MEDPAC Medicare Payment Advisory Commission

NEWS RELEASE

EMBARGOED FOR RELEASE UNTIL:
June 15, 2021, 1:00 PM

CONTACT: **Stephanie Cameron** ● (202) 220-3729
scameron@medpac.gov

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

Washington, DC, June 15, 2021—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2021 *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 10 chapters:

Rebalancing Medicare Advantage benchmark policy. The current Medicare Advantage (MA) program is thriving with respect to plan participation, beneficiary enrollment, and the value of extra benefits provided to enrollees. At the same time, MA plans' bids for providing the Medicare benefit have declined to a record low of 87 percent of fee-for-service spending in their markets in 2021. However, despite the apparent relative efficiency of MA, no iteration of private plan contracting has yielded net aggregate savings for Medicare. In this chapter, the Commission recommends that the Congress implement a new MA benchmark policy that: uses a relatively equal blend of per capita local area FFS spending and standardized national FFS spending; uses a rebate of at least 75 percent; integrates a discount rate of at least 2 percent; and applies the Commission's prior MA benchmark recommendations so that Medicare can benefit more directly from MA efficiency and achieve savings for the program. Our simulations suggest that this change would likely have little impact on plan participation or MA enrollees.

Streamlining CMS's portfolio of alternative payment models. The Affordable Care Act (ACA) established the Center for Medicare and Medicaid Innovation (CMMI) to implement and study new payment and care delivery models, including alternative payment models (APMs), that alter how clinicians are paid. The ACA also created the Medicare Shared Savings Program (MSSP), a permanent APM that operates outside of CMMI. In CMMI's first 10 years, many of its payment models generated gross savings for the Medicare program before model payments (e.g., performance bonuses) were taken into account, suggesting they have the potential to change provider practice patterns. But effects are hard to measure because providers can participate in multiple APMs simultaneously, and Medicare beneficiaries can be treated by providers participating in multiple models at the same time. In addition, providers participating in multiple models may face conflicting incentives. In this chapter, the Commission recommends that the Secretary implement a smaller, more harmonized portfolio of APMs that are designed to work together to support the strategic objectives of reducing spending and improving quality. Operating a smaller portfolio of more harmonized models, with more consistent parameters and clearer and more aligned incentives, should more successfully encourage providers to furnish care efficiently across the continuum of care, which could, in turn, decrease Medicare spending.

Congressional request: Private equity and Medicare. In March 2020, the Chair of the Committee on Ways and Means asked the Commission to examine four issues related to private equity and Medicare:

gaps in Medicare data that create challenges in tracking private equity investments; private equity funds' business models when investing in health care; how private equity investments may have affected Medicare costs and quality of care; and private equity investments in companies that participate in the Medicare Advantage (MA) program. The Commission concludes that: more complete ownership data and greater transparency of ownership are important but challenging to implement; private equity firms use several common strategies to increase the profitability of health care companies including increasing revenues and reducing costs; findings from studies on the cost and quality of hospitals and nursing homes with private equity ownership were mixed, but there is a lack of evidence for physician practices; and about 2 percent of companies offering MA plans in January 2021 were owned by private equity funds, but we were unable to find research that examines the effects of private equity investments in MA companies on Medicare costs.

Mandated report: Evaluating the skilled nursing facility value-based purchasing program. Pursuant to a mandate in the Protecting Access to Medicare Act of 2014, the Commission reviewed the progress of the skilled nursing facility (SNF) value-based purchasing (VBP) program. The current VBP program uses a single measure to gauge SNF performance and is funded by a 2 percent reduction in payments each year, some of which Medicare retains as savings. Our review concluded that the SNF VBP program has a number of fundamental design flaws that recent statutory changes do not completely correct. We recommend that the current SNF VBP program be immediately eliminated, and a replacement value incentive program (VIP) be established as soon as feasible. Our recommended SNF VIP would: score a small set of performance measures; incorporate strategies to ensure reliable measure results; establish a system for distributing rewards with minimal "cliff" effects; account for differences in patients' social risk factors using a peer-grouping mechanism; and distribute a provider-funded pool of dollars in its entirety as rewards based on provider performance. The Commission also recommends that the Secretary finalize development of and begin to report patient experience measures for SNFs.

Congressional request: Medicare beneficiaries' access to care in rural areas (interim report). A bipartisan request by the House Committee on Ways and Means asked the Commission to update its 2012 analysis of rural beneficiaries' access to care. In this update, we find that rural and urban beneficiaries generally have comparable utilization rates among the following types of services: clinician visits, hospital inpatient admissions, hospital outpatient visits, home health episodes, and skilled nursing facility days. Consistent with our 2012 report, we found substantial variation across geographic regions of the country, and those differences often were far larger than differences between rural and urban beneficiaries in a given region. Because of the increase in rural hospital closures in recent years, we studied the causes and effects of rural hospital closures on access to care in affected communities. We found that rural hospital closures were preceded by declines in inpatient admissions, largely driven by patients opting to bypass their local hospital for inpatient care.

Revising Medicare's indirect medical education payments to better reflect teaching hospitals' costs. Medicare's indirect medical education (IME) payments are designed to support teaching hospitals' higher costs of inpatient care and are implemented through IME adjustments in the inpatient operating and inpatient capital prospective payment systems. In fiscal year 2019, the roughly 1,100 acute care teaching hospitals received over $10 billion in IME payments. The Commission contends that the current inpatient-centric IME policy does not reflect the range of hospital settings in which residents train and patients receive care, and results in IME payments above teaching hospitals' additional costs for patient care in inpatient settings but below their additional costs for patient care in hospital outpatient settings. In this chapter, we model a revised budget-neutral combined inpatient and outpatient IME policy. The revised policy would shift IME payments toward teaching hospitals with additional costs not accounted for in the current policy, including most hospitals that currently treat a larger share of Medicare patients

in outpatient settings. Over time, the aggregate level of IME payments would be calibrated to the level empirically justified by teaching hospitals' costs. A revised IME policy would better align IME payments with the contemporary spectrum of settings in which residents train and patients receive hospital care; reduce the financial penalty of lost IME revenue when teaching hospitals treat Medicare beneficiaries in appropriate outpatient, rather than inpatient, settings; and make IME payments more equitable for teaching hospitals that have shifted—or will shift in the future—to providing more care and resident training in hospital outpatient settings.

Medicare vaccine coverage and payment. Currently, Medicare covers vaccines under both Part B and Part D. Part B covers preventive vaccines explicitly listed in statute—influenza, pneumococcal disease, hepatitis B, and COVID-19, as well as other vaccines when used to treat an illness or an injury or direct exposure. Part D covers all commercially available preventive vaccines not covered by Part B. In 2007, the Commission recommended that all preventive vaccine coverage be moved to Part B, and there continues to be a strong rationale for this approach. In this report, the Commission recommends that all preventive vaccine coverage be moved to Part B, but without beneficiary cost sharing. We also recommend that the Congress shift the basis of payment for Part B vaccines from an average wholesale price basis to 103 percent of wholesale acquisition cost (WAC), which would bring payment rates closer to market prices and generate savings for beneficiaries and taxpayers. In addition, the Commission recommends that the Secretary require manufacturers to report average sales price (ASP) data for vaccines so that CMS can study how payment rates would differ if they were based on ASP rather than WAC.

Improving Medicare's policies for separately payable drugs in the hospital outpatient prospective payment system. The hospital outpatient prospective payment system (OPPS) has two policies that provide separate payment for drugs: the pass-through policy and the separately payable non-pass-through (SPNPT) policy. While the two policies cover somewhat different categories of drugs, arguably both are inflationary, and neither includes a criterion that the product receiving separate payments be clinically superior to an existing product. To improve the system of drug payment in the OPPS, the Commission recommends that the Congress modify the pass-through policy so that it includes only drugs that are supplies to a service and requires drugs to be clinically superior to other therapeutically similar drugs to be eligible for pass-through status. The Commission also recommends that the Secretary modify the SPNPT policy so that it is explicitly focused on drugs that are the reason for a visit, including those that are new to the market.

Mandated report: Assessing the impact of recent changes to Medicare's clinical laboratory fee schedule payment rates. Pursuant to the Protecting Access to Medicare Act, beginning in 2018, CMS set clinical laboratory fee schedule (CLFS) payment rates based on the rates private payers paid for laboratory tests. The Further Consolidated Appropriations Act of 2020 mandated that the Commission examine the methodology CMS used to set private-payer-based payment rates for CLFS services and report on the least burdensome data collection process that would result in a representative and statistically valid data sample of private market rates. In this chapter, the Commission finds that independent laboratories were overrepresented in the data collected by CMS, and hospital and physician-office laboratories were underrepresented. We also found that using private-payer data substantially lowered Medicare payment rates for some, but not all CLFS tests, with substantial reductions in payments for low-cost, routine tests but smaller reductions (or even payment increases) for newer, more expensive tests. We also determined that collecting private-payer data using a survey could reduce the number of labs required to report data to CMS and could produce a more representative distribution of all laboratories in the data. However, despite being technically feasible,

incorporating private-payer rates from a representative sample of all types of laboratories may not be prudent given the trajectory of private-payer prices for new high-tech laboratory tests.

Mandated report: Relationship between clinician services and other Medicare services. Pursuant to Section 101(a)(3) of the Medicare Access and CHIP Reauthorization Act of 2015, the Commission updates its analysis from 2017 that examined the relationship between beneficiaries' use of and Medicare program spending on clinician services and all services covered under Medicare Part A and Part B, and the relationship between beneficiaries' use of and Medicare program spending on clinician services and use of and spending on prescription drugs (as measured by gross drug spending) covered under Medicare Part D. Spending on clinician services as a share of Medicare spending on all Part A and Part B services, and per capita use of clinician services as a share of total Part A and Part B service use both decreased after 2013. We found a weak negative correlation between per capita use of clinician services and per capita use of nonclinician Part A and Part B services, and little relationship between the percentage change in clinician services and the percentage change in nonclinician Part A and Part B services over time. Our analysis also showed that from 2013 through 2018, Medicare spending on services covered under the physician fee schedule remained flat while spending on drugs covered under the Part D benefit grew by 26 percent. Nearly all of the growth in drug spending was due to higher prices rather than an increase in the number of prescriptions filled by beneficiaries. Consistent with our previous analysis, in 2018 there was a modest positive correlation between the levels of clinician service use and Part D drug use.

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

# # #

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.