services—are not used to determine payment through the risk adjustment model for several reasons: (1) adding diagnoses from these sources does not improve the model’s ability to predict medical expenditures; (2) concerns exist about the reliability of diagnoses from providers with less clinical training (e.g., home health and durable medical equipment providers); and (3) a high proportion of reported diagnoses (e.g., lab and imaging tests) are used to rule out having the diagnosis.
 - 22 In 2015, CMS combined RAPS data and encounter data for risk adjustment, meaning that plans were paid for HCCs identified through at least one of the two data sources submitted to CMS.
 - 23 CMS pooled inpatient RAPS data with encounter data because the agency found that inpatient encounter record submissions were low relative to inpatient RAPS submissions, implying that some inpatient encounter records were missing and inpatient RAPS data were needed in its place. Our analysis concluded that the RAPS data were faulty—

- specifically, the provider type was indicated to be inpatient hospital when the provider was likely an outpatient hospital or physician—and in comment letters we stated that RAPS inpatient data should not be pooled with encounter data. Our analysis leading to this conclusion is more thoroughly described in the March 2019 report to the Congress (Medicare Payment Advisory Commission 2019b).
- 24 Except for Program of All-Inclusive Care for the Elderly contracts, which will continue to use pooled RAPS and encounter data as the basis for risk scores.
 - 25 The actual dollar amount a plan will receive for coding a new HCC depends on several additional factors, including the version of the HCC model applied for a beneficiary and factors that affect a plan’s base rate. Dollar-value coefficients are standardized relative to average FFS spending before being applied to each plan’s base rate. CMS maintains separate HCC models for enrollees who lack a full calendar year of diagnostic data or have end-stage renal disease. A plan’s base rate varies according to the plan’s bid and the local area’s benchmark.
 - 26 The share of FFS Medicare payments that flow through accountable care organizations and other alternative payment models is increasing and has the potential to increase diagnostic coding incentives in FFS Medicare, but we have yet to see an effect on our analysis.
 - 27 This statement is supported by the legal complaints cited in this section. One complaint includes exhibits of plan documents that detail the financial performance of the plan’s chart review program (United States of America v. Anthem 2020).
 - 28 Partial Medicaid enrollment generally provides coverage of Medicare premiums and, for some categories, cost-sharing assistance for Medicare benefits, while full Medicaid enrollment includes premium and cost-sharing assistance and also covers additional services not covered in the Medicare benefit.
 - 29 The 2017 model also determines Medicaid enrollment status on a monthly basis during the payment year, which improves the accuracy of payment for these enrollees. The model has separate segments based on aged or disabled status, combined with no, partial, or full Medicaid enrollment status.
 - 30 FFS risk score growth matched MA risk score growth between 2015 and 2016 for the first time since the full implementation of the HCC model in 2007. Risk score growth between 2015 and 2016 was affected by the transition from International Classification of Diseases (ICD)–9 to ICD–10 diagnosis codes. MA risk scores were still higher than FFS risk scores for comparable beneficiaries because of prior differences in coding rates.
 - 31 CMS identifies diagnoses from physician visits using a different method for RAPS and encounter data. Eligible physician visits in RAPS data are determined by physician specialty code, and eligible physician visits in encounter data are determined by procedure code. The two methods of filtering physician claims for use in risk adjustment were intended to produce equivalent results, but it is possible that RAPS-based and encounter-based risk scores would not be equivalent because of the different methods of filtering physician claims.
 - 32 CMS observed that encounter data inpatient submissions were low compared with corresponding RAPS inpatient submissions and therefore supplemented encounter data with inpatient RAPS data to calculate risk scores. However, we believe a large number (1.5 million in 2015) of physician office visits and outpatient hospital visits have been inaccurately reported as “inpatient stays” in RAPS data. Therefore, we believe CMS should not supplement encounter data with inpatient RAPS data to adjust for the discrepancy between the two data sources.
 - 33 Less than 1 percent of MA enrollees are enrolled in a contract with fewer than 2,500 enrollees.
 - 34 For RADV audits in 2011, CMS grouped all contracts into high, medium, and low levels of coding intensity and selected 20 high-level, 5 medium-level, and 5 low-level contracts at random.
 - 35 Other criteria include Part B enrollment for the full data collection year, continuous enrollment in the contract for the full data collection year and January of the payment year, and no end-stage renal disease or hospice status.
 - 36 Additional HCCs that were not submitted for payment but were supported in one of up to five medical records submitted through the audit can offset beneficiary payment error rates but will not result in additional payments to the MA plan. MA plans are required to submit diagnoses for payment.
 - 37 CMS proposed this method of determining overpayment recovery amounts in 2018 but has not yet issued a final rule (Centers for Medicare & Medicaid Services 2018). For extrapolation, a contract’s payment error rate would be set at the lower 99th percent confidence interval of beneficiary-level error rates in the sample. For contract payment error rates greater than zero, the overpayment recovery amount would be the payment error rate at that confidence interval multiplied by the total payment for eligible enrollees in the contract.

- 38 The Commission previously assessed the completeness of encounter data by comparing the data with other sources of MA utilization information. The Commission recommended that the Secretary establish thresholds for encounter data completeness, evaluate plans' submitted data, apply a payment withhold based on data completeness, and allow providers to submit records through the Medicare administrative contractors (Medicare Payment Advisory Commission 2019a). The Commission's most recent evaluation is summarized in our March 2020 report to the Congress (Medicare Payment Advisory Commission 2020d).
- 39 The American Kidney Fund is a nonprofit organization that provides needs-based financial assistance to dialysis patients, including assistance with health insurance premiums, transportation to and from treatment, medical supplies, and prescription drugs. In 2019, the American Kidney Fund provided nearly \$271 million in direct patient aid (American Kidney Fund 2019a).
- 40 Plans can offer a "voluntary" MOOP limit lower than the mandatory limit in exchange for the ability to impose higher cost-sharing amounts for certain services, up to the limits CMS specifies. Cost-sharing limits vary by service category, and some service category limits are higher for plans using the voluntary MOOP. Some service-specific limits are specified in statute, including dialysis services, which cannot exceed the cost sharing of FFS Medicare (20 percent coinsurance per treatment).
- 41 Individuals with ESRD include patients on dialysis, patients undergoing kidney transplant, and patients with a functioning graft, but the prohibition on enrolling in an MA plan did not apply to ESRD patients with a functioning graft.
- 42 Prior to 2021, other SNPs (besides ESRD C-SNPs) had the option to enroll ESRD beneficiaries; however, we do not know whether any SNPs elected to allow beneficiaries with ESRD to enroll.
- 43 As of January 2020, ESRD C-SNPs were offered in select counties in Arizona, California, Connecticut, New Jersey, Nevada, and Texas.
- 44 Two possible exceptions are enrollment for ESRD beneficiaries in Medicare-Medicaid plans and certain SNPs for dual-eligible Medicare beneficiaries (who are also eligible for Medicaid). For these plans, known as D-SNPs, integrating Medicare and Medicaid coverage and services is the primary goal, and depending on the state, enrollment of ESRD patients in these plans may be restricted.
- 45 Medicare payment applies distinct risk-adjustment models for beneficiaries with ESRD based on their disease status: dialysis, transplant (month and two subsequent months), and postgraft (four or more months after transplant). Payments for beneficiaries in dialysis and transplant status are based on ESRD state rates, and payments for beneficiaries in postgraft status are based on county-level benchmarks used for non-ESRD enrollees.
- 46 The ESRD subsidy is a feature of the "bid pricing tool"—a form that includes the plan's bid for non-ESRD enrollees and plan information about revenues and costs for ESRD enrollees.
- 47 Employer group waiver plans do not submit bids and are not represented in the cost-to-revenue ratio analyses. We separately analyzed ESRD cost and revenue information for ESRD C-SNPs.
- 48 ESRD C-SNPs submit financial information using a specialized BPT because the plans do not have non-ESRD enrollees.
- 49 Dialysis status is indicated when a patient begins dialysis and the managing nephrologist submits a medical evidence form, required regardless of the patient's payer, to the CMS registry. A monthly dialysis status indicator is maintained in risk score data. The mechanism for turning off the dialysis status indicator is somewhat unclear for patients who continue living but choose to end dialysis treatment without receiving a kidney transplant (i.e., there is no kidney transplant claim or date of death documentation that can be used as evidence that the individual is no longer in dialysis status).
- 50 We applied the following exclusion criteria to both MA encounters and FFS claims (although many more MA encounters than FFS claims were excluded by these criteria): missing beneficiary identifier, age, or provider zip code on a claim/encounter; missing revenue center code, payment, or date; a claim or encounter record spanning more than one month; or a calculated monthly average price per treatment amount below \$92 (the FFS Medicare base rate for Puerto Rico, the area with the lowest wage index) or above \$3,900 (an amount that excluded about 5 percent of MA enrollee months with the highest average price per treatment). We also excluded home dialysis training treatments from both FFS claims and MA encounter records because it was unclear how MA plans reported payments for those services in the MA encounter data.
- 51 Social Security Act Section 1853(d)(3).
- 52 This analysis used a 5 percent sample of FFS claims. Although the analysis focused on large metropolitan areas where there are likely to be more ESRD beneficiaries in the sample data, analysis of complete Medicare data would more accurately estimate variation in FFS ESRD spending for metropolitan areas relative to the state average.

53 The Commission's March 2018 report to the Congress provides a more complete discussion of clinical and nonclinical factors that affect the use of home dialysis (Medicare Payment Advisory Commission 2018b).

54 The Commission has recommended eliminating the benchmark caps and quality double bonuses (Medicare Payment Advisory Commission 2016), basing benchmarks on FFS beneficiaries enrolled in both Part A and Part B (Medicare Payment Advisory Commission 2017), and revising geographic units for payment and quality assessment (Medicare Payment Advisory Commission 2020c).

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CHAPTER

13

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

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

Chapter summary

In 2020, the Part D program paid for outpatient prescription drug coverage on behalf of more than 47 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits. Part D also includes a low-income subsidy (LIS) that provides assistance with premiums and cost sharing to nearly 13 million individuals with low income and assets. The 2020 benefit year was extraordinary due to the coronavirus pandemic and its toll on Medicare beneficiaries and health care providers. However, Medicare beneficiaries experienced comparatively less disruption of access to medicines than to other types of health care services; only 7 percent had to forgo medications compared with 36 percent for medical services.

In 2019, Part D program expenditures totaled \$102.3 billion, accounting for about 12 percent of Medicare spending. Enrollees paid \$13.9 billion of the \$102.3 billion in plan premiums for basic benefits and separately were responsible for paying an additional \$16.7 billion in cost sharing plus additional amounts in premiums for enhanced benefits. Part D has been a success in many respects. It has improved beneficiaries' access to prescription drugs. Generic drugs account for nearly 90 percent of the prescriptions filled. More than 9 in 10 Part D enrollees report they are satisfied with the program.

In this chapter

- Part D's approach
- Enrollment, plan choices in 2020, and benefit offerings for 2021
- Plan sponsors and their tools for managing benefits and spending
- Drug pricing
- Program costs
- Beneficiaries' access to prescription drugs
- Quality in Part D

However, changes to Part D's benefit design combined with trends in drug spending have eroded plans' incentives for cost control. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based subsidies rather than capitated payments, and the financial risk that plans bear has declined markedly. Last year, the Commission recommended major changes to the Part D benefit design and Medicare's subsidies to restore the role of risk-based, capitated payments that was present at the start of the program and provide drag on drug price increases. Separately, we are concerned that the LIS has features that limit premium competition among plans that serve low-income beneficiaries.

Nearly 300 organizations sponsor Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. Most large plan sponsors are vertically integrated with their own pharmacy benefit manager (PBM) and many also operate mail-order and specialty pharmacies. Formularies remain plan sponsors' most important tool for managing drug benefits. Generally, pharmaceutical manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that increases the likelihood of winning market share over competing drugs. Plan sponsors and PBMs have negotiated rebates that have grown as a share of Part D spending. However, the wide gap between spending before and after rebates raises concerns about the accuracy of Part D's risk adjustment system.

Enrollment in 2020 and benefit offerings for 2021—In 2020, 74.6 percent of Medicare beneficiaries were enrolled in Part D plans. An additional 1.9 percent obtained drug coverage through employer-sponsored plans that received Medicare's retiree drug subsidy. The remaining 23.5 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 2019 and 2020, enrollment in stand-alone prescription drug plans (PDPs) declined from 25.5 million to 25.1 million, while enrollment in Medicare Advantage–Prescription Drug plans (MA–PDs) expanded. As a result, in 2020, 47 percent of enrollees were in MA–PDs compared with 30 percent in 2007. The number of enrollees who received the LIS has grown more slowly than the broader Part D population. In 2020, LIS enrollees made up 27 percent of total enrollment.

For 2021, beneficiaries have a broad choice of plans. Compared with plan offerings in 2020, sponsors are offering 5 percent more PDPs, 12 percent more MA–PDs open to all beneficiaries, and 14 percent more MA–PDs tailored to specific populations (special needs plans). In 2021, over 1,600 plans are participating in the Center for Medicare and Medicaid Innovation's new Part D senior savings model that covers certain insulins at cost sharing of no more than \$35 per one-month

supply. Most plans use a 5-tier formulary that uses differential cost sharing between preferred and nonpreferred drugs, as well as a specialty tier for high-cost drugs. For 2021, the \$33.06 base beneficiary premium increased by 1 percent, reflecting the increase in the total average estimated cost for basic benefits. However, individual plans' premiums can vary substantially. In 2021, 259 premium-free PDPs are available to enrollees who receive the LIS, a 6 percent increase from 2020. All regions have at least five premium-free PDPs for LIS enrollees.

Part D program costs—Between 2007 and 2019, Part D program spending increased from \$46.2 billion to \$88.4 billion (average annual growth of 5.6 percent). Medicare's reinsurance (which covers 80 percent of spending in the catastrophic phase of the benefit) continues to be both the largest and fastest growing component of program spending, at an annual average rate of about 16 percent since 2007. As a result, between 2007 and 2019, the portion of the average basic benefit paid to plans through the capitated direct subsidy fell from 54.7 percent to 15.3 percent. In 2019, Part D saw the largest increase ever in beneficiaries without the LIS reaching the benefit's catastrophic phase (high-cost enrollees). This growth was due, in large part, to changes in law that increased the coverage-gap discount paid by brand manufacturers from 50 percent to 70 percent. In 2019, high-cost enrollees accounted for 64 percent of Part D spending, up from about 40 percent before 2011. Overall, our index of Part D prices declined in 2019, owing to increased generic competition. However, the price decline was not uniform across therapeutic classes. In classes dominated by brand-name drugs or biologics, prices continued to rise. Despite deceleration in overall price growth, inflation in prices of drugs taken by high-cost enrollees will likely continue to drive their spending upward. In 2019, over 483,000 enrollees (11 percent of high-cost 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. The increase in the number of beneficiaries with such claims has accelerated in recent years, rising by more than 100,000 since 2017.

Beneficiary access and quality in Part D—Data from CMS audits and Part D appeals processes suggest that beneficiaries may be less likely to encounter access issues for most drugs than in previous years. However, among beneficiaries without the LIS, high cost sharing for expensive therapies may be a barrier to access. Part D enrollees have experienced comparatively less disruption of access to medicines due to the pandemic than access to other types of health care services. In 2021, the average star rating among Part D plans increased somewhat for PDPs and decreased for MA-PDs. While average star ratings for MA-PDs continue to exceed those of PDPs, the trend among MA-PD sponsors of consolidating contracts leads us to question the validity of MA-PD ratings. It is not clear that current quality

metrics help beneficiaries make informed choices among their plan options. In the past, the Commission has expressed concerns about the effectiveness of plans' medication therapy management (MTM) programs to improve the quality of pharmaceutical care due to the lack of financial incentives for sponsors of stand-alone PDPs. In 2017, CMS implemented the Enhanced MTM program that rewards PDPs for reducing medical spending. However, the evaluation of the first two years of the five-year demonstration program has found no significant reductions in Medicare spending for Part A and Part B services among enrollees in Enhanced MTM plans. ■

Background

Each year, the Commission provides a status report on Part D that examines several performance indicators: enrollment, plan benefit offerings, market structure, drug pricing, program costs, beneficiaries' access to medications, and quality. In 2020, the Part D program paid for outpatient prescription drug coverage on behalf of more than 47 million Medicare beneficiaries. For Part D plan enrollees, Medicare subsidizes about three-quarters of the cost of basic benefits, defined as Part D's standard benefit or benefits with the same average value. Separately, Part D includes a low-income subsidy (LIS) that pays for much of the cost sharing and premiums on behalf of nearly 13 million individuals with low income and assets. In 2019, Part D program expenditures totaled \$102.3 billion on an incurred basis, accounting for about 12 percent of Medicare spending (Boards of Trustees 2020). Of that amount, Medicare spending for the LIS totaled \$29.8 billion: \$26.0 billion for cost sharing and \$3.8 billion for premiums. Of the \$102.3 billion program spending total, Part D enrollees paid \$13.9 billion in plan premiums for basic benefits. Above and beyond program spending, enrollees paid \$16.7 billion in cost sharing plus additional amounts in premiums for enhanced benefits.

In several ways, Part D has been a success. Since 2006 when it began, the program has improved Medicare beneficiaries' access to prescription drugs; from 2006 to 2018, the share with Part D or drug coverage at least as generous as Part D increased from 75 percent to 88 percent. Stand-alone prescription drug plans (PDPs) and Medicare Advantage–Prescription Drug plans (MA–PDs) are available in every region of the country. Nearly 90 percent of Part D prescriptions filled are for generic drugs, which tend to have lower prices and cost sharing than brand-name drugs. More than 9 in 10 Part D enrollees report they are satisfied with the program and with their plan (Medicare Today 2020).

Initially, most of Medicare's subsidies to Part D plans took the form of fixed-dollar payments per enrollee, giving plan sponsors strong incentives to manage benefit spending. However, changes in Part D's benefit design and trends in drug spending have resulted in a growing share of Part D subsidies taking the form of cost-based reimbursements to plans, and the financial risk that plans bear has declined markedly (Medicare Payment Advisory Commission 2020c). Last year, the Commission recommended major changes to the Part D benefit design

and Medicare's subsidies to restore the role of risk-based, capitated payments and provide some drag on drug price increases. These changes would shift more responsibility for Part D spending from Medicare (that is, the taxpayers) to Part D plans sponsors and drug manufacturers.

The 2020 benefit year was extraordinary due to the coronavirus pandemic and its toll on Medicare beneficiaries and health care providers. However, the pandemic's effects on the use of outpatient prescription drugs under Part D have been less pronounced than the effects on other health care services (see text box on the effects of COVID-19, p. 412).

Part D's approach

Medicare's payment system for Part D is different from payment systems under Part A and Part B. In Part D, Medicare pays competing private plans to deliver outpatient drug benefits to beneficiaries whether they enroll in a PDP or MA–PD. Instead of setting prices administratively, Medicare bases payments on bids submitted by plan sponsors. Plan sponsors establish networks of pharmacies and apply formularies—lists of drugs the plan will cover that use differential cost-sharing tiers—to manage enrollees' use of and spending for prescription drugs. For drug classes that have competing therapies, plan sponsors negotiate with biopharmaceutical manufacturers to place brand-name drugs on the plan's formulary, potentially on a preferred (lower) cost-sharing tier, in return for postsale rebates.

Benefit design

Medicare law defines a standard Part D basic benefit, but in practice, plan sponsors offer alternative benefit designs with equivalent or more generous coverage. Most LIS enrollees pay nominal copayments throughout the benefit; Part D's LIS pays for the remainder of plans' cost-sharing requirements on their behalf. Changes in law altered the design of the standard benefit for most Part D enrollees (those without the LIS, about 72 percent in 2019); the law did not do so for those who receive the LIS. As a result, there are two distinct standard Part D benefit designs.

Part D's defined standard benefit

For the majority of Part D enrollees (those without the LIS), Part D's defined standard benefit covers 75 percent of drug spending above a deductible and all but 5 percent

Effects of COVID-19 within Part D

Although the coronavirus pandemic has affected Medicare beneficiaries' lives in many ways, Part D enrollees have experienced comparatively less disruption of access to medicines than to other types of health care services. Results of a nationally representative survey of community-dwelling Medicare beneficiaries conducted in the fall of 2020 found that while 36 percent had missed a regular check-up or treatment for an ongoing condition due to the pandemic, only 7 percent had forgone prescription drugs or medications (Centers for Medicare & Medicaid Services 2020f).

In March 2020, as state and local governments placed restrictions on the operation of many businesses, most grocery stores and retail pharmacies were permitted to stay open, which helped to maintain access to medicines. Consumers stockpiled prescriptions, many with 90-day supplies. CMS encouraged Part D plan sponsors to allow extended fills of prescriptions without requiring face-to-face contact through relaxation of “refill-too-soon” restrictions and home delivery. Although we do not yet have 2020 claims for Part D, dispensing data that include claims from many payers show that in late March, pharmacies experienced about a 20 percent increase in prescription volume adjusted for days' supply (National Council for Prescription Drug Programs 2020). Throughout April and May, data for all payers show that individuals drew down those stockpiles and pharmacy dispensing volumes experienced single-digit declines. By August, however, the volume of adjusted prescriptions had rebounded somewhat closer to the volume for August 2019. Mail-order volume expanded, but patterns of patients visiting community pharmacies reverted closer to previous years' trends.

Initiation of new drug therapies has been affected by the pandemic more than prescription refills have. Between March and May 2020, as fewer patients visited providers in person, new starts of prescriptions fell by one third and, by August, remained more than 7 percent below 2019 levels (IQVIA Institute 2020,

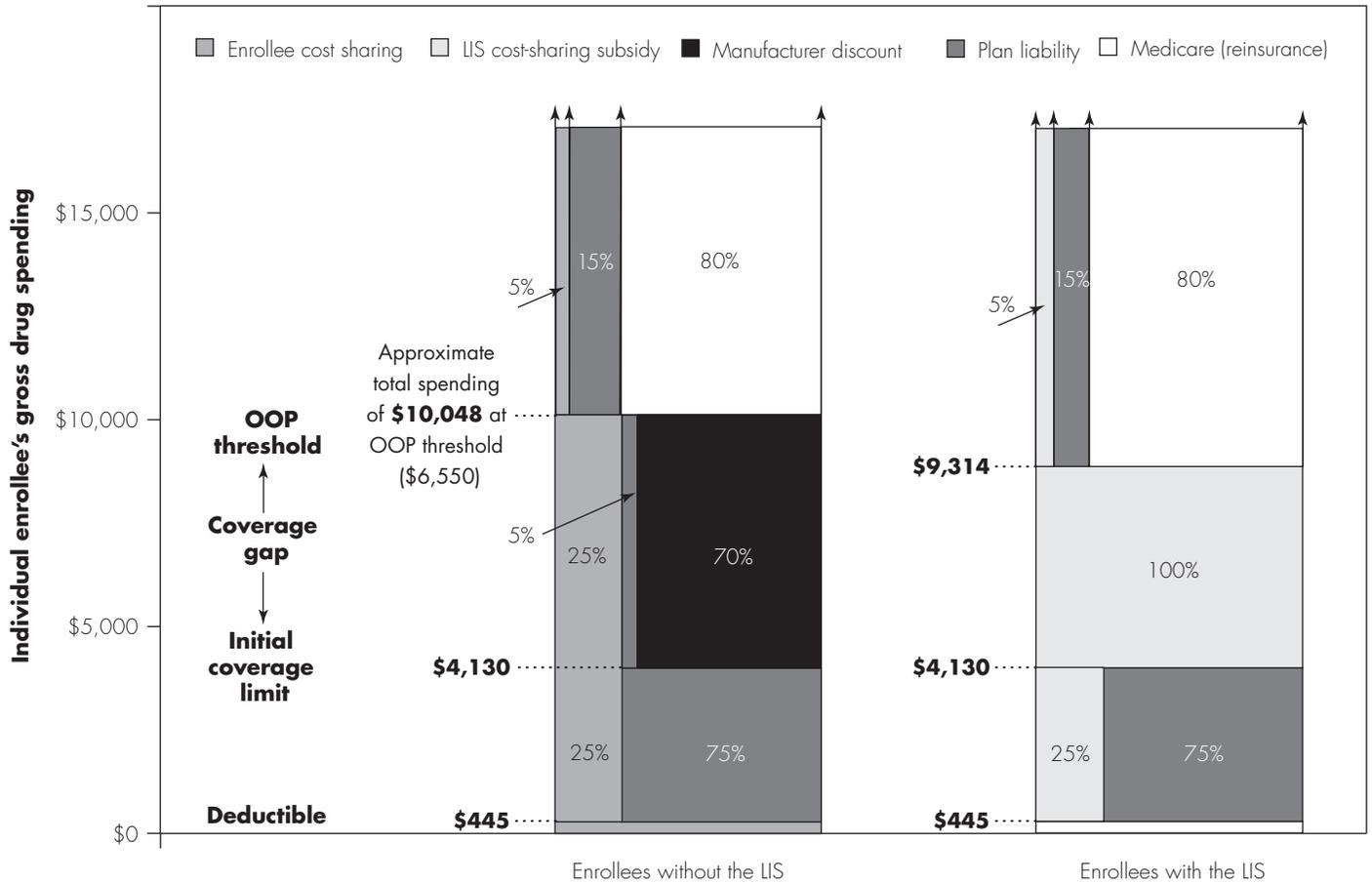
National Council for Prescription Drug Programs 2020). Even though patients substituted telehealth for some in-person visits, providers were more likely to have telehealth visits with existing patients than with new patients and were less willing to initiate drug therapy remotely (National Council for Prescription Drug Programs 2020). Subsequently, providers developed protocols for safe in-person visits and the volume of new prescriptions gained ground but did not recover fully.

The overall effects of the coronavirus pandemic on prescription use and spending remain uncertain but are much less likely to have adversely affected Part D plans than Medicare fee-for-service providers. Much of plans' revenues do not depend on how frequently enrollees seek health care services because Medicare pays Part D plans monthly capitated amounts. Those payments are based on plan sponsors' bids for the cost of providing prescription drugs rather than updates to administered prices. Because plans submitted their bids for 2020 benefits in June 2019, well before the pandemic began, and because prescription volume had been modestly lower, bids were more likely to have been too high than too low. Bids that were, on average, higher than actual plan costs would result in plan profits. However, Part D applies symmetric risk corridors around plan bids. If actual benefit spending is significantly lower than what plans bid, Medicare recoups some of the profit associated with payments that are too high.

Similarly, for the 2021 benefit year, plan sponsors submitted bids to CMS in June 2020—amid the public health emergency. It is unclear what specific assumptions about use and spending plans incorporated into their bids. However, nationwide, plans' average bid for basic benefits in 2021 was fairly similar to that for 2020—about 1 percent higher. Because Part D's risk corridors are symmetric, they provide protection for plans that underbid relative to actual costs and allow the program to recoup profits if actual drug spending is lower than expected. ■

FIGURE 13-1

Part D has two distinct benefit structures for enrollees with and without the LIS



Note: LIS (low-income subsidy), OOP (out of pocket). For beneficiaries without the LIS (left bar), the coverage gap is depicted as it would apply to brand-name drugs, which are eligible for a 70 percent manufacturers' discount in the coverage gap. There is no discount for generic prescriptions, and thus cost sharing in the coverage gap is 25 percent and plans are responsible for 75 percent. Because of this difference, total covered drug spending at the OOP threshold depends on the mix of brand and generic prescriptions each individual fills while in the coverage gap. The dollar amount shown (\$10,048) was estimated by CMS for an individual with an average mix of drugs who does not receive Part D's LIS and has no other supplemental coverage. The bar depicting LIS enrollees (right) reflects full rather than partial LIS coverage. LIS enrollees do not receive brand discounts from manufacturers. For most LIS enrollees, Medicare's LIS pays for all cost sharing except nominal copayments, thereby including most spending in the coverage gap.

Source: MedPAC depiction of Part D benefit structure for 2021 as set by law.

coinsurance once an enrollee reaches an out-of-pocket (OOP) threshold (Figure 13-1). Each year, the standard benefit's parameters change at the same rate as the annual change in beneficiaries' average drug expenses. For 2021, the deductible in Part D's standard benefit is \$445 and enrollees pay 25 percent coinsurance until reaching an OOP threshold of \$6,550. That threshold is based on "true OOP" costs because it excludes beneficiary cost

sharing paid by most sources of supplemental coverage, such as employer-sponsored policies and more generous (enhanced) benefits from their Part D plan.

In the past, enrollees without the LIS whose spending exceeded an initial coverage limit were responsible for paying each subsequent prescription's full price at the pharmacy (i.e., 100 percent cost sharing) until they

reached an OOP threshold. This range of spending is known as the coverage gap or donut hole.¹ Enrollees no longer face higher cost sharing in the coverage gap; however, plans continue to identify whether a prescription is filled in that benefit phase because, under changes in law, enrollees without the LIS are eligible for a 70 percent discount from manufacturers on brand-name prescriptions in the coverage gap. No discount is applied to prescriptions for any generic drugs or for brand-name prescriptions filled by LIS enrollees. In 2021, brand discounts begin when an enrollee without the LIS has reached \$4,130 in cumulative drug spending and continue until the individual reaches \$6,550 in combined OOP spending plus brand discounts. Above this OOP threshold, enrollees pay the greater of 5 percent coinsurance or \$3.70 to \$9.20 per prescription.

Benefit for LIS enrollees

For low-income beneficiaries, Medicare's LIS pays for the difference between cost-sharing amounts set by each plan and nominal copayments set by law (Figure 13-1, p. 413). In 2021, most individuals receiving the LIS pay between \$0 and \$3.70 per prescription for generic drugs and between \$0 and \$9.20 per prescription for brand-name drugs.² If, for example, a plan normally charges a \$40 copayment to fill a brand-name prescription, an LIS enrollee would pay up to \$9.20 and Medicare's LIS would pay \$30.80. Because 100 percent of the costs in the coverage gap count toward the OOP threshold, LIS beneficiaries reach the catastrophic phase at a lower level of spending than other enrollees do. Above the OOP threshold, LIS enrollees pay no cost sharing.

Plan sponsors typically use alternative benefit designs

In practice, the defined standard benefit is used primarily to set the average value of basic benefits that plan sponsors must offer under alternative benefit designs. Most sponsors structure their basic benefits in ways that differ from the defined standard benefit, such as setting the deductible lower than \$445 or using tiered copayments rather than coinsurance. Some plans also encourage use of lower cost medicines by not applying a deductible when a prescription is filled with certain preferred generics. However, alternative designs must meet requirements for actuarial equivalence, demonstrating that they have the same average value as the defined standard benefit for a beneficiary of average health. CMS also sets maximum

cost-sharing amounts for drug tiers to ensure that a sponsor's plan design is not discriminatory.³ Once a sponsor offers a PDP with basic benefits in a region, it can also offer up to two "enhanced" PDPs that combine basic benefits with supplemental coverage. For 2021, estimated OOP costs in a sponsor's basic and enhanced plans must differ by at least \$22 per month.

Two avenues for premium competition

The hallmark of Part D is that private plans compete for enrollees based on premiums, formularies, pharmacy networks, and quality of services. There are two pathways through which premium competition takes place: rivalry to attract members and competition to keep premiums at or below benchmarks that reflect the maximum amount Medicare will contribute toward LIS enrollee premiums.

General premium competition

Part D plan sponsors compete to attract enrollees through low premiums, but sponsors do not set their premiums directly. Instead, sponsors submit bids to CMS that represent their revenue requirements (including administrative costs and profit) for delivering basic benefits to an enrollee of average health. CMS then calculates a nationwide enrollment-weighted average among all the bid submissions. From this average, enrollees pay a portion as a base beneficiary premium (\$33.06 per month in 2021) plus (or minus) any difference between their plan's bid and the nationwide average bid (Medicare Payment Advisory Commission 2020b). If enrollees pick an enhanced plan, the enrollee must pay the full price for the supplemental coverage (i.e., Medicare does not subsidize it). This approach is designed to give sponsors the incentive to control enrollees' spending so that they can bid low and keep premiums attractive. At the same time, sponsors must balance this incentive with beneficiaries' desire to have access to medications. A plan with a very limited number of covered drugs might not attract enrollees.

Competition to keep premiums below LIS benchmarks

Sponsors also compete to keep the premiums for some plans at or below regional LIS benchmarks. When policymakers developed the premium subsidy for LIS enrollees, they wanted to encourage enrollment in less expensive plans while ensuring that low-income beneficiaries had access to coverage. Policymakers

balanced these goals by creating a subsidy with two key features: (1) a benchmark that limits how much Medicare contributes toward a beneficiary's premium, and (2) automatic enrollment of LIS enrollees in PDPs with premiums at or below the benchmark. CMS calculates separate LIS benchmarks for each of Part D's 34 regions and updates them annually. Each LIS benchmark equals a region's average premium for basic coverage; plans that offer basic coverage and have premiums at or below the benchmark are premium free to LIS enrollees.^{4,5}

This approach to setting Part D's LIS premium subsidy was intended to provide incentives for plan sponsors to control drug spending and bid low. LIS enrollees who have not selected a plan themselves are automatically enrolled in a benchmark PDP to which CMS assigns them randomly. Once LIS enrollees select a plan themselves, CMS no longer reassigns them to a new plan. Instead, the agency sends them letters about premium-free plan options. Many plans offered by larger sponsors have kept their benchmark status from year to year or have opted to forgo a de minimis amount of their premium in order to retain LIS enrollees.⁶ Nevertheless, each year there is also some turnover in benchmark plans. If LIS enrollees are in a PDP with a premium that will exceed the benchmark and have not chosen a plan other than their assigned PDP, CMS reassigns them randomly to a new benchmark PDP.⁷ If sponsors bid at or near the benchmark, they can gain or maintain market share for LIS enrollees without having to incur marketing expenses. Some aspects of how CMS calculates benchmarks and auto-enrolls beneficiaries temper premium competition (see text box on features of the LIS that limit competition, pp. 416–417).

For plan sponsors, auto-enrollees make up an important component of the PDP market. In 2019, 62 percent of the 7.3 million LIS beneficiaries in PDPs had been placed in their plans through the auto-enrollment and reassignment processes. As of November 2020, CMS expected to reassign randomly only about 100,000 LIS beneficiaries for benefit year 2021 (Liu 2020).⁸ However, CMS also auto-enrolls LIS beneficiaries who are new to Part D among plans with premiums below regional benchmarks. Between 2015 and 2019, an average of 875,000 beneficiaries were randomly assigned to a benchmark PDP annually; roughly 85 percent were new Part D enrollees who had not yet selected a plan. As LIS enrollees remain in Part D, an increasing share choose a plan themselves and become ineligible for CMS reassignment.

Concerns about Part D and recommended changes

Over time, changes to Part D's benefit design combined with trends in prescription drug pricing and spending have led to concerns about whether plan sponsors have incentives for cost control that are as strong as they were at the start of the program. Factors that have eroded those incentives include brand discounts in the coverage gap, growth in postsale rebates to plans from drug manufacturers, reduced plan liability for drugs filled in the coverage gap and catastrophic phases, and greater use of specialty and other high-priced drugs. As a result, plans' financial risk has declined in recent years. Recently, the Commission recommended major changes to the Part D program that would restructure its defined standard benefit.

Brand discounts in the coverage gap distort relative prices

Changes in law phased out the coverage gap for enrollees who do not receive the LIS. Much of this benefit expansion was financed by requiring manufacturers of brand-name drugs to discount prices in the coverage gap. While those steps lowered OOP costs for some beneficiaries, the manufacturer discount artificially lowers prices for brand-name drugs relative to generics, reducing incentives to use generics. Those incentives are further undermined because the 70 percent discount is treated as though it were the enrollee's own OOP spending. As a result, enrollees without the LIS reach Part D's catastrophic phase more quickly when they use brand-name drugs than when they use generics. Brand manufacturers benefit when enrollees reach the catastrophic phase because they are no longer required to discount prices.

Reduced plan liability undermines plans' formulary incentives

Even though Part D has two distinct benefit structures, plan sponsors bear little liability under either structure for spending in the coverage gap and catastrophic phases. In the coverage gap, sponsors are responsible for just 5 percent of brand spending for enrollees without the LIS and bear no liability for LIS enrollees. Sponsors cover 15 percent of spending in the catastrophic phase. Meanwhile, sponsors receive postsale rebates and discounts that, according to projections by CMS's Office of the Actuary, will average about 29 percent of total drug costs in 2021

The low-income subsidy has features that limit competition among benchmark plans

In the Part D program, the prescription drug plans (PDPs) that offer basic coverage and have premiums that are lower than or equal to the low-income subsidy (LIS) benchmark are known as *benchmark plans*. These plans play an important role in providing coverage because LIS beneficiaries can enroll without paying a premium (the LIS covers the entire amount on their behalf) and Medicare automatically enrolls in benchmark plans any LIS beneficiaries who do not select a plan on their own. For 2021, there are a total of 246 benchmark plans; most Part D regions (30 of 34) have between 5 and 9 plans.

This approach provides LIS beneficiaries with a stable source of drug coverage, but it also reduces the incentives for benchmark plans to bid competitively. A plan that wants to serve low-income beneficiaries has an incentive to keep its premium below the benchmark to ensure that LIS beneficiaries can enroll without paying a premium and the plan can receive auto-enrollments. However, once a plan has qualified as a benchmark plan in a given year, it does not have an incentive to reduce its premium any further (Congressional Budget Office 2014). If the plan does lower its premium further below the benchmark, it cannot expect to receive any more enrollees in return, for two reasons. First, every benchmark plan in a region typically receives the same number of auto-enrollments. Second, LIS beneficiaries do not have an incentive to switch to the plan because they will not benefit from the lower premium. (Medicare saves money if they enroll in the lower-premium plan instead of another benchmark plan that is more expensive, but the beneficiaries themselves pay no premium in either case.) At the margin, a benchmark plan that lowers its

premium thus receives less Medicare revenue for the same number of enrollees.

As a result, benchmark plans try to keep their premiums just below the benchmark. The top half of Figure 13-2 shows the distribution of the 2021 premiums for basic PDPs, based on the difference between the plan's premium and the benchmark. Almost 90 percent of benchmark plans have premiums that are within \$6 of the benchmark, and only one has a premium that is more than \$10 below the benchmark. The bottom half shows the distribution of the premiums for enhanced PDPs for comparison, using the portion of the plan's premium that reflects the cost of basic coverage. These plans cannot qualify as benchmark plans, and their premiums do not show the same clustering pattern as basic plans. More than 60 percent of enhanced plans have premiums that are more than \$10 below the benchmark, which suggests that benchmark plans do not bid as competitively as they could, and that LIS benchmarks and spending are higher than they need to be.

Policymakers could consider modifying the LIS to encourage plans to submit lower bids, particularly by changing the practice of giving each benchmark plan in a region an equal number of auto-enrollments. For example, benchmark plans that charge lower premiums could receive a larger share of auto-enrollments. Such a change would make the market for benchmark PDPs more competitive—and thus complement the Commission's recommendations to restructure the Part D benefit (Medicare Payment Advisory Commission 2020c)—but it could also reduce the number of benchmark plans and increase the number of LIS beneficiaries who need to switch plans to avoid paying a premium. ■

(continued next page)

(Boards of Trustees 2020). For some brand prescriptions filled in the coverage gap and catastrophic phases, the value of rebates and discounts can exceed plan liability. As a result, plan sponsors may reduce their plan liability by including certain brand-name drugs on their formulary and giving that drug preferred status. However, those

formulary placement decisions can also increase costs for enrollees and Medicare (that is, the taxpayers) (Dusetzina et al. 2019).

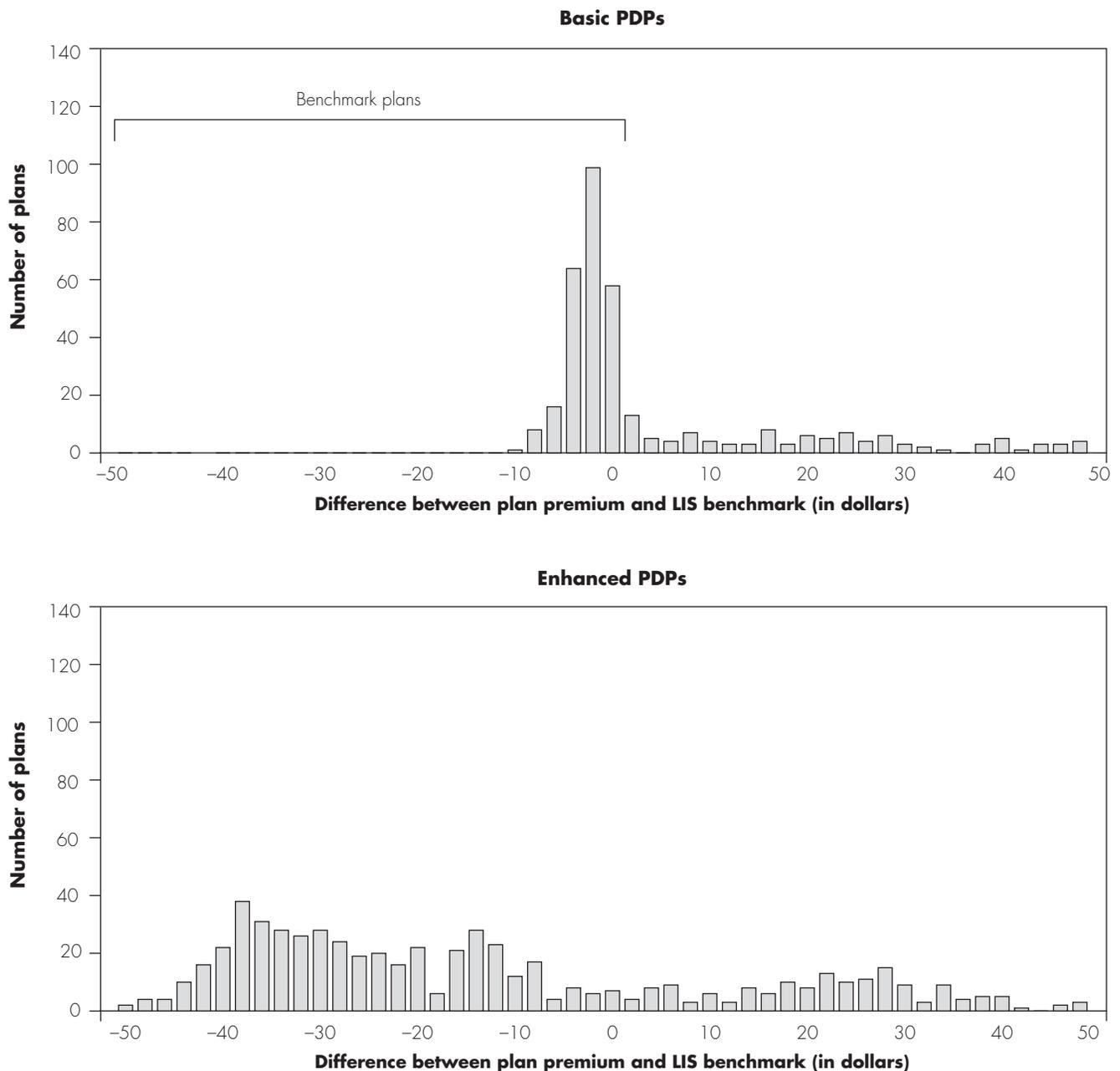
Some enrollees have high OOP spending

In Part D, many plans charge a percentage of a drug's price at the pharmacy for prescriptions on certain

The low-income subsidy has features that limit competition among benchmark plans (cont.)

FIGURE 13-2

The premiums for most benchmark plans are clustered around the LIS benchmark



Note: LIS (low-income subsidy), PDP (prescription drug plan). This figure is based on plan premiums and benchmarks for 2021 and does not include plans in the U.S. territories. For enhanced PDPs, we used the portion of the premium that reflects the cost of basic Part D coverage only; we did not include the supplemental premium that those plans charge to finance the cost of their enhanced benefits. This figure does not include plans with premiums that are more than \$50 below the benchmark (8 enhanced PDPs) or more than \$50 above the benchmark (29 basic PDPs and 13 enhanced PDPs).

Source: MedPAC analysis of CMS Part D premium and benchmark data.

formulary tiers or phases of the benefit rather than fixed-dollar copayments. For example, CMS permits plan sponsors to use a specialty tier with coinsurance of 25 percent to 33 percent for expensive therapies. Above Part D's OOP threshold, enrollees without the LIS pay 5 percent coinsurance with no OOP maximum. The share of Medicare Part D spending for specialty drugs and biologics has risen rapidly. At the same time, the gap between brand prices charged at the pharmacy and brand prices net of manufacturers' rebates has widened. When patients use rebated drugs, they pay coinsurance that is effectively higher (as a percentage of a drug's net price) than the stated coinsurance rate of 25 percent to 30 percent. The higher effective coinsurance results from manufacturers providing rebates to plans *after* patients fill their prescriptions, and plans charge coinsurance on the higher "gross" price at the pharmacy. High patient cost sharing can pose a financial hurdle to treatment, potentially affecting certain beneficiaries' decisions to fill their prescriptions.

Weak incentives for LIS enrollees to select lower cost medicines

Although the LIS helps ensure access to medicines for low-income beneficiaries, its limits on cost sharing also give LIS enrollees weaker incentives to use lower cost drugs and make it more difficult for plan sponsors to manage drug spending. For enrollees without the LIS, plan sponsors set tiered cost sharing to provide strong incentives to select lower cost drugs: for example, a \$5 copayment for generics compared with \$40 to fill a prescription for a preferred brand-name drug (or higher amounts for nonpreferred drugs). In this example, for an enrollee without the LIS, the savings associated with choosing a generic would be \$35 (\$40 minus \$5). By comparison, because an LIS enrollee pays a maximum of \$3.70 for a generic prescription and up to \$9.20 for any brand-name drug, their OOP savings from taking a generic over a brand would be just \$5.50 (\$9.20 minus \$3.70). Similarly, LIS enrollees have no incentive to use a plan's preferred brand-name drug rather than nonpreferred ones (or nonformulary ones gotten through an exceptions process) because they would pay the same \$9.20 copayment regardless.

Expanded role of high-priced drugs has driven growth in reinsurance

At the start of Part D in 2006, most spending was attributable to brand prescriptions for widely prevalent conditions such as high cholesterol and depression.

Blockbuster drugs for such conditions lost patent protection toward the end of that decade and many Part D enrollees switched to generic versions of their medicines. As those brand revenues fell, manufacturers turned to developing orphan drugs, biologics, and other high-priced specialty drugs for smaller patient populations. These trends have changed the distribution of Part D spending. Between 2006 and 2018, increased generic use kept growth in average Part D drug expenses to about 4 percent per year, but prices of brand-name drugs and biologics grew by more than 7 percent annually (Medicare Payment Advisory Commission 2019). As a result, an increasing share of Part D spending is in the benefit's catastrophic phase, in which Medicare pays 80 percent of costs through reinsurance. Between 2010 and 2018, the share of Part D spending attributable to the catastrophic phase increased from 20 percent to 41 percent (Medicare Payment Advisory Commission 2020c). Higher prices, reflecting both increases in prices of existing products and the use of new high-priced drugs, have been the primary driver of the growth in catastrophic spending.

Marked decline in plan risk over time

The share of enrollees' benefit spending for which plan sponsors are at risk has declined markedly over time. We estimate that between 2007 and 2017, among enrollees without the LIS, the share of aggregate basic benefit costs for which plan sponsors were responsible declined from 53 percent to 29 percent (Medicare Payment Advisory Commission 2020c). For LIS enrollees, plan liability decreased from 30 percent to 19 percent. Meanwhile, the Medicare program's share of benefits reimbursed through cost-based mechanisms—reinsurance and LIS-paid cost sharing—rose commensurately. This decrease in plans' liability undermines incentives for plan sponsors to manage benefits and negotiate lower drug prices.

The Commission's recommendations for improving Part D

In its June 2020 report to the Congress, the Commission recommended major changes to the Part D program that would restructure its defined standard benefit as follows:

- For spending below the catastrophic threshold, eliminate the manufacturers' coverage-gap discount that currently applies to enrollees without the LIS and remove the coverage gap for LIS enrollees. These changes would create a standard benefit for all enrollees in which plans would become responsible

for 75 percent of spending for benefits between the deductible and the catastrophic threshold, with enrollees responsible for the remaining 25 percent through cost sharing.

- For catastrophic spending, reduce Medicare’s reinsurance by shifting insurance risk to plan sponsors and drug manufacturers. Medicare would provide 20 percent reinsurance rather than the current 80 percent. Manufacturers would become responsible for at least 30 percent of catastrophic spending on high-priced medicines, while plan sponsors would be liable for the remaining 50 percent. The policy would also provide enrollees with greater financial protection by adding an annual cap on beneficiaries’ OOP costs.

The Commission recommended phasing in the reduction in Medicare’s reinsurance payments and increased plan liability for catastrophic spending. Sponsors would incorporate lower expected Medicare reinsurance subsidies and higher expected benefit liability into plan bids. In turn, Medicare’s capitated payments to plans would increase to incorporate their new, higher share of spending below and above the catastrophic threshold.

To help plan sponsors manage overall drug spending more effectively, the Commission recommended that the Congress establish a higher copayment amount under the LIS for nonpreferred and nonformulary drugs. In addition, plan sponsors would be provided with greater formulary flexibility for drugs in the protected classes. The Commission also recommended that plans be allowed to establish preferred and nonpreferred tiers for specialty-tier drugs to encourage their enrollees to use lower priced therapies.

The Commission’s recommended reforms would result in higher capitated payments for all enrollees, with a larger impact, in dollar terms, for LIS beneficiaries. However, given the structure of the risk adjustment model, CMS would need to recalibrate its model to ensure that overall payment rates were adequate for both LIS enrollees and other Part D beneficiaries.

Given plans’ greater insurance risk associated with catastrophic spending under these reforms, policymakers could consider modifying the Part D risk corridors to temporarily provide plan sponsors with greater protection during a transition to the new benefit structure. While the enhanced protection would be available to all plans, in practice, the protection would be particularly valuable

for smaller plans and plan sponsors that do not have the scale to spread the insurance risk or the capital to reinsure themselves.

The Congressional Budget Office estimated that the combined package of Commission recommendations would lead to one-year program savings of more than \$2 billion relative to baseline spending and savings of more than \$10 billion over five years.

Enrollment, plan choices in 2020, and benefit offerings for 2021

Over time, a growing proportion of Medicare beneficiaries has enrolled in Part D. An important reason is a shift in enrollment from retiree drug plans to Part D plans set up for employer groups. Enrollment has also grown faster in MA–PDs compared with stand-alone PDPs.

In 2020, over three-quarters of Medicare beneficiaries were in Part D plans or employer plans that received the retiree drug subsidy

In 2020, 47.0 million individuals—74.6 percent of Medicare’s total enrollment—were enrolled in Part D plans (Table 13-1, p. 420). That share is up from 54 percent of Medicare beneficiaries in 2007 (data not shown). An additional 1.9 percent of beneficiaries obtained drug coverage through employer-sponsored plans that received Medicare’s retiree drug subsidy (RDS) for serving as the primary provider. (The RDS is paid from the Part D program.) The remaining 23.5 percent of Medicare beneficiaries 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 (data not shown).

The share of Medicare beneficiaries covered under Part D has grown over time. However, between 2019 and 2020, enrollment in PDPs declined from 25.5 million to 25.1 million (Table 13-2, p. 421). Instead, MA–PD enrollment (including special needs plans (SNPs)) has expanded, as has membership in employer group waiver plans (EGWPs)—Part D plans established for Medicare-eligible retirees of certain employers.⁹ EGWPs can take the form of PDPs or MA–PDs. Between 2007 and 2020, enrollment in EGWPs grew by an annual average of 11 percent, reflecting the shift from employers operating

**TABLE
13-1**

More than three-quarters of Medicare enrollees received drug coverage through Part D, 2020

	Beneficiaries	
	In millions	Share of Medicare enrollment
Medicare enrollment	63.0	100%
Part D enrollment*		
In Part D plans	47.0	74.6
In plans receiving RDS	1.2	1.9
Total Part D	48.2	76.5**

Note: RDS (retiree drug subsidy). Enrollment in Part D plans based on data as of April 1, 2020.

*Excludes federal government and military retirees covered by either the Federal Employees Health Benefits Program or the TRICARE for Life program.

**The remaining 23.5 percent of beneficiaries not enrolled in Part D are divided roughly equally between those who receive comparable drug coverage through other sources (such as the Federal Employees' Health Benefits Program, Tricare for Life, and the Department of Veterans' Affairs), and those who had no drug coverage or had coverage less generous than Part D.

Source: MedPAC based on Table IV.B7 and Table V.B3 of the 2020 annual report of the Boards of Trustees of the Medicare trust funds and CMS Part D enrollment data as of April 1, 2020.

plans that receive the RDS to Part D plans established for their retirees. In 2013, EGWPs accounted for 17 percent of Part D enrollment, but that share declined to 15 percent in 2020.

By 2020, among all Part D plans (including EGWPs), 47 percent of Part D enrollees were in MA-PDs compared with 30 percent in 2007 (Table 13-2). This trend in MA-PD enrollment is consistent generally with more rapid growth in MA enrollment compared with traditional fee-for-service (FFS) Medicare. Over the period from 2007 to 2020, among nonemployer plans, enrollment in MA-PDs grew an average 9 percent annually compared with 2 percent in PDPs.

In 2020, 12.8 million beneficiaries (27 percent of Part D enrollees) received the LIS (data not shown). Of these individuals, approximately 8.3 million were eligible for

both Medicare and full Medicaid benefits (Boards of Trustees 2020). The remainder qualified either because they received benefits through the Medicare Savings Programs or Supplemental Security Income program or because they were eligible after they applied directly to the Social Security Administration. Compared with other Part D enrollees, LIS enrollees are more likely to be female; more than twice as likely to be Black, Hispanic, or Asian or Pacific Islander; and over five times more likely to be under age 65 (Medicare Payment Advisory Commission 2020a).

Between 2007 and 2020, enrollment growth for Part D enrollees without the LIS was faster (7 percent per year) than for LIS enrollees (2 percent per year). This faster growth is partly attributable to the growth of EGWPs, which have few LIS enrollees. Over the same period, the share of Part D enrollees who received the LIS fell from 39 percent to 27 percent. In 2020, about 52 percent (6.7 million) of LIS enrollees were in PDPs; the rest were in MA-PDs. Although most individuals receiving the LIS are enrolled in traditional FFS Medicare rather than MA, since 2016, LIS enrollment in MA-PDs has grown while LIS enrollment in PDPs has declined due to the growth of their enrollment in SNPs (Boards of Trustees 2020).

Beneficiaries' enrollment decisions in 2020

Most enrollees are in plans that are actuarially equivalent to Part D's defined standard benefit or are enhanced in some way, rather than being in plans that follow the defined standard benefit. Enrollees in MA-PDs tend to have more generous benefits than beneficiaries enrolled in PDPs—in part because MA-PD plan sponsors are permitted to use a portion of their Medicare Advantage (MA) (Part C) payments to supplement their Part D benefits.

MA-PD enrollees were more likely to be in enhanced plans than PDP enrollees

In 2020, 55 percent of PDP enrollees had basic coverage that was actuarially equivalent to the defined standard benefit, most with tiered copayments (Table 13-3, p. 422). The remaining 45 percent of PDP enrollees had enhanced benefits. No plan sponsors offered a PDP that used the defined standard benefit. Enrollees in MA-PDs, excluding SNPs, were overwhelmingly in enhanced plans. Typically, enhanced plans have no deductible or a lower deductible than that used for Part D's defined standard benefit. In MA-PDs, 49 percent of enrollees had no deductible in

**TABLE
13-2**

Part D enrollment trends by plan type, 2007-2020

	2007	2013	2019	2020	Average annual growth rate 2007-2020
Total Part D enrollment (in millions)	24.2	35.4	45.4	47.0	5%
Share of Medicare beneficiaries	54%	67%	74%	75%	N/A
Enrollment by type (in millions)					
PDP	16.9	22.5	25.5	25.1	3
MA-PD	7.2	12.9	20.0	21.9	9
Share in MA-PD	30%	36%	44%	47%	N/A
Non-employer plan enrollees (in millions)					
PDP	16.2	18.1	20.8	20.4	2
MA-PD	<u>6.2</u>	<u>11.4</u>	<u>17.6</u>	<u>19.4</u>	9
Subtotal	22.4	29.4	38.4	39.8	5
Share in MA-PD	28%	39%	46%	49%	N/A
EGWPs (PDP and MA-PD, in millions)					
	1.8	6.0	7.1	7.2	11
Share in EGWP	7%	17%	16%	15%	N/A

Note: N/A (not applicable), PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), EGWP (employer-group waiver plan). Figures based on enrollment as of April 1 of each year with the exception of 2007 (as of July 1, 2007).

Source: MedPAC based on Part D enrollment data and Table IV.B7 and Table V.B3 of the 2020 annual report of the Boards of Medicare trust funds.

their plan’s benefit design. By comparison, only 15 percent of PDP enrollees and 8 percent of SNP enrollees were in plans with no deductible. However, 56 percent of PDP enrollees and 34 percent of SNP enrollees were in plans that do not apply a deductible to prescriptions filled from certain cost-sharing tiers, such as preferred generic drugs (data not shown). In addition, most SNP enrollees are individuals dually eligible for Medicare and Medicaid who receive Part D’s LIS, which covers most of their premium and cost sharing.

Under the MA payment system, MA-PD plan sponsors may use a portion of their Part C payments to supplement Part D drug benefits (e.g., by lowering deductibles) or to lower Part D premiums.¹⁰ In 2020, MA-PD sponsors applied on average \$35 per month (27 percent) of their Part C rebate dollars to Part D benefits. Of that amount, 43 percent was used to lower Part D premiums for basic

benefits and the rest was used for supplemental drug benefits.

Average enrollee premiums decreased in 2020

Despite significant growth in catastrophic benefits, average premiums for basic Part D benefits have remained low for several reasons, including growth in manufacturer rebates and postsale pharmacy fees, a higher coverage-gap discount for brand-name drugs, and the entry of relatively large cohorts of younger enrollees into Part D. In addition, Medicare’s reinsurance subsidy has offset benefit spending that would otherwise have increased enrollee premiums.¹¹ In 2020, monthly beneficiary premiums averaged about \$27 across all types of plans (basic and enhanced), a 7 percent decline from the prior year. Average premiums have remained around \$30 per month since 2010. However, underlying that average is wide variation in

**TABLE
13-3**

MA-PD enrollees more likely to be in enhanced plans, 2020

	PDP		General MA-PD		SNP	
	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent	Number of enrollees (in millions)	Percent
Total	20.5	100%	15.3	100%	3.0	100%
Type of benefit						
Defined standard	0.0	0	0.1	<0.5	1.7	54
Actuarially equivalent*	11.3	55	0.2	1	0.4	12
Enhanced	9.2	45	15.0	98	1.0	34
Type of deductible						
Zero	3.0	15	7.4	49	0.2	8
Reduced	5.0	25	7.3	48	0.4	12
Defined standard**	12.4	61	0.5	4	2.5	81

Note: MA-PD (Medicare Advantage-Prescription Drug [plan]), PDP (prescription drug plan), SNP (special needs plan). "General MA-PD" enrollment excludes employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans. In 2020, 85 percent of SNP enrollees were in plans for dual eligible (Medicare and Medicaid) beneficiaries, 12 percent in plans for beneficiaries with certain chronic conditions, and 3 percent in plans for institutionalized individuals. Totals may not sum due to rounding.

*Includes actuarially equivalent standard and basic alternative benefits.

**Deductible of \$435 in 2020.

Source: MedPAC analysis of CMS landscape, plan report, and enrollment data.

premiums, from \$0 for many MA-PDs to \$191 per month for the most expensive PDP offering enhanced coverage.

On average, prescription drug premiums were lower for beneficiaries enrolled in MA-PDs compared with those enrolled in PDPs, in part reflecting plan sponsors' use of Part C rebate dollars. In 2020, the average monthly premium for an MA-PD enrollee's Part D benefit was \$15, with an additional \$35 of premium costs paid through Part C rebates for basic and supplemental drug benefits (Medicare Payment Advisory Commission 2020d). By comparison, PDP enrollees faced an average premium of \$38 per month.

Two other factors affect the premium amounts enrollees pay. First, higher income individuals have a lower federal subsidy of their Part D benefits. As of October 2020, 3.8 million enrollees (about 8 percent) were subject to the income-related premium (Liu 2020). As with the income-related premium for Part B, higher Part D premiums

apply to individuals with an annual adjusted gross income greater than \$88,000 and to couples with an adjusted gross income greater than \$176,000. A beneficiary whose income exceeds these levels pays a monthly adjustment amount in addition to their Part D plan premium. For 2021, adjustments range from \$12.30 to \$77.10 per month, depending on income (Centers for Medicare & Medicaid Services 2020g).

Second, individuals enrolling in Part D outside their initial enrollment period must have proof that they had drug coverage as generous as the standard benefit under Part D (i.e., "creditable coverage") to avoid the late enrollment penalty (LEP) that would be added to their premiums for the duration of their Part D enrollment. The LEP amount depends on the length of time an individual goes without creditable coverage and is calculated by multiplying 1 percent of the base beneficiary premium by the number of full, uncovered months an individual was eligible but was not enrolled in a Part D plan and went without other

**TABLE
13-4**

Comparison of PDP, general MA-PD, and SNP offerings, 2021

	PDP		General MA-PD		SNP	
	Number of plans	Percent	Number of plans	Percent	Number of plans	Percent
Total	996	100%	3,133	100%	949	100%
Type of benefit						
Defined standard	1	<0.5	31	1	307	32
Actuarially equivalent*	377	38	66	2	103	11
Enhanced	618	62	3,036	97	539	57
Type of deductible						
Zero	139	14	1,582	50	194	20
Reduced	192	19	1,317	42	136	14
Defined standard**	665	67	234	7	619	65

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), SNP (special needs plan). The PDPs described here exclude employer-only plans and plans offered in U.S. territories. MA-PD plans exclude employer-only plans, plans offered in U.S. territories, 1876 cost plans, demonstrations, and Part B-only plans. SNP plans exclude U.S. territories. Among SNPs for 2021, 575 are for beneficiaries dually eligible for Medicare and Medicaid, 200 are for beneficiaries with certain chronic conditions, and 174 are for institutionalized beneficiaries. Totals may not sum due to rounding.

*Includes actuarially equivalent standard and basic alternative benefits.

**Deductible of \$445 in 2021.

Source: MedPAC analysis of CMS landscape and plan report data.

creditable coverage. As of October 2020, 2.3 million Part D enrollees (nearly 5 percent) paid the LEP (Liu 2020).

Benefit offerings for 2021

Beneficiaries are encouraged to reexamine plan options each year during an annual open enrollment period that runs from October 15 until December 7. In addition to changes in plan availability and premiums, most plans make some changes to their benefit offerings—such as deductible amounts and plan formularies—that can affect access to medications and beneficiaries’ OOP costs.

Beneficiaries have more plan options in 2021

For 2021, plan sponsors are offering 996 PDPs, 3,133 general MA-PDs, and 949 SNPs—5 percent, 12 percent, and 14 percent more plans, respectively, than in 2020. The increase in PDPs reflects a greater number of enhanced plan offerings. Rapid growth in MA-PD offerings likely reflects interest among plan sponsors in gaining a share of MA’s expanding enrollment. At the same time, some MA-PD sponsors have expanded their SNP offerings.

In each of the nation’s 34 PDP regions, beneficiaries continue to have broad choice. Options range from 25 PDPs in Alaska to 35 PDPs in Texas, along with many MA-PDs in most areas. The number of MA plans available to a beneficiary varies by the county of residence, with the average beneficiary having 32 MA plans available.¹²

MA-PDs that are open to all enrollees are much more likely to offer more generous coverage than PDPs. For example, in 2021, 97 percent of MA-PDs include enhanced coverage beyond basic benefits, compared with 62 percent of PDPs (Table 13-4). Among plans with basic benefits, the 2021 marketplace includes just 1 PDP and 31 general MA-PDs (1 percent) with the standard benefit design. A larger share of MA-PDs than PDPs charges no deductible (50 percent vs. 14 percent), and 67 percent of PDPs use the same \$445 deductible as Part D’s defined standard benefit. By comparison, SNPs (i.e., MA-PDs designed for certain groups of beneficiaries) are much more likely to use the defined standard benefit (32 percent of SNPs) or the same deductible amount as the standard

**TABLE
13-5**

Change in 2021 premiums for PDPs with high 2020 enrollment

Plan name in 2021	Benefit type	2020 enrollment (in millions)	Weighted average monthly premium*		
			2020 premium	Projected 2021 premium	Percent change
SilverScript Choice	Basic	3.9	\$29	\$28	-2%
AARP MedicareRx Preferred	Enhanced	2.0	79	89	12
Humana Basic Rx	Basic	1.5	31	31	0
Humana Premier Rx	Enhanced	1.4	58	65	13
AARP MedicareRx Saver Plus	Basic	1.2	32	33	2
WellCare Classic	Basic	1.1	29	28	-4
Humana Walmart Value Rx	Enhanced	0.8	13	17	30
WellCare Medicare Rx Saver	Basic	0.8	30	32	4
Elixir Rx Plus**	Basic	0.8	22	23	6
WellCare Value Script	Enhanced	0.8	17	17	0

Note: PDP (prescription drug plan).

*Reflects the average of all PDPs offered under the same plan name in each region of the country, weighted by March 2020 enrollment. The projected weighted average premium for 2021 does not reflect any enrollment switching among plans. Percent changes were calculated before rounding.

**Renamed from Envision Rx Plus in 2020.

Source: Cubanski and Damico 2020.

benefit (65 percent of SNPs). In 2021, 61 percent of SNPs are designed for beneficiaries who are dually eligible for Medicare and Medicaid, 21 percent for individuals who have certain chronic conditions, and 18 percent for institutionalized beneficiaries (data not shown). Because most beneficiaries in SNPs are LIS enrollees, those individuals pay nominal copayments rather than the cost sharing in their plan's benefit design.

Varied changes in plan premiums

For 2021, CMS calculated that Part D's base beneficiary premium—enrollees' share of the monthly national average expected cost for basic benefits—is \$33.06, a 1 percent increase (32 cents) from their share in 2020. However, premiums for individual Part D plans can vary substantially from the base beneficiary premium because they reflect any difference between the sponsor's bid and the national average bid, as well as any enhanced (supplemental) benefits the plan offers. In addition, in 2021, MA-PD sponsors are applying on average \$40 per month of Part C rebate dollars to lower their Part D premiums compared with \$35 per month the prior year (a nearly 16 percent increase). Of the 2021 amount, \$19 pays for basic benefits and \$21 for enhanced benefits.

The 10 stand-alone PDPs with the highest enrollment in 2020 experienced a mixture of premium increases and decreases for 2021 (Table 13-5). Premiums for PDPs that provide basic benefits changed relatively little, with more substantial increases among some popular PDPs that offer enhanced benefits. For example, members of SilverScript Choice, a basic PDP with 3.9 million enrollees in 2020, saw a \$1 decrease in their monthly premiums for 2021. However, the 2 million individuals enrolled during 2020 in AARP MedicareRx Preferred (an enhanced PDP) faced a \$10 increase in their premium, now \$89 per month.

More zero-premium PDPs available for LIS enrollees

In 2021, monthly premium benchmarks that reflect the maximum amount Medicare will pay on behalf of LIS beneficiaries range from \$22 in Texas to \$42 in New York. Compared with 2020 levels, the number of zero-premium PDPs available to LIS enrollees in 2021 increased by 6 percent to 259 plans.¹³ All regions have at least 5 zero-premium PDPs available, while 3 regions (Arizona, Illinois, and Pennsylvania–West Virginia) have 10 such

PDPs. The number of zero-premium PDPs in Ohio expanded from two in 2020 to five for 2021.

About 0.6 million LIS enrollees (10 percent of LIS enrollees in PDPs) were enrolled in plans in 2020 that, in 2021, have premiums higher than regional benchmarks (Cubanski and Damico 2020). Unless they changed plans, those LIS enrollees would be responsible for paying some of the 2021 premium, which averages \$33 per month.

Large cost-sharing differences between preferred generics and other drugs

The top 10 PDPs (ranked by 2020 enrollment) tend to use 5-tiered formularies with differential cost sharing among drugs listed on preferred generic, other generic, preferred brand, and nonpreferred drug tiers, as well as a specialty tier for high-cost drugs. For 2021, PDPs that were available nationwide generally kept generic copays very low: Median copays are zero for preferred generics and \$5 for prescriptions filled from the other-generics tier (Cubanski and Damico 2020). The top 10 PDPs had a mix of cost-sharing increases and decreases for preferred brand-name drugs, generally on the order of a \$40 copayment, and a median coinsurance rate of 40 percent for nonpreferred drugs.

Demonstration models in Part D

CMS's Center for Medicare & Medicaid Innovation (CMMI) is testing several models that aim to provide stronger incentives to sponsors for improving the quality of pharmacy services, increasing adherence to treatments that may reduce medical spending, and managing benefits.

- **Enhanced Medication Therapy Management (MTM) model.** MTM includes services such as medication reviews and adherence education that aim to uncover or prevent problems related to prescriptions (Center for Medicare & Medicaid Innovation 2020b). Although Part D requires all sponsors to offer MTM services, for years the Commission has had concern about the effectiveness of these efforts, particularly in stand-alone PDPs. In 2017, CMS began testing an Enhanced MTM model to see whether payment incentives and regulatory flexibility could improve enrollee therapeutic outcomes and reduce Medicare spending. Six Part D sponsors operating 22 PDPs in 5 regions of the country are participating over a 5-year period. About 1.3 million PDP enrollees in those plans were targeted for enhanced MTM services and 30 percent to 40 percent received services. Over the first

two years of the program, CMS found no significant reductions in Medicare spending for Part A and Part B services among enrollees in enhanced MTM plans (Acumen LLC 2020). In both years, plan payments under the model were slightly larger than observable decreases in spending, resulting in net costs to Medicare.

- **Part D payment modernization model.** In 2020, CMMI launched a model that aims to address rising Medicare reinsurance subsidy costs in Part D while preserving or improving quality of care (Center for Medicare & Medicaid Innovation 2020c). Participating plan sponsors accept two-sided (but asymmetric) risk and are eligible for performance-based payments or losses based on plans' actual reinsurance spending relative to predetermined benchmarks.¹⁴ The model gives plans regulatory flexibilities to help manage enrollees' drug spending and permits plans to use rewards and incentives as tools for encouraging enrollees to use clinically equivalent lower-cost drugs. Two plan sponsors have participated so far, but CMMI has not yet provided details about their interventions or results.
- **MA value-based insurance design (VBID) model.** Encompassing both medical and drug offerings, the VBID model gives MA–PD sponsors flexibility to vary their supplemental benefits to encourage enrollees with certain chronic conditions to use high-value care.¹⁵ Such benefits may include lowering or eliminating cost sharing for certain classes of prescription medicines such as antihypertensives. For 2021, 19 sponsors are offering VBID plans that include tailored rewards and incentives to a projected 1.6 million enrollees. An evaluation of the model's first three years (2017 through 2019) found small but statistically significant increases in prescription fills for certain targeted drugs, no significant changes to Medicare or MA costs, and lower Part D bids associated with the model in 2018 and 2019 (Center for Medicare & Medicaid Innovation 2020a).
- **Part D Senior Savings Model.** CMMI's newest Part D model lets participating enhanced drug plans include coverage of certain insulins at cost sharing of no more than \$35 per one-month supply. The model is intended to provide diabetics who do not receive Part D's LIS better access to insulin through more predictable cost sharing (see text box on the Senior Savings Model, pp. 426–427).

Part D Senior Savings Model for insulin

Before 2021, as beneficiaries reached the coverage-gap phase of Part D’s benefit, most plans set their cost sharing at 25 percent coinsurance—even when the plan charged fixed-dollar copayments in the initial coverage phase of the benefit (Cubanski et al. 2020, Dusetzina et al. 2020a, Verma 2020). Plan sponsors used coinsurance in the coverage gap because of differences in how brand manufacturers’ discounts are applied to basic versus enhanced plans. For beneficiaries without the low-income subsidy (LIS), manufacturers are required to offer a 70 percent discount on prescriptions filled in the coverage gap. However, when an enhanced plan charges lower cost sharing in the coverage gap than does the defined standard benefit, prices are not discounted until after supplemental benefits are covered (Center for Medicare & Medicaid Innovation 2020d). That lowers the amount of manufacturer discounts while increasing plans’ benefit costs and enrollee premiums. According to CMS, this financial disincentive for

offering supplemental benefits during the coverage gap has resulted in “virtually no enhanced plans lowering beneficiary cost sharing in this phase for insulin or other brand drugs, biologics, or biosimilars” (Verma 2020). Under the Center for Medicare & Medicaid Innovation’s (CMMI’s) Senior Savings Model, participating insulin manufacturers pay the 70 percent discount before the application of supplemental benefits (Centers for Medicare & Medicaid Services 2020j).

At 2019 list prices for insulin, 25 percent coinsurance would amount to median out-of-pocket (OOP) costs ranging from \$70 to \$236 per month (Dusetzina et al. 2020a). By comparison, in 2019 many plans charged about \$45 per prescription in the initial coverage phase. To provide diabetics without the LIS better access to insulin through more predictable cost sharing, CMMI’s Part D Senior Savings Model lets participating enhanced drug plans include coverage of certain insulins at cost sharing of no more than \$35 per

(continued next page)

Plan sponsors and their tools for managing benefits and spending

Nearly 300 organizations sponsor Part D plans, but most beneficiaries are enrolled in plans sponsored by a handful of large health insurers. In addition to their role as insurers, plan sponsors carry out marketing, enrollment, customer support, claims processing, coverage determinations, and exceptions and appeals processes. Other key functions are performed by plans’ pharmacy benefit managers (PBMs): developing formularies, establishing pharmacy networks, and negotiating with manufacturers and pharmacies for postsale rebates and discounts. Most large plan sponsors are vertically integrated with their own PBMs and many also operate mail-order and specialty pharmacies. Smaller plan sponsors typically contract for PBM services. By law, the Medicare program is prohibited from becoming involved in negotiations among sponsors, drug manufacturers, and pharmacies.

For the delivery of outpatient drug benefits, PBMs do not take physical possession of prescription medicines; pharmacies do. Pharmacies typically buy drugs from wholesalers and specialty drug distributors, dispense prescriptions to plan members, and are paid by PBMs for the difference between a negotiated amount and the member’s cost sharing.

Final prices that plan sponsors pay for prescription drugs are usually lower than manufacturers’ list prices, and the size of the discount sponsors obtain varies depending on negotiations for postsale rebates. Sponsors and their PBMs gain bargaining leverage with manufacturers through the relative size of their market shares of enrollees and by influencing market shares of drug products through their formularies. In drug classes that have competing therapies, PBMs negotiate with brand manufacturers for rebates that the manufacturers pay after each prescription has been filled. In this way, final prices that manufacturers

Part D Senior Savings Model for insulin (cont.)

one-month supply. Plans participating in the model are not required to cover all insulins, but they must offer enrollees access to at least one of each type of insulin (e.g., short-acting insulin in a vial form) marketed by participating pharmaceutical manufacturers. CMS actuaries estimate that premium increases for participating plans associated with the model will be on the order of \$1 per month (Centers for Medicare & Medicaid Services 2020j). Beneficiaries in enhanced plans who take insulin could see their average annual OOP spending for insulins decrease from \$675 to \$229 (Verma 2020).

The agency notes that over 3.3 million Medicare beneficiaries who took insulin were enrolled in Part D plans. Of that total, 2 million were LIS enrollees who paid nominal copayments or were enrolled in an employer group waiver plan, which may have offered more generous coverage. Of the remaining 1.3 million beneficiaries, over 0.9 million (73 percent) were enrolled in enhanced plans.

Participation in the model by insulin manufacturers and plan sponsors is voluntary. For 2021, all three major manufacturers (Eli Lilly, Novo Nordisk, and Sanofi-Aventis) agreed to participate (Centers for Medicare & Medicaid Services 2020j). Over 1,600 plans are also participating, with 8 to 10 PDP options available in each region, in addition to multiple MA–PDs (Cubanski and Damico 2020).¹⁶ Participating plans were identified in the Medicare Plan Finder tool on Medicare.gov so that beneficiaries could search for and select them during the fall 2020 open enrollment period.

The Senior Savings Model reduces cost sharing for insulin-dependent diabetics and may help their adherence to this important treatment. Nevertheless, beneficiaries with other conditions continue to face high OOP costs. Moreover, underlying structural features of Part D’s benefit design and subsidies that may have contributed to rapid growth in insulin prices remain unaddressed. ■

obtain for their drugs are individualized by payer. PBMs (and manufacturers) consider rebates highly confidential because broader knowledge about the magnitude of discount could affect what competitors demand in their own negotiations with manufacturers, compressing (and for some payers, reducing) rebates.

Concentrated enrollment among plan sponsors

Most of the largest sponsors are insurers whose core business function has been to offer commercial and MA health plans with combined medical and pharmacy benefits. However, because some 60 percent of Medicare beneficiaries are in FFS Medicare, if those individuals choose to enroll in Part D, they obtain benefits through stand-alone PDPs. For this reason, PDPs remain an important market opportunity and many MA plan sponsors also offer PDPs.

Since the start of Part D in 2006, many large sponsors have horizontally merged or acquired other sponsors, thereby expanding enrollment and market shares. In 2020, the top seven sponsors ranked by enrollment and a group of Blue Cross and Blue Shield companies that collectively own Prime Therapeutics (a PBM) together accounted for 84 percent of Part D enrollment. In 2007, those same organizations accounted for 61 percent of enrollment.

Part D sponsors differ in competitive strategies and tend to focus on certain subsectors of enrollees. For example, in 2020, UnitedHealth Group plans accounted for 25 percent to 30 percent of national MA–PD enrollment and 22 percent of PDP enrollees without the LIS, but a comparatively smaller 12 percent of LIS enrollees in PDPs (Table 13-6, p. 428). Conversely, CVS Health (which owns insurer Aetna) had their highest market share among LIS enrollees in PDPs but a comparatively smaller share of the MA–PD market.

**TABLE
13-6**

Part D enrollment is more concentrated among PDP and employer group plan sponsors than MA-PD sponsors, 2020

Stand-alone PDPs				MA-PDs				Employer group plans	
Without LIS		With LIS		Without LIS		With LIS		All enrollees	
Parent organization	Market share	Parent organization	Market share						
UnitedHealth Group	22%	CVS Health	31%	UnitedHealth Group	25%	UnitedHealth Group	30%	Cigna	24%
CVS Health	19	Centene	22	Humana	19	Humana	17	UnitedHealth Group	24
Centene	16	Humana	16	CVS Health	9	Anthem	8	CVS Health	24
Humana	15	UnitedHealth Group	12	Kaiser Foundation	9	Centene	8	Kaiser Foundation	7
Cigna	14	Cigna	11	Anthem	4	CVS Health	5	Humana	5
Top 5	86	Top 5	92	Top 5	67	Top 5	69	Top 5	84

Note: PDP (prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]), LIS (low-income subsidy). Enrollees in each group total: PDP enrollees without LIS (18.4 million), PDP enrollees with LIS (6.7 million), MA-PD enrollees without LIS (15.9 million), MA-PD enrollees with LIS (6.1 million), and employer group plans enrollees (7.2 million). Components may not sum to totals due to rounding.

Source: MedPAC analysis based on April 2020 enrollment data from CMS.

Nationally, MA-PD enrollment is less concentrated than that for PDPs and employer-group plans. In 2020, the top five MA-PD sponsors enrolled 67 percent of enrollees without the LIS and 69 percent of LIS enrollees (Table 13-6). In addition to large health plans, MA-PD sponsors include a broader variety of companies, such as smaller regional organizations, religiously affiliated groups, and integrated delivery systems. By comparison, the top five PDP sponsors accounted for 86 percent of enrollees without the LIS and 92 percent of LIS enrollees.¹⁷ Among employer-group plans, 84 percent of enrollees were in plans offered by the top five sponsors. Because some smaller sponsors contract for services with PBMs owned by large plan sponsors, PBMs' market concentration is higher than that shown for plan sponsors.

Formulary management and manufacturer rebates

Formularies remain plan sponsors' most important tool for managing drug benefits. Sponsors and their PBMs decide

which drugs to include and exclude, which cost-sharing tier is appropriate for each drug, and whether a drug will be subject to utilization management—quantity limits, step therapy, and prior authorization. Those decisions require that plan sponsors strike a balance between providing access to medications while encouraging enrollees to use preferred therapies.

CMS requires plan sponsors to cover the types of drugs commonly needed by Part D enrollees as recognized in national treatment guidelines, and the agency reviews each plan's formulary as part of the process of deciding whether to approve its bid. For most drug classes, plans must cover at least two distinct drugs that are not therapeutically equivalent or bioequivalent, as well as "all or substantially all drugs" in six protected classes—anticonvulsants, antidepressants, antipsychotics, immunosuppressants, antiretrovirals, and antineoplastics.

Generally, manufacturers pay larger rebates when a sponsor positions a drug on its formulary in a way that

increases the likelihood of winning market share over competing drugs. For example, a manufacturer might pay a base rebate for including the product on a plan's formulary but might pay larger rebates if the drug is on a preferred tier or if prior authorization requirements are waived. Producers of brand-name drugs with no therapeutic substitutes might not provide any rebates. An analysis of 2016 data provided by a group of Part D plan sponsors found that only about a third of brand-name drugs had more than nominal manufacturer rebates (Johnson et al. 2018). Rebates were largest in drug classes in which brand-name drugs competed directly with one another or when the brand drug faced competition from three or more generics. Payers and PBMs also negotiate "price-protection" provisions under which manufacturers rebate a drug's midyear price increases above a specified threshold.

Medicare policy can affect rebates. The Part D requirement to cover all protected-class drugs likely reduces plan sponsors' bargaining leverage with manufacturers; rebates are less easily obtained and smaller, on average, for brand-name drugs in protected classes. In the study described above, of 124 brand-name drugs in protected classes, only 16 received rebates, and among those drugs, rebates averaged 14 percent of point-of-sale (POS) prices compared with 30 percent for all brand-name drugs (Johnson et al. 2018).

Pharmacy networks and postsale fees

Plan sponsors try to encourage enrollees to use pharmacies that dispense prescriptions at lower cost. For example, enrollees in some (non-Medicare) employer plans are required to fill prescriptions within an exclusive network of retail pharmacies, refill prescriptions by mail rather than through community pharmacies, and fill prescriptions with a 90-day rather than a 30-day supply. Likewise, in the commercial sector, vertically integrated plan sponsors often encourage their clients to dispense specialty drugs exclusively through their own specialty pharmacies.

Part D law and CMS guidance limit plan sponsors' ability to use those approaches. Most notably, plan sponsors must permit within their networks any pharmacy that is willing to accept the sponsors' terms and conditions; that is, plan sponsors cannot use exclusive pharmacy contracts.¹⁸ Plan sponsors must also demonstrate that their network of pharmacies meets access standards. Nor can plan sponsors set up a narrower network of specialty pharmacies. With

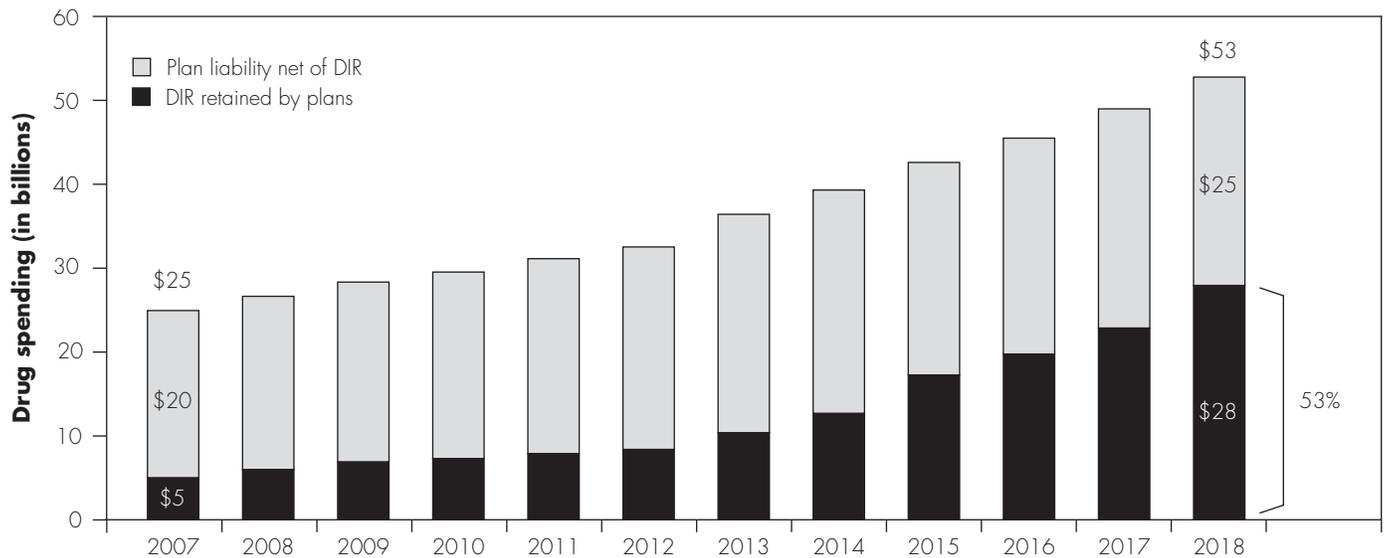
a few exceptions, Part D's convenient-access standards apply to the dispensing of all types of drugs, including specialty drugs.¹⁹ However, traditional access standards may be less applicable to specialty pharmacies because typically they fill prescriptions primarily through home delivery.

Sponsors can, however, designate a subset of network pharmacies that offer preferred (lower) cost sharing. In 2021, 98 percent of PDPs use preferred cost-sharing pharmacies (Fein 2020b). The strategy of designating certain pharmacies as preferred has the potential to lower costs for Medicare and enrollees if it encourages enrollees to fill prescriptions at pharmacies that, for example, may be more effective at encouraging generic drug use. However, in previous years, tiered pharmacy networks have been controversial because of concerns that some Part D members have less access to preferred pharmacies. If LIS enrollees have less opportunity to use preferred pharmacy networks, the tiered network strategy could lead to higher Medicare spending because Medicare pays for most or all of LIS enrollees' cost sharing.

Although Part D sponsors cannot set up exclusive pharmacy networks, they can include other network contract terms that try to achieve the same aims—terms that have largely led to postsale payments from pharmacies to plans. The terms can include fees that are a condition for participating as a preferred cost-sharing pharmacy, periodic payment reconciliations related to drug reimbursement rates, or performance-based fees that are assessed on quality measures (Fein 2016). While participants in preferred networks gain more prescription volume, the pharmacies are essentially agreeing to lower and less predictable reimbursements from plans, which for some pharmacies has made participation in preferred networks much less desirable. For example, in 2021, some groups of independent pharmacies have chosen not to participate (Fein 2020a).

Aggregate postsale rebates and discounts have grown over time

When Part D began in 2006, postsale rebates and discounts, referred to collectively as direct and indirect remuneration (DIR), offset a relatively small share of Part D's spending. However, DIR has grown rapidly in subsequent years. Manufacturer rebates make up the vast majority of DIR; in 2017, manufacturer rebates made up more than 80 percent of the \$35 billion in total Part D DIR

**FIGURE
13-3****Rebates and discounts offset over 50 percent of plan liability
in 2018, up from about 20 percent in 2007**

Note: DIR (direct and indirect remuneration). Gross plan liability (\$53 billion in 2018) is calculated as the difference between gross spending for Part D's basic benefit costs and the portion of the benefit costs paid by Medicare's reinsurance (80 percent of gross spending above the annual out-of-pocket threshold) before postsale rebates and discounts.

Source: MedPAC analysis based on Part D aggregate payment data from CMS Office of the Actuary and Part D's prescription drug event data.

obtained by plan sponsors (Fein 2018b).²⁰ In 2018, plan sponsors' share of DIR totaled \$28 billion and offset over 50 percent of the sponsors' benefit liability, up from about 20 percent in 2007 (Figure 13-3).²¹ The widening gap between prescription prices at the pharmacy and prices net of rebates and discounts has led to concerns about the accuracy of Part D's risk-adjustment system, among other issues (see text box on the rapid growth in pharmaceutical manufacturer rebates).

Recent regulatory issues in Part D

High prices of prescription drugs have been the focus of the administration for the last several years. In 2020 alone, there have been multiple executive orders and policy proposals aimed at addressing high drug prices. Two executive orders released in the summer of 2020 would have eliminated postsale pharmaceutical manufacturer rebates in Part D ("the rebate rule") and tied the payments for certain drugs covered under Part B and Part D to prices

paid in other countries (the "most favored nation" (MFN) pricing rule") (Executive Office of the President 2020a, Executive Office of the President 2020b). On November 20, 2020, the administration finalized the rebate rule and published an interim final rule for the MFN pricing rule that applied only to drugs covered under Part B (Centers for Medicare & Medicaid Services 2020h, Department of Health and Human Services 2020c).

Unlike most policies affecting Part D that are promulgated by CMS, the rebate rule is under the purview of the Department of Health and Human Services (HHS) Office of Inspector General. The final rule would modify the federal health care program's anti-kickback statute (AKS) safe harbor rule to disallow postsale rebates from manufacturers in Part D. The sunset of this safe harbor would have become effective on January 1, 2022, but has been delayed by a year (until January 1, 2023) as the new administration and stakeholders decide how to proceed.

Rapid growth in pharmaceutical manufacturer rebates undermines the accuracy of Part D's risk adjustment

CMS risk adjusts Medicare's monthly capitated payments to plans using the prescription drug hierarchical condition category (RxHCC) model. The model predicts plan liability for Part D's basic benefit costs based on medical diagnoses and demographic factors.²² The model is calibrated so that coefficients for condition categories reflect average drug costs associated with specific disease groups as reflected in Part D's prescription drug event (PDE) data.

In the early years of the program, Part D's risk adjustment system, estimated using gross prices (before deducting direct and indirect remuneration (DIR)), provided a reasonable approximation of the relative costliness of disease conditions. Because manufacturer rebates are typically tied to the sales of specific drugs, DIR's increasing role and variability across therapeutic classes raises concerns about the accuracy of the RxHCC model (Johnson et al. 2018, Langreth et al. 2016). When prediction inaccuracies occur systematically, risk adjustment may no longer be effective in mitigating risk-selection incentives (i.e., plans attracting enrollees with certain conditions and avoid enrollees with other conditions).

We examined how manufacturer rebates can affect Part D's risk adjustment by comparing the risk-adjustment factors estimated with and without rebates

for two categories of drugs—insulins used for the treatment of diabetes and tumor necrosis factor (TNF) inhibitors used to treat inflammatory conditions such as rheumatoid arthritis, ulcerative colitis, and Crohn's disease. We chose these two categories of drugs because we were able to obtain information on rebates and discounts from published studies and reports.²³ We also focused on these classes because they represented two very different types of drugs used by Part D enrollees: one, a widely used therapy with monthly costs in the hundreds of dollars per user; the other, a specialty drug used by a small number of beneficiaries with monthly costs in the thousands of dollars per user.

For simplicity, we used a single community segment model.²⁴ The base case was calibrated using 2017 diagnoses to predict 2018 gross plan liability, as reflected in the 2018 Part D prescription drug event data. Then we re-estimated the model using plan costs net of rebates for insulins and TNF inhibitors (net-cost model). Both models included the identical set of 76 RxHCCs and demographic variables (the same explanatory variables included in the current version of the RxHCC model).

Using costs net of rebates reduced risk-adjustment factors by up to 75 percent

We found that using net costs lowered the risk-adjustment factors for conditions affected by insulins

(continued next page)

While eliminating the safe harbor for rebates, the final rule also would create two new safe harbor protections for:

- price reductions (discounts) given by drug manufacturers that are set in advance through a written agreement and are passed through to beneficiaries at the point of sale.
- service fees that a manufacturer pays to a PBM in exchange for a service provided by the PBM when the payments are based on fixed-dollar amounts (i.e., not related to the sales or prices of drug products).

The change to the AKS safe harbor rule is subject to review by the new administration and to legal challenge (Pharmaceutical Care Management Association 2021). One challenge relates to whether the proposed version of the rule had been officially withdrawn; if so, finalizing the rule may violate the Administrative Procedures Act (Ropes & Gray 2020).²⁵ Another point of contention is that the executive order on rebates mandated that the rule not increase federal spending, premiums, or patient out-of-pocket costs. There are a variety of ways in which

Rapid growth in pharmaceutical manufacturer rebates undermines the accuracy of Part D's risk adjustment (cont.)

and TNF inhibitors.²⁶ Among the conditions affected by insulins, the reduction in risk-adjustment factors ranged from just over 10 percent for diabetes without complications (RxHCC31) to 75 percent for diabetic retinopathy (RxHCC241). For conditions affected by TNF inhibitors, the reduction in the risk-adjustment factors ranged from 13 percent for inflammatory bowel disease (RxHCC67) to 30 percent for rheumatoid arthritis and other inflammatory polyarthropathy (RxHCC83). The potential financial impact of incorporating rebates would vary depending on the individual plan bid. For a hypothetical plan with a bid equal to the national average bid in 2018 (\$57.93, or \$695 for 12 months), the use of net insulin costs would have lowered Medicare's annual payments for an enrollee who has diabetic retinopathy by \$214.

Changes in the relative costs of conditions affect risk scores for all beneficiaries

A decrease in the relative costliness of a specific condition (e.g., diabetes) means that other conditions, not affected by the change in costs, are by definition

more costly relative to that condition. To illustrate this, we compared the changes in average risk scores for beneficiaries with a diagnosis of diabetes to those without the diagnosis. Under the net-cost model, risk scores averaged 1.39 among beneficiaries with diabetes compared with 1.53 in the base case (Table 13-7). That is, using net costs for insulins reduced the average risk scores by 0.14, or by 9 percent. The risk scores for other beneficiaries (i.e., without diabetes), on the other hand, increased by 0.06, or by 8 percent, on average.

The effects of using costs net of rebates on risk scores of beneficiaries with inflammatory conditions were similar (a decrease by 0.13, or 7 percent). However, the effects on other beneficiaries (i.e., without inflammatory conditions) were relatively small—an increase in the average risk scores of 0.01, or 1 percent. The impact on other beneficiaries, in this case, is much smaller than in the case of insulins because TNF inhibitors, while significantly more costly per patient than insulins, are used by less than 1 percent of Part D beneficiaries.

(continued next page)

**TABLE
13-7**

Changes in the relative costs of specific conditions affect risk scores for all beneficiaries

	Risk score		Change in average risk score	
	Base case	Net costs	Value	Percent
Beneficiaries with diabetes	1.53	1.39	-0.14	-9%
Beneficiaries without diabetes	0.77	0.83	0.06	8
Beneficiaries with inflammatory conditions	1.75	1.63	-0.13	-7
Beneficiaries without inflammatory conditions	0.95	0.96	0.01	1

Note: The "base case" model was calibrated using 2017 diagnoses to predict 2018 gross plan liability, as reflected in the 2018 Part D prescription drug event data. Then we re-estimated the model using plan costs net of rebates for insulins and tumor necrosis factor inhibitors ("net-costs" model). "Beneficiaries with diabetes" includes all individuals who had an indication for prescription drug hierarchical condition category (RxHCC)30 (diabetes with complications) or RxHCC31 (diabetes without complications). "Beneficiaries with inflammatory conditions" includes all individuals who had an indication for RxHCC67 (inflammatory bowel disease), RxHCC82 (psoriatic arthropathy and systemic sclerosis), RxHCC83 (rheumatoid arthritis and other inflammatory polyarthropathy), or RxHCC316 (psoriasis other than arthropathy).

Source: MedPAC analysis of 2018 Part D prescription drug event data and Part D risk score file.

Rapid growth in pharmaceutical manufacturer rebates undermines the accuracy of Part D's risk adjustment (cont.)

Risk scores would vary less for plans than for individual beneficiaries

While the effects on risk scores of using net, rather than gross, costs in the risk-adjustment model on risk scores could be large for individual beneficiaries, plan payments are ultimately determined by the average of risk scores of all of their enrollees. As a result, the impact on an individual plan would depend on the plan's mix of RxHCCs indicated for its enrollees.

We found that, under the net-cost model, plan-level average risk scores increased for PDPs by 0.7 percent, on average, and decreased for MA-PDs by 1.5 percent (these averages are calculated using plan weights, not weighted by enrollment) (Table 13-8). Because inflammatory conditions affect only 6 percent of Part D enrollees, the effects on plan-level risk scores were relatively small (a reduction of less than 0.5 percent) (data not shown). Instead, most of the effects appear to be driven by change in the cost of insulins. Risk scores tended to decline among MA-PDs likely because a higher share of MA-PD enrollees with diabetes had an indication for RxHCC30 (diabetes with complications), a condition category for which using net insulin costs had a greater impact compared with RxHCC31 (diabetes without complications).

There were, however, wide variations around these averages. For example, average risk scores would have declined by 5.4 percent or more for 10 percent of MA-

PDs and increased by 2.1 percent or more for at least 10 percent of MA-PDs compared with the base case.

Our findings are specific to insulin and TNF inhibitors and therefore are not generalizable to other therapies or broader classes of therapies. However, there are several general implications for the program. First, the existence of manufacturer rebates on some, but not all brand-name drugs, likely results in overpayments for some conditions and inadequate payments for others. Second, Part D's risk adjustment may no longer provide adequate adjustment to mitigate against plan sponsors' incentives to engage in risk selection. The opportunity for financial gains could also encourage the use of formulary structures that favor high-price, high-rebate drugs even when lower-cost alternatives are available (Antos and Capretta 2019, Arambadjis et al. 2020, Dusetzina et al. 2019). This situation could worsen, particularly if manufacturer rebates continue to grow in tandem with higher prices. The findings also imply that both the magnitude of rebates and the prevalence of the condition(s) treated by the medication contribute to greater inequity across plans in their average risk scores, and therefore, their payments. Finally, using net, rather than gross, costs in the risk-adjustment model would improve the adequacy and accuracy of payments across plans. This change would be particularly important under the Commission's recent recommendations to restructure the Part D benefit that would increase the capitated payments' share of plan sponsors' revenues to cover Part D's benefit costs. ■

**TABLE
13-8**

Effects on plan-level average risk scores would be muted by the averaging of risk scores across enrollees

	Number of plans	Change in plan-level average risk score		
		Mean	10th percentile	90th percentile
PDPs	890	0.7%	-1.5%	2.7%
MA-PDs	3,171	-1.5	-5.4	2.1

Note: PDP ([stand-alone] prescription drug plan), MA-PD (Medicare Advantage-Prescription Drug [plan]).

Source: MedPAC analysis of 2018 Part D prescription drug event data and Part D risk score file.

**TABLE
13-9**

Part D prices grew more slowly in 2019 compared with prior years

	Price index as of December		Average annual percent change	
	2018	2019	2006-2018	2018-2019
All drugs and biologics	1.86	1.91	5.3%	2.6%
Single-source brand-name drugs and biologics	3.36	3.55	10.6	5.7
Generic drugs	0.17	0.15	-13.7	-11.0
After accounting for generic substitution	1.14	1.11	1.1	-2.1

Note: Chain-weighted Fisher price indexes. Prices reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies. Indexes are measured at the median of the distribution relative to prices as of January 2006. Price indexes shown are rounded; the change between 2018 and 2019 were calculated using unrounded data.

Source: Acumen LLC analysis for MedPAC.

manufacturers, plan sponsors, and PBMs could react to such a policy change, and consultants have estimated potential effects that range from higher to lower spending (Department of Health and Human Services 2020a). However, estimates by CMS’s Office of the Actuary and others suggest the policy would result in higher federal spending, and in some cases, higher beneficiary premiums (Department of Health and Human Services 2020a). CMS’s Office of the Actuary estimated that the policy would cost \$186 billion over 10 years, while the Congressional Budget Office estimated that it would cost \$177 billion over the same period. However, in November 2020, the HHS Secretary asserted that the implementation of the final rule would not increase federal spending, Medicare beneficiary premiums, or patients’ total OOP costs (Department of Health and Human Services 2020b).

Drug pricing

Growth in gross or POS prices—prices at the pharmacy counter—has been the focus of much recent attention. Most Part D enrollees primarily use generic drugs, and many (but not all) generic prices remain low. However, enrollees without the LIS who use brand-name drugs often feel the effects of rising POS prices when they pay coinsurance.

As policymakers have debated what to do about drug price growth, they have examined not only the market power of manufacturers in setting and raising prices but also the drug supply and distribution chains and benefits management. At all levels, incentives exist that drive prices higher. For one, payments for pharmaceuticals or services provided in conjunction with drug distribution are often based on a percentage of prices (Diplomat Specialty Pharmacy 2017, Fein 2018a, Feldman 2018, Garthwaite and Morton 2017). For another, some participants in the drug supply chain have tended to rely on drug price inflation for revenue growth (Cahn 2017, Fein 2017, Lopez 2016, Sell 2015). At the same time, manufacturers have shifted their development pipelines toward higher cost drugs and biologics, products that may not have direct therapeutic competitors. Over time, these factors, combined with the increasing market concentration of supply chain participants, have put upward pressure on both POS prices and rebates.

While some analysts contend that growth in prices net of rebates is the primary measure of importance, changes in POS and net prices are both important to monitor. Especially for drugs and biologics that are subject to coinsurance, prices paid at the pharmacy are an important indicator of Part D’s costs, since POS prices affect beneficiary cost sharing and the rate at which beneficiaries reach Part D’s catastrophic phase. At the same time, net

drug prices affect the premiums paid by Part D enrollees and subsidized by the Medicare program. Until recently, POS prices have grown aggressively. Although the Commission does not have data on rebates for individual drugs, Medicare Trustees report that average rebates have grown significantly.²⁷ Because, on average, rebates have grown even faster than POS prices, there has been a widening divergence between gross and net drug prices. As a result, a growing share of drug costs net of rebates have shifted to beneficiaries and the Medicare program.

Prices paid at the point of sale

To examine growth in POS prices, the Commission contracted with Acumen LLC to construct a series of volume-weighted price indexes that reflect total amounts paid to pharmacies for Part D prescriptions, including ingredient costs and dispensing fees. The price indexes reflect POS prices before retrospective rebates and discounts paid by pharmaceutical manufacturers and pharmacies and are measured at the median of the distribution unless otherwise noted.

In 2019, average prices decreased owing to new and existing generic competitors

Between 2006 and 2019, drug prices, measured by individual national drug codes (NDCs), rose by an average of 91 percent (an index value of 1.91) (Table 13-9).²⁸ Overall, prices for Part D drugs and biologics grew more slowly in 2019 (2.6 percent) compared with an average annual increase of 5.3 percent before 2019.

Prices of generics are often a small fraction of the prices of their brand-name counterparts (Government Accountability Office 2016, Schondelmeyer and Purvis 2019). As a result, the use of generic drugs can provide significant savings to beneficiaries and the Medicare program. When measured by prices that take generic substitution into account, Part D prices decreased by 2.1 percent in 2019, a reversal of the inflationary trend that began after the 2012 “patent cliff.”²⁹

“Deflation” was limited to specific therapeutic classes that experienced new or increased generic competition

Price deflation, however, did not occur uniformly across therapeutic classes. Changes in price indexes between 2018 and 2019 varied widely, ranging from a drop of nearly 30 percentage points for anticonvulsants to an increase of about 10 percentage points for anti-

inflammatory drugs used for the treatment of conditions such as rheumatoid arthritis (annual changes are measured as the difference in cumulative price indexes as of December of respective years) (Table 13-10, p. 436).

New and increased generic competition for selected therapeutic classes played an important role in the decline in the overall Part D price index. Market entry of generic competitors to the anticonvulsant Lyrica (pregabalin) and a prostate cancer drug, Zytiga (abiraterone acetate), in late 2018 and 2019 likely accounted for most, if not all, of the decrease in price indexes for anticonvulsants (–29.9 percentage points) and antineoplastics (–2.6 percentage points).

For therapies to treat multiple sclerosis, the decrease in the price index in 2019 (by 6.5 percentage points) was likely due to the increased competition from the generic versions of Copaxone (glatiramer acetate) (Weintraub 2019) (Table 13-10, p. 436). With total Part D spending of nearly \$1.5 billion at its peak sales in 2017, Copaxone was considered one of the “blockbuster” drugs for the treatment of multiple sclerosis (Centers for Medicare & Medicaid Services 2019b, Weintraub 2019). Despite the availability of generics since 2015, its Part D market share was not materially affected until a court ruling invalidated Teva’s dosing patents for Copaxone in late 2018 (Elvidge 2018). Between 2017 and 2019, Copaxone’s share of all prescriptions for glatiramer acetate in Part D fell from 93 percent to 62 percent. Because generic versions of glatiramer acetate cost less than half that of Copaxone, the shift in market shares resulted in a lower average price.³⁰

For other therapeutic classes that are dominated by brand-name drugs or biologics such as anti-inflammatory drugs and antidiabetic therapies including insulins, prices continued to rise. As a result, between 2018 and 2019, price indexes for high-priced specialty drugs and biologics also continued to increase.

With the share of generic prescriptions nearing 90 percent, there is less opportunity for generic substitutions.³¹ Meanwhile, rapid growth in prices of single-source brand-name drugs and biologics will put upward pressure on Part D prices and program spending. Of particular concern is the increasing role of high-priced drugs and biologics. Between 2006 and 2019, our price index for biologics grew by a cumulative 266 percent (an index value of 3.66) (Table 13-10, p. 436). Accounting for generic (biosimilar) substitutions had almost no effect on

**TABLE
13-10**

Prices declined in some therapeutic classes but increased in others, 2018–2019

	Price index as of December 2019 (relative to prices in January 2006)	Change from December 2018	
		Percentage points	Percent
Part D (after accounting for generic substitution)	1.11	-2.4%	-2.1%
Specialty-tier drugs*	2.58	1.8	0.7
Biologics	3.66	8.6	2.4
Selected therapeutic classes			
Antidepressant	0.24	-1.0	-4.0
Antipsychotic	0.61	1.1	1.9
Anticonvulsant	0.37	-29.9	-44.7
Immunosuppressant	0.41	1.2	2.9
Antiretroviral	1.89	7.3	4.0
Antineoplastic	2.17	-2.6	-1.2
Multiple sclerosis therapy	3.82	-6.5	-1.7
Anti-inflammatory	3.27	10.1	3.2
Antidiabetics**	2.86	8.7	3.1
Insulin	4.14	9.5	2.4

Note: Chain-weighted Fisher price indexes. Prices account for generic substitution and reflect total amounts paid to pharmacies before rebates or discounts from manufacturers and pharmacies.
 *Because there was no specialty tier defined for Part D plans until 2007, the price index for specialty-tier drugs is measured relative to prices as of January 2007 rather than January 2006 (i.e., set to 1.0 in January 2007).
 **Antidiabetics include both oral antidiabetic medications and insulins.

Source: Acumen LLC analysis for MedPAC.

the prices of biologics because competitive tactics among manufacturers and regulatory hurdles have so far worked to thwart entry of and price competition from biosimilars in Part D (see text box on lack of biosimilar competition, addressed in the March 2020 report to the Congress, pp. 430–431). High-priced drugs and biologics will pose a considerable challenge for the financing of the program as plan sponsors have little to no leverage to negotiate prices for many of these products.

Program costs

The costs of providing Part D benefits are shared by Medicare and its enrollees. Medicare pays plan sponsors two major subsidies on behalf of each enrollee in their plans:

- **Direct subsidy**—A monthly prospective amount set as a share of the national average bid for Part D basic benefits, adjusted for the risk of the individual enrollee.
- **Reinsurance**—Reimbursement to plans for 80 percent of drug spending above an enrollee’s annual OOP threshold (the catastrophic phase of the benefit). Plans receive prospective payments for reinsurance that are reconciled with actual spending (net of postsale rebates and discounts) for each enrollee who reached the OOP threshold after the end of the benefit year.

Combined, the direct subsidy and expected reinsurance payments aim to cover 74.5 percent of the expected cost of basic benefits. Today, a much larger share of Medicare’s payments takes the form of reinsurance (cost-based reimbursement) rather than the direct subsidy (capitated

**TABLE
13-11**

Medicare’s reimbursement amounts for Part D

	Calendar year							Average annual growth rate	
	2007	2010	2015	2016	2017	2018	2019	2007–2018	2018–2019
Reimbursement amount (in billions):									
Direct subsidy*	\$17.6	\$19.6	\$18.1	\$17.1	\$14.6	\$13.5	\$11.6	-2.4%	-14.1%
Reinsurance	<u>8.0</u>	<u>11.2</u>	<u>33.2</u>	<u>35.5</u>	<u>37.6</u>	<u>40.6</u>	<u>46.3</u>	15.9	14.0
Subtotal, basic benefits	25.6	30.8	51.3	52.6	52.2	54.1	57.9	7.0	7.0
Low-income subsidy	16.7	21.1	25.6	26.4	27.3	28.5	29.8	5.0	4.6
Retiree drug subsidy	<u>3.9</u>	<u>3.9</u>	<u>1.1</u>	<u>1.0</u>	<u>0.8</u>	<u>0.8</u>	<u>0.7</u>	-13.4	-12.5
Total Part D	46.2	55.8	78.0	80.0	80.3	83.4	88.4	5.5	6.0
Enrollee premiums**	4.1	6.7	11.5	12.7	14.0	14.2	13.9	12.0	-2.1

Note: The numbers presented reflect reconciliation. Components may not sum to stated totals due to rounding.

*Net of risk-sharing payments using Part D’s risk corridors.

**For basic benefits, excluding low-income premium subsidies.

Source: MedPAC analysis based on Table IV.B10 of 2020 annual report of the Boards of Trustees of the Medicare trust funds.

payments). In addition to reinsurance, Medicare shares financial risk with plan sponsors by risk adjusting direct-subsidy payments to reflect the expected costliness of a plan’s enrollees and by limiting each plan’s overall losses or profits through risk corridors if actual benefit spending, excluding reinsurance, is much higher or lower than the plan sponsor anticipated in its bid.

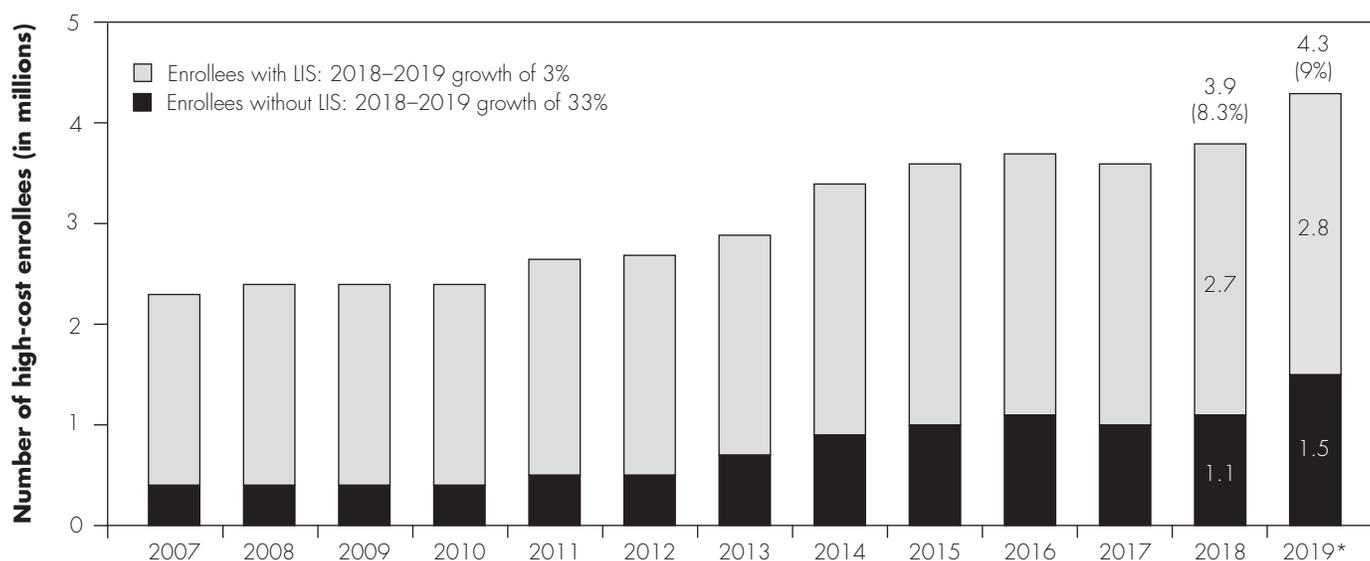
Beneficiary premiums are designed to cover the remaining 25.5 percent of the expected cost of basic benefits. In addition to monthly premiums, Part D enrollees also pay any cost sharing required by plan sponsors or, in the case of LIS enrollees, cost-sharing amounts set in law.

Trends in program subsidies and costs

Between 2007 and 2019, program spending (including expenditures for the RDS) rose from \$46.2 billion to \$88.4 billion (Table 13-11), or an average 5.5 percent per year. In 2019, Medicare paid \$11.6 billion for direct subsidies, \$46.3 billion for individual reinsurance, \$29.8 billion for the LIS, and \$0.7 billion for the RDS. Medicare payments for individual reinsurance have grown faster than other

components of Part D spending. Between 2018 and 2019, reinsurance payments rose by 14 percent, compared with a decline of 14.1 percent for the capitated direct subsidy payments (Table 13-11).

In 2019, premiums paid by Part D enrollees for basic benefits (not including the premiums paid by Medicare on behalf of LIS enrollees) totaled \$13.9 billion, a decrease of 2.1 percent from \$14.2 billion in 2018. Before 2019, premiums paid by enrollees grew by an average of 12 percent per year, reflecting primarily growth in enrollment by beneficiaries who do not receive the low-income subsidy and some increase in benefit costs.³² Despite significant growth in the catastrophic benefit (paid mostly by Medicare’s reinsurance), average premiums for basic Part D benefits have remained low, in part because plans tend to underestimate the amount of reinsurance they will need when they submit their bids. This behavior reduces beneficiary premiums because projected program spending is too low and results in Medicare subsidizing more than the 74.5 percent of program spending set in law.

**FIGURE
13-4****Part D enrollees reaching the benefit's catastrophic phase, 2007-2019**

Note: LIS (low-income subsidy). Growth rates were calculated using figures before rounding was applied. Components may not sum to stated totals due to rounding.
*Preliminary figure based on Part D TAP prescription drug event data.

Source: Enrollee counts from 2007 are based on published figures from CMS. Enrollee counts for 2010 to 2019 are based on MedPAC analysis of Part D prescription drug event data.

2019 saw the largest ever increase in the number of beneficiaries without the LIS reaching the catastrophic phase

In 2019, 9.0 percent of Part D enrollees had spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees), up from 8.3 percent in 2018 (Figure 13-4). In 2019, the number of beneficiaries reaching the catastrophic phase grew 12 percent to 4.3 million. The growth was driven by the largest-ever increase in the number of beneficiaries without the LIS reaching the catastrophic phase, which rose by 33 percent.

Medicare's spending for reinsurance grew correspondingly. Since 2010, changes in law coupled with rapid growth in POS prices and high take-up of new hepatitis C treatments led to a double-digit increase in the number of enrollees without the LIS who incurred spending high enough to reach the catastrophic phase (Hartman et al. 2018). This rate of increase in 2019 is unprecedented, likely reflecting recent changes in law that accelerated the closure of the coverage gap by increasing

the manufacturer coverage-gap discount on brand-name drugs (and biologics) from 50 percent to 70 percent. Because the manufacturer coverage-gap discount is treated as though it were the enrollee's own spending, a larger discount amount contributing toward the annual OOP threshold means that enrollees without the LIS reach the catastrophic phase more quickly.

In 2019, more enrollees reached the catastrophic phase with lower levels of spending than in 2018

From the perspective of beneficiaries without the LIS, the higher manufacturer discount (70 percent) meant that (1) their cost-sharing liability for brand-name drugs and biologics was lower, and (2) a higher percentage of each prescription's price was counted toward the beneficiary's annual OOP threshold. As a result, when beneficiaries filled prescriptions for brand-name drugs or biologics in the coverage gap, the total amount of drug spending and OOP cost sharing needed to reach the annual OOP threshold was lower.

**TABLE
13-12**

In 2019, most high-cost enrollees without the LIS had lower levels of spending than in 2018

	2018	2019*	Change 2018-2019
Annual OOP threshold	\$5,000	\$5,100	\$100
Median gross spending per high-cost beneficiary			
With LIS	14,108	14,621	513
Without LIS	17,073	15,641	-1,432
Median OOP spending per high-cost beneficiary**			
With LIS	60	56	-4
Without LIS	2,852	2,168	-684

Note: LIS (low-income subsidy), OOP (out-of-pocket). An individual's total gross drug spending at the annual OOP threshold depends on each beneficiary's mix of brand-name and generic drugs filled in the coverage gap.

*Preliminary figures based on Part D TAP prescription drug event data.

**Typically OOP spending paid by high-cost beneficiaries is lower than the annual OOP threshold because both Medicare's low-income cost-sharing subsidy and the coverage-gap discount paid by pharmaceutical manufacturers are counted toward the annual OOP threshold as if it were incurred by the beneficiary.

Source: MedPAC analysis of Part D prescription drug event data.

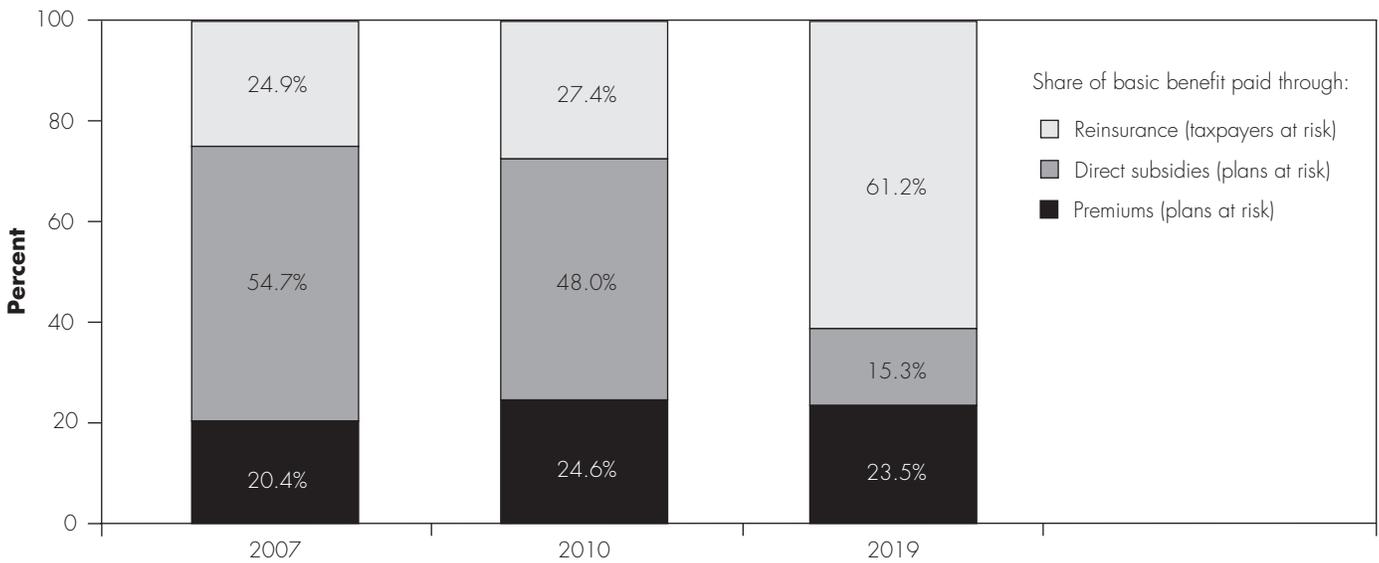
In 2019, the annual OOP threshold was set at \$5,100, up \$100 from \$5,000 in 2018 (based on a statutory formula) (Table 13-12). CMS's estimates for total (gross) spending at annual OOP thresholds in 2018 and 2019 were \$8,417.60 and \$8,139.54, respectively (Centers for Medicare & Medicaid Services 2018a).³³ The estimate for 2019 was lower because the changes made by the Bipartisan Budget Act of 2018 increased the coverage gap discount from 50 percent to 70 percent, and as a result, 95 percent of an enrollee's spending for brand-name drugs and biologics filled in the coverage gap counted toward the OOP threshold, compared with 85 percent in 2018.

In 2019, average levels of spending incurred by high-cost enrollees without the LIS were lower than in 2018 (Table 13-12). In 2019, median gross spending for high-cost enrollees without the LIS was over \$1,400 lower (\$15,641 compared with \$17,073 in 2018.) Correspondingly, these enrollees' OOP cost sharing fell—median OOP costs of \$2,168 in 2019 compared with \$2,852 in 2018. In contrast, for high-cost LIS enrollees, median gross spending rose by about \$500 while OOP cost sharing amounts fell slightly.

The surge in number of beneficiaries reaching the catastrophic phase of the benefit in 2019 pushed up the share of high-cost enrollees' aggregate spending (i.e., including catastrophic and noncatastrophic spending) to 64 percent of Part D spending from 61 percent in 2018. Despite the deceleration in the per capita spending for high-cost enrollees in 2019, the rapid growth in the average price of prescriptions filled will likely continue to drive spending for high-cost enrollees. Moreover, the number of beneficiaries filling a single prescription for a high-priced drug that was sufficient to meet the OOP threshold continued to grow. In 2019, more than 483,000 enrollees (about 11 percent of high-cost enrollees) filled such a prescription, up from just 33,000 in 2010.³⁴ The increase in the number of beneficiaries with such claims has accelerated in recent years, rising by more than 100,000 since 2017.

Taxpayers bear an increasing share of the risk for Part D spending

In nearly every year since 2007, the portion of basic benefits paid through enrollee premiums has been below the 25.5 percent objective specified in law. In

**FIGURE
13-5****Taxpayers bear increasing share of the risk for Part D benefit spending**

Note: Figures represent aggregate values for incurred basic benefits net of risk corridor payments. Figures for enrollee premiums include amounts paid to Part D plans by enrollees and by Medicare on behalf of enrollees who receive the low-income subsidy.

Source: MedPAC analysis based on Table IV.B10 of 2020 annual report of the Boards of Trustees of the Medicare trust funds.

2019, premiums paid by enrollees or by Medicare’s LIS accounted for 23.5 percent of basic benefit costs (Figure 13-5). According to the Boards of Trustees, for 2019, enrollees’ share of the basic benefit costs were below the 25.5 percent set in statute because plan bids assumed higher DIR and slow reinsurance growth, and as a result, “reinsurance amounts in the 2019 [plan] bids were significantly underestimated” (Boards of Trustees 2020).

Insurance risk provides an incentive for plan sponsors to offer attractive benefits while managing their enrollees’ spending through formularies and other tools. However, data from the Boards of Trustees show that between 2007 and 2019, the portion of the average basic benefit paid to plans through Medicare’s capitated direct subsidy fell from 54.7 percent to 15.3 percent (Figure 13-5). Correspondingly, in 2019, the portion for which plans are at risk (direct subsidy payments plus enrollee premiums) accounted for less than 40 percent of benefit costs (23.5 percent plus 15.3 percent), down from about 75 percent in 2007 (20.4 percent plus 54.7 percent). Over the same

period, the portion paid through Medicare’s reinsurance subsidies (for which taxpayers are at risk) grew from about 25 percent to just over 61 percent. The Commission has been concerned that the shift of risk from plan sponsors to Medicare has eroded plans’ incentives to manage spending.

Beneficiaries’ access to prescription drugs

Formulary management is the most important tool used by plan sponsors. Greater flexibility to use formulary tools could help plan sponsors manage spending while ensuring that prescribed medicines are safe and appropriate for the patient, potentially reducing overuse and misuse. However, for some Part D enrollees, those same tools could limit access to needed medications. To ensure access, CMS reviews each plan’s formulary to check that it includes medicines in a wide range of therapeutic

classes used by the Medicare population and applies utilization management tools in appropriate ways. Further, Part D law requires sponsors to have a transition process to ensure that new enrollees, as well as current members whose drugs are no longer covered or are subject to new restrictions, have access to the medicines they have already been taking.³⁵

Medicare also requires plan sponsors to establish a process for coverage determination and appeals. Part D requires quicker adjudication times than for most medical benefits covered by Medicare Advantage (MA) plans.³⁶ If an enrollee is dissatisfied with a plan's final coverage decision (redetermination), he or she may appeal the decision to an independent review entity (IRE) and then to higher levels of appeal.

Measuring access is inherently complicated because clinical appropriateness can vary across patients. In reviewing beneficiaries' access to Part D drugs, we examined general program-wide indicators of access using data from CMS audits and Part D's appeals process, as well as recent research focused on Part D beneficiary access.

Audit results suggest improvements in formulary administration, coverage determinations, and appeals

CMS audits a selection of sponsoring organizations each year for compliance with program requirements, ultimately covering most plan sponsors over its multiyear work cycle. Each year, CMS selects different plan sponsors to audit, and as a result, comparison across years is not always straightforward. In 2019, the audit covered 12 plan sponsors and about 71 percent of beneficiaries enrolled in the MA and Part D programs, up from 2 percent of beneficiaries in 2018 (Centers for Medicare & Medicaid Services 2020a).³⁷ Because of this seeming difference, CMS cautions against reading too much into the changes in audit performance from year to year.

Between 2017 and 2019, CMS found “no particular trend” in plan sponsors' performance for Part D formulary and benefit administration (FA) (e.g., accuracy of claims processing and appropriateness of utilization management applied) while over the same period observing improvements in coverage determinations, appeals, and grievances (CDAG) (Centers for Medicare & Medicaid Services 2020a). CMS noted, however, that the performance for formulary administration remained consistently strong during this period, with better than

average scores in all three years, compared with the audit results in 2015 and 2016 (Centers for Medicare & Medicaid Services 2020a).

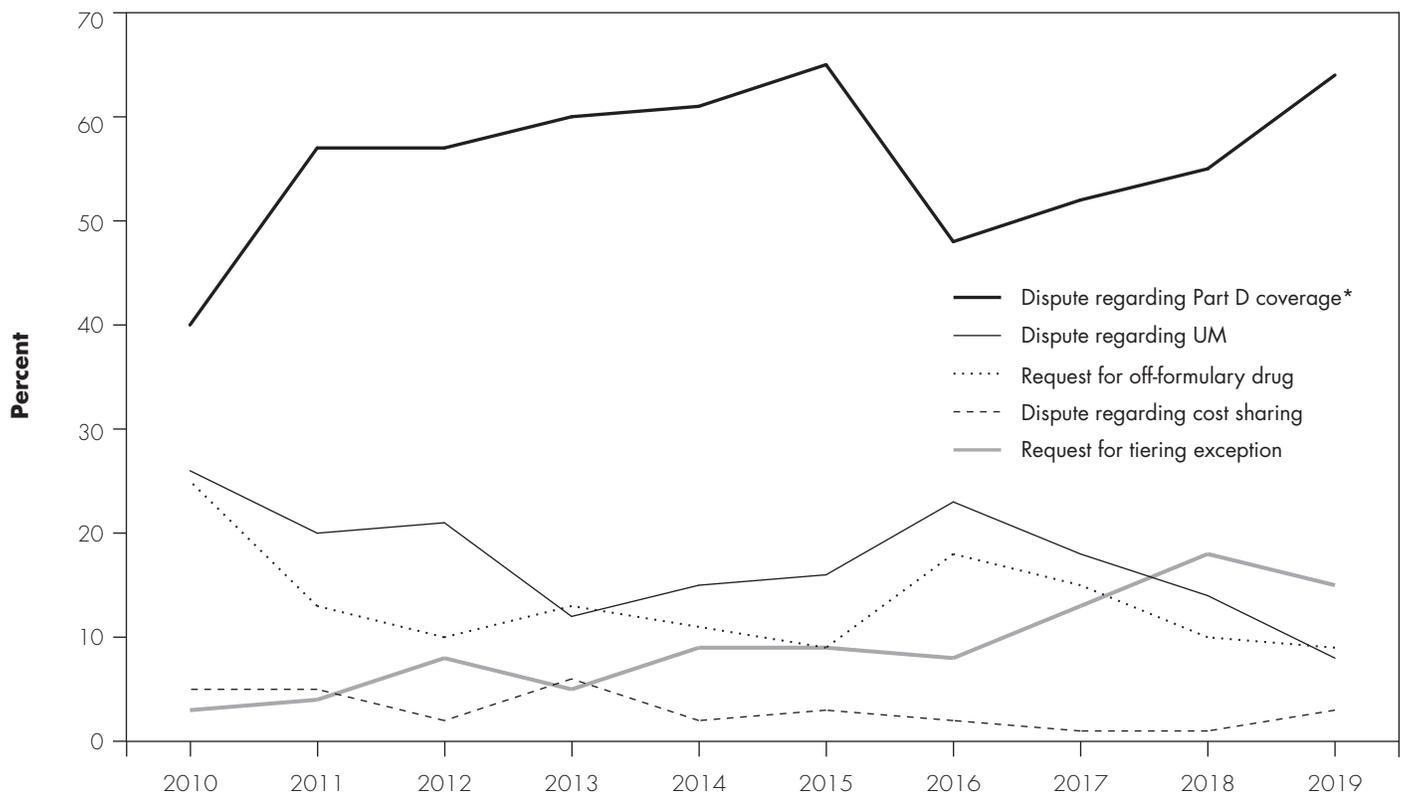
At the same time, plan sponsors' performance varied widely. For example, in 2019, for half of plan sponsors, CMS audits found no FA issues, but among other sponsors, the number and the severity of noncompliant actions led to audit scores ranging from 0.5 to 2.5 (lower scores are better) (Centers for Medicare & Medicaid Services 2020a).³⁸ Similar variation was observed for CDAG. The two plan sponsors that used a single formulary across all plans performed substantially better on both FA and CDAG than sponsors that used multiple formularies.

Independent reviewers were more likely to agree with plans' coverage decisions than in previous years

Assessing how well Part D's exceptions and appeals processes work can be a challenge.³⁹ Currently, the IRE reports information about cases in the IRE step of the appeals process to CMS, which uses these data for measures in Part D plans' star ratings. Typically, only a small share of redeterminations is appealed or automatically forwarded to an IRE.⁴⁰ In 2019, the number of cases appealed or forwarded to an IRE totaled 36,227, or about 0.8 cases per 1,000 enrollees. The number of cases has fluctuated over the years, ranging from 0.4 cases per 1,000 enrollees to 0.9 per 1,000 enrollees.

The IRE hears Part D cases related to cost sharing, plans' application of utilization management tools, requests for formulary and tiering exceptions, and sponsors' decisions regarding plan coverage of a drug. Between 2010 and 2019, appeals related to drug coverage accounted for the largest share of the cases, ranging from 40 percent to 65 percent (Figure 13-6, p. 442). These cases typically relate to disputes about whether a prescription was written for a medically accepted indication or whether the drug meets the statutory definition of a Part D-covered drug (Centers for Medicare & Medicaid Services 2020i).

Between 2010 and 2019, appeals related to utilization management tools such as prior authorization and requests for coverage of a drug not on formulary generally declined, with the exception of an uptick in 2016, when many plan sponsors used prior authorization and quantity limits or limited formulary coverage to manage the use of new hepatitis C treatments (Hoadley et al. 2015, Jung et al. 2016).

**FIGURE
13-6****Changes in the types of appeals that reach IRE, 2010–2019**

Note: IRE (independent review entity), UM (utilization management). UM tools used by plan sponsors include prior authorization, step therapy, and quantity limits.
*Part D coverage issues may arise, for example, from disputes about whether a prescription was written for a medically accepted indication or whether the drug meets the statutory definition of a Part D-covered drug.

Source: Part D reconsideration and appeals data from CMS for 2010 through 2019.

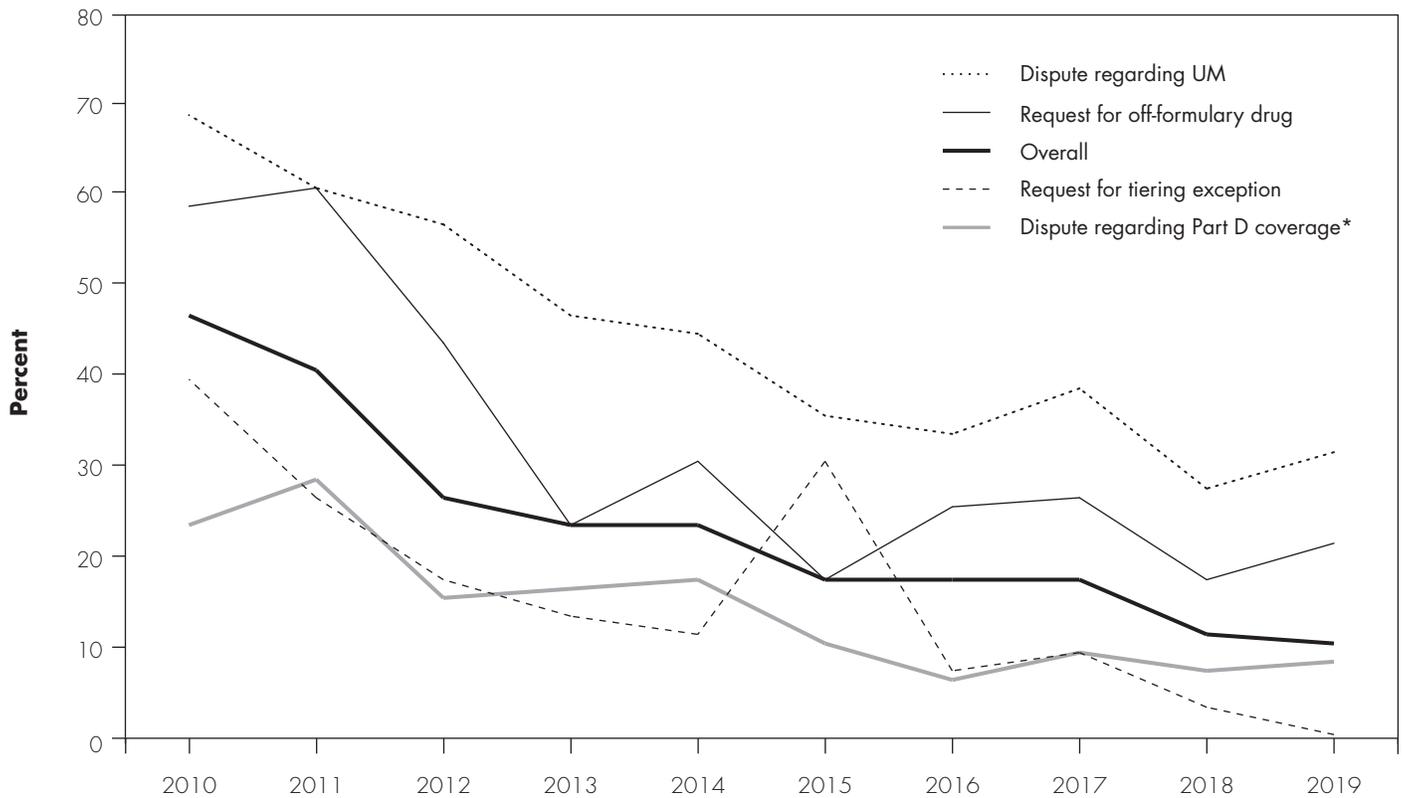
Between 2010 and 2019, the share of all appeals that were reversed by the IRE declined over time, from 47 percent to 11 percent (Figure 13-7). Despite fluctuations from year to year, all categories of appeals exhibited this general downward trend. These trends suggest that plans have improved their compliance with Part D's formulary rules and have applied rules consistently in their coverage determinations (Office of Inspector General 2018b).

Despite these improvements, some beneficiaries still face difficulty obtaining prescribed medicines. Each year, millions of prescriptions are rejected at pharmacies. Many of these pharmacy rejections may be appropriate, such as when the beneficiary has not met prior authorization requirements to ensure safe use. However, the Office of Inspector General found that some rejections were

inappropriate and avoidable, potentially delaying or deterring beneficiaries' access to needed medications (Office of Inspector General 2019).

Need to improve electronic communication between Part D plans and prescribers

A more constructive approach toward ensuring appropriate access would be to provide enrollees and prescribers with real-time information about formulary coverage and utilization management requirements in ways that fit into providers' workflow at the point of prescribing. Rather than relying on the exceptions and appeals process, a better approach would be to resolve questions about coverage with electronic tools, such as real-time benefit tools (RTBT) and electronic prior authorization (ePA).

**FIGURE
13-7****Reversal of plan coverage decisions by IRE has generally declined over time, 2010–2019**

Note: IRE (independent review entity), UM (utilization management). UM tools used by plan sponsors include prior authorization, step therapy, and quantity limits.
*Part D coverage issues may arise, for example, from disputes about whether a prescription was written for a medically accepted indication or whether the drug meets the statutory definition of a Part D–covered drug.

Source: Part D reconsideration and appeals data from CMS.

If built into the prescriber’s workflow, standardized approaches to ePA and automated coverage determinations could save patients and providers significant time and resources and speed up delivery of care (American Medical Association-convened workgroup of 17 state and specialty medical societies 2019). In 2019, CMS finalized a rule requiring Part D sponsors to implement one or more RTBC tools capable of integrating with at least one prescriber’s electronic health record system by January 1, 2021 (Centers for Medicare & Medicaid Services 2019c). However, the extent to which this requirement increases the use of RTBCs in Part D will depend on the degree to which clinicians—who face no requirements under this rule—adopt them when prescribing for their Medicare patients. In 2020, CMS issued a final rule that requires

Part D plan sponsors to implement real-time comparison tools for enrollees by January 1, 2023 (Centers for Medicare & Medicaid Services 2021).

For some beneficiaries, high OOP costs may be a barrier to access

More than 80 percent of Part D enrollees report that their Part D plans provide good value and that their OOP costs are reasonable (Medicare Today 2020). At the same time, in focus groups convened for the Commission, physicians and beneficiaries were acutely aware of high drug costs and reported having frequent discussions about ways to lower costs (Catterson et al. 2020). These seemingly conflicting results reflect the dichotomy between the majority of beneficiaries who take generic drugs for

common conditions and the relatively small number of beneficiaries who use many brand-name drugs or high-cost specialty drugs.

For an individual enrollee without the LIS, the cost-sharing burden for high-cost specialty drugs can be substantial, totaling thousands of dollars in the catastrophic phase of the benefit alone (Cubanski et al. 2019). (Most enrollees who receive Part D's LIS do not face a large financial hurdle because their cost sharing is limited to nominal copayments.) In recent years, even as Part D's coverage gap was closing, OOP costs incurred by beneficiaries who used specialty drugs rose because those individuals paid coinsurance on medicines with list prices that rose rapidly (Cubanski et al. 2019).

For many reasons, when generic specialty drugs have entered the market, beneficiaries have not always benefited from lower prices (Dusetzina et al. 2020b). For example, the list price differential between a generic and its brand counterpart may be relatively small. As a result, sponsors may continue to prefer the brand version that has lower costs for the plan owing to the coverage-gap discount and rebates paid by the manufacturer. Even when entries of multiple generic competitors result in substantially lower prices and plan sponsors adjust their formularies to prefer the generic version, beneficiaries may still pay relatively high OOP costs because the coverage-gap discount does not apply to generic drugs (Dusetzina et al. 2020b).

High cost sharing can result in beneficiaries not initiating therapy or abandoning prescriptions at the pharmacy (Doshi et al. 2018, Dusetzina et al. 2020b).⁴¹ For drugs placed on specialty tiers, beneficiaries have little recourse as they may not request a tiering exception to obtain the specialty-tier drugs at lower (preferred) cost sharing.⁴² It is not possible to measure the extent to which high prices are impeding access to needed medications. However, increases in the number of therapies that command very high prices is likely to increase the number of beneficiaries who face affordability issues (Dusetzina et al. 2020b, Park and Look 2020).

Quality in Part D

CMS collects quality and performance data to monitor sponsors' operations. A subset of data is used to rate plans in a 5-star system, from which CMS determines MA quality bonus payments. (Although both MA-PDs

and stand-alone PDPs are evaluated for quality with star ratings, only MA-PDs are eligible for quality bonus payments in the Part C payment system.) Quality data are also made available to the public to help beneficiaries evaluate their plan options during Part D's annual open enrollment period. Additionally, CMS requires plan sponsors to carry out medication therapy management (MTM) programs to improve the quality of pharmaceutical care for high-risk beneficiaries. Although the Commission supports CMS's goal of improving medication management, we have ongoing concerns about the effectiveness of plans' MTM programs. In 2017, CMS began a new, enhanced MTM model.

Measuring plan performance

CMS collects Part D quality and performance data at the contract level from several sources—the Consumer Assessment of Health Providers and Systems[®] (CAHPS[®]) survey, agency monitoring of plans, data furnished by plan sponsors, and claims information (Centers for Medicare & Medicaid Services 2020d).⁴³ Selected performance measures are available on the Plan Finder at www.medicare.gov to help beneficiaries evaluate their plan options during Part D's annual open enrollment period. The lowest rated plans are flagged to caution beneficiaries about choosing those plans. The highest rated plans can enroll beneficiaries outside the annual open enrollment period. In addition, for MA-PDs, Part D performance data affect the MA program's overall plan ratings used to determine the amount of bonus payment.

For 2021, Part D plan ratings are based on up to 14 metrics that measure plan performance on intermediate outcomes, patient experience and access, and process (Centers for Medicare & Medicaid Services 2020d). Intermediate outcome measures (four metrics, including adherence to selected classes of medications) typically each receive a weight of 3, but one (statin use in persons with diabetes) received a weight of 1 because it was a new measure. Weights for the seven measures related to patient experience and access (e.g., CAHPS survey results on ease with which plan members get needed medicines) were increased to 2.0 (from 1.5 for 2020). Two process measures (e.g., accuracy of drug prices posted on the Plan Finder) receive a weight of 1. Finally, drug plan quality improvement, a measure reflecting changes in drug plans' performance from one year to the next, is assigned the highest weight, which is 5 (Centers for Medicare & Medicaid Services 2020d). Most MA-PDs are rated on up to 44 measures that assess the quality of plan services

provided under the MA program, including 14 measures used to assess the quality of prescription drug (Part D) services provided. PDPs are evaluated only on scores for the 14 Part D measures.

CMS aggregates individual scores for each measure on the Plan Finder in a 5-star system; a 5-star rating reflects excellent performance, and 1 star reflects poor performance. Among PDPs, the average star rating for 2021 (weighted by 2020 enrollment) increased to 3.58 from 3.50 a year earlier (Centers for Medicare & Medicaid Services 2020b). About 42 percent of PDP enrollees (based on 2020 enrollment) are in 2021 contracts (covering one or more plans) with 4 or more stars, and another 35 percent are in contracts with 3.5 stars. Among MA-PDs offered for 2021, the average star rating decreased from 4.16 to 4.06. Based on 2020 enrollment, CMS estimated that just under 49 percent of MA-PD enrollees were in contracts rated 4 or more stars for 2021. However, as we noted in our chapter about the MA program, the current state of quality reporting in MA is such that we continue to question the reliability of the quality ratings for MA-PDs. Further, the MA-PD results are averaged across a much broader set of measures than the 14 metrics specific to Part D services. When comparing just Part D measures, MA-PDs had the same or lower values than PDPs on 8 of the 14 measures.

Star ratings are intended to provide useful information when enrollees are choosing among plan options with similar costs or when plan sponsors are evaluating certain areas for improvement. However, none of the beneficiaries who participated in the Commission's 2019 focus groups mentioned using Medicare's star ratings as information for choosing a health plan (Catterson et al. 2020). Instead, beneficiaries tended to choose a plan that had the lowest costs.

The Commission supports the use of quality measurements that are patient oriented, encourage coordination across providers, and promote positive change in the delivery system. Because the provision of prescription drug services is different from the provision of medical services, quality measures currently used for Part D may not help beneficiaries make informed choices among plan options.

For example, three intermediate outcome measures rate plans based on member adherence to select classes of medications. Because outcome measures are weighted more heavily than patient access and process measures, the three adherence measures have a disproportionate

impact on plan ratings. However, for prospective enrollees, medication adherence of current members is not likely an important factor when choosing among plan options. Additionally, plans are not in the best position to assess whether the prescribed medications were clinically appropriate. At the same time, measuring plans on member adherence to medications could encourage plans to structure benefits in a way to provide better access.

Medication therapy management programs

Part D plans are required to implement MTM programs to optimize therapeutic outcomes and reduce adverse drug events through improved medication use among beneficiaries who have multiple chronic conditions, take multiple medications, and are likely to have drug spending that exceeds an annual cost threshold (\$4,376 for 2021).

Plan sponsors are required to enroll, with opt-out provisions, all eligible enrollees in their MTM programs. At a minimum, MTM programs must offer a comprehensive medication review (CMR) at least annually and a targeted medication review (TMR) at least quarterly for ongoing monitoring and follow-up of any medication-related issues.⁴⁴ CMS has changed the criteria for MTM programs over time to broaden eligibility. Our earlier review of MTM programs revealed wide variations in eligibility criteria and the kinds of interventions provided to enrollees (Medicare Payment Advisory Commission 2009). Today, plan sponsors can no longer set eligibility criteria narrower than requiring beneficiaries to have more than three chronic conditions or use more than eight medications.⁴⁵

In focus groups convened for the Commission in 2020, clinicians and beneficiaries both reported having routine reviews of their medications (Catterson et al. 2020). Some beneficiaries believed they were on too many medications while clinicians described frequently managing patient requests for more drugs (Catterson et al. 2020). In previous focus groups, several primary care doctors gave examples of cases in which an insurer had caught polypharmacy problems. However, many clinicians reported that obtaining a complete list of medications taken by their patients continues to be a challenge (Catterson et al. 2020).

We continue to be concerned that sponsors of stand-alone PDPs do not have financial incentives to engage in MTM or other activities that, for example, reduce unnecessary medical expenditures. CMS's analysis of the data found lower rates of medication reviews among MTM enrollees in PDPs compared with those in MA-PDs. Further, the

effectiveness of the current MTM services in improving the quality of overall patient care is unclear (Centers for Medicare & Medicaid Services 2016, Marrufo et al. 2013).

In 2017, CMS implemented an enhanced MTM model to test whether payment incentives and greater regulatory flexibility in designing MTM programs would lead to “improved therapeutic outcomes, while reducing net Medicare expenditures” (Center for Medicare & Medicaid Innovation 2015). However, as noted earlier, the evaluation of the first two years of the five-year demonstration program found no significant reductions in Medicare

spending for Part A and Part B services among enrollees in enhanced MTM plans.

The Commission is generally supportive of providing Part D plan sponsors with regulatory flexibility combined with appropriate financial incentives to improve the pharmaceutical services provided under the program. We encourage the agency to continue to explore the kinds of intervention strategies that may be effective in improving pharmaceutical care and health outcomes for beneficiaries, as well as how MTM or other services could improve health outcomes and lower medical spending. ■

Endnotes

- 1 Even today, when the defined standard benefit has 25 percent coinsurance in both the initial coverage phase and coverage-gap phase, many Part D plans structure their cost sharing differently across the two phases, with copayments for generics and preferred drugs initially, but 25 percent coinsurance in the coverage gap.
- 2 A small share of LIS enrollees (about 3 percent) with slightly higher levels of income or assets receive a partial subsidy. In 2021, those individuals pay a \$92 deductible and 15 percent coinsurance on prescriptions up to the OOP threshold. Above the OOP threshold, those LIS enrollees pay \$3.70 for each generic prescription and \$9.20 for brand prescriptions.
- 3 For example, in 2021, generic tiers must have a per prescription copayment of \$20 or less or charge coinsurance of 25 percent or less in the benefit phase between the deductible and the initial coverage limit. Plans may not use copayments of more than \$100 or coinsurance higher than 50 percent for drugs on nonpreferred tiers (Centers for Medicare and Medicaid Services 2020).
- 4 CMS calculates benchmarks using a weighted average of both PDP and MA–PD premiums. For plans that offer enhanced coverage, CMS uses the portion of the plan’s premium that reflects the cost of basic coverage. For MA–PDs, CMS uses plans’ premiums for basic coverage before plan sponsors have applied any MA rebates (a portion of the difference between the MA payment rate and plans’ bids to provide Part A and Part B services) to reduce or eliminate the premium. The weight for each plan equals its share of LIS enrollment.
- 5 The small share of LIS enrollees who receive a partial subsidy pay a portion of the premium for most PDPs, including those with premiums below the LIS benchmark.
- 6 Under CMS’s de minimis policy, plan sponsors may voluntarily waive the portion of the monthly adjusted basic beneficiary premium that is above the LIS benchmark for a subsidy-eligible individual, up to a de minimis amount. The de minimis amount for 2021 is \$2.
- 7 Instead of accepting the new assignment, LIS enrollees may choose a plan themselves. However, if their selected plan has a premium higher than the benchmark, the LIS enrollee must pay the difference between the plan’s premium and the benchmark amount.
- 8 Beneficiaries who are current or former Part D enrollees can be auto-enrolled for a variety of reasons, such as losing and then regaining their LIS and Part D coverage, moving out of their plan’s service area, asking to disenroll from their current plan without selecting a new plan, or failing to pay the premium for their current plan.
- 9 EGWPs are sponsored by employers that contract directly with CMS or on a group basis with an insurer or pharmacy benefit manager to administer the Part D benefit. They differ from employer plans that receive the RDS in that Medicare Part D is the primary payer rather than the employer.
- 10 A portion of the difference between an MA plan’s payment benchmark and its bid for providing Part A and Part B services is referred to as “MA rebate dollars.” Plan sponsors can use MA rebate dollars to supplement benefits or lower Part D, Part B, or MA premiums for supplemental benefits.
- 11 After the end of each benefit year, CMS reconciles what plans expected to receive in reinsurance subsidies from Medicare with reinsurance due based on 80 percent of their enrollees’ actual catastrophic spending net of rebates. On net, Medicare has made additional payments to plans for individual reinsurance at reconciliation in nearly every year except 2017, meaning that actual costs were higher than plans’ expected reinsurance costs that were used to calculate enrollee premiums. This effectively results in a higher overall Medicare subsidy rate than the 74.5 percent target set in law.
- 12 Most MA plans are MA–PDs, offering combined medical and outpatient drug benefits. However, a small share of MA plans (including Medicare Savings Account plans) do not offer prescription drug coverage.
- 13 That number includes 13 plans that had premiums within \$2 of their regional LIS threshold. The plan sponsors chose to waive the de minimis premium amount so that LIS enrollees would pay no premium in those plans.
- 14 CMS will pay participating plans 30 percent of any savings up to 3 percent of the difference between actual reinsurance and the plan’s benchmark, and 50 percent of savings beyond 3 percent. If reinsurance costs are higher than the plan’s benchmark, the plan pays 10 percent of that difference.
- 15 Conditions targeted by participating plans include coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and hypertension.
- 16 For 2021, the over 1,600 participating plans are offered by 76 plan sponsors, including 5 plan sponsors offering stand-alone PDP options nationwide (Centers for Medicare & Medicaid Services 2020j).

- 17 Among stand-alone PDPs, market concentration at the level of a PDP region (one of 34 states or combinations of states) can be high. Using the Herfindahl-Hirschman Index, a measure of market concentration used by the Department of Justice and Federal Trade Commission to evaluate mergers, in 2020, 33 of 34 PDP regions had moderately concentrated PDP enrollment and one region (Hawaii) was highly concentrated. When focusing on LIS enrollment in PDPs, 22 regions were moderately concentrated and 11 were highly concentrated.
- 18 Some pharmacies choose not to contract with certain plans because they do not like the terms and conditions the plans offer. Plan sponsors are not obligated to cover prescriptions at an out-of-network pharmacy, except under certain circumstances.
- 19 Plan sponsors cannot restrict access to a subset of network pharmacies unless dispensing a drug requires “extraordinary specialty handling, provider coordination, or patient education that cannot be met by a network pharmacy” (Centers for Medicare & Medicaid Services 2011). An exception is made if a manufacturer uses a limited distribution network. In this situation, the Part D enrollee would be able to fill that prescription at only one of the designated specialty pharmacies.
- 20 Postsale pharmacy fees and discounts made up the remaining \$4 billion (Centers for Medicare & Medicaid Services 2018b).
- 21 DIR is shared between Medicare and Part D plan sponsors to offset their respective benefit liabilities. Medicare retains a portion of the DIR equal to 80 percent of gross spending above Part D’s OOP threshold divided by total gross spending (i.e., gross reinsurance as a share of total gross spending) and plan sponsors retain the remainder.
- 22 The predicted spending excludes the value of Medicare’s individual reinsurance subsidies because that risk is borne by Medicare rather than by the plan.
- 23 For our analysis, we assumed that, in 2018, Part D sponsors received manufacturer rebates for insulin and tumor necrosis factor (TNF) inhibitors that averaged 50 percent and 20 percent, respectively, of their corresponding gross Part D sales. Both figures are below the average rebates and discounts manufacturers paid to participants in the drug supply chain (Herman 2020, Hernandez et al. 2020, Indianapolis Business Journal 2016, Kakani et al. 2020, Langreth et al. 2016). To be conservative, we also assumed that manufacturers would include the amount they would owe in coverage gap discount as part of the overall rebates they would pay to plan sponsors. These assumptions resulted in effective discount rates of 43 percent for insulins and 17 percent for TNF inhibitors.
- 24 The current version of the RxHCC model estimates five sets of model coefficients for long-term institutional enrollees, aged low-income enrollees, aged non-low-income enrollees, disabled low-income enrollees, and disabled non-low-income enrollees. The use of a single community segment model is a divergence from the method used by CMS. However, our model structures and methods (linear regression with restrictions imposed to ensure hierarchy among RxHCCs) are consistent with the current version of the RxHCC model that has been in use since 2018.
- 25 While there has not been a formal *Federal Register* publication of withdrawal of the proposed rule, if being listed as withdrawn on the OMB website qualifies as an official withdrawal, HHS would have to start over with a new notice of proposed rulemaking.
- 26 Specifically, we compared the risk-adjustment factors with and without rebates for the following condition categories: RxHCC30 (diabetes with complications), RxHCC31 (diabetes without complications), RxHCC241 (diabetic retinopathy), RxHCC311 (chronic ulcer of skin, except pressure), RxHCC67 (inflammatory bowel disease), RxHCC82 (psoriatic arthropathy and systemic sclerosis), RxHCC83 (rheumatoid arthritis and other inflammatory polyarthropathy), and RxHCC316 (psoriasis other than arthropathy).
- 27 Using plan sponsors’ assumptions about rebates from their 2020 bids, the Medicare Trustees estimated that direct and indirect remuneration (DIR)—consisting predominantly of manufacturers’ rebates, but also pharmacy concessions after the point of sale—amounted to 28.4 percent of total drug costs (averaged across all drugs, including those for which plans do not receive any rebates) (Boards of Trustees 2020, Weintraub 2019). This amount is a significant increase from DIR in 2007 of about 9.6 percent, and even from 2015, when the intensified competition in the hepatitis C drug market resulted in higher DIR (18.3 percent) than expected.
- 28 An individual NDC uniquely identifies the drug’s labeler, drug, dosage form, strength, and package size.
- 29 For this index, Acumen groups NDCs that are pharmaceutically identical, aggregating prices across drug trade names, manufacturers, and package sizes. As a result, brand-name drugs are grouped with their generics if they exist, and this price index more closely reflects the degree to which market share has moved between the two. The “patent cliff” refers to a year in which manufacturers of widely used brand-name drugs lost market power over pricing because of expirations of patents and periods of exclusivity.
- 30 In 2018, relative to the average per beneficiary cost of Copaxone, the costs of the generic versions were about 63

- percent lower for glatiramer acetate by Mylan N.V. and 53 percent lower for Glatopa by Sandoz Pharmaceuticals owned by Novartis A.G. (Centers for Medicare & Medicaid Services 2019b).
- 31 In 2019, generic drugs accounted for about 87 percent of all Part D drugs dispensed and 21 percent of total Part D spending (Boards of Trustees 2020).
 - 32 Between 2007 and 2019, the number of Part D beneficiaries without the low-income subsidy grew, on average, by just over 7 percent annually.
 - 33 The amounts reflect an average mix of drugs for a beneficiary who does not receive Part D's low-income subsidy and who has no other supplemental coverage.
 - 34 Examples of medications in which a single claim was sufficient to reach the catastrophic phase of the benefit include newer antivirals for the treatment of hepatitis C, antineoplastics, and certain medications used for the treatment of pulmonary hypertension.
 - 35 The transition fill is a temporary one-time supply provided within the first 90 days of coverage in a new plan or the new contract year for existing enrollees.
 - 36 Plan sponsors must make coverage determination and exception decisions within 72 hours of a request or within 24 hours for expedited requests. If the initial exceptions request does not include the necessary supporting statement, the plan has up to 14 calendar days to obtain the information. See March 2020 Report to the Congress for more detail (Medicare Payment Advisory Commission 2020d).
 - 37 CMS audits a selection of sponsoring organizations each year for compliance with program requirements, ultimately covering most plan sponsors over its several-year work cycle. 2018 was the fourth year of the four-year audit cycle, and sponsors selected from those not yet audited for the work cycle that tended to be smaller sponsors. The addition of the approximately 2 percent of beneficiaries enrolled in the MA and Part D programs in 2018 brought the total percentage of beneficiaries covered during the audit cycle to 95 percent (Centers for Medicare & Medicaid Services 2019a).
 - 38 Because the calculated audit score uses the number of noncompliant conditions discovered, the maximum audit score is unlimited. For most of the program areas, the highest score obtained by any plan sponsor was less than 3.0 (Centers for Medicare & Medicaid Services 2020a).
 - 39 Until recently, CMS required Part D plan sponsors to report data on rejected pharmacy claims. However, that information provided only limited insight into the exceptions and coverage determination process because counts of pharmacy claims and rejections often contain duplicate records. Moreover, data are not available on what happens once a plan rejects a claim—for example, whether the beneficiary was ultimately able to fill the original prescription, obtained an alternative therapy, or abandoned the prescription. As of 2019, sponsors are no longer required to submit rejected pharmacy claims unless under audit.
 - 40 For example, in 2017, less than 5 percent of redeterminations were appealed or automatically forwarded to an IRE (Office of Inspector General 2019).
 - 41 The relationship between higher cost sharing and adherence, treatment initiation, or the rate of prescription abandonment is likely to vary widely across therapeutic classes. For example, patients may be less sensitive to higher cost sharing for certain cancer treatments compared with therapies for chronic conditions such as rheumatoid arthritis (Medicare Payment Advisory Commission 2019).
 - 42 Part D enrollees can apply to bona fide independent charity patient assistance programs (PAPs) for help with cost sharing. Pharmaceutical manufacturers can provide cash donations to independent charity PAPs without invoking anti-kickback concerns if the charity is structured properly. However, recent enforcement actions regarding manufacturer donations to charities suggests some PAPs may be in violation of the anti-kickback statute (Office of Inspector General 2018a, Sagonowsky 2017).
 - 43 Due to concerns related to the COVID-19 public health emergency, CMS eliminated the requirement to submit Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey data for the 2021 star ratings. The 2021 Part D star rating measures calculated based on CAHPS data were replaced with earlier values from the 2020 star ratings (Centers for Medicare & Medicaid Services 2020e).
 - 44 CMRs must include an interactive person-to-person or telehealth consultation performed by a pharmacist or other qualified provider and a written summary of the review that includes a medication list and action plan, if any, provided to beneficiaries in CMS's standardized format. A TMR is distinct from a CMR because it is focused on specific medication-related problems, actual or potential. A TMR can be conducted person to person or be system generated, and interventions can be delivered by mail or faxed to the beneficiary or the prescriber, as appropriate (Centers for Medicare & Medicaid Services 2014).
 - 45 42 CFR section 423.153(d).

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CHAPTER

14

**Telehealth in Medicare
after the coronavirus
public health emergency**

Telehealth in Medicare after the coronavirus public health emergency

Chapter summary

During the coronavirus public health emergency (PHE), the Congress and CMS have temporarily expanded coverage of telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and reduce their risk of exposure to COVID-19. Hospitals, physicians, and other providers have responded by rapidly adopting telehealth to provide continued access to medical care for their patients. Without legislative action, many of the changes will expire at the end of the PHE.

Although the temporary telehealth expansions affect virtually all settings of care, most of the changes affect the services paid under the physician fee schedule (PFS). Prior to the PHE, Medicare paid for a limited number of telehealth services only if they were provided to beneficiaries in a clinician's office or a facility in a rural area. Most telehealth services were paid at the lower PFS rate used to pay clinicians providing care in facilities, such as hospital outpatient departments (the facility-based rate), rather than the higher rate used to pay office-based clinicians (the nonfacility rate), because the practice expenses associated with furnishing telehealth services were presumed to be lower. During the PHE:

- Clinicians may bill for specified telehealth services provided to Medicare beneficiaries in any location, including their homes, and in urban as well as rural areas.

In this chapter

- Use of telehealth during the public health emergency
- Telehealth expansions in FFS Medicare after the public health emergency
- Additional safeguards needed to protect Medicare and beneficiaries against telehealth-related unnecessary spending and fraud

- CMS has added over 140 PFS services to the list of services it will pay for when delivered through telehealth (e.g., emergency department visits, observation and inpatient care, nursing facility care, and home visits). Clinicians can bill for some of these services if they are provided using audio-only interaction, and CMS added new codes for audio-only evaluation and management visits.
- CMS pays the same rate it would pay if the service were provided in person (the PFS's facility-based or non-facility-based rate, depending on the clinician's location).
- Clinicians may reduce or waive beneficiaries' cost-sharing obligations for telehealth services.

CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect these telehealth expansions will remain in place throughout the PHE. There is ongoing debate about whether the expansions should be made permanent. The Commission has previously recommended that policymakers use the principles of access, quality, and cost to evaluate individual telehealth services before covering them under Medicare. There are some clinical trials comparing telehealth and in-person care, but at this time, there is not yet evidence on how the combination of telehealth and in-person care affects quality and costs in the Medicare program.

In this chapter, we present a policy option for expanding fee-for-service Medicare's coverage of telehealth services after the PHE. Under this policy option, policymakers should temporarily continue the following telehealth expansions for a limited duration (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on access, quality, and cost, and they should use this evidence to inform any permanent changes. During this limited period:

- Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location.
- Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit.
- Medicare should temporarily cover certain telehealth services when they are provided through an audio-only interaction if there is potential for clinical benefit.

After the PHE ends, Medicare should return to paying the fee schedule's facility rate for telehealth services and collect data on the cost of providing these services.

In addition, providers should not be allowed to reduce or waive cost sharing for telehealth services after the PHE. CMS should also implement other safeguards to

protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth, including:

- applying additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians;
- requiring clinicians to provide an in-person, face-to-face visit before they order high-cost durable medical equipment or high-cost clinical laboratory tests; and
- prohibiting “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly.

This chapter also describes CMS’s existing authority to offer telehealth flexibilities to clinicians participating in advanced alternative payment models, such as accountable care organizations. ■

Background

Telehealth includes health care services delivered through a range of online, video, telephone, and other communication methods. Although many providers across multiple settings may deliver services via telehealth, Medicare does not always pay separately for such services. This chapter focuses on telehealth services that Medicare pays for separately under the physician fee schedule (PFS). Under the PFS, Medicare is limited by statute to paying only for telehealth services provided to beneficiaries who receive the service at a clinician’s office or certain health care facilities (known as “originating sites”) located in a rural area, with some exceptions (e.g., recent legislation covered mental health services provided by telehealth in urban and rural areas and in patients’ homes).¹ To increase access to care and help limit community spread of COVID-19 during the public health emergency (PHE), Medicare temporarily has expanded coverage of telehealth to all Medicare beneficiaries, including telehealth visits provided to patients at home.² Table 14-1 describes some of Medicare’s telehealth policies in the PFS before the PHE

and during the PHE (see text box, pp. 473–474 for more information about Medicare’s coverage and payment for telehealth services prior to the PHE).

During the PHE, many providers and patients have embraced telehealth, and there are calls to permanently implement the expansions. CMS made these changes quickly out of necessity, and we applaud the agency for acting rapidly to preserve access to care during the PHE. We expect the telehealth expansions will continue throughout the PHE. This chapter presents a policy option for policymakers and the Congress to consider in expanding telehealth in Medicare after the PHE.

Use of telehealth during the public health emergency

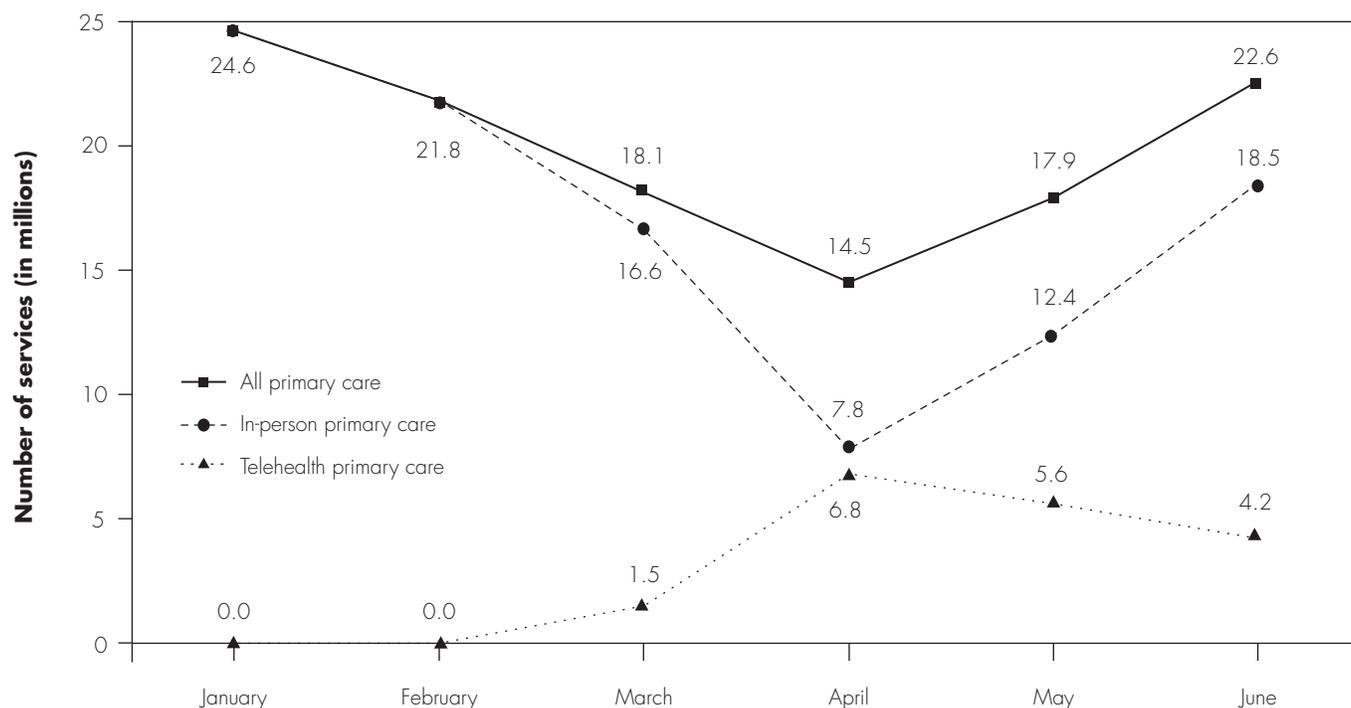
The coronavirus pandemic had tragic effects on beneficiaries’ health in 2020 and changed the demand for and delivery of health care. In the physician sector, demand for telehealth services soared as providers and beneficiaries sought to reduce the spread of infection by avoiding in-person visits. According to our analysis of

**TABLE
14-1**

Selected temporary telehealth expansions to the physician fee schedule during the public health emergency

	Pre-PHE	During the PHE
Who can receive telehealth services?	Clinicians can provide telehealth services to Medicare beneficiaries in certain originating sites in rural areas (e.g., a clinician’s office or hospital but not the beneficiary’s home).	Clinicians may provide telehealth services to Medicare beneficiaries outside of rural areas and in the patient’s home.
Which types of telehealth services does Medicare pay for?	Limited set of services (does not include audio-only E&M visits).	CMS pays for over 140 additional services (e.g., emergency department visits, radiation treatment management). CMS allows audio-only interaction for some of the telehealth services and covers audio-only E&M codes.
How much does Medicare pay for telehealth services?	PFS rate for facility-based services (less than the nonfacility rate).	PFS rate is the same as if the service were furnished in person (facility or nonfacility rate, depending on the clinician’s location). Same for audio-only visits.
What are the costs to beneficiaries?	Standard cost sharing.	Clinicians are permitted to reduce or waive cost sharing.

Note: PHE (public health emergency), E&M (evaluation and management), PFS (physician fee schedule). Under the PFS, clinicians who provide services in facilities such as hospitals receive a lower payment rate (the facility rate) than clinicians who provide services in offices (the nonfacility rate).

**FIGURE
14-1****Primary care services provided via telehealth partially offset the drop in the number of in-person services, January–June 2020**

Note: Primary care services include the following physician fee schedule services: office/outpatient evaluation and management (E&M) visits, home E&M visits, E&M visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.

Source: Analysis of Medicare claims data for 100 percent of fee-for-service beneficiaries.

fee-for-service (FFS) Medicare claims data, there were 8.4 million telehealth services paid under the PFS in April 2020, compared with 102,000 in February 2020. The number of telehealth services declined to 5.6 million in June 2020 (the latest month for which we have complete claims data), as the number of in-person services began to rebound. More than three-quarters (78 percent) of the telehealth services provided to FFS beneficiaries during the first six months of 2020 were primary care services, and 31 percent of the primary care services were audio-only evaluation and management (E&M) visits.³ During the first 6 months of 2020, 10.3 million beneficiaries in FFS Medicare (32 percent of the total) received at least one telehealth service, compared with 134,000 beneficiaries during the first 6 months of 2019.

The growth of telehealth services partially offset the drop in the use of in-person services in March and April.

Between January and April 2020, the number of in-person primary care services provided to FFS beneficiaries dropped steeply from 24.6 million to 7.8 million (Figure 14-1). The share of all primary care services delivered by telehealth rose dramatically from less than 1 percent in January to 47 percent in April. The share declined to 31 percent in May and 18 percent in June as in-person primary care services rebounded.

Telehealth expansions in FFS Medicare after the public health emergency

The Congress and CMS are under pressure to make the telehealth expansions permanent after the PHE, and both are considering such policy changes (Association of American Medical Colleges 2020, Ross 2020). Many

providers and beneficiaries have described the benefits of increased access and convenience from telehealth during the PHE. Advocates of telehealth services assert that these services can expand access to care, increase convenience to patients, improve quality, and reduce costs relative to in-person care. Others caution, however, that under FFS Medicare, telehealth services could supplement—rather than substitute for—in-person services, thereby increasing spending for payers and patients (Ashwood et al. 2017, Mehrotra et al. 2020). Telehealth could lead to higher volume if telehealth providers induce demand for their services or if the greater convenience of telehealth leads beneficiaries to use telehealth services more frequently than in-person services. Expanding telehealth services also raises program integrity concerns. Telehealth companies have been involved in several large fraud cases, resulting in several billions of dollars in losses for Medicare. For example, the Department of Justice (DOJ) recently charged defendants—including telemedicine companies—with submitting false and fraudulent claims worth more than \$4.5 billion to federal health programs and private insurers (Department of Justice 2020). Telehealth technology might make it easier to carry out fraud on a large scale because clinicians employed by fraudulent telehealth companies can interact with many beneficiaries from many parts of the country in a short amount of time. In addition, if telehealth is expanded and beneficiaries become more comfortable receiving care through telehealth, they might become more vulnerable to being exploited by companies that pretend to be legitimate telehealth providers. For these reasons, Medicare has historically been cautious about covering telehealth services. In considering a permanent expansion of telehealth, a key issue is how to achieve the benefits of telehealth while limiting the risks to beneficiaries and the program.

Clinicians who participate in advanced alternative payment models (A-APMs), such as accountable care organizations, have greater flexibility to bill for telehealth services than other clinicians in FFS Medicare (see text box on A-APMs, pp. 464–465). These flexibilities preceded the PHE and will continue after it ends. Therefore, the Commission’s work focuses on expansions of telehealth services in FFS Medicare outside of A-APMs.

We discuss a policy option for expanding Medicare’s coverage of telehealth services after the PHE. In developing the policy option, the Commission maintains its previous recommendation that policymakers should

use the principles of access, quality, and cost to evaluate individual telehealth services before covering them under Medicare (Medicare Payment Advisory Commission 2018b). There are some clinical trials comparing telehealth and in-person care, but at this time, there is not yet evidence on how the combination of telehealth and in-person care affects quality and costs in the Medicare program. Therefore, policymakers should temporarily continue some elements of the telehealth expansions for a limited duration (e.g., one to two years) after the PHE to gather more evidence about the impact of the expansions on access, quality, and cost, and use this evidence to inform any permanent policy. Other elements of the policy option, such as how much to pay for telehealth services, address how Medicare’s telehealth policies should change immediately after the PHE ends.

Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location

Prior to the PHE, Medicare paid for telehealth services provided to beneficiaries who received them at certain locations (known as “originating sites”) in rural areas. During the PHE, Medicare has temporarily expanded payment for telehealth services provided to all Medicare beneficiaries, including to patients at home. During focus groups we held in the summer of 2020, clinicians and beneficiaries supported continued access to telehealth visits with some combination of in-person visits. They cited benefits of telehealth, including improved access to care for those with physical impairments, increased convenience from not traveling to an office, and increased access to specialists outside of a local area. In our annual beneficiary survey, over 90 percent of respondents who had a telehealth visit reported being “somewhat” or “very satisfied” with their video or audio visit, and nearly two-thirds reported being “very satisfied.” Although telehealth can improve convenience and access, it is unclear how expanded availability of telehealth affects clinical outcomes and program spending outside of the PHE. Consequently, the Commission maintains that the Congress should temporarily give CMS the authority to pay for telehealth services provided to all FFS beneficiaries (regardless of geographic location), including to beneficiaries at home. After a period of time, policymakers should use data collected during this period in considering whether any permanent policy changes should be implemented, weighing the principles of access, quality, and cost.

CMS has granted additional telehealth flexibilities to clinicians in advanced alternative payment models

CMS has provided clinicians in certain advanced alternative payment models (A-APMs) that have prospective beneficiary assignment with additional flexibility to bill Medicare for Part B services, including telehealth services. For example, the Center for Medicare & Medicaid Innovation (CMMI) created a waiver for Next Generation accountable care organizations (ACOs) that allows clinicians in an ACO to bill for telehealth services provided to their aligned beneficiaries in urban or rural areas and to beneficiaries at home.⁴ They can bill for any service on CMS's approved list of telehealth services that is provided to beneficiaries in an originating site other than their home (e.g., a hospital or clinician's office) in an urban or rural area. They can bill for a smaller set of telehealth services provided to beneficiaries in their home, such as evaluation and management visits. Between 2016 and 2018, four Next Generation ACOs (8 percent of the total) used this waiver to provide telehealth services (NORC at the University of Chicago 2020).⁵ In addition to the telehealth waiver, CMMI also allows

Next Generation ACOs to waive cost sharing for Part B services, which may include telehealth services.

CMS allows Medicare Shared Savings Program (MSSP) ACOs that bear two-sided risk and have prospective beneficiary assignment to bill for telehealth services provided to their aligned beneficiaries in urban or rural areas and to beneficiaries at home.⁶ Clinicians in these ACOs are allowed to bill for any service on CMS's approved list of telehealth services. However, they can only bill for telehealth services provided to beneficiaries at home if such services are appropriate to furnish in a home (e.g., not inpatient visits).

There are potential benefits to allowing telehealth flexibilities for clinicians in A-APMs. First, the Commission has long supported the evolution of Medicare from fee-for-service to value-based payment such as A-APMs (Medicare Payment Advisory Commission 2020). Waiving telehealth restrictions for clinicians in A-APMs could be another incentive

(continued next page)

Temporarily allowing clinicians to bill for telehealth services provided to beneficiaries in any location also raises questions about the role of telehealth vendors in Medicare (see text box, pp. 466–467).

Medicare should temporarily cover selected telehealth services in addition to services covered before the PHE if there is potential for clinical benefit

Prior to the PHE, CMS allowed clinicians to bill for about 100 services provided by telehealth to beneficiaries in rural areas. CMS has established a regulatory process and criteria to review whether a service should be added or deleted from the list of allowable telehealth services. The criteria include whether the service is similar to an existing telehealth service in authorizing legislation or whether it demonstrates clinical benefit (see text box on

CMS's process for revising the list of allowable telehealth services, p. 468). Citing clinical benefit during the PHE, CMS has temporarily added over 140 PFS services to the list of telehealth services that Medicare will pay for, such as emergency department visits, radiation treatment management, and home visits. CMS has recently added nine of these services to the allowable telehealth services list, which means they will be permanently covered after the PHE. CMS has also allowed about 60 of these telehealth services to be billable through the calendar year in which the PHE ends to gather more evidence of potential clinical benefit (Centers for Medicare & Medicaid Services 2020c).

Some of the services added temporarily to the list of allowable telehealth services could improve access and quality or reduce program spending after the PHE.

CMS has granted additional telehealth flexibilities to clinicians in advanced alternative payment models (cont.)

for clinicians to participate in these models. Second, because A-APMs require providers to assume at least some financial risk for Medicare spending or utilization and to be held accountable for quality of care, they have an incentive to improve quality while restraining the growth of spending or utilization. This incentive mitigates the concern that a broad expansion of telehealth could lead to additional Medicare spending. If telehealth leads to additional spending by an A-APM, this higher spending would be at least partially offset by penalties or lower bonuses.

However, there are some drawbacks to granting additional flexibilities to clinicians in A-APMs. First, doing so could be administratively complex for clinicians. We assume that telehealth and cost-sharing flexibilities would apply only to beneficiaries who are prospectively assigned (i.e., assigned at the beginning of a performance period) to an A-APM entity because clinicians would need to know at the time of the service whether a beneficiary is eligible for a telehealth or cost-sharing waiver. Some A-APM models use retrospective assignment, in which beneficiaries are

assigned to an entity at the end of a performance year. For example, MSSP ACOs have the option to choose retrospective assignment, in which beneficiaries are provisionally assigned to an ACO at the beginning of the performance year but final assignment is made at the end of the year. Consequently, a clinician in an ACO that uses retrospective assignment will not know definitively at the time of service whether a beneficiary is eligible for a waiver because the beneficiary's final assignment will not be determined until the end of the year. If this clinician provides a telehealth service under a waiver to a beneficiary who is not assigned to the clinician's ACO at the end of the year, the telehealth service could be denied. Therefore, to take advantage of a telehealth or cost-sharing waiver, clinicians in an A-APM would need to keep track of which of their Medicare patients are in their A-APM, which could be complicated because clinicians in an A-APM often see patients who are not assigned to their A-APM. Second, beneficiaries are often not familiar with ACOs and may be confused if they are treated differently by ACO clinicians than by other clinicians. ■

Therefore, CMS should continue to temporarily cover select services that the agency determines have the potential for clinical benefit. We favor this approach instead of permanently covering all of the telehealth services that are temporarily covered during the PHE. After a period of time, policymakers should use information gathered during the temporary period of coverage to consider permanently covering the additional telehealth services based on the principles of access, quality, and cost.

Medicare should temporarily cover certain telehealth services when provided by audio-only interaction if there is potential for clinical benefit

Telehealth services payable by Medicare must be furnished using an interactive telecommunications system that includes two-way audio and video communication technology (Centers for Medicare & Medicaid Services

2020c). During the coronavirus PHE, however, CMS has waived this requirement because not all beneficiaries have the capability to engage in a video telehealth visit from their home. Specifically, during the PHE, CMS allows audio-only interactions to meet the requirements for some telehealth services based on the agency's clinical assessment (Centers for Medicare & Medicaid Services 2020b). For example, CMS pays for most behavioral health services that are provided through audio-only interaction, but not for audio-only physical therapy or eye exams. Telehealth services that are payable when provided by audio-only interaction are paid the same rates as those provided by audiovisual telehealth.

Allowing audio-only interaction for certain telehealth services can improve beneficiary choice and equity in access to care for beneficiaries who do not have access to the technology for a video telehealth visit. Also, during the Commission's clinician and beneficiary focus

Vendors that provide direct-to-consumer telehealth services

Several vendors currently provide a range of telehealth services and technologies, from direct-to-consumer (DTC) telehealth visits for urgent care to the technology needed to enable telehealth communication. Telehealth companies also often have relationships with commercial, Medicaid, and Medicare Advantage health plans as well as employers to supply both the clinicians and technology to offer telehealth visits. As telehealth and digital health continue to evolve, the range of services offered by these companies will also continue to grow. This text box presents some preliminary research into telehealth vendors and their role in traditional Medicare.

Health systems currently work with telehealth vendors in several ways. Some systems outsource telehealth services to a company that supplies both the clinicians and the technology to perform telehealth visits. Health systems can also work in partnership with vendors, where the health system's clinicians perform telehealth visits using a vendor's technology. These two approaches can also be combined, with a health system's clinicians staffing telehealth visits during normal business hours

and a telehealth company supplying both the technology and the staff for after-hours visits. Some systems also contract with vendors to provide telehealth visits to patients who are seeking care in a state where the system's providers are not licensed.

Prior to the public health emergency (PHE), DTC telehealth vendors did not typically bill traditional fee-for-service (FFS) Medicare because their services were generally provided in a patient's home. With the expansion of telehealth services to all beneficiaries in their homes during the PHE, clinicians who provide services through these companies now have the option to bill Medicare. One vendor (Doctor on Demand) stated that it enrolled some of its employed primary care clinicians in FFS Medicare, set up a process to check patient eligibility, and is working on the connectivity to transmit Medicare claims (Jennings 2020). Doctor on Demand is currently waiving cost sharing for Medicare Part B beneficiaries (Doctor on Demand 2020). Another company (MDLive) has announced it is preparing to offer telehealth services to Medicare Part B beneficiaries (Jennings 2020).

(continued next page)

groups conducted in the summer of 2020, we learned that sometimes a scheduled telehealth visit would switch to audio-only because of technical issues at the start of the visit. Since Medicare has not previously covered audio-only interactions, there is limited evidence on the quality and cost effects. Under the Commission's policy option, CMS should continue to temporarily cover some telehealth services delivered through an audio-only interaction when the agency determines there is potential for clinical benefit. These services should include audio-only E&M visits with established patients. After a period of time, policymakers should consider permanently allowing audio-only interaction for some telehealth services while weighing the principles of access, quality, and cost.

After the PHE ends, Medicare should return to paying the fee schedule's facility rate for telehealth services and collect data on the cost of providing these services

Prior to the PHE, most telehealth services generated two Medicare payments: (1) a payment to the originating site where the beneficiary was located (e.g., a clinician's office or hospital) and (2) a payment to the clinician at the distant site who provided the telehealth service. In 2021, Medicare pays the originating site a flat fee of \$27 per service. However, CMS does not pay an originating site fee if the beneficiary is not located at an originating site (e.g., if the beneficiary is at home). Medicare pays the clinician at the distant site a PFS payment based on the type of service provided (e.g., an E&M office/

Vendors that provide direct-to-consumer telehealth services (cont.)

Temporarily allowing clinicians to bill for telehealth services provided to beneficiaries in their home raises questions about the role of these DTC telehealth vendors in Medicare. These companies can expand access to urgent care if a beneficiary's primary care provider is not accessible when the patient needs such care. They might also provide behavioral health services, which could improve beneficiaries' access to these services. However, if beneficiaries receive DTC services from clinicians who are not their usual source of care, their care may become fragmented.

The Commission's policy option would allow providers—including clinicians who provide services through a DTC telehealth vendor—to temporarily bill Medicare for telehealth services provided to beneficiaries in their home, which raises questions about how much Medicare should pay for services provided through a DTC vendor. One argument is that services provided by clinicians through a DTC telehealth vendor should be paid less than telehealth services provided by clinicians who also see patients in person because DTC vendors probably have lower costs. Clinicians providing services through a DTC

telehealth vendor do not need to acquire office space or equipment (e.g., exam tables, blood pressure cuffs) because they do not see patients in person. While it is logical to expect that these lower practice costs should translate to lower Medicare payments for telehealth services provided by DTC vendors, in practice, such a policy would be difficult to implement. Medicare claims do not contain information on clinicians' employers or corporate affiliations. Nor does Medicare Part B currently make payment distinctions on the basis of ownership, raising the possibility that Medicare would need to define DTC vendors as a new provider type. Nevertheless, during the period of temporary expansion after the PHE, CMS should collect cost information from providers to determine whether services provided through a DTC telehealth vendor should be paid at lower rates than telehealth services provided by clinicians who also treat patients in person, and if so, what those rates should be. Before paying lower rates for telehealth services provided by DTC vendors, CMS would need to explore whether it is feasible to distinguish between different types of telehealth providers. ■

outpatient visit). Many PFS services have two payment rates, depending on whether they are provided in a facility setting (e.g., a hospital or a skilled nursing facility) or a nonfacility setting (e.g., a freestanding clinician's office) (see text box on PFS payment rates, p. 470). Prior to the PHE, CMS paid clinicians at the distant site the PFS's lower, facility-based payment rate instead of the higher, nonfacility rate because the practice expenses for telehealth services are presumed to be lower than for services provided in person in a clinician's office. (The portion of the payment for the clinician's work does not vary by location.) During the PHE, however, CMS pays the same PFS rate for a telehealth service that it would pay if the service were furnished in person (either the facility

or nonfacility rate). For example, if the service would have been provided in a clinician's office, CMS pays the distant-site clinician the PFS nonfacility rate.⁷

When the PHE ends, CMS should return to paying the PFS facility rate for telehealth services provided by distant-site clinicians. CMS should then collect data from practices and other entities on the costs they incur to provide telehealth services and make any changes to telehealth payment rates based on those costs. We expect the rates for telehealth services to be lower than rates for in-person services because services delivered via telehealth likely do not require the same practice costs as services provided in a physical office. Although telehealth

CMS's criteria and process for revising the list of allowable telehealth services

In 2002, CMS established a process for adding services to or deleting services from the Medicare allowable telehealth services list (Centers for Medicare & Medicaid Services 2020b, Centers for Medicare & Medicaid Services 2020c). This process provides the public with an ongoing opportunity to submit requests for adding services, which are then reviewed by CMS. Any changes to the Medicare allowable telehealth services list are made through the annual physician fee schedule rule-making process.

Under CMS's review process, potential telehealth services are reviewed based on one of three categories of criteria.

Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the Medicare telehealth services list. In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services that are included in the authorizing legislation. Among these similarities are the roles of and interactions among the beneficiary, the physician (or other practitioner) at the distant site, and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. The agency also looks for similarities in the telecommunications system used to deliver the service, such as the use of interactive audio and video equipment.

Category 2: Services that are not similar to those on the current Medicare telehealth services list. CMS reviews whether the billing code's description of the service applies when the service is furnished via telehealth. They also review whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include a description of relevant clinical studies that demonstrate the service

furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings. CMS's evidentiary standard of clinical benefit does not include minor or incidental benefits. CMS cites some examples of clinical benefit:

- ability to diagnose a medical condition in a patient population without access to clinically appropriate in-person diagnostic services
- treatment option for a patient population without access to clinically appropriate in-person treatment options
- reduced rate of complications
- decreased rate of subsequent diagnostic or therapeutic interventions (for example, due to reduced rate of recurrence of the disease process)
- decreased number of future hospitalizations or physician visits

CMS does not consider the potential spending implications of adding a service to the telehealth list.

Category 3: Services that were added during the public health emergency. In response to the coronavirus pandemic, CMS created a third category of services that are added to the Medicare-allowable telehealth services list on a temporary basis through the end of 2021 (Centers for Medicare & Medicaid Services 2020e). This new category includes services that were added during the public health emergency and which likely have a clinical benefit when furnished through telehealth, but for which there is not yet sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. ■

may require upfront investments in technology and training, in the long run the marginal cost of a telehealth service should be lower than that of an in-person service (Mehrotra et al. 2020). Therefore, continuing to set rates

for telehealth services equal to rates for in-office services after the PHE ends could distort prices and lead clinicians to favor telehealth services over comparable in-person services, even when an in-person service may be more clinically appropriate.

After the PHE ends, providers should no longer be permitted to reduce or waive cost sharing for telehealth services

Prior to the PHE, beneficiaries were subject to the same cost-sharing liabilities for telehealth services as they were for other services. However, the Office of Inspector General (OIG) has issued a policy statement notifying clinicians that they will not be subject to administrative sanctions for reducing or waiving cost sharing for telehealth services during the PHE (Office of Inspector General 2020).⁸

A few clinicians in our focus groups said they were waiving cost sharing for telehealth visits and several were unsure. Some said that waiving cost sharing would not have much of an effect since so many of their Medicare patients have supplemental coverage. About 80 percent of FFS beneficiaries have supplemental coverage through employer-sponsored insurance (30 percent of beneficiaries), Medigap plans (29 percent), or Medicaid (22 percent), which typically covers some or all of Part B's cost-sharing requirements (Cubanski et al. 2018). Consequently, most FFS beneficiaries are shielded from most cost-sharing responsibilities for telehealth services, even if their clinicians do not waive cost sharing during the PHE.

Nevertheless, some FFS beneficiaries do not have supplemental coverage for Part B cost sharing, and these beneficiaries could be influenced by a cost-sharing waiver. Because telehealth services are more convenient for beneficiaries to access, they have a higher risk of overuse than in-person services, particularly in the context of an FFS payment system in which providers have a financial incentive to bill for more services. Requiring beneficiaries to pay a portion of the cost of telehealth services would help reduce the possibility of overuse. Therefore, after the PHE has ended, we encourage OIG to discontinue its policy that allows clinicians to reduce or waive cost sharing.

Requiring clinicians to collect cost sharing from beneficiaries for telehealth services should not impose an additional burden on them. In the case of beneficiaries with Medigap coverage, CMS sends information from Part B claims to most Medigap plans, which pay the cost-sharing amount directly to the clinician (Centers for Medicare & Medicaid Services 2020a). For beneficiaries who have other supplemental coverage, clinicians are able to collect the cost-sharing amount from the beneficiary's supplemental payer rather than bill the beneficiary directly. Although the cost sharing for telehealth services may be relatively small, clinicians currently collect cost

sharing for other services with low payment rates, such as electrocardiograms.⁹

Additional safeguards needed to protect Medicare and beneficiaries against telehealth-related unnecessary spending and fraud

We assume that CMS would monitor telehealth services to prevent fraud, waste, and abuse after the PHE, using its regular program integrity tools. However, CMS should permanently establish three additional safeguards after the PHE to protect the program and beneficiaries from unnecessary spending and potential fraud related to telehealth:

- apply additional scrutiny to outlier clinicians who bill many more telehealth services per beneficiary than other clinicians or who bill for a high number of services in a week or a month,
- require clinicians to provide an in-person, face-to-face visit with a beneficiary before they order expensive durable medical equipment (DME) or expensive clinical laboratory tests, and
- prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly.

Apply additional scrutiny to outlier clinicians

After the coronavirus PHE, CMS should apply additional scrutiny to clinicians who are outliers in terms of volume of telehealth services compared with other clinicians. To do so, CMS could examine the distribution of clinicians by the number of telehealth services they bill per beneficiary and identify clinicians in the extreme tail of the distribution. In this way, CMS could compare clinicians in the same specialty because some specialties might provide a large share of their services through telehealth. Alternatively, CMS could use billing information to estimate the amount of time that a clinician spends on telehealth services during a week or month.¹⁰ If this estimate exceeds the total number of hours in a week or month, CMS could consider this clinician an outlier.

Next, CMS could instruct the Medicare administrative contractors (MACs), which process Medicare claims, to apply additional scrutiny to telehealth claims submitted

Physician fee schedule payment rates are usually lower when a service is provided in a facility setting compared with a nonfacility setting

Medicare’s physician fee schedule (PFS) usually pays different rates depending on whether a service is provided in a facility setting (e.g., a hospital) or a nonfacility setting (e.g., a freestanding clinician’s office). The portions of the PFS payment rate for the clinician’s work and professional liability insurance (PLI) are the same in both settings, but the portion for practice expense is usually lower when a service is delivered in a facility setting because Medicare makes a separate payment to the facility to cover the cost of the physical space, medical supplies, medical equipment, and clinical staff time.¹¹

For example, the 2021 PFS rate for a Level 3 office/outpatient evaluation and management visit (Current Procedural Terminology code 99213) includes the following components: the clinician’s work (\$45.36), PLI (\$3.49), and practice expense (\$19.19 in a facility and \$43.62 in a nonfacility setting) (Table 14-2). The total PFS facility rate for this service is \$68.04 and the total PFS nonfacility rate is \$92.47. When this service is provided in a hospital outpatient department, Medicare pays the PFS facility rate and makes a separate payment to the hospital under the hospital outpatient prospective payment system (\$118.74 in 2021). ■

**TABLE
14-2**

Physician fee schedule payment rate for a Level 3 office/outpatient E&M visit is lower in a facility setting than a nonfacility setting, 2021

	Facility	Nonfacility
Work component	\$45.36	\$45.36
PLI component	3.49	3.49
Practice expense component	<u>19.19</u>	<u>43.62</u>
Total payment rate	68.04	92.47

Note: E&M (evaluation and management), PLI (professional liability insurance). The Current Procedural Terminology code for this service is 99213. Facility settings include hospitals. Nonfacility settings include freestanding clinician’s offices. The total payment rate is the national average rate and includes the program payment and beneficiary cost sharing.

Source: Analysis of Medicare physician fee schedule payment rates for 2021.

by outlier clinicians. The MACs could use their traditional tools for targeted review of providers, which include reviewing the medical records that support clinicians’ claims to determine whether they meet Medicare’s rules for billing, coverage, and medical necessity. If they do not, the MACs could deny these claims or seek to recover the payments if the claims have already been paid. Clinicians who primarily provide telehealth services—such as those who work for direct-to-consumer telehealth vendors—could be flagged as outliers more frequently than other clinicians. If so, their claims would be subject to additional

scrutiny but would not be denied if they meet Medicare’s requirements.

Require clinicians to provide a face-to-face visit before they order high-cost durable medical equipment or high-cost clinical lab tests

Several companies that provide telehealth services have recently been involved in very large fraud cases, resulting in billions of dollars of losses for Medicare. The DOJ recently charged over 300 defendants with submitting more than \$6 billion in false and fraudulent claims to

federal health programs and private insurers, including more than \$4.5 billion related to telemedicine (Department of Justice 2020). Executives of telehealth companies allegedly paid physicians and nurse practitioners (NPs) to order unnecessary DME, genetic tests, other diagnostic tests, and pain medication without interacting with patients or with only a brief telephone conversation with patients they had never met. These companies then sold the orders from physicians and NPs to DME companies, laboratories, and pharmacies, which in turn submitted fraudulent claims for these items and services to Medicare and other government insurers.

In a previous enforcement action—Operation Brace Yourself—federal investigators uncovered schemes in which DME companies allegedly paid illegal kickbacks and bribes to medical professionals working with telemedicine companies to order unnecessary back, shoulder, wrist, and knee braces for Medicare beneficiaries (Department of Justice 2019a). This second set of cases—which involved more than \$1.2 billion in losses—resulted in charges against executives of five telemedicine companies. In Operation Double Helix, federal law enforcement charged individuals associated with dozens of telemedicine companies and cancer genetic testing laboratories with fraudulently billing Medicare more than \$2.1 billion for cancer genetic tests (Department of Justice 2019b). In several of these cases, physicians working for telemedicine companies allegedly ordered unnecessary cancer genetic tests for patients, even though they did not treat or speak with these patients.

If Medicare’s temporary expansion of coverage for telehealth services becomes permanent, there is a risk that such fraudulent schemes could become more common. A major concern is that telehealth arrangements make it easier to carry out fraud on a large scale because clinicians can speak with many beneficiaries from many parts of the country in a short amount of time, and beneficiaries do not need to see a clinician in person to receive an order for DME items or lab tests.

To protect the Medicare program and beneficiaries, CMS should, after the PHE, require clinicians to provide a face-to-face, in-person visit with a beneficiary on the date that they order a high-cost DME product or a high cost lab test for that beneficiary or within six months before such date. This approach—which was described in a prior Commission report—would prevent clinicians from ordering expensive DME items or lab tests during a

telehealth visit (Medicare Payment Advisory Commission 2018a). It would help ensure that a beneficiary needs a product or test based on a needs assessment conducted by a clinician before Medicare pays for it. CMS currently requires an in-person or telehealth visit for some DME items, such as certain hospital beds, but not for others (e.g., knee or back braces), and there is no such requirement for lab tests. To meet the current requirement for certain DME items, a clinician must have had an in-person or telehealth encounter with the beneficiary on the date the DME product was ordered or within six months before such date. The safeguard that we are proposing differs from the current policy because our approach would require an in-person visit while the current policy requires an in-person or telehealth visit. In addition, our proposal would apply to high-cost DME items and high-cost lab tests, whereas the current policy applies only to certain DME items.

Prohibit “incident to” billing for telehealth services provided by any clinician who can bill Medicare directly

Under certain conditions, Medicare pays for services that are billed by physicians and certain other clinicians but performed by nonphysician staff such as registered nurses (RNs), medical assistants, technicians, physician assistants (PAs), advanced practice registered nurses (APRNs), and physical therapists. These services are called “incident to” services. Examples of these services include Part B drugs administered in a physician’s office by a nurse, therapeutic exercises provided by a physical therapist in a physician’s office, and venipuncture (blood drawn for a laboratory test) performed by a medical assistant. Medicare’s “incident to” rules are complex and apply only to services furnished to certain patients (e.g., established patients who are not being treated for a new problem) and in nonfacility settings (e.g., clinicians’ offices) (Medicare Payment Advisory Commission 2019). In addition, “incident to” services usually require the direct supervision of a clinician, which means that the billing clinician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the service. The “incident to” rules allow clinicians to bill for services performed by any staff, whether they are licensed or unlicensed.

Little information exists regarding the types of “incident to” services received by beneficiaries, the types of nonphysician staff who provide them, and the quality of

these services. Medicare claims do not contain information on whether a service is billed as an “incident to” service. In one of the few studies of these services, OIG examined services billed by a sample of physicians in 2007 who appeared to bill for “incident to” services (Office of Inspector General 2009).¹² OIG found that half of these services were not personally performed by a physician and that unqualified nonphysicians, such as nurses and medical assistants, performed 21 percent of the services that physicians did not personally perform.¹³ Services performed by unqualified individuals ranged from venipuncture to surgical procedures such as complex skin surgery.

In 2019, the Commission recommended eliminating “incident to” billing for APRNs and PAs and requiring these clinicians to bill Medicare directly (Medicare Payment Advisory Commission 2019). This change would increase transparency about the services delivered by APRNs and PAs. It would improve Medicare’s ability to identify and support clinicians providing primary care. It also would reduce Medicare spending because Medicare pays 85 percent of the PFS rate for services that are billed directly by APRNs and PAs, compared with the full PFS rate for “incident to” services. This recommendation did not apply to other individuals who may provide services under “incident to” rules, such as nurses, medical assistants, and physical therapists.

The Commission supports expanding its earlier recommendation to prohibit “incident to” billing for services provided by APRNs and PAs by applying it to telehealth services performed by *any* clinician who can bill Medicare directly. In addition to APRNs and PAs, physical therapists, occupational therapists, licensed clinical social

workers, registered dietitians, nutrition professionals, speech–language pathologists, and clinical psychologists are able to bill Medicare directly and are allowed to bill Medicare for telehealth services during the PHE (Centers for Medicare & Medicaid Services 2020d). Expanding our earlier recommendation would mean that any clinician who is able to bill Medicare directly would have to bill under their own national provider identifier (NPI) when they deliver a telehealth service to a beneficiary after the PHE.¹⁴

Expanding the Commission’s earlier recommendation would accomplish two objectives. First, it would provide Medicare with more information about the types of providers and the specific clinicians who deliver telehealth services to beneficiaries, which would help CMS ensure that beneficiaries are receiving high-quality, appropriate care. Second, it would enable CMS to better monitor the use of telehealth services to prevent overuse. Under the current “incident to” rules, it is difficult for CMS to determine whether an individual clinician is providing an excessive number of telehealth services because multiple individuals could be billing for these services under the clinician’s NPI. If, however, CMS required clinicians who can bill Medicare directly for telehealth services do so under their own NPI, the agency could more easily identify outlier clinicians.

Such a policy change would not apply to clinical staff, such as RNs and medical assistants, who are not able to bill Medicare directly for telehealth services. In addition, this change would not affect the delivery of care to beneficiaries. It would change only how certain providers bill Medicare. ■

Medicare coverage and payment for telehealth services prior to the coronavirus public health emergency

Medicare pays separately for telehealth services provided by clinicians under the physician fee schedule (PFS). Before the coronavirus public health emergency (PHE), Medicare generally covered a limited set of telehealth services in rural locations under the PFS.¹⁵ Under Medicare’s prospective payment systems (e.g., for inpatient hospitals and home health agencies), providers have the flexibility to use telehealth as part of an episode of care (e.g., a hospital admission), but because providers are paid on a per diem or per episode basis, the use of telehealth does not affect Medicare’s payments.¹⁶ Under the Medicare Advantage (MA) program, payments to plans are capitated. Plan coverage must include the telehealth services covered under the PFS, but plans are also allowed to cover electronic delivery of any Part B service as part of the basic Medicare benefit.

Payment for telehealth under Medicare’s prospective payment systems

Under Medicare’s prospective payment systems (including payment systems for inpatient and outpatient hospitals, skilled nursing facilities (SNFs), inpatient rehabilitation facilities, long-term care hospitals, outpatient dialysis providers, home health agencies, and hospices), providers have the flexibility to use telehealth to deliver care if they believe it will improve patient outcomes or help keep costs below the applicable payment amount. These payment systems differ from the PFS because providers receive a fixed payment for all services delivered per day or during an episode of care. For example, hospitals can use telehealth technology to remotely monitor and treat patients in the inpatient intensive care unit, but they do not receive an additional payment for the use of telehealth technology. Clinicians are paid separately under the PFS for services they provide in hospitals, SNFs, and other facilities.

Payment for telehealth under the physician fee schedule

The Social Security Act specifies that Medicare cover a limited set of telehealth services and modalities under

the PFS, and only in specified settings in rural locations (with certain exceptions).¹⁷ For most telehealth services, the patient must be located at an “originating site” in a rural area, defined as rural health professional shortage areas or a county outside of a metropolitan statistical area, and the clinician must be located at a “distant site” in any location. Originating sites include physicians’ offices, hospitals, critical access hospitals, rural health centers, SNFs, federally qualified health centers, community mental health centers, and hospital-based dialysis facilities.¹⁸

Many covered telehealth services are defined in statute, but CMS has also expanded coverage to some services through regulation. Covered telehealth services include general health care services (e.g., evaluation and management (E&M) visits and annual wellness visits) and those related to kidney disease, behavioral health, substance use disorders, nutrition therapy, pharmacological management, stroke, and cardiovascular disease.¹⁹ Under the PFS, providers billing for transitional care management services or chronic care management services may use telehealth technology, such as telephone calls or emails, to provide this care. However, the payment for the use of telehealth is part of the monthly payment for these services.²⁰

Prior to the PHE, CMS began covering other remote services that, according to the agency, do not meet the statutory definition of “telehealth.” These services include:

- virtual check-ins, in which a patient checks in briefly with a clinician by telephone or other telecommunications device to decide whether an office visit is needed;
- clinicians’ remote evaluation of images or recorded videos sent to them by a patient and follow-up with the patient;
- remote monitoring and interpretation of physiological data (e.g., weight, blood pressure, pulse oximetry, and glucose monitoring) that are digitally stored and/or transmitted to a clinician;

(continued next page)

Medicare coverage and payment for telehealth services prior to the coronavirus public health emergency (cont.)

- interprofessional consultations, in which a consulting clinician provides an opinion or advice to the patient’s treating clinician via telephone, internet, or electronic health record, without the need for face-to-face contact with the patient; and
- online digital evaluation services (e-visits), which are non-face-to-face patient-initiated communications with a clinician using an online patient portal (Centers for Medicare & Medicaid Services 2019, Centers for Medicare & Medicaid Services 2018).

Because these services do not meet the statutory definition of telehealth, CMS does not consider them subject to the geographic limits on where patients can be located. Consequently, Medicare pays for these services regardless of the patient’s location. However, because these services involve the exchange of medical information from one site to another through electronic communications, we consider them telehealth for the purpose of this chapter.

Payment for direct-to-consumer services

Most telehealth services covered under the PFS are direct-to-consumer services, such as routine E&M visits and mental health visits. The originating site receives a \$27 telehealth facility fee payment, and the clinician at the distant site receives the usual PFS payment rate based on the type of service provided (e.g., an E&M office/outpatient visit).²¹ Prior to the PHE, CMS paid providers for distant-site telehealth services at the PFS facility-based payment rate instead of the higher PFS nonfacility (office-based) rate.²² Beneficiary cost-sharing responsibilities for telehealth services are the same as for other Part B services, although clinicians may reduce or waive cost sharing during the PHE.

Payment for interprofessional consultations

Interprofessional consultations involve two payments. The treating clinician, who initiates the consultation, receives a flat payment amount and the consulting clinician receives an amount that varies based on the time involved. Clinicians are required to obtain beneficiary consent to furnish these services because beneficiaries are responsible for cost sharing.

Payment for telehealth under Medicare Advantage

MA plans are required to cover all of the telehealth services covered in fee-for-service (FFS) Medicare, and they can offer telehealth services not covered under FFS Medicare as supplemental benefits (benefits that plans can provide in addition to the basic Medicare FFS benefit). Plans have offered a small number of supplemental telehealth benefits. For plan year 2017, CMS reported that 8 percent of plans covered remote patient monitoring services and 77 percent of plans covered “remote access technologies”—a broad category of services including email, two-way video, and nurse call-in telephone lines (Centers for Medicare & Medicaid Services 2016).

Starting in 2020, MA plans are allowed to cover electronic delivery of any Part B service as part of the basic Medicare benefit (these telehealth benefits are included in plans’ bids and are not treated as supplemental benefits) and can include access to telehealth from an enrollee’s home. The scope of telehealth coverage is determined by each plan’s benefit package. CMS’s temporary expansions of telehealth coverage in FFS Medicare during the PHE also apply to coverage through MA plans. ■

Endnotes

- 1 Medicare pays for certain telehealth services outside of rural areas and in any location, including a patient’s home, including telehealth services for substance use disorders, for end-stage renal disease patients receiving home dialysis, and for mental health conditions (if the physician or practitioner has furnished an in-person service to the individual within the six months prior to the first time they furnish the telehealth service, and during subsequent periods that the Secretary would determine). Medicare also covers telehealth services to treat patients with a stroke in hospitals in urban and rural areas.
- 2 Under Section 319 of the Public Health Services Act, the Secretary of Health and Human Services may determine that a disease or disorder presents a PHE or that a PHE, including significant outbreaks of infectious disease or bioterrorist attacks, otherwise exists. The Secretary first determined the existence of the coronavirus PHE, based on confirmed cases of COVID-19 in the U.S., on January 31, 2020. At the time of publication, the coronavirus PHE had been renewed four times, most recently on January 7, 2021.
- 3 Primary care services include the following PFS services: office/outpatient E&M visits, home E&M visits, E&M visits to patients in certain non-inpatient hospital settings (nursing facility, domiciliary, rest home, and custodial care), audio-only E&M visits, chronic care management, transitional care management, Welcome to Medicare visits, annual wellness visits, e-visits, and advance care planning services.
- 4 CMMI has statutory authority to waive most of Medicare’s statutory requirements to test alternative payment models. Next Generation ACOs bear two-sided risk and have prospective beneficiary assignment.
- 5 Most ACOs did not adopt this waiver because they lacked the appropriate staff, technology, and provider buy-in.
- 6 CMS has statutory authority to waive many of Medicare’s requirements for MSSP ACOs.
- 7 Certain services, such as remote monitoring and interpretation of physiological data, are exceptions to this policy because CMS sets a single rate for each of these services because they are provided only remotely. Therefore, their payment rates have not changed during the PHE.
- 8 This policy applies to beneficiaries of Medicare and other federal health programs.
- 9 The 2020 nonfacility payment rate for electrocardiogram complete (Current Procedural Terminology (CPT) code 93000) was \$17.32, and the rate for electrocardiogram report (CPT code 93010) was \$8.66.
- 10 Many services, such as E&M visits, are based on the estimated amount of time (or range of time) that clinicians spend providing the service. Under the current “incident to” rules, it is difficult for CMS to determine the number of services personally performed by an individual clinician because multiple individuals may be performing those services but billing under the clinician’s national provider identifier (NPI). If, however, CMS requires that clinicians who are able to bill Medicare directly for telehealth services do so under their own NPIs, it would be easier for the agency to determine the number of services performed by each clinician.
- 11 For example, Medicare pays for the cost of services provided in hospital outpatient departments through the hospital outpatient prospective payment system.
- 12 OIG’s sample included physicians who billed Medicare for more than 24 hours of services in a day; OIG assumed that these physicians were more likely to have billed for services provided by other individuals.
- 13 Unqualified nonphysicians did not possess the necessary licenses or certifications, had no verifiable credentials, or lacked the training to perform the service.
- 14 Physical therapists, occupational therapists, and speech language pathologists are able to bill directly for telehealth services during the PHE under a waiver established by CMS. Unless CMS extends this waiver after the PHE, these clinicians would no longer be able to bill directly for telehealth services. In addition, under the Commission’s policy option, these clinicians would no longer be able to perform telehealth services that are billed as “incident to” services by other clinicians because such “incident-to” billing would be prohibited after the PHE.
- 15 Section 1834(m) of the Social Security Act specifies telehealth coverage under FFS Medicare and the PFS. The law specifies the permitted originating sites, authorized practitioners, and geographic location restriction to patients in rural areas. In the Coronavirus Preparedness and Response Supplemental Appropriations Act of 2020 and the Coronavirus Aid, Relief, and Economic Security Act of 2020, the Congress allowed CMS to waive all the restrictions

on telehealth, including the originating site and geographic location restrictions, during the PHE.

- 16 In addition to the areas of the Medicare program mentioned here, there is limited coverage of telehealth services under Medicare Part D. Section 10328 of the Affordable Care Act requires prescription drug plan sponsors to offer, at a minimum, an annual comprehensive medication review that may be furnished person to person or through telehealth technologies.
- 17 Section 1834(m) of the Social Security Act defines telehealth services as “professional consultations, office visits, and office psychiatry services” plus any other services specified by the Department of Health and Human Services. The statute limits Medicare’s coverage of telehealth to live two-way video, with one exception: It permits asynchronous store-and-forward technology (e.g., emailing a saved diagnostic image or video) in Medicare demonstrations in Alaska and Hawaii.
- 18 Clinicians are not required to be present at the originating site with the beneficiary unless it is medically necessary.
- 19 The Bipartisan Budget Act of 2018 expanded the coverage of telehealth services to include the treatment of stroke in hospitals located in urban areas and services for patients with end-stage renal disease who receive home dialysis in urban areas. The Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act of 2018 allowed coverage of telehealth services for the treatment of substance use disorders in urban areas and in patients’ homes. In the Consolidated Appropriations Act, 2021, the Congress gave the Secretary the authority to allow beneficiaries to receive mental health services through telehealth from the beneficiary’s home and outside of rural areas. The beneficiary must be seen at least once in person by the practitioner during the six-month period prior to the first telehealth service and other time periods as determined by the Secretary.
- 20 Providers who bill for a transitional care management service must have interactive contact with the beneficiary, such as a phone call or email, within two business days following the beneficiary’s discharge from an institutional setting. Clinicians who bill for a chronic care management services must provide enhanced opportunities for patients to communicate with clinicians by telephone, secure messaging, email, or electronic patient portal.
- 21 A critical access hospital may also receive payment as a distant site.
- 22 Under the PFS, the payment rate is based on three RVU components: work, practice expense, and professional liability insurance. When a service is performed in a facility (e.g., hospital outpatient department or skilled nursing facility), the practice expense amount is lower because the clinician does not incur costs for overhead, staff, equipment, and supplies. These costs are incurred by the facility, and Medicare pays for them under a different payment system. By contrast, when a service is delivered in a nonfacility setting (e.g., a clinician’s office), the practice expense amount is higher to account for the cost of overhead, staff, equipment, and supplies. The work component amount is the same regardless of setting.

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A P P E N D I X

A

**Commissioners' voting
on recommendations**



Commissioners' voting on recommendations

In the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Congress required MedPAC to call for individual Commissioner votes on each recommendation and to document the voting record in its report. The information below satisfies that mandate.

Chapter 1: Context for Medicare payment policy

No recommendations

Chapter 2: Assessing payment adequacy and updating payments in fee-for-service Medicare

No recommendations

Chapter 3: Hospital inpatient and outpatient services

For fiscal year 2022, the Congress should update the 2021 Medicare base payment rates for acute care hospitals by 2 percent.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 4: Physician and other health professional services

For calendar year 2022, the Congress should update the 2021 Medicare payment rates for physician and other health professional services by the amounts determined under current law.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 5: Ambulatory surgical center services

5-1 For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare conversion factor for ambulatory surgical centers.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

5-2 The Secretary should require ambulatory surgical centers to report cost data.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 6: Outpatient dialysis services

For calendar year 2022, the Congress should eliminate the update to the 2021 Medicare end-stage renal disease prospective payment system base rate.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 7: Skilled nursing facility services

For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for skilled nursing facilities.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 8: Home health care services

For calendar year 2022, the Congress should reduce the 2021 Medicare base payment rate for home health agencies by 5 percent.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 9: Inpatient rehabilitation facility services

For fiscal year 2022, the Congress should reduce the 2021 Medicare base payment rate for inpatient rehabilitation facilities by 5 percent.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 10: Long-term care hospital services

For fiscal year 2022, the Secretary should increase the 2021 Medicare base payment rate for long-term care hospitals by 2 percent.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 11: Hospice services

For fiscal year 2022, the Congress should eliminate the update to the 2021 Medicare base payment rates for hospice and wage adjust and reduce the hospice aggregate cap by 20 percent.

Yes: Casalino, Chernew, DeBusk, DeSalvo, M. Ginsburg, P. Ginsburg, Grabowski, Jaffery, Navathe, Perlin, Pyenson, Rambur, Riley, Ryu, Safran, Thompson, Wang

Chapter 12: The Medicare Advantage program: Status report

No recommendations

Chapter 13: The Medicare prescription drug program (Part D): Status report

No recommendations

Chapter 14: Telehealth in Medicare after the coronavirus public health emergency

No recommendations

Acronyms

Acronyms

AAGR	average annual growth rate	COVID-19	coronavirus disease 2019
A-APM	advanced alternative payment model	CPC+	Comprehensive Primary Care Plus
ACA	Affordable Care Act	CPI-U	consumer price index for all urban consumers
ACH	acute care hospital	CPT	Current Procedural Terminology
ACO	accountable care organization	CRNA	certified registered nurse anesthetist
ACS	ambulatory care sensitive	C-SNP	chronic condition special needs plan
AKI	acute kidney injury	CT	computed tomography
AKS	anti-kickback statute	DIR	direct and indirect remuneration
ALF	assisted living facility	DME	durable medical equipment
ALOS	average length of stay	DPP	discharge payment percentage
APC	ambulatory payment classification	DRG	diagnosis related group
APM	alternative payment model	DSH	disproportionate share hospital
APR-DRG	all-patient refined–diagnosis related group	D-SNP	dual-eligible special needs plan
APRN	advanced practice registered nurse	DTC	direct-to-consumer
ASC	ambulatory surgical center	DVP	Drug Value Program
ASCQR	ASC Quality Reporting	E&M	evaluation and management
ASP	average sales price	EBITDA	earnings before interest, taxes, depreciation, and amortization
BBA	Bipartisan Budget Act	ED	emergency department
BPT	bid pricing tool	EDS	Encounter Data System
CAHPS®	Consumer Assessment of Healthcare Providers and Systems®	eGFR	estimated glomerular filtration rate
C-APC	comprehensive ambulatory payment classification	EGWP	employer group waiver plan
CARES	Coronavirus Aid, Relief, and Economic Security Act	ePA	electronic prior authorization
CBO	Congressional Budget Office	ESA	erythropoiesis-stimulating agent
CC	complication or comorbidity	ESRD	end-stage renal disease
CCI	chronically critically ill	FA	formulary and benefit administration
CCP	coordinated care plan	FDA	Food and Drug Administration
CDAG	coverage determinations, appeals, and grievances	FFS	fee-for-service
CDC	Centers for Disease Control and Prevention	FY	fiscal year
CHC	continuous home care	g/dL	grams per deciliter
CHIP	Children’s Health Insurance Program	GAO	Government Accountability Office
CKD	chronic kidney disease	GDP	gross domestic product
CMG	case-mix group	GI	gastrointestinal
CMI	case-mix index	GIP	general inpatient care
CMMI	Center for Medicare & Medicaid Innovation	H-CAHPS®	Hospital Consumer Assessment of Healthcare Providers and Systems®
CMR	comprehensive medication review	HCBS	home- and community-based services
CMS	Centers for Medicare & Medicaid Services	HCC	hierarchical condition category
CMS-HCC	CMS hierarchical condition category	HCPCS	Healthcare Common Procedure Coding System
CON	certificate of need	HEDIS®	Healthcare Effectiveness Data and Information Set®
COPD	chronic obstructive pulmonary disease	HHA	home health agency

HHS	Department of Health and Human Services	MLR	medical loss ratio
HI	Hospital Insurance (Medicare Part A)	MMSEA	Medicare, Medicaid, and SCHIP Extension Act of 2007
HMO	health maintenance organization	MOOP	maximum out-of-pocket
HOPD	hospital outpatient department	MRI	magnetic resonance imaging
HOPE	Hospice Outcomes & Patient Evaluation	MSA	Medicare Savings Account
HRRP	Hospital Readmissions Reduction Program	MSA	metropolitan statistical area
HRS	Health and Retirement Study	MS-DRG	Medicare severity–diagnosis related group
HSA	hospital service area	MS-LTC-DRG	Medicare severity long-term care diagnosis related group
HUD	Department of Housing and Urban Development	MSS	medical social services
HVIP	hospital value incentive program	MTM	medication therapy management
ICD	International Classification of Diseases	MV	mechanical ventilation
ICU	intensive care unit	N/A	not applicable
IOL	intraocular lens	N/A	not available
IPPS	inpatient prospective payment system	NDA	new drug application
IRC	inpatient respite care	NDC	national drug code
IRE	independent review entity	NIH	National Institutes of Health
IRF	inpatient rehabilitation facility	NP	nurse practitioner
I-SNP	institutional special needs plan	NPI	national provider identifier
KDE	kidney disease education	NTA	nontherapy ancillary
LDO	large dialysis organization	OB/GYN	obstetrics and gynecology
LEP	late enrollment penalty	OIG	Office of Inspector General
LIS	low-income [drug] subsidy	OOP	out of pocket
LOS	length of stay	OPPS	outpatient prospective payment system
LPN	licensed practical nurse	OQR	Outpatient Quality Reporting
LTCH	long-term care hospital	OR	operating room
LVH	low-volume hospital	PA	physician assistant
MA	Medicare Advantage	PAC	post-acute care
MAC	Medicare administrative contractor	PACE	Program of All-Inclusive Care for the Elderly
MACRA	Medicare Access and CHIP Reauthorization Act of 2015	PAMA	Protecting Access to Medicare Act of 2014
MA-PD	Medicare Advantage–Prescription Drug [plan]	PAP	patient assistance program
MB	market basket	PBD	provider-based department
MCBS	Medicare Current Beneficiary Survey	PBM	pharmacy benefit manager
MCC	major complication or comorbidity	PBPM	per beneficiary per month
MCCM	Medicare Care Choices Model	PCI	percutaneous coronary intervention
MDH	Medicare-dependent hospital	PCIP	Primary Care Incentive Payment
MedPAC	Medicare Payment Advisory Commission	PD	peritoneal dialysis
MedPAR	Medicare Provider Analysis and Review	PDE	prescription drug event
MEI	Medicare Economic Index	PDGM	Patient-Driven Groupings Model
MFN	most favored nation	PDP	prescription drug plan
MGMA	Medical Group Management Association	PDPM	patient-driven payment model
MIPPA	Medicare Improvements for Patients and Providers Act of 2008	PDUFA	Prescription Drug User Fee Act
MIPS	Merit-based Incentive Payment System	PFFS	private fee-for-service
		PFS	physician fee schedule

PHC4	Pennsylvania Health Care Cost Containment Council	RTBC	real-time benefit check
PHE	public health emergency	RTBT	real-time benefit tool
PLI	professional liability insurance	RVU	relative value unit
PMPM	per member per month	RxHCC	prescription drug hierarchical condition category
POS	point of sale	SCH	sole community hospital
POS	Provider of Services [file]	SGR	sustainable growth rate
PPE	personal protective equipment	SMI	Supplementary Medical Insurance
PPO	preferred provider organization	SNF	skilled nursing facility
PPS	prospective payment system	SNP	special needs plan
PSA	prostate-specific antigen	SSA	Social Security Act
Q	quarter	SSI	surgical site infection
QIP	Quality Incentive Program	TDAPA	transitional drug add-on payment adjustment
QRP	Quality Reporting Program	TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
RAC	recovery audit contractor	TMR	targeted medication review
RADV	risk adjustment data validation	TNF	tumor necrosis factor
RAPS	Risk Adjustment Processing System	TPNIES	transitional add-on payment adjustment for new and innovative equipment and supplies
RCT	randomized controlled trial	UA	urbanized area
RDS	retiree drug subsidy	UC	urban cluster
REIT	real estate investment trust	UM	utilization management
RHC	routine home care	USRDS	United States Renal Data System
RIC	rehabilitation impairment category	VA	Department of Veterans Affairs
RN	registered nurse	VBID	value-based insurance design
ROI	return on investment	VBP	value-based purchasing

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Lawrence Casalino, M.D., Ph.D., is the Livingston Farrand Professor of Public Health and chief of the Division of Health Policy and Economics in the Weill Cornell Medical School Department of Population Health Sciences. His research focuses on the intended and unintended effects of public and private policies on the types of provider organizations that exist, on the processes they use to provide care, and on the quality and cost of care, as well as the impact of policies and organizational processes on socioeconomic and racial/ethnic disparities. Dr. Casalino has served as a senior advisor to the director of the Agency for Healthcare Research and Quality and as chair of the AcademyHealth annual meeting. He currently serves on the Congressional Budget Office's Panel of Health Advisors. He was a primary care physician in private practice for 20 years. He received his M.D. from the University of California, San Francisco, and his Ph.D. in health services research from the University of California, Berkeley.

Michael E. Chernew, Ph.D., is the Leonard D. Schaeffer Professor of Health Care Policy and the director of the Healthcare Markets and Regulation Lab in the Department of Health Care Policy at Harvard Medical School. Dr. Chernew's research examines several areas related to improving the health care system, including studies of novel benefit designs, Medicare Advantage, alternative payment models, low-value care, and the causes and consequences of rising health care spending. He is also a member of the Congressional Budget Office's Panel of Health Advisors and vice chair of the Massachusetts Health Connector Board. Dr. Chernew is a member of the National Academy of Sciences, a research associate at the National Bureau of Economic Research, and a MITRE fellow. He is currently a coeditor of the *American Journal of Managed Care*. He has served on a number of CMS technical advisory panels reviewing the assumptions used by Medicare actuaries to assess the financial status of the Medicare trust funds. He was awarded the John D. Thompson Prize for Young Investigators by the Association of University Programs in Public Health in 1998 and received the Alice S. Hersh Young Investigator Award from the Association of Health Services Research in 1999. Dr. Chernew previously served on the Commission from 2008 to 2014 and was vice chair from 2012 to 2014. He earned his undergraduate degree from

the University of Pennsylvania and his Ph.D. in economics from Stanford University.

Brian DeBusk, Ph.D., is chief executive officer of DeRoyal Industries in Powell, TN, which operates in the surgical, orthopedic, wound care, and health care information technology markets. He also serves as vice chairman of the Board of Trustees of Lincoln Memorial University in rural Tennessee, which includes graduate medical education programs for physicians, physician assistants, nurse practitioners, and nurses. Dr. DeBusk's prior employment includes General Electric, Inobis, and Pace Energy Systems. He has served on the faculty of both the University of Tennessee and Lincoln Memorial University, teaching classes in information technology and business strategy. Dr. DeBusk holds a Ph.D. in electrical engineering from Vanderbilt University and a master of business administration from Emory University.

Karen DeSalvo, M.D., M.P.H., MSc., is chief health officer at Google Health. She also is an adjunct professor of medicine and population health at the Dell Medical School at the University of Texas at Austin and co-convenor of the National Alliance to Impact the Social Determinants of Health. She is also past president of the Society of General Internal Medicine and serves on the board of directors for Welltower. Before joining the University of Texas, Dr. DeSalvo was dually appointed as the acting assistant secretary for health and the national coordinator for health information technology at the Department of Health and Human Services. She has also served as the New Orleans health commissioner and as vice dean for community affairs and health policy at Tulane School of Medicine. Dr. DeSalvo received her medical and public health degrees from Tulane University School of Medicine, where she also completed her residency and fellowship in internal medicine. She has a master's degree in clinical epidemiology from the Harvard School of Public Health.

Marjorie Ginsburg, B.S.N., M.P.H., is the founding executive director of the Center for Healthcare Decisions Inc., which she ran from 1994 through 2016. In that role, she was responsible for the design, implementation, and evaluation of projects and programs that fostered civic engagement around health policy issues that affected individuals and society at large. Among the policy issues

Ms. Ginsburg studied were end-of-life care, health plan benefits design, and strategies to reduce overuse of unnecessary medical care. Ms. Ginsburg currently volunteers as a Medicare counselor with California's State Health Insurance Assistance Program (called the Health Insurance Counseling and Advocacy Program) in Sacramento, CA.

Paul B. Ginsburg, Ph.D., is the Leonard Schaeffer Chair in Health Policy Studies at the Brookings Institution in Washington, DC, and professor of health policy at the University of Southern California, where he is affiliated with the USC Schaeffer Center for Health Policy and Economics. He directs the USC-Brookings Schaeffer Initiative for Health Policy. Prior positions include founder and president of the Center for Studying Health System Change, founding executive director of the Physician Payment Review Commission, senior economist at RAND, and deputy assistant director at the Congressional Budget Office. Dr. Ginsburg earned his doctorate in economics from Harvard University.

David Grabowski, Ph.D., is a professor in the Department of Health Care Policy at Harvard Medical School in Boston, MA. His research primarily focuses on the economics of aging, with an emphasis on post-acute and long-term care financing, organization, and delivery of services. He has published over 175 peer-reviewed papers related to these issues. Dr. Grabowski has served as a member of multiple CMS technical expert panels related to post-acute care payment and quality reporting. He also was a member of the CMS Coronavirus Nursing Home Commission. He serves on the editorial board of several journals, including the *American Journal of Health Economics*. Dr. Grabowski received his Ph.D. in public policy from the Irving B. Harris School of Public Policy at the University of Chicago.

Jonathan Jaffery, M.D., M.S., M.M.M., is a professor of medicine at the University of Wisconsin School of Medicine and Public Health. Dr. Jaffery serves as senior vice president/chief population health officer at UW Health and as president of UW Health ACO Inc., where he is responsible for the overall development, coordination, and implementation of the population health strategy. A board-certified nephrologist, Dr. Jaffery holds a B.A. in Russian literature from the University of Michigan and an M.D. from the Ohio State University College of Medicine. He completed an internal medicine residency and nephrology fellowship at the University of Vermont.

A former Robert Wood Johnson Foundation Health Policy Fellow and chief medical officer for the Wisconsin State Medicaid program, Dr. Jaffery has graduate degrees from the University of Wisconsin School of Medicine and Public Health and the University of Southern California Marshall School of Business.

Amol Navathe, M.D., Ph.D., is director of the Payment Insights Team, codirector of the Healthcare Transformation Institute, and associate director of the Center for Health Incentives and Behavioral Economics in the Department of Medical Ethics and Health Policy at the University of Pennsylvania's School of Medicine. He is also an assistant professor at Penn and staff physician at the Corporal Michael J. Crescenz VA Medical Center in Philadelphia, PA. Dr. Navathe's research group designs, tests, and evaluates payment models for national insurers and state Blue Cross Blue Shield plans. His work led to the founding of Embedded Healthcare, a health care technology company that accelerates high-value practice using behavioral economics. Dr. Navathe received his M.D. from the University of Pennsylvania and his Ph.D. in health care management and economics from the Wharton School at the University of Pennsylvania.

Jonathan Perlin, M.D., Ph.D., M.S.H.A., is the president of clinical operations and chief medical officer of HCA Healthcare in Nashville, TN. In that role, he has leadership responsibility for clinical services and improving performance at HCA's hospitals and other sites of service. Before joining HCA, Dr. Perlin was Under Secretary for Health in the U.S. Department of Veterans Affairs. Dr. Perlin is a member of the National Academy of Medicine and has faculty appointments at Vanderbilt University and Virginia Commonwealth University. Dr. Perlin received his Ph.D. in pharmacology and his medical degree from the Medical College of Virginia at Virginia Commonwealth University, where he also completed his residency training in internal medicine.

Bruce Pyenson, F.S.A., M.A.A.A., is principal and consulting actuary at Milliman Inc. in New York, NY. His recent work includes studies on Medicare Advantage enrollment, innovative reinsurance arrangements, definitions of value in health care, and financial modeling of therapeutic interventions. He has co-authored publications on such topics as the cost-effectiveness of lung cancer screening, pandemic influenza, alternative payment models for accountable care organizations, and site-of-service cost differences for chemotherapy.

Mr. Pyenson is a fellow of the Society of Actuaries and a member of the American Academy of Actuaries. He is adjunct clinical associate professor of New York University's College of Global Public Health.

Betty Rambur, Ph.D., R.N., F.A.A.N., is the Routhier Endowed Chair for Practice and professor of nursing in the College of Nursing at the University of Rhode Island, where she has conducted research on such topics as alternative payment models, telehealth nursing, and value-based workforce redesigns. Before joining the University of Rhode Island, Dr. Rambur served on the Green Mountain Care Board—a five-member regulatory, innovation, and evaluation board that has broad responsibility for cost containment and oversight of Vermont's transition to post-fee-for-service provider reimbursement. Previously, Dr. Rambur served as dean of the College of Nursing and Health Sciences at the University of Vermont and was chairperson for the North Dakota Health Task Force, a statewide health care financing reform initiative. Dr. Rambur received her Ph.D. in nursing from Rush University.

Wayne J. Riley, M.D., M.P.H., M.B.A., is president of the State University of New York (SUNY) Downstate Health Sciences University, where he also holds tenured professorships in both internal medicine and in health policy and management. Immediately before joining Downstate, Dr. Riley served as clinical professor of medicine and adjunct professor of health care management at Vanderbilt University. He was the also 10th president and chief executive officer of Meharry Medical College. He began his career at Baylor College of Medicine, where he completed residency training in internal medicine and held several key administrative posts, including vice president and vice dean for health affairs and governmental relations, assistant dean for education, and assistant chief of medicine at Ben Taub General Hospital—a leading public safety net teaching hospital. Dr. Riley is a member of the National Academy of Medicine (NAM) of the National Academy of Sciences, where he served as vice chair and chair of the NAM Section on Education, Research, and the Administration of Health Services. He is also president emeritus of the American College of Physicians—the nation's largest medical specialty society representing internal medicine—and president elect of the Society of Medical Administrators—an organization of 50 of the nation's leading physician-executives. He is an independent director of HCA Healthcare Inc. Dr. Riley earned a B.A.

in anthropology from Yale University, an M.P.H. in health systems management from the Tulane University School of Public Health and Tropical Medicine, an M.D. from Morehouse School of Medicine, and an M.B.A. from Rice University's Jesse H. Jones Graduate School of Business.

Jaewon Ryu, M.D., J.D., is the president and CEO for Geisinger, an integrated health care system headquartered in Danville, PA, that comprises hospitals, employed providers, a health plan, a medical school, and research and innovation centers. He previously served as president of integrated care delivery at Humana and held leadership roles at the University of Illinois Hospital & Health Sciences System and at Kaiser Permanente. Dr. Ryu received his undergraduate education at Yale University and his medical and law degrees from the University of Chicago, after which he completed his residency training in emergency medicine at Harbor-UCLA Medical Center.

Dana Gelb Safran, Sc.D., is senior vice president, Value Based Care and Population Health at Well Health Inc., a communications platform enabling dynamic, personalized communications between patients and their providers and plans. She leads the expansion of the platform's uses to improve health care outcomes and affordability through partnerships with payers and accountable care organization providers, and she is establishing an enterprise-wide measurement function to quantify customer results and inform continuous improvement and best-practice sharing. Previously, Dr. Safran was a founding executive team member at Haven, the joint venture of Amazon, Berkshire Hathaway, and JPMorgan Chase. At Haven, Dr. Safran was head of measurement and head of insurance markets and benefit redesign. Before joining Haven, Dr. Safran was chief performance measurement and improvement officer at Blue Cross Blue Shield of Massachusetts (BCBSMA). As an architect of the BCBSMA Alternative Quality Contract and the leader responsible for its unique use of behavioral economics and payer-provider collaboration to reduce cost while improving quality, Dr. Safran is widely recognized as having contributed to the national push toward value-based payment. Before joining BCBSMA, she led a research institute at Tufts University School of Medicine dedicated to developing patient-reported measures of health and health care quality. She remains on the faculty at Tufts and serves on a number of state and national advisory bodies related to health care quality and affordability. She earned her master's and doctor of science degrees from the Harvard School of Public Health.

Susan Thompson, M.S., B.S.N., is interim president and chief executive officer of UnityPoint Health, an integrated delivery system serving Iowa, central and western Illinois, and central Wisconsin. She is also the chief executive officer of UnityPoint Health Accountable Care LC, an Iowa limited liability company that brings together a diverse group of health care providers including hospitals, employed and independent physicians, and other providers, as well as other health initiatives. Previously, she was senior vice president of integration and optimization for UnityPoint and was president and chief executive officer of UnityPoint Health–Fort Dodge, which serves a predominantly rural and aging population and includes a sole community hospital, a primary care and multispecialty physician group, management contracts with five critical access hospitals throughout the region, and a Pioneer Accountable Care Organization. She also served in successive clinical and management positions at Trinity Regional Medical Center, as intensive care staff nurse, director of quality systems, assistant

director of patient-focused care, chief information officer, chief operating officer, and chief executive officer. Ms. Thompson obtained her B.S. in nursing and her M.S. in health services management from Clarkson College in Omaha, NE.

Pat Wang, J.D., is president and chief executive officer of Healthfirst in New York, NY. Healthfirst is a regional not-for-profit health plan, founded by area health care systems, that serves Medicare enrollees, including those who are eligible for low-income subsidies and those who are dually eligible for Medicare and Medicaid. Healthfirst incorporates a value-based payment model that aligns incentives with hospital and physician partners. Ms. Wang is a graduate of Princeton University and received her law degree cum laude from the New York University School of Law.

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