

## Report to the Congress • March 2018

The Medicare Payment Advisory Commission (MedPAC) is required by law annually to review Medicare payment policies and make recommendations to the Congress. In the March 2018 report, MedPAC makes payment policy recommendations for nine provider sectors in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and Medicare's prescription drug benefit (Part D). MedPAC also recommends changing the way Medicare pays for clinician services in FFS by moving beyond the Merit-based Incentive Payment System (MIPS), recommends changes to MA and Part D to improve the equity and efficiency of those programs, and responds to a Congressional mandate on telehealth in Medicare. In the Bipartisan Budget Act of 2018, Congress enacted several policies that are similar to recommendations contained in this report.

### **FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS**

To meet its legislative mandate, the principal focus of the March report is MedPAC's recommendations for annual rate adjustments (or "updates") under Medicare's various FFS payment systems. MedPAC assesses payment adequacy by examining beneficiary access to care (supply of providers, service use, access surveys); quality of care; providers' access to capital; and provider costs and Medicare payments, where available. MedPAC's recommendations for the 2019 payment year are listed below.

#### **Hospitals: Inpatient and outpatient services**

- For 2019, the Congress should update the 2018 Medicare base payment rates (inpatient and outpatient) for acute care hospitals by the amount determined under current law.

#### **Physicians and other health professionals.**

- For calendar year 2019, the Congress should increase the calendar year 2018 payment rates for physician and other health professional services by the amount specified in current law.

#### **Ambulatory surgical centers**

- The Congress should eliminate the calendar year 2019 update to the Medicare payment rates for ambulatory surgical centers.
- The Secretary should require ambulatory surgical centers to report cost data.

#### **Outpatient dialysis**

- For 2019, the Congress should update the calendar year 2018 Medicare end-stage renal disease prospective payment system base rate by the amount determined under current law.

#### **Post-acute care: Increasing the equity of Medicare's payments within each setting**

- The Congress should direct the Secretary to begin to base Medicare payments to post-acute care (PAC) providers on a blend of each sector's setting-specific relative weights and the unified PAC prospective payment system's relative weights in fiscal year 2019.

## **Skilled nursing facilities**

The Congress should:

- eliminate the market basket update for skilled nursing facilities for fiscal year 2019 and 2020;
- direct the Secretary to implement a redesigned prospective payment system (PPS) in fiscal year 2019 for skilled nursing facilities; and
- direct the Secretary to report to the Congress on the impacts of the revised PPS and make any additional adjustments to payments needed to more closely align payments with costs in fiscal year 2021.

## **Home health agencies**

- The Congress should reduce Medicare payments to home health agencies by 5 percent in calendar year (CY) 2019 and implement a two-year rebasing of the payment system beginning in CY 2020. The Congress should direct the Secretary to revise the prospective payment system to eliminate the use of therapy visits as a factor in payment determinations, concurrent with rebasing.

## **Inpatient rehabilitation facilities**

- The Congress should reduce the fiscal year 2019 Medicare payment rate for inpatient rehabilitation facilities by 5 percent.
- Additionally, the Commission reiterates its March 2016 recommendations on the inpatient rehabilitation facility prospective payment system.

## **Long-term care hospitals**

- The Congress should eliminate the fiscal year 2019 Medicare payment update for long-term care hospitals.

## **Hospice**

- The Congress should eliminate the fiscal year 2019 update to the Medicare payment rates for hospice services.

## **STATUS OF THE MEDICARE ADVANTAGE PROGRAM**

- Between 2016 and 2017, enrollment in MA plans grew by about 8 percent to 18.9 million enrollees. Thirty-two percent of all Medicare beneficiaries were enrolled in MA plans in 2017. Among plan types, HMOs continue to enroll the most beneficiaries (12.2 million enrollees).
- In 2018, access to MA plans remains high: 99 percent of Medicare beneficiaries have access to an MA plan. Nearly all Medicare beneficiaries (96 percent) have an HMO or a local preferred provider organization (PPO) plan operating in their county of residence. In 2017, 84 percent of Medicare beneficiaries had access to an MA plan that includes Part D drug coverage and charges no premium (beyond the Medicare Part B premium). The average beneficiary in 2018 has 20 available plans to choose from.
- 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 costs and are based in part on diagnoses that providers code. MA plans have a financial incentive to ensure that their providers record all possible diagnoses because higher enrollee risk scores result in higher payments to the plan. For several years now, the Commission has observed that risk scores for MA enrollees are higher than the risk scores of similar beneficiaries in FFS. In 2016, CMS applied the statutory minimum adjustment and reduced MA risk scores by 5.41 percent. However, our analysis of 2016 data finds that higher coding intensity resulted in MA risk scores that were 8 percent higher than scores for similar beneficiaries in traditional FFS Medicare. The Commission previously recommended that CMS change the way diagnoses are collected for use in risk

adjustment and estimate a new coding adjustment that improves equity across plans and eliminates the impact of differences in MA and FFS coding intensity.

- In 2018, MA benchmarks, bids, and payments (including quality bonuses) average 107 percent, 90 percent, and 101 percent of FFS spending, respectively. However, all these values increase by about 2 percentage points if coding intensity (discussed above) is fully reflected (e.g., payments for MA plans would average 103 percent of FFS spending). On average, quality bonuses in 2018 add 4 percent to the average plan's base benchmark and add 3 percent to plan payments.
- Plans receive bonus payments if their contract has an overall rating of 4 stars or higher on CMS's 5-star rating system. Plans in a lower-performing contract can receive a bonus payment if their contract is absorbed by a contract that is rated 4 stars or higher. At the end of 2017, 1.4 million enrollees were in a non-bonus contract that was absorbed by another contract with a rating of 4 stars or higher and which will, thus, receive bonus payments in 2018. Since 2013, over 20 percent of MA enrollees (over 4 million enrollees) have been moved by organizations among contracts to secure bonus payments. In addition to unwarranted bonus payments, contract consolidations have resulted in inaccurate reporting of Medicare Plan Finder star ratings that beneficiaries use to choose among plans in their area. The Commission recommends that contract consolidations should not be allowed to affect star ratings and bonus payments when two contracts serving different geographic areas are consolidated.

### **RECOMMENDATION FOR THE MEDICARE ADVANTAGE PROGRAM**

For Medicare Advantage contract consolidations involving different geographic areas, the Secretary should:

- for any consolidations effective on or after January 1, 2018, require companies to report quality measures using the geographic reporting units and definitions as they existed prior to consolidation, and
- determine star ratings as though the consolidations had not occurred, and maintain the pre-consolidation reporting units until new geographic reporting units are implemented.

The Secretary should:

- establish geographic areas for Medicare Advantage quality reporting that accurately reflect health care market areas, and
- calculate star ratings for each contract at the geographic level for public reporting and for the determination of quality bonuses.

### **STATUS OF THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)**

- In 2017, 73 percent of all Medicare beneficiaries (42.5 million beneficiaries) were enrolled in Part D plans. Among Part D plan enrollees, 12.2 million individuals received the low-income subsidy (LIS). An additional 3 percent of all Medicare beneficiaries received drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. The remaining 25 percent of Medicare beneficiaries were divided about equally between those who had other sources of coverage at least as generous as Part D and those with no coverage or less generous coverage.
- Of those Medicare beneficiaries enrolled in Part D in 2017, 59 percent were in stand-alone prescription drug plans (PDPs) and 41 percent were in Medicare Advantage–Prescription Drug (MA–PD) plans. For 2018, beneficiaries continue to have broad choice among plans, ranging from 19 PDPs to 26 PDPs depending on where they live, and typically 10 or more MA options.
- In 2016, Medicare spending and enrollee premiums for Part D benefits totaled \$91.6 billion. Enrollee premiums made up \$12.7 billion of that total (enrollees also paid cost sharing). Between 2007 and 2016, Part D spending increased at an average annual rate of about 6 percent. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) have been driving Part D program

costs, accounting for 57 percent of gross spending in 2015. Spending for these high-cost individuals was driven almost entirely by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used).

- There are three types of payments Medicare makes to plan sponsors: direct subsidy payments (capitated monthly payments to plans that reduce premiums for all enrollees), low-income subsidy payments (which pay for most of the premiums and cost sharing for LIS enrollees), and reinsurance payments (which pay for 80 percent of spending in the catastrophic portion of the benefit). Spending on reinsurance became the largest component of program spending in 2014 and has remained the fastest growing component, at an average annual growth rate of nearly 18 percent between 2007 and 2016.
- Biologics make up a fast-growing segment in the biopharmaceutical sector and their use is expected to expand. Biosimilars have the potential to increase price competition among biologics, but there are design features of Part D that may discourage plans from covering them. MedPAC makes a recommendation to apply the same discount that manufacturers of originator biologics and brand-name drugs provide in the coverage gap to biosimilar products. Consistent with the Commission's 2016 recommendations, discounts on biosimilars would not count as though they were an enrollee's own out-of-pocket spending for purposes of determining when an enrollee reached Part D's catastrophic phase.

#### **RECOMMENDATION FOR THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)**

The Congress should change Part D's coverage-gap discount program to:

- require manufacturers of biosimilar products to pay the coverage-gap discount by including biosimilars in the definition of "applicable drugs" and
- exclude biosimilar manufacturers' discounts in the coverage gap from enrollees' true out-of-pocket spending.

#### **MOVING BEYOND THE MERIT-BASED INCENTIVE PAYMENT SYSTEM**

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) established a new framework for how traditional FFS Medicare pays for clinician services. The Commission supports the elements of MACRA that repealed the SGR and encouraged comprehensive, patient-centered care delivery models such as advanced alternative payment models (A-APMs). MACRA also created the Merit-based Incentive Payment System (MIPS), which measures individual clinicians in traditional Medicare on a set of measures that they choose.
- MedPAC shares Congress' goal, expressed in MIPS, of having a value component for clinician services in traditional Medicare that promotes high-quality care. However, the Commission believes that MIPS will not fulfill this goal and therefore should be eliminated.
- MIPS is premised on the assumption that Medicare can measure and pay for quality at the level of the individual clinician, but a system built on that assumption will be fundamentally inequitable for two reasons: (1) clinicians will be evaluated and compared on dissimilar measures, and (2) many clinicians will not be evaluated at all, because as individuals, they will not treat enough Medicare beneficiaries to produce statistically reliable scores. In addition:
  - MIPS imposes a significant reporting burden on clinicians (estimated by CMS as over \$1.3 billion in the first year).
  - MIPS scores are not comparable among clinicians because each clinician's composite MIPS score will reflect a mix of different, self-chosen measures.

- MIPS is complex and inequitable, with different rules for clinicians based on location, practice size, and other factors, and in 2018 it exempts more clinicians than will participate.
- MIPS-based payment adjustments will be small in the first years, providing little incentive, and then arbitrary and possibly very large in later years, creating significant uncertainty for clinicians.
- After a two-year deliberative process, the Commission recommends that the Congress eliminate MIPS and adopt an alternative approach for achieving the shared goal of promoting high-quality clinician care for beneficiaries in traditional Medicare.
- To help improve the quality of care in Medicare, quality measures should be reliable, encourage coordination across providers and time, and promote change in the delivery system. Quality measurement should focus on population-based measures and give rewards or penalties based on clear, absolute, and prospectively set performance targets. In addition, quality measurement should not be overly burdensome for providers or divert resources needed for patient care.

### **RECOMMENDATION FOR THE MERIT-BASED INCENTIVE PAYMENT SYSTEM**

The Congress should:

- eliminate the current Merit-based Incentive Payment System; and
- establish a new voluntary value program in fee-for-service Medicare in which:
  - clinicians can elect to be measured as part of a voluntary group; and
  - clinicians in voluntary groups can qualify for a value payment based on their group's performance on a set of population-based measures.

### **MANDATED REPORT: TELEHEALTH SERVICES AND THE MEDICARE PROGRAM**

- The 21<sup>st</sup> Century Cures Act of 2016 mandated that the Commission provide, by March 15, 2018, information about (1) coverage of telehealth services under the Medicare FFS program, (2) coverage of telehealth services under commercial insurance plans, and (3) ways in which the telehealth coverage policies of commercial insurance plans might be incorporated into the Medicare FFS program. The Commission fulfills this mandate in the March report.
- *Medicare coverage of telehealth services*—Medicare coverage of telehealth services is broad and flexible under payment systems in which providers or payers bear some degree of financial risk, but more limited under the physician fee schedule (PFS).
  - The PFS covers telehealth services originating at rural medical facilities and offices, as well as certain telehealth services paid for as part of a bundle of services delivered in both urban and rural areas. Under Medicare's other FFS payment systems (e.g., hospital inpatient and home health), providers receive a fixed payment for patient encounters and under the fixed payment system are able to use telehealth services that best serve beneficiaries. Some entities bearing financial risk (e.g., accountable care organizations (ACOs) in the Next Generation ACO Model) have waivers from PFS rules to use telehealth in urban areas or from a patient's residence.
  - The use of telehealth under the PFS has grown rapidly in recent years, but remains low. In 2016, 0.3 percent of FFS beneficiaries accounted for 300,000 telehealth visits totaling \$27 million. These services were most commonly used for basic physician office visits and mental health services. Use was concentrated among a small group of clinicians and beneficiaries. Beneficiaries using telehealth tended to be under 65, disabled, and dually eligible; reside in rural areas; and disproportionately have chronic mental health conditions. Our analysis suggests that some portion of telehealth claims are supplemental to, rather than a substitute for, in-person services.

- *Commercial insurance plan coverage of telehealth*—Coverage of telehealth services by commercial insurance plans in 2017 varied. In general, most plans we surveyed covered some form of telehealth services, but few covered a comprehensive set of services. As with Medicare FFS, commercial use was low (less than 1 percent of plan enrollees). Commercial insurers often test telehealth using pilot programs before implementation. In general, cost reduction does not appear to be a significant consideration in plans’ decisions to cover telehealth services. Plan representatives cited competitive pressures from employers or other insurers rather than cost reduction as the primary rationale for covering telehealth services.
- *Expanding Medicare coverage of telehealth*—Our analysis found relatively little use of telehealth services among enrollees in commercial plans and a lack of uniformity in how commercial insurers covered telehealth services. We also found that cost is not a significant consideration in commercial insurers’ adoption of telehealth services. However, as a public payer, Medicare is obligated to consider costs to the program, beneficiaries, and taxpayers in determining whether to expand coverage of telehealth.
- The Commission recommends that policymakers use a set of principles (cost, access, and quality) to evaluate individual telehealth services separately before adoption into Medicare coverage. Because we do not see clear examples of commercial payer practices that should be imported into FFS Medicare, this report does not make recommendations about coverage of specific telehealth services.
- In cases where evidence exists that services balance the cost, access, and quality principles, policymakers should consider adopting them for Medicare. However, when such evidence is lacking, policymakers should consider pilot testing these services through the Center for Medicare & Medicaid Innovation, just as testing before implementation is common among commercial insurers. Under the Medicare FFS payment systems other than the PFS, providers maintain adequate flexibility to evaluate and use telehealth services. Risk-bearing ACOs could be granted greater flexibility to use telehealth services because, in bearing financial risk, they have the financial incentive to assess the value of these services.