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

**Washington, DC, June 15, 2016**—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2016 *Report to the Congress: Medicare and the Health Care Delivery System*. As part of its mandate from the Congress, each June MedPAC reports on issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services.

**Medicare payment for drugs under Part B and Part D.** Three chapters in this report examine policy issues related to prescription drugs. The Commission remains concerned about rapid growth in drug prices, which can affect beneficiary access to needed medications, as well as the financial sustainability of the Medicare program. The report addresses:

- *Medicare drug spending in its broader context.* 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, also affect the prices Medicare pays for prescription 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. A second chapter in this report considers two broad issues: potential modifications to the way Medicare Part B pays for drugs, and approaches to improve the quality and restrain the costs of oncology care, given that more than half of Medicare Part B drug spending is associated with anticancer and related drugs.
- *Improving the Medicare Part D prescription drug program.* A third chapter includes the Commission's recommendations for strengthening Medicare Part D. One set of changes would give plan sponsors greater financial incentives to manage enrollees' benefits and stronger tools with which to do so. 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.

**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 of a unified prospective payment system (PPS) that could replace the four siloed post-acute care (PAC) payment systems currently used by Medicare. Our work confirms that a PAC PPS is feasible and within reach. The PPS prototype that the Commission developed accurately predicts resource needs for nearly all patient groups,

indicating that it can be used to set fair and accurate payments. In fact, we find that a unified PAC payment system could likely be developed and implemented based on currently available data and then refined once uniform patient assessment data is collected as mandated by the IMPACT Act. Implementation of a new PPS should include a transition period to give providers time to adjust to the new rates, as well as an outlier policy to protect beneficiaries with complex and costly care needs who might otherwise have difficulty obtaining services.

**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 to updating payments to clinicians. This approach creates incentives for clinicians to participate in alternative payment models (APMs). We present basic principles concerning the APM provisions. For example, the Commission believes that eligible alternative payment entities should be responsible for total Part A and B spending for their enrollees, should have opportunities to share savings with beneficiaries, and should receive some regulatory relief from CMS. We also discuss some key considerations for the Merit-based Incentive Payment System (MIPS) created in MACRA.

**Using competitive pricing to set beneficiary premiums in Medicare.** Beneficiaries in Medicare can elect to receive their Part A and Part B benefits through either traditional fee-for-service Medicare or through a private Medicare Advantage plan. Currently, beneficiaries do not have a strong incentive to make this choice based on which model provides the highest value in their market. Medicare could seek to encourage beneficiaries to choose the more efficient (high quality, low cost) model, thereby reinforcing incentives that encourage providers and plans to provide care more efficiently. The report examines three illustrative designs for creating such beneficiary incentives.

**Preserving access to emergency care in rural areas.** Given the recent closures of some small, rural hospitals, ensuring access to emergency services in sparsely populated rural areas is a growing challenge. Current subsidies to rural hospitals are tied to inpatient admissions, which are declining rapidly in rural areas. As a supplement to the current inpatient-centric subsidies, we discuss giving isolated rural hospitals the option of converting to an outpatient-only model that would be sustainable in a community with declining inpatient volumes. The objective of a new outpatient-only option would be to ensure access and promote efficiency.

**Telehealth services and the Medicare program.** We present our analysis of telehealth services—a multidimensional set of health care services delivered through a range of online, video, and telephone communication. The Commission raises issues for policymakers to consider in addressing how telehealth services will fit into the Medicare program in the future. We suggest that until more is known about the efficacy and costs of telehealth, risk-based payment models such as Medicare Advantage, bundles, and accountable care organizations may be the most appropriate areas in which to begin expanding Medicare’s coverage of telehealth.

**Issues affecting dual-eligible beneficiaries.** We provide a status report on the “financial alignment” demonstration project, an initiative by CMS and states to test new models of care for dual-eligible beneficiaries. We also examine 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.

The full report is available at MedPAC’s website: <http://medpac.gov/documents/reports/june-2016-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf>

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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.*