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**MEDICARE PAYMENT ADVISORY COMMISSION
RELEASES REPORT ON MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM**

Washington, DC, June 14, 2019—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2019 *Report to the Congress: Medicare and the Health Care Delivery System*. Each June, as part of its mandate from the Congress, MedPAC reports on issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services. This year's report includes:

Beneficiary enrollment in Medicare: Eligibility notification, enrollment process, and Part B late-enrollment penalties. Under current law, the government does not notify all individuals that they are eligible for Medicare at the age of 65. As a result, unnotified individuals might not enroll in Part B when they are first eligible to do so, and they are then subject to a late-enrollment penalty. Policymakers should address the lack of a notification process to ensure that all individuals are aware of their eligibility for and enrollment options under Medicare when they turn 65. We suggest several ways to address this issue.

Restructuring Medicare Part D for the era of specialty drugs. Since the start of Medicare Part D (Medicare's outpatient prescription drug benefit) in 2006, the share of Part D spending represented by high-cost specialty drugs and biologics has grown dramatically. At the same time, the gap between prices beneficiaries are charged at the point of sale and prices paid to manufacturers by plans has widened, putting an undue financial burden on beneficiaries. In response to the concerning shift in the distribution of drug spending, the Commission discusses modifications to Part D's benefit design to improve plans' financial incentives to manage drug spending, restrain manufacturers' incentives to increase the prices of specialty drugs, and provide better financial protection to all Part D enrollees.

Medicare payment strategies to improve price competition and value for Part B drugs. Spending for drugs covered under Medicare Part B (including drugs that are administered in physician offices and hospital outpatient departments) has grown rapidly over the last decade. Rising drug prices account for the majority of that spending growth, reflecting the significant leverage that manufacturers have when pricing their products. Building on our June 2017 recommendation to improve Medicare's payment for Part B drugs, the Commission examines two strategies to improve price competition and value for Part B drugs—reference pricing and binding arbitration.

Mandated report on clinician payment in Medicare. The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the previous formula used for setting clinician payments, established permanent statutory updates for clinician services in Medicare, created an incentive payment for clinicians who participate in certain types of payment arrangements, and created a new value-based purchasing program for all other clinicians. MACRA required the Commission to conduct a study of the statutory payment updates to clinician

services from 2015 through 2019 and their effect on the access to, supply of, and quality of clinician services. In this mandated report, the Commission concludes that, based on available data, the statutory updates for clinician services thus far have been sufficient to maintain beneficiary access. However, the Commission will continue to evaluate the adequacy of clinician payment and advise the Congress annually regarding future payment updates.

Issues in Medicare beneficiaries' access to primary care. The Commission has a long-standing interest in ensuring that Medicare beneficiaries have good access to primary care services. We discuss two aspects of this issue: (1) improving payment policies for advanced practice registered nurses (APRNs) and physician assistants (PAs), and (2) ensuring an adequate supply of primary care physicians. The Commission recommends eliminating “incident to” billing for APRNs and PAs and refining their specialty designations to give Medicare a fuller accounting of the services provided by these clinicians, improve policymakers' ability to target resources toward primary care, and produce savings for Medicare and its beneficiaries. Policymakers may also want to explore a scholarship or loan repayment program for geriatricians to increase beneficiary access to their services.

Assessing the Medicare Shared Savings Program's effect on Medicare spending. About a third of Medicare FFS beneficiaries are now attributed to accountable care organizations (ACOs)—mostly ACOs participating in the Medicare Shared Savings Program (MSSP), a permanent ACO model established by the Patient Protection and Affordable Care Act of 2010. The Commission assesses the performance of the MSSP on cost through 2016, and we estimate that Medicare spending on beneficiaries in the MSSP grew slightly less than it would have in the absence of the MSSP. However, this estimate is sensitive to how the analysis is designed. We find that beneficiaries who “switch” into and out of ACOs have higher spending growth than both those beneficiaries consistently assigned to an ACO and those never assigned to an ACO. Because ACO assignment is tied to use of health care services, a decline in a beneficiary's health could cause both a change in the physicians the beneficiary sees (thus a change in ACO assignment) and an increase in his or her use of health care services and spending. This finding may have significant implications for how ACO performance is assessed and how ACO models are designed.

Ensuring the accuracy and completeness of Medicare Advantage encounter data. Information on the “encounters” that Medicare Advantage (MA) enrollees have with their providers (interactions that would create a claim in the traditional FFS program) could be used to inform both FFS and MA payment policies. To improve encounter data so that they can be used for program oversight and comparisons with traditional FFS Medicare, we recommend that the Congress direct the Secretary to establish thresholds for the completeness and accuracy of encounter data, a payment withhold to encourage MA plans to submit the data, and a mechanism for provider submission of encounter data through Medicare Administrative Contractors.

Redesigning the Medicare Advantage quality bonus program. We find that the current MA quality bonus program (QBP) is flawed and is inconsistent with the Commission's principles for quality measurement for several reasons. The QBP includes process and administrative measures that are not meaningful to Medicare or its beneficiaries; the QBP also measures quality at a contract level, which may not be a useful indicator of the quality of care in a beneficiary's local area. Further, unlike most quality incentive programs in FFS Medicare, which are budget neutral or produce program savings, the QBP is financed with about \$6 billion a year in additional spending. We discuss an option to replace it with an MA value incentive program (MA-VIP) that is designed to be patient oriented, encourage coordination across providers and time, and promote improvement in the delivery system. The Commission's proposed MA-VIP would be budget neutral, financed through withholding a small percentage of plan payments. This design would better align MA and FFS quality incentives and would produce savings to the Medicare program and beneficiary premiums.

Payment issues in post-acute care. As mandated by the Congress, in June 2016, the Commission evaluated a design for a unified post-acute care (PAC) prospective payment system (PPS) and concluded that a PAC PPS,

as opposed to the four separate payment systems used today, would establish accurate payments and increase the equity of payments across beneficiary conditions. We examine three additional issues that policymakers will need to consider: (1) the advantages and disadvantages of stay-based versus episode-based payments, (2) the functional assessment data recorded by PAC providers, and (3) approaches for establishing aligned regulatory requirements for providers under a PAC PPS.

Mandated report: Changes in post-acute and hospice care after implementation of the long-term care hospital dual payment-rate structure. The Pathway to SGR Reform Act of 2013 changed how Medicare pays long-term care hospitals (LTCHs) for certain cases by creating a dual payment-rate structure. The Congress mandated that the Commission report on the effects of this policy change. We found that from 2015 through 2017, spending, the number of LTCH stays, and the number of facilities decreased, but the share of cases meeting the criteria for the standard LTCH PPS rate increased. These findings are consistent with the objectives of the dual payment-rate structure.

Options for slowing the growth of Medicare fee-for-service spending for emergency department services. Medicare spending for hospital emergency department (ED) visits has increased in recent years. We find that this spending growth may be the result of providers coding visits at higher acuity levels in response to payment incentives. The Commission recommends that the Secretary create and implement national ED coding guidelines for hospitals that would result in more accurate payments for patients in the ED setting.

Promoting integration in dual-eligible special needs plans. Individuals who qualify for both Medicare and Medicaid (known as dual-eligible beneficiaries) can receive care that is fragmented because of the challenges inherent in dealing with two distinct programs. There are several types of managed care plans that integrate Medicare and Medicaid services for dual-eligible beneficiaries that aim to better coordinate care for this population. We examine the integrated plan type with the largest enrollment, the MA dual-eligible special needs plan (D-SNP), but find the level of integration between D-SNPs and state Medicaid programs is generally low. We describe several policy changes that could improve the level of Medicare–Medicaid integration in D-SNPs.

The full report is available at MedPAC's website (<http://www.medpac.gov>).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.