

Report to the Congress: Medicare and the Health Care Delivery System - June 2016

The Commission's June 2016 report examines a variety of Medicare payment system issues. In the nine chapters of this report, we consider: Medicare drug spending in its broader context, Medicare Part B drug and oncology payment policy issues, improving the Medicare Part D prescription drug program, using competitive pricing to set beneficiary premiums in Medicare, Medicare's new framework for paying clinicians, developing a unified payment system for post-acute care, improving efficiency and preserving access to emergency care in rural areas, telehealth services and the Medicare program, and issues affecting dual-eligible beneficiaries.

MEDICARE DRUG SPENDING IN ITS BROADER CONTEXT

- The Commission remains concerned about the rapid growth in drug prices because that growth can affect beneficiary access to needed medications, as well as the financial sustainability of the Medicare program. In 2013, drugs and pharmacy services made up 19 percent of program spending. This value is larger than the oft-cited ten percent because it is a broader measure that includes spending for drugs and pharmacy services used as inputs at health care facilities, e.g. hospitals and skilled nursing facilities.
- Medicare does not purchase drugs directly. Instead, it makes payments to drug plans, physicians, and health care facilities, which in turn negotiate rates with drug manufacturers, both directly and indirectly. Because Medicare does not purchase drugs from manufacturers, its ability to influence drug prices is indirect. External factors, including the FDA approval process and patent law, can also affect the prices Medicare pays for prescription drugs. The Commission will continue to recommend changes to Medicare policies intended to promote drug price competition and improve incentives for providers and beneficiaries to seek better value when they purchase drugs.

MEDICARE PART B DRUG AND ONCOLOGY PAYMENT POLICY ISSUES

- Medicare Part B covers drugs that are administered by infusion or injection in physician offices and hospital outpatient departments. It also covers certain drugs furnished by suppliers. Medicare pays for most Part B-covered drugs based on the average sales price (ASP) plus a 6 percent add-on. This chapter explores potential modifications to the way Medicare Part B pays for drugs.
- There are concerns that the 6 percent add-on to ASP may create incentives for use of higher priced drugs when lower priced alternatives exist, although few studies have looked at this issue. In addition to concerns about the incentives created by a percentage add-on, Commission analysis suggests that the current 6 percent add-on may be too high. Our analyses of Part B drug prices suggest that many drugs were sold to clinics at a price that was less than 102 percent of ASP. This finding suggests that there may be room for a reduction to the add-on portion of the payment rates for Part B drugs, which could create savings for the Medicare program.
- We modeled a policy option that changes part of the 6 percent add-on to a flat fee. Assuming no utilization changes, we estimate that this option would reduce Part B drug spending by about 1.3 percent. It might also increase the likelihood that a provider would choose a lower cost drug in situations where differently priced therapeutic alternatives exist, potentially generating additional savings for Medicare and its beneficiaries.
- The largest component of Medicare's payments for Part B drugs is the ASP, not the 6 percent add-on. If policymakers wish to influence Part B drug payments to a larger degree than is possible through add-on payments, they could consider Medicare payment policies that create more price competition among

drugs or that put downward pressure on ASP. We examine three such policy options. The first would limit the amount that Medicare's ASP-based payment for a drug could grow over time, which could help insulate the program from substantial price increases. The second would combine single billing codes for Part B drugs with similar health effects, predominantly biosimilars, into consolidated codes, to spur price competition among these drugs. The third policy would restructure Medicare's suspended competitive acquisition program through which physicians could obtain Part B drugs from a vendor.

- This chapter also considers approaches to improve the quality and efficiency of oncology care, as more than half of Medicare Part B drug spending is associated with anticancer drugs. For this report, we examined four approaches, used in Medicare and non-Medicare settings, which aim to improve the efficiency of oncology and related care. Two approaches attempt to improve the value of drug spending. These include oncology clinical pathways and risk-sharing agreements between product manufacturers and payers. Two broader approaches take a more holistic view of cancer care by improving care management and coordination. These include oncology medical homes and bundling Part B oncology drugs with non-oncology services, which would hold providers accountable for the total cost of services across an episode of care.
- The Office of Inspector General has reported that Medicare Part B pays substantially higher dispensing fees than the rates paid by Medicare Part D plans and Medicaid for inhalation drugs furnished by durable medical equipment suppliers. Medicare also pays higher supplying fees for Part B-covered immunosuppressives, oral anticancer, and oral antiemetic drugs furnished by pharmacies. We believe that Medicare should not pay dispensing and supplying fees higher than other payers.

Recommendations:

- The Secretary should reduce the Medicare Part B dispensing and supplying fees to rates similar to other payers.

IMPROVING THE MEDICARE PART D PRESCRIPTION DRUG PROGRAM

- The structure of Part D, launched in 2006, was designed to encourage broad participation of private plan sponsors in a new program. The design features included a basic subsidy, subsidies for the poor, risk corridors, and a large subsidy for catastrophic costs. However, the markets for Medicare Advantage (MA) prescription drug plans and for stand-alone prescription drug plans are now firmly established, and the program's incentives need to be restructured to better ensure financial sustainability.
- Financial sustainability is a growing concern because of sizable increases in program expenditures for high-cost enrollees (those who reach Part D's out-of-pocket (OOP) threshold). Much of those spending increases have been driven by increases in the average price of prescriptions filled by non-low-income-subsidy (LIS) beneficiaries (which reflects both growth in drug prices and changes in the mix of drugs used), and therefore many more enrollees are reaching the OOP threshold. Going forward, many new biopharmaceutical products in the development pipeline will have substantially higher prices than previous treatments, even when they have therapeutic competitors. This will exert strong upward pressure on costs and premiums.
- The Commission recommends improvements intended to increase incentives and tools for private plans to manage drug costs. Together, the recommendations make up a package of policy changes. One set of changes shift more financial risk to plans and would give sponsors greater financial incentives and stronger tools to manage the benefits of high-cost enrollees. Other parts of the Commission's recommendations would exclude manufacturer discounts on brand-name drugs from counting as enrollees' true out-of-pocket spending, while providing greater insurance protection by eliminating beneficiary cost sharing above the catastrophic cap. The recommendations would also allow plans to send greater price signals to low-income beneficiaries to use generic drugs and would allow plans to use selected tools to manage specialty drug benefits.

- Under the combined recommendations, Part D’s risk adjusters would become more important as a tool for counterbalancing plan incentives for selection, and CMS would need to take steps to recalibrate the risk-adjustment system. Similarly, because plans would have greater flexibility to use formulary tools to manage benefits, CMS would need to continue monitoring plan operations to ensure appropriate beneficiary access. The agency would also need to ensure that the exceptions and appeals process under Part D functions effectively.

Recommendations:

- The Congress should change Part D to:
 - transition Medicare’s individual reinsurance subsidy from 80 percent to 20 percent while maintaining Medicare’s overall 74.5 percent subsidy of basic benefits,
 - exclude manufacturers’ discounts in the coverage gap from enrollees’ true out-of-pocket spending, and
 - eliminate enrollee cost sharing above the out-of-pocket threshold
- The Congress should change Part D’s low-income subsidy to:
 - modify copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs, preferred multisource drugs, or biosimilars when available in selected therapeutic classes;
 - direct the Secretary to reduce or eliminate cost sharing for generic drugs, preferred multisource drugs, and biosimilars; and
 - direct the Secretary to determine appropriate therapeutic classifications for the purposes of implementing this policy and review the therapeutic classes at least every three years.
- The Secretary should change Part D to:
 - remove antidepressants and immunosuppressants for transplant rejection from the classes of clinical concern,
 - streamline the process for formulary changes,
 - require prescribers to provide standardized supporting justifications with more clinical rigor when applying for exceptions, and
 - permit plan sponsors to use selected tools to manage specialty drug benefits while maintaining appropriate access to needed medications.

USING COMPETITIVE PRICING TO SET BENEFICIARY PREMIUMS IN MEDICARE

- The Commission has been studying how Medicare could structure premiums to encourage beneficiaries to choose the most efficient (high-quality, low-cost) option for receiving Medicare benefits while maintaining equity for beneficiaries across different geographic areas.
- We discuss three methods for setting premiums. Under each design, beneficiaries can enroll in either fee-for-service (FFS) Medicare or MA, but the premium they pay will differ depending on their choice. In addition, the federal contribution is financially neutral across payment systems—that is, equal for FFS Medicare and MA in each market. Under two designs, beneficiaries who choose the less efficient option will pay a higher premium. Exactly how much higher that premium will be depends on the difference between average FFS costs and the cost of the reference MA plan in the area. Under either design, if the beneficiary premium impact is deemed too expensive in some markets, policymakers could mitigate the increase in beneficiary premiums in a variety of ways (e.g., by limiting how much premiums can differ between FFS and MA or by phasing in increases over time), though these steps would also limit the power of the incentive.

MEDICARE'S NEW FRAMEWORK FOR PAYING CLINICIANS

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) repealed the sustainable growth rate (SGR) system and established a new approach for updating payments to clinicians. Essentially, MACRA establishes two paths for payment updates—a path for clinicians who participate in eligible alternative payment entities and a path for all other clinicians.
- This chapter presents the Commission's principles concerning the alternative payment model (APM) provisions of MACRA. It also discusses some key considerations for clinicians who do not qualify for the APM incentive payment. For these clinicians, a separate program exists for assessing their performance—the Merit-based Incentive Payment System (MIPS). Our discussion is intended to assist in thinking through the implementation of this legislation and to help move the Medicare program from one oriented toward FFS payment to one that encourages delivery system reform oriented toward payment for value. The Commission's basic principles for APMs are:
 - Clinicians should receive an incentive payment only if the eligible alternative payment entity in which they participate is successful in controlling cost, improving quality, or both.
 - The eligible alternative payment entity should be at financial risk for total Part A and Part B spending.
 - The eligible alternative payment entity should be responsible for a beneficiary population sufficiently large to detect changes in spending and quality.
 - The eligible alternative payment entity should have the ability to share savings with beneficiaries.
 - Eligible alternative payment entities should receive relief from certain CMS regulations.
 - Each eligible alternative payment entity should assume financial risk and enroll clinicians.
- For MIPS, we outline some lessons that can be learned from CMS's experience with the performance incentive programs that may be components of the eventual MIPS program, and we discuss how to consider factors such as quality and resource use at the individual clinician level. We also underscore the Commission's position that quality measures should emphasize population-based outcomes.

DEVELOPING A UNIFIED PAYMENT SYSTEM FOR POST-ACUTE CARE

- The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires the Commission to develop a prototype for a unified prospective payment system that spans the four post-acute care (PAC) settings—skilled nursing facilities (SNFs), home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. The Commission is required to recommend features of a unified PAC PPS and consider the impact of moving to such a payment system.
- In this chapter, we report that a PAC PPS is within reach. The Commission's research found that it is feasible to develop a common unit of payment for PAC services, with patient and stay characteristics forming the basis of risk adjustment. Available administrative data can accurately predict the costs (and establish payments) for most of the patient groups we examined, but patient assessment data collected using a common assessment tool would increase the accuracy for certain types of stays.
- We estimate that a PAC PPS would redistribute payments among types of stays and from higher cost settings and providers to lower cost settings and providers. Under a PAC PPS, profitability would be more uniform across different types of stays or patients; therefore, providers would have less financial incentive to admit certain types of patients over others. This would also protect beneficiaries with complex care needs who might otherwise have difficulty obtaining care.
- To temper the initial impact of the PAC PPS, policymakers will need to consider a transition period for moving toward a new payment system. Yet given our encouraging results using currently available data,

the Secretary could consider implementing a unified PAC PPS sooner than is currently legislated, with refinements made over time to incorporate patient assessment data.

- Policymakers will also need to consider the level of PAC payments. The Commission estimates that, in 2013, PAC payments were 19 percent higher than the cost of stays. Consistent with the Commission’s recommendations over multiple years, Medicare’s payment rates for PAC should be reduced.
- The chapter discusses setting-specific regulations that might be waived at the same time the PAC PPS is implemented to “level the playing field” between providers in different settings. Over the longer term, the Secretary should consider developing a “core” set of conditions of participation for all PAC providers and a limited set of additional requirements for providers that opt to treat patients who require specialized care. Regulations would focus on requirements to treat specific types of patients rather than on specifications for each setting. The Secretary should implement a readmission policy to prevent unnecessary hospital readmissions and a value-based purchasing policy to tie payments to outcomes (to protect beneficiaries against stinting) and resource use (to prevent unnecessary service use, including serial PAC stays). MedPAC will continue to evaluate the payment system annually.

IMPROVING EFFICIENCY AND PRESERVING ACCESS TO EMERGENCY CARE IN RURAL AREAS

- Efficiently providing access to inpatient and emergency services is a growing challenge in sparsely populated rural areas. Declining populations can lead to declining hospital admissions and reductions in efficiency, which can cause financial difficulties for hospitals. Low volumes may also make it hard for clinicians at rural hospitals to have enough practice with different types of patients to provide patient outcomes equal to neighboring higher volume facilities.
- Most rural hospitals are critical access hospitals (CAHs), which receive cost-based payment for Medicare inpatient and outpatient services. The CAH model, as well as the other current subsidy programs for small rural hospitals, require providers to maintain inpatient services, which may not be best for all rural communities.
- The chapter discusses creating two new options that would allow hospitals that lack the population to support efficient, high-quality inpatient services to shift to an outpatient-only model while maintaining some supplemental Medicare dollars that would keep them financially viable:
 - **24/7 emergency department.** Under this model, the supplemental payments hospitals currently get for maintaining CAH inpatient services are redirected to support stable access to emergency care. A rural hospital that gives up acute inpatient services and cost-based payment would receive an annual grant or fixed payment from Medicare to help cover the standby costs of 24/7 emergency services. The facility would also be paid Medicare outpatient hospital PPS rates for outpatient services. The facility would be paid Medicare SNF PPS rates if it chooses to use inpatient beds as SNF beds.
 - **Clinic and ambulance.** Under this model, communities that cannot support a 24/7 emergency department could opt to convert their existing inpatient facilities into a primary care clinic with an affiliated ambulance service. Medicare could provide prospective rates for primary care visits and ambulance transports, but it could also provide an annual grant or fixed payment to support the capital costs of having a primary care practice, the standby costs of the ambulance service, and uncompensated care costs.
- As the Commission has stated in previous reports, supplemental payments beyond the standard PPS rates should be targeted to isolated rural providers. A new program to support rural stand-alone EDs should be limited to facilities at least some minimum number of road miles from the nearest hospital.

TELEHEALTH SERVICES AND THE MEDICARE PROGRAM

- This chapter provides the Commission’s analysis of telehealth services—a multidimensional set of health care services delivered through a range of online, video, and telephone communication. Medicare’s coverage of telehealth in FFS is limited to certain services and providers and to care provided in rural locations. MA plans must cover telehealth services that are covered under FFS Medicare. MA plans can cover additional telehealth services as supplemental benefits.
- Medicare telehealth use is low but has grown rapidly in recent years. Beneficiaries using telehealth services tend to be under 65, be disabled, be dually eligible for Medicare and Medicaid, and reside in rural areas. Outside of the Medicare program, interest in telehealth services has grown, but the use of services is not widespread. Commercial insurers and most state Medicaid programs cover some telehealth services. A growing share of large employers provides telehealth services to create convenience for their employees and reduce their health care spending. The Department of Veterans Affairs has also implemented telehealth programs.
- Evidence is mixed regarding the ability of telehealth services to expand access and create convenience, improve quality and outcomes, and reduce costs. Evidence that certain telehealth services improve access and create convenience is much stronger compared with that regarding quality improvement or cost reduction. Telehealth for patients with chronic conditions has shown some positive quality and cost results, as has telestroke care. More targeted research isolating specific telehealth interventions for specific patient populations is needed.
- If policymakers consider expanding telehealth services in Medicare, they should differentiate between the financial incentives that exist under Medicare’s payment models. In MA, many bundled payment models, and ACOs, the financial risk of providing such services falls to the insurers or providers. By contrast, under traditional FFS Medicare, the additional cost for telehealth services would be borne by the Medicare program, unless such services were substitutes for traditional face-to-face clinical services.

ISSUES AFFECTING DUAL-ELIGIBLE BENEFICIARIES

- Policymakers have long been concerned that dual-eligible beneficiaries—those who qualify for both Medicare and Medicaid—may receive fragmented or ineffective care because they are generally in poorer health than other Medicare beneficiaries and must obtain care from two distinct programs. These concerns also reflect the high costs of caring for dual-eligible beneficiaries. In 2011, dual eligibles represented about 20 percent of Medicare beneficiaries but accounted for about 35 percent of Medicare spending.
- This chapter provides a status report on the “financial alignment” demonstration project, an initiative by CMS and states to test new models of care for dual eligibles in 13 states. About 450,000 dual eligibles are currently enrolled in the demonstrations. Most demonstrations are testing a “capitated” model, which uses managed care plans called Medicare–Medicaid plans (MMPs) to provide all Medicare and Medicaid benefits to dual eligibles.
- Enrollment in the MMPs has been lower than some expected. Under the demonstration, states can “passively” (that is, automatically) enroll dual eligibles in MMPs to help ensure that the plans have enough enrollment to justify up-front investments in care coordination activities. However, many beneficiaries have opted out because they are satisfied with their existing care or are uncertain about how the demonstration will affect them. Passive enrollment has helped generate sufficient participation for most MMPs, but its use could be improved in the future.
- The chapter also examines the potential cost of three illustrative scenarios for expanding the Medicare Savings Programs (MSPs), which provide assistance with Medicare premiums and cost sharing to certain low-income Medicare beneficiaries. We summarize MSP eligibility rules and assistance and examine the potential effects of expanding MSP eligibility under three illustrative scenarios. The scenarios highlight some of the key issues that policymakers would need to consider as part of an MSP expansion.