

EMBARGOED FOR RELEASE UNTIL 1:00 PM March 15, 2018

Contact: Paul Masi—(202) 220-3700

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

Washington, DC, March 15, 2018—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2018 *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. 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.

Moving Beyond MIPS. 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 The Commission supports the elements of MACRA that repealed the SGR and encouraged comprehensive, patient-centered care delivery models such as advanced alternative payment models (A-APMs).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 MIPS, which measures individual clinicians in traditional Medicare on a set of measures that the clinicians choose. MedPAC shares the 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. Clinicians have already incurred over \$1.3 billion in reporting costs, and they should be relieved of future burdens.

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 because clinicians will be evaluated and compared on dissimilar measures, and many clinicians will not be evaluated at all due to an insufficient number of cases for reliable scores. After a two-year deliberative process, the Commission recommends that the Congress instead eliminate MIPS and adopt an alternative approach for achieving the shared goal of high-quality clinician care for beneficiaries in traditional Medicare.

Fee-for-service payment rate recommendations. The report presents MedPAC’s recommendations for how Congress should update payment rates in FFS Medicare for 2019. 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 are expected to reduce spending in the Medicare program while preserving beneficiaries' access to high-quality care. MedPAC recommends that payments be increased by the amount specified in current law for hospitals, dialysis facilities, and for physicians and other health professionals. MedPAC recommends no payment increase for 2019 for three FFS payment systems: ambulatory surgical centers, long-term care hospitals, and hospice. MedPAC recommends no payment increase for both 2019 and 2020 for skilled nursing facilities. For home health agencies and inpatient rehabilitation facilities, MedPAC recommends reducing payments by 5 percent. For skilled nursing facilities and home health agencies, MedPAC recommends reforming the prospective payment systems to more equitably distribute payments among providers and better maintain access for all beneficiaries. Lastly, MedPAC recommends that the Congress direct the Secretary to begin to base Medicare payments to post-acute care (PAC) providers in fiscal year 2019 on a blend of each sector's setting-specific relative weights and the relative weights that would be used under a unified PAC prospective payment system.

Medicare Advantage. Participation in MA increased in 2017, with 32 percent of all Medicare beneficiaries enrolled in MA plans in that year. In 2018, access to MA plans remains high, with 99 percent of Medicare beneficiaries having access to an MA plan, and the average beneficiary being able to choose from 20 available plans. In 2018, MA benchmarks, bids, and payments averaged 107, 90, and 101 percent of FFS spending, reflecting positive trends in the MA program. However, for several years, the Commission has expressed concerns 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 payments to plans by about 2 to 3 percent; the Commission previously made recommendations to reduce excess payments stemming from coding intensity, and thus improve equity across plans.

The Commission recommends curtailing the practice of MA plan consolidation to obtain unwarranted quality bonus 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-rated contract can obtain a bonus payment if their contract is absorbed into a contract that is rated 4 stars or higher. 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 payments, contract consolidations have resulted in inaccurate reporting of star ratings that beneficiaries use to choose among plans in their area. The Commission's recommendation to require plans to report and CMS to use pre-consolidation quality data would stop unwarranted bonus payments and also improve the accuracy of information that beneficiaries have available when deciding among plans.

Part D. Seventy-three percent of Medicare beneficiaries (about 42.5 million beneficiaries) participated in private Medicare drug plans in 2017. Beneficiaries continue to have broad choice among plans, ranging from 19 to 26 prescription drug plans (PDPs) depending on where they live, along with many MA plans that also offer drug benefits. In 2016, Part D spending was \$91.6 billion, or over 13 percent of total Medicare spending. Part D enrollees paid about \$12.7 billion of that amount in plan premiums (enrollees also paid cost sharing). Since 2014, reinsurance payments paid by the Medicare program have been the largest and fastest growing component of spending. These payments have grown at an average annual rate of 18 percent since 2007. Growth in spending for enrollees who incur high enough spending to reach the catastrophic phase of the benefit 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).

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 recommends

applying 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.

Mandated report: Telehealth. The 21st Century Cures Act of 2016 mandated that the Commission report to the Congress on 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 coverage policies of commercial insurance plans might be incorporated into the Medicare FFS program. The Commission fulfills this mandate in the March report.

MedPAC finds that 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 use of telehealth under the PFS has grown rapidly in recent years but remains low (0.3 percent of FFS beneficiaries). Similarly, MedPAC's analysis found relatively little use of telehealth services among enrollees in commercial plans (less than 1 percent of plan enrollees). MedPAC also found a lack of uniformity in how commercial insurers cover telehealth services. Importantly, cost reduction does not appear to be a significant consideration in plans' decisions to cover 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. Because MedPAC does 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. Instead, the Commission recommends that policymakers use a set of principles (cost, access, and quality) to evaluate individual telehealth services separately before expanding Medicare coverage of them.

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

###

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.