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Contact: Paul Masi— (202) 220-3700
pmasi@medpac.gov

**MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS
ON MEDICARE PAYMENT POLICY**

Washington, DC, March 15, 2019—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2019 *Report to the Congress: Medicare Payment Policy*. The report includes MedPAC’s analyses of payment adequacy in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and the prescription drug benefit, Part D. Also, MedPAC recommends that the Congress replace the four current hospital quality payment programs with a single streamlined program—the hospital value incentive program (HVIP). Lastly, as mandated by the Congress, we report on incentives for prescribing opioid and non-opioid pain treatment under Medicare’s hospital inpatient and outpatient payment systems.

Fee-for-service payment rate update recommendations. The report presents MedPAC’s recommendations for how Congress should update payment rates in FFS Medicare for 2020. These “update” recommendations, which MedPAC is required by law to submit each year, are based on an assessment of payment adequacy that examines beneficiaries’ access to and use of care, the quality of the care they receive, supply of providers, and providers’ costs and Medicare’s payments.

Overall, these recommendations would reduce expected spending in the Medicare program while preserving beneficiaries’ access to high-quality care. MedPAC recommends that payments be updated by the amount specified in current law for dialysis facilities and for physicians and other health professionals. For long-term care hospitals, MedPAC recommends that payments be increased by 2 percent. MedPAC recommends no payment increase for 2020 for two FFS payment systems: ambulatory surgical centers and skilled nursing facilities. For skilled nursing facilities, MedPAC also recommends that the Secretary proceed with plans to reform the payment system to more equitably distribute payments among providers and better maintain access for all beneficiaries. For hospice providers, MedPAC recommends reducing payments by 2 percent. For home health agencies and inpatient rehabilitation facilities, MedPAC recommends reducing payments by 5 percent. Lastly, for acute care hospitals, MedPAC recommends payments be increased by 2 percent; the Commission recommends the difference between our recommended 2 percent update and the payment increase specified in current law (expected to be 2.8 percent) be used to increase the rewards hospitals receive under the HVIP.

Redesigning Medicare’s hospital quality programs: The hospital value incentive program. For several years, Medicare has encouraged higher-quality hospital care by adjusting hospitals’ payments based on their participation and performance in a set of four quality programs: The Hospital Inpatient Quality Reporting Program (IQRP), the Hospital Readmissions Reduction Program (HRRP), the Hospital-Acquired Condition Reduction Program (HACRP), and the Hospital Value-Based Purchasing (VBP) Program. The quality of hospital care provided to beneficiaries has improved over the last decade, in part, because of these programs.

However, despite their successes, the designs of the current hospital quality payment programs are complex, in some instances duplicative, and send different performance signals to hospitals. Last year, in its June 2018 report to the Congress, the Commission developed an alternative program—the hospital value incentive program, or

HVIP—for rewarding quality hospital care, based on a set of principles for measuring quality in the Medicare program. In this year’s report, the Commission recommends the Congress replace the four current programs for measuring and rewarding hospital quality with the HVIP.

The HVIP 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. The HVIP is simpler to administer, reduces provider burden, and more equitably considers differences in providers’ patient populations compared with existing programs.

Payments under the HVIP would be financed by a payment withhold and increased by the difference between the Commission’s update recommendation for acute care hospitals and the amount specified in current law. The increased payment under the HVIP will better reward hospitals providing high-quality care to beneficiaries. In addition, eliminating the existing penalty-only programs (i.e., the HRRP and HACRP) will remove about \$1 billion in overall penalties that hospitals currently incur each year. Taken together, our recommendations to update hospital payments and implement the HVIP are expected to increase Medicare’s overall payments to hospitals relative to current law.

Medicare Advantage. MA continued to experience strong enrollment growth in 2018, with 33 percent of all Medicare beneficiaries enrolled in MA plans. Medicare paid plans about \$233 billion (not including Part D drug plan payments) in 2018 to manage beneficiaries’ care. In 2019, before accounting for differences in coding intensity, access to MA plans remains high; 99 percent of Medicare beneficiaries have access to an MA plan, and the average beneficiary has 23 available plans to choose from. In 2019, MA benchmarks, bids, and payments averaged 107, 89 and 100 percent of FFS spending, respectively, reflecting positive trends in the MA program. However, for several years, the Commission has expressed concern that enrollees in MA plans have higher risk scores than similar beneficiaries in FFS because of plans’ more intensive coding practices. Those higher risk scores inflate Medicare’s payments to plans by about 1 to 2 percent. The Commission previously recommended that CMS reduce excess payments stemming from plans’ intensive coding practices, which would improve equity across plans and produce savings for Medicare.

The Commission has also recommended curtailing the practice of MA plan consolidation to obtain unwarranted quality bonus payments. This concern was partly addressed in the Bipartisan Budget Act of 2018, which provides that, beginning at the end of 2019, the quality rating for consolidated contracts be based on an enrollment-weighted average of the results of each contract.

However, the Commission continues to have concerns with the MA star rating system, which serves as the basis for plan quality bonuses and public reporting of plan quality. MA star ratings continue to be determined at the contract level. Because contracts can cover wide (and discontinuous) geographic areas and quality results are often determined based on only a small sample of beneficiary medical records, Medicare and beneficiaries lack important information about the quality of care of MA plans in their market. As a result, it is difficult to reliably compare quality among plans, and the MA star rating system continues to award unwarranted quality bonus payments. Medicare also continues to lack the information necessary to compare MA quality with the quality of care in FFS. To address these issues, the Commission discusses using encounter data as the source of quality metrics in MA and moving to market areas as the reporting unit.

Part D. Over 73 percent of Medicare beneficiaries (about 44 million beneficiaries) participated in private Medicare drug plans in 2018. Beneficiaries continue to have broad choice among plans in 2019. Beneficiaries’ options range from 22 to 30 prescription drug plans (PDPs) depending on where they live, in addition to several MA plans that also offer prescription drug benefits (MA–PDs). In 2017, total Part D spending was nearly \$94 billion, accounting for about 13 percent of Medicare spending. Plan enrollees paid \$14 billion of that amount in plan premiums (enrollees also paid additional amounts in cost sharing). In several ways, Part D has succeeded: Part D has improved beneficiaries’ access to prescription drugs, generic drugs now account for nearly 90 percent of the prescriptions filled, and enrollees’ average premiums for basic benefits have remained steady for many years (around \$30 per month).

However, changes to Part D's benefit design, in combination with growth in the use of high-cost medicines, may be eroding plans' incentives to manage benefit costs. Over time, a growing share of Medicare's payments to plans have taken the form of cost-based reinsurance instead of fixed-dollar payments (which provide incentives to control spending). Between 2007 and 2017, reinsurance payments increased at an average annual rate of nearly 17 percent, while Medicare's fixed-dollar direct subsidy payments *decreased* nearly 2 percent per year. In addition, beginning in 2019, brand-drug manufacturers must provide a 70 percent discount in the coverage gap (an increase from 50 percent), decreasing plan sponsors' responsibility. This change further weakens sponsors' incentives to manage spending.

Policymakers are taking steps to give plans new flexibilities to manage drug spending. However, measures to increase the financial risk that plans bear (such as those recommended by the Commission in 2016) are essential to ensure plans have incentives to use their new management tools to reduce spending growth for Medicare and its beneficiaries.

Mandated report: Opioids and alternatives in hospital settings—Payments, incentives, and Medicare data.

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act of 2018 mandated that the Commission describe how Medicare pays for both opioid and non-opioid pain management treatments in hospital inpatient and outpatient settings, the existing incentives under the inpatient and outpatient prospective payment systems (the IPPS and OPSS, respectively) for prescribing opioids and non-opioids, and how opioid use is monitored through Medicare claims data.

Medicare uses bundled payments to pay for pain management drugs and services in both the inpatient and outpatient settings. The IPPS and OPSS payment bundles create a financial incentive for hospitals to be cost conscious when purchasing items and services. Medicare's quality measurement and reporting programs are designed to balance this financial incentive. Ideally, these balanced incentives, along with providers' clinical expertise, are designed to result in high-quality outcomes at the best prices for beneficiaries and taxpayers. However, if opioids are systematically cheaper than non-opioid alternatives, providers might be more inclined to opt for them, especially if doing so does not affect performance on quality measures.

The Commission analyzed certain list prices (likely an upper bound on the prices hospitals actually pay) for opioids and non-opioid alternatives commonly used in the hospital setting and found that both opioids and non-opioids are available at a range of prices, and there are expensive and inexpensive options for both. The Commission concludes that there is no clear indication that Medicare's IPPS or OPSS discriminates against non-opioids. Our study is not intended to be an assessment of the clinical appropriateness of the use of opioids versus non-opioid alternatives, and we recognize that clinicians' decisions about which pain management drug to prescribe are based on a multitude of patient-specific factors.

CMS monitors opioid use through tracking programs in Part D, but Medicare does not operate similar tracking programs in Part A or Part B. Policymakers may wish to direct CMS to track opioid use in the hospital inpatient and outpatient settings. If Medicare were to undertake an opioid monitoring program in Part A and Part B, there are structural differences from Part D that would require adaptation of CMS's current Part D monitoring programs.

A list of recommendations is included in the accompanying fact sheet. The entire report is available online at <http://www.medpac.gov>.

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The Medicare Payment Advisory Commission is a congressional agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.