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

**Washington, DC, June 15, 2020**—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2020 *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 seven chapters:

**Realizing the promise of value-based payment in Medicare: An agenda for change.** The Commission outlines a strategic direction for Medicare payment policy and delivery system design. The Commission asserts that the Medicare program must continue to move away from traditional fee-for-service payment approaches and develop new payment models that promote the use of value-based payment. Accountable care organizations and Medicare Advantage plans could serve as the foundation for these new payment models, but both need to be improved to realize that potential.

**Challenges in maintaining and increasing savings from accountable care organizations (ACOs).** Medicare ACOs are groups of providers that voluntarily take responsibility for the cost and quality of a group of beneficiaries “assigned” to them in various ways. If an ACO can reduce spending for its beneficiaries below a target amount (benchmark), Medicare shares some of those savings with the ACO. To date, ACOs have generated savings of 1 to 2 percent. But those relatively small savings could be jeopardized by unwarranted shared savings payments stemming from patient selection. Currently, patient assignment uses the provider’s taxpayer identification number (TIN) to link them to an ACO. But the use of TINs creates an opportunity for the organization to alter the providers and patients in an ACO, which creates “apparent” savings, without actually changing the delivery of patient care. To reduce the incentives to select patients and providers and reduce opportunities for unwarranted shared savings, the Commission recommends moving beyond TINs and determining an ACO’s historical baseline spending using the same set of clinician national provider identifiers used to compute the ACO’s performance year spending.

**Replacing the Medicare Advantage quality bonus program.** In its June 2019 report to the Congress, the Commission identified substantial flaws with the Medicare Advantage quality bonus program (QBP), which Medicare uses to measure and reward MA plan quality. The deficiencies of the QBP are such that the Commission contends that MA plan quality cannot be adequately assessed. In 2019 we discussed the parameters of a replacement for the QBP, the MA value incentive program (MA–VIP), which would: score a small set of population-based measures, evaluate quality at the local market level, use a peer-grouping mechanism to account for differences in enrollees’ social risk factors, establish a system for distributing rewards with no “cliff” effects, and distribute plan-financed rewards and penalties at the local market level. In this chapter, we describe our modeling of a prototype MA–VIP, which demonstrates that the MA–VIP produces a better way of measuring

plan quality and, relative to the QBP, more fairly treats plans that disproportionately enroll populations with certain social risk factors. On the basis of this modeling, we recommend that the Congress replace the QBP with the MA–VIP.

**Mandated report: Impact of changes in the 21st Century Cures Act to risk adjustment for Medicare Advantage enrollees.** Pursuant to a mandate in the 21<sup>st</sup> Century Cures Act, the Commission evaluated changes to the CMS hierarchical condition category (CMS–HCC) risk-adjustment model that CMS made in response to its own Cures Act mandate and assessed how each of those changes affects the ability of the CMS–HCC model to predict costs for various Medicare beneficiary populations. CMS was required to make three changes to the model—add certain diagnoses, add an indicator for full- or partial-dual eligible status, and add the count of diagnoses. We found that each model produces accurate payment adjustments for groups that have characteristics defined by variables in the model. We also found that all the models continue to produce underpayments for beneficiaries with very high levels of Medicare spending and overpayments for those with very low levels of Medicare spending.

**Realigning incentives in Medicare Part D.** In 2016, the Commission recommended restructuring the Part D benefit to give plan sponsors stronger incentives to manage enrollees’ drug costs, consistent with the market-based foundation of the Part D benefit. Since that time, the role of high-priced drugs in driving Part D spending has led the Commission to evolve its 2016 recommendations and to align the incentives of both Part D plans and pharmaceutical manufacturers with the interest of the Medicare program and Part D enrollees. In this report, we recommend a redesign with two major changes: (1) for spending below the catastrophic threshold, we recommend eliminating the manufacturers’ coverage-gap discount that currently applies to enrollees without the low-income subsidy (LIS) and removing the coverage gap for LIS enrollees, and (2) for spending above the catastrophic threshold, we recommend imposing a manufacturer discount on high-cost drugs and biologics to reduce incentives to continually raise prices, and we recommend providing enrollees with greater financial protection by adding an annual cap on enrollees’ out-of-pocket costs. We also recommend statutory and regulatory changes to the program that would provide greater formulary flexibility and help plan sponsors transition to our recommended benefit redesign.

**Separately payable drugs in the hospital outpatient prospective payment system (OPPS).** Medicare pays for hospital outpatient services using a prospective payment system that covers the primary service, along with ancillaries such as certain imaging and laboratory tests, supplies, and some pharmaceuticals. Bundled payments give providers an incentive to be judicious about the cost of the inputs to the services they provide, and paying outside the bundle should only be done in exceptional circumstances. There are two distinct policies for paying for some OPPS drugs separately from their associated primary services, but the criteria for separately payable status are inconsistent between the two policies, and neither includes a criterion that the separately payable drug must be clinically superior to a product covered in the bundle for which it would substitute. In this chapter, we start to develop a more rational framework for identifying products that may warrant separate payment outside of the OPPS. The framework includes parameters such as absolute cost of the drug, cost as a share of the total cost of the service with which it is provided, and whether the drug represents substantial clinical improvement over products currently contemplated in the OPPS payment.

**Improving Medicare’s end-stage renal disease (ESRD) prospective payment system (PPS).** Medicare pays dialysis facilities under a PPS that is based on a bundle of services that includes ESRD drugs (including biologics), clinical laboratory tests, and other items and services. The ESRD PPS includes a mechanism to pay for some new drugs and devices outside of the payment bundle in a

manner that undermines the efficiency incentives of the payment bundle. Separately, the PPS includes facility-level payment adjusters that increase payments for low-volume and rural facilities, but these adjusters do not appropriately target those facilities most essential for beneficiary access to dialysis services. In this chapter, the Commission recommends that: (1) the Congress should direct the Secretary to eliminate the transitional drug add-on payment adjustment for new drugs that are in an existing ESRD functional category and (2) the Secretary replace the current low-volume and rural payment adjustments for dialysis facilities with a single payment adjustment for isolated and consistently low-volume facilities—those most essential for maintaining beneficiary access to dialysis services.

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.*