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MedPAC January 2017 Report

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The Medicare Payment Advisory Commission (MedPAC) convened for its first meeting of 2017 in the midst of the initial Affordable Care Act (ACA) repeal efforts and just one week before President Trump was inaugurated. Given the topics being discussed by MedPAC, it's no wonder the public packed into the Ronald Regan Building's Horizon Ballroom over both meeting days.

This recap covers the following topics:

- Medicare Advantage (MA) Status Report
- Part D Status Report
- Payment Update Recommendations
- Implementing a Unified Payment System for Post-Acute Care
- Approaches to Medicare Access and CHIP Reauthorization Act (MACRA) Implementation: Balancing Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)
- Next Steps in Primary Care

Day One

The morning of January 12 consisted of two sessions, focused on MA and Medicare Part D.

The MA Status Report

MedPAC staff began the discussion by explaining the cross-walking of contracts to obtain increased bonus payments for MA plans. By cross-walking, an entity has the ability to consolidate options within one contract, even if the plans are in different states. Because star ratings are assigned at the contract level, when a contract is cross-walked, its star rating follows to the other plans within the contract. Some Commissioners have mentioned it may be more logical to take an average, as opposed to a plan with smaller enrollment determining the larger.

MedPAC staff mentioned alternative methods of plan consolidation through averaging the separate contracts, or strategically combining contracts to ensure bonus status.

The Commissioners' long-standing recommendation since March 2010 has been to measure and report quality at the market area level. This would mean quality results and bonus payments would attach to an individual plan's enrollees in a specific market area, irrespective of contract configuration.

Staff closed by reiterating that the MA program continues to thrive as enrollment and plan rebates continue to grow. However, while benchmarks average 106 percent of fee-for-service (FFS) and bids average 90 percent of FFS, there continues to be unresolved coding intensity differences and inter-county equity issues.

The implications of this recommendation would result in spending increases between $750 million and $2 billion over one year and between $5 billion and $10 billion over five years. For plans, most benchmarks would increase and the increase would vary by county. Thus most plans would be paid more, depending on the counties they serve. For beneficiaries, access to plans and enhanced benefits may increase based on reactions to higher benchmarks.

Following the presentation, several Commissioners asked clarifying questions.

One Commissioner questioned whether there are any examples of plans that have low star ratings that have acquired other plans and raised their rating through the cross-walking process. In response, staff noted there was a recent report from a stock analyst where this occurred. The buying company had no four-star (quality bonus status) contracts and the purchaser did. Once the plans were crossed-walked, the plan without the four-star contract was determined by the contract that had four stars.

Commissioner Ginsburg noted that it appears CMS contract consolidation undermines the star rating strategy. When consumers look at a plan's star ratings, they tend to look at the plans in the county where they live. By pulling in multiple states into a single contract, you eliminate the beneficiary from the equation, he said.

Commissioners noted that philosophically the recommendation makes sense, but the Commission must ensure it examines the beneficiary systems for both Part A and B. The biggest concern is doing something that would cost a significant amount over five years, as there could be a risk of a downstream impact.

Executive Director Miller reminded Commissioners there had been previous recommendations where Commissioners addressed coding that created net savings that Congress wanted to offset. He noted it's hard drawing a comparison given these happened at different times, but there are things that would leave the treasury in balance. However, make no mistake that this particular recommendation is a cost, he said.

Commissioner Nerenz noted that the benefit seems to be in areas that are already penetrated, expressing concern about the impact, to which staff responded that penetrated areas benefit more.

Commissioner Buto expressed the need for a methodological correction, and stated, "I would ask that we remind people in the bundle that there is a strong recommendation to stratify coding adjustments among plans. We should also figure out whether there's a threshold of penetration in MA that would make us say the rate should be tied to a broader geographic area. We should be willing to spend money where it needs to be spent."

Commissioner Hoadley supported the recommendation, and noted that in relation to the cost point, the cost will be geographically skewed, and questioned whether there is any thought on how to do this with budget neutrality. Commissioner Redberg also expressed concern about costs and questioned how this recommendation increases access or value.

Executive Director Miller noted that several years ago, MedPAC examined bidding in the MA program. In such circumstances, he said, there could be a problem where you draw all your people out of FFS and then have crazy bids. Miller noted MedPAC contemplated those issues in the premium support discussion.

Draft Recommendation: The Secretary should calculate MA benchmarks using FFS spending data only for beneficiaries enrolled in both Part A and Part B.

The group voted, and the recommendation passed unanimously.

Part D Status Report

MedPAC staff provided a brief introduction of the Part D drug program, noting that of 57 million Medicare beneficiaries, 41 million (72 percent) were enrolled in the Part D program. In 2015, the program spent approximately $80 billion dollars, which accounts for nearly 12 percent of total Medicare dollars.

In 2016, Part D plans were nearly split with 60 percent of Part D enrollees being enrolled in prescription drug plans (PDPs) and 40 percent enrolled in MA-PDPs. In 2017, plan offerings will look significantly different as plan offerings will have 16 percent fewer PDPs, although MA-PDPs will grow by 3 percent. While premiums have remained stable, MA-PDP premiums have grown slightly faster than PDP premiums at 3 percent and 2 percent, respectively. Medicare reinsurance continues to be a hot button issue for MedPAC, considering Medicare pays 80 percent of catastrophic costs in Part D and reinsurance plans have grown 25 percent per year between 2010 and 2015.

MedPAC staff proceeded to discuss the growth in brand drug prices and its effect on generic drug use. Staff mentioned the Commission's October meeting, where they discussed plan incentives for plans to put higher price, high rebate drugs on formularies. Staff stated this is a problem that MedPAC will continue to address given the growth in reinsurance. As drugs shift to being higher cost, additional pressure will be placed on Medicare program costs, specifically in relation to reinsurance.

Staff noted the Commission will discuss a number of issues in the spring, including the exceptions and appeals process as well as the move to electronic prior authorization. Staff also mentioned having a discussion around enrollees reaching the out-of-pocket threshold and the rising cost of reinsurance.

Following questions, Commissioners moved into the discussion portion of the session. Commissioner Bricker stated that manufacturers create business and set pricing based on the landscape Medicare creates; plan sponsors, however, do not have the ability in Part D to use the same tools available in the commercial market to manage cost. She suggested MedPAC consider options in the best interest of the plan as it relates to Medicare benefits. As it stands, plans are unable to make midyear changes, while in the commercial world, drugs are played against each other. The Commissioner noted that "luxury" does not exist if you are a Part D sponsor because you are forced to put both drugs on the formulary and your ability to negotiate is in limbo.

With respect to access, Medicare has embraced the any willing provider mentality. Commissioner Bricker noted Medicare should have the ability to narrow a network even for 90 days, or require 90 fills. She said MedPAC should not feel hesitant about putting parameters around the benefit. More also needs to be done with respect to appeals, considering very few denials of appeals are granted. Lastly, she suggested MedPAC address incentives for manufacturers to invest where sole source processes exist. She noted that plan sponsors would likely embrace more risk if they had the opportunity to manage the benefit like the commercial market.

Commissioner Hoadley indicated the recommendation MedPAC put forth last year was a balance in trying to reach a number of goals; going forward, that challenge persists. He acknowledged there should be plan flexibility, but indicated MedPAC must put forth the appropriate approach for beneficiary access. If a beneficiary chooses a plan because they have access to a certain drug and suddenly the formulary is changed mid-stream, beneficiaries would be irate. Hoadley noted that transparency is key when making these decisions.

Commissioner Hoadley also expressed a need to focus on the out-of-pocket (OOP) cost burden, the examination of trends, and to consider how the push for high cost drugs affects all of this.

Commissioner Pyenson noted that one of the common features in commercial plans is copay cards, which are prohibited in Part D. He mentioned however, that he thinks there are patient assistance programs that can affect spending for high cost Part D drugs.

Commissioner Thompson stated there is an assumption on the access side that all drugs are good, and the beneficiary is the one who pays for this. She suggested the Commission examine the cost of overmedicating the geriatric population. While MedPAC is concerned about access and fairness, the Commission has an obligation from a beneficiary standpoint to look at what is being done with patients who are taking too many drugs.

Commissioner Bricker noted the Commission must be careful, as manufacturers do not give coupons out of generosity, but rather to counter plan formularies. When a coupon is given at the point of sale, the formulary is moot because the plan does not receive a rebate on that.

Commissioner Thomas suggested MedPAC take a similar approach in Part D as what occurs in the commercial area. It creates a challenge, but new drugs are always entering the market and not having the opportunity to adjust midstream a major cause of cost escalation. Commissioner Thomas also stressed that the Commission is not dealing with drug pricing with enough urgency. "Yes, we've made minor adjustments, but this is the most pressing issue in healthcare. The idea that companies can set their own drug prices, change them as they see fit, and use federal dollars along the way is outrageous. I encourage us to continue to look at indexing and inflators to handle the increase in drug pricing. We should be more focused on capping increases and setting prices where there are sole source products and shortages."

Commissioner Ginsburg stated that a lot of the issues the Commission is dealing with today were negotiated politically in 2003, but the drug market is very different now. He noted that the market needs a different solution as it relates to the flexibility Part D sponsors now need.

Commissioner Wang expressed hope that the Commission's 2016 recommendations are broad enough to encompass the factors raised by Commissioner Bricker. Wang stated that MedPAC must be more explicit about market flexibility going forward, and also have a broader conversation around value. Commissioner Wang also mentioned value-based purchasing, and encouraged Commissioners to think about how MedPAC could demonstrate value in payment methodologies. She noted, "perhaps we need a broader conversation on generic price escalation, regardless we need to understand where the value is and where is the return."

Payment Update Recommendations

The Commission voted on a package of recommendations for payment updates in 2018. MedPAC had previously discussed such payment recommendations during its December meeting, and reached a consensus on them at that time. MedPAC's recommendations which will be included in the March Report to Congress are as follows:

- MedPAC approved retaining the inpatient and outpatient hospital payments as specified in current law, as well as for physician and other health professional services. The Commission also approved its recommendation that the Secretary of Health and Human Services (HHS) require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities.
- The Commission recommended Congress reduce the Medicare payment rate by five percent for inpatient rehabilitation facilities and home health care.
- The Commission recommended that Congress increase the outpatient dialysis base payment rate by the update specified in current law for Calendar Year 2018.
- For hospice, ambulatory surgical centers, and long-term care hospitals, the Commission voted to eliminate the update payment for Fiscal Year 2018.
- Finally, for skilled nursing facilities (SNFs), MedPAC recommended Congress eliminate the basket update for 2018 and 2019, and direct the Secretary of HHS to revise the prospective payment system for SNFs.

Implementing a Unified Payment System for Post-Acute Care

During the discussion phase of this session, Commissioner Redberg recommended a transition period and recognition that post-acute settings have varying regulatory requirements. Commissioner Gradison noted that Congress outlined a timeline for the implementation of the unified payment system, and based upon that schedule, there will be a great deal of planning over the next few years, but nothing significant will occur in terms of implementation. He noted that MedPAC should discuss how to "get the train moving," as it has not moved at all, which is reflected by the failure of Congress to act on MedPAC's recommendations, which he noted are significantly more modest than changing the entire payment system.

Commissioner DeBusk questioned whether there should be a negotiation with providers, such as a delay in cuts in exchange for providers engaging in faster adoption of the unified payment system. Commissioner Ginsburg disagreed, stating it would be unfair to offer providers more money in exchange for skipping out on a transition. Commissioner Ginsburg noted that by asking service

providers to change, MedPAC should offer them a transition, as it takes time to change. Commissioner Buto recommended MedPAC proceed with the highest quality policy positions and leave it up to Congress to make the tradeoffs.

Approaches to MACRA Implementation: Balancing MIPS and APMs

MedPAC staff began the presentation by summarizing MACRA's statutory requirements. Staff noted that MedPAC has expressed an interest in moving clinicians from MIPS to advanced APMs, and stated that one way to do this is to make MIPS unattractive. For the discussion, MedPAC staff questioned how MIPS should be redesigned, and whether the 5 percent advanced APM incentive payment should be redesigned.

Commissioner Coombs questioned how one could implement gradual changes to the MIPS program without affecting access for Medicare beneficiaries. She acknowledged the goal of moving MIPS clinicians to advanced APMs, but expressed concerns related to the workforce. MedPAC staff responded by stating that over 90 percent of MIPS clinicians will receive a payment increase under the MIPS but as a result, the increases are very small.

Commissioner Nerenz emphasized the substantive nature of the rule and provided several comments in relation to the rule, first noting that there should be more thought about the rule's "more than nominal risk" phrase, and recommended lowering the threshold and expanding the types of entities that qualify as advanced APMs. For example, the Commissioner believes Medicare Shared Savings Program (MSSP) Track 1 Accountable Care Organizations (ACOs) should qualify as advanced APMs, given that many of them are losing money, which constitutes significant risk. He also recommended clarifying who actually is bearing the risk.

Commissioner Nerenz also stated it is imperative to ensure there are adequate advanced APM options for specialty physicians. He also recommended a modification to MIPS that would allow a clinician's MA patients to be considered in determining the threshold of Medicare patients. He expressed concern that if MA patients cannot be considered, some models may drive clinicians backwards, encouraging clinicians to move away from MA and back to FFS models.

Commissioner Ginsburg recommended MedPAC create a concrete plan to develop APMs that are feasible for the majority of physicians. Commissioners spent a great deal of time evaluating the differences between MIPS and advanced APMs, and questioned methods to incentivize providers to transition from MIPS to advanced APMs. They also questioned evaluating providers on an individual basis versus in the aggregate.

Day Two

Medicare Part B Drug Payment Policy Issues

MedPAC staff kicked off Friday's morning session by first providing a background of Medicare Part B and then outlining potential reforms to Part B. Specifically, the proposals offered by staff included:

- Improvements to current average sales price (ASP) system
  - Improved ASP data reporting
    - This policy would requirement manufacturers to report ASP data for all Part B drugs and increase penalties for non-reporting
  - Wholesale acquisition cost (WAC) + 3 percent
    - This policy would reduce the payment rate for WAC-priced drugs by 3 percentage points
    - One could reduce the WAC add-on further if the ASP add-on is reduced to maintain parity between WAC-priced and ASP-priced drugs
  - ASP inflation rebate
    - Manufacturers could be required to pay a rebate when the ASP for its drug exceeds the inflation-adjusted ASP for the billing code
    - Could base beneficiary cost-sharing and provider add-on payments on lower inflation-adjusted ASP
    - Exempt low cost drugs
    - Avoid duplicate discounts (the ASP inflation rebate would not apply to Medicare utilization already subject to a 340B discount or Medicaid rebate)
    - An inflation benchmark would need to be chosen
  - Consolidated billing codes
    - The Commission has held that Medicare should pay similar rates for similar care.
    - This policy would give the HHS Secretary the authority to:
      - Group a reference biologic and its biosimilars in a common billing code
      - Group drugs with similar health effects in a common billing code and group biologics with similar health effects in a common billing code

- A medical exception process could be considered; the clinician could be required to provide medical justification to the Medicare Administrative Contractor

- Gradually reduce ASP add-on to encourage enrollment in drug value program (DVP)
  - Intent: Develop a market-based alternative to the ASP system to create more incentives for provider efficiency and obtain lower prices from manufacturers. This policy would give the Secretary authority to create a Part B DVP that would use private vendors to negotiate prices and offer providers shared savings opportunities

MedPAC staff spent a significant amount of time discussing the development of an alternative to the current ASP system – the DVP. While the DVP would be voluntary for providers, it would be important to create incentives to encourage providers to enroll. As a way to transition to the DVP, a policy that could be considered is to reduce the ASP add-on gradually. Staff then discussed key design elements of the DVP.

As mentioned, the DVP would allow for voluntary provider enrollment and multiple DVP vendors; vendors could negotiate rates but not ship the product. Providers would buy drugs for Medicare beneficiaries at the DVP rate and Medicare would pay providers the DVP rate. Providers also would have shared savings opportunities and beneficiaries would save through lower cost-sharing. Vendors would be paid an administrative fee, and potentially shared savings.

DVP vendors would utilize a formulary, with an exceptions and appeals process. Prices under the DVP would be limited to no more than 100 percent of the ASP. This would ensure vendors could get typical market prices for all drugs. Other tools vendors might use include step-therapy, prior authorization, or innovative purchasing approaches like risk-based contracts or indication-specific pricing. Arbitration could also be considered for use in the DVP to facilitate negotiations between DVP vendors and manufacturers for drugs without close substitutes.

Staff noted DVP prices would be excluded from the ASP and that it will take time to develop the program; there also could be benefits to phasing in DVP with a subset of drug classes. Staff concluded the presentation and requested the Commissioners provide feedback on the potential policies discussed, as it is the Chairman's goal to develop a draft recommendation to be reviewed at the March 2017 meeting.

Commissioner Ginsburg encouraged the Commission to consider the impact of the sequester and, whatever recommendation is drafted, ensure the recommendation addresses the possibility of sequestration.

Executive Director Miller noted that the biggest concern of Commissioners is that the beneficiary not carry any more liability than they have to and the provider be held harmless. Commissioner Buto questioned why a previous policy recommendation is no longer being discussed (the physicians purchasing the drugs would only be reimbursed by last year's price plus 5 percent; the payment rate would be limited by inflation). Buto noted that the policies presented during the meeting were designed to hold harmless the beneficiaries and providers and are severely complex, and questioned why MedPAC is going out of its way to accommodate the provider.

Commissioner Thomas questioned how the WAC is calculated, to which staff responded that the WAC is calculated as the list price put out by the manufacturer until the ASP is available, which can be as long as six–to–nine months. When the ASP is released, it accounts for the discounts afforded by the WAC. Commissioner Thomas then asked for clarification on the DVP and how it differs or would be more successful than current group purchasing organization (GPO) or current purchasing processes. Staff noted the DVP would have certain tools applicable to Medicare Part B drugs that currently do not exist, such as the ability to create a formulary.

Commissioner DeBusk then commented, noting the DVP would be a specialized GPO; he commended staff for developing a novel program. DeBusk expressed concern with paying administrative fees to the vendors, as he has concerns that the higher the price, the more money vendors will make; Crosson clarified the intent is not to pay vendors more based upon the cost of the drug.

Commissioner Thomas questioned how difficult implementing consolidated billing codes would be, as it appears relatively easy on its face. Staff noted that for reference biologics and biosimilars, CMS could rely on the FDA process; for other drugs and other biologics, there is some complexity and CMS could reach out to clinical experts for assistance, and also look to see what private payers have been doing.

Commissioner Pyenson questioned whether there is enough volume for a DVP to go at risk in some form, to which staff responded by stating they have not examined that, but it is something they could consider.

Commissioner Redberg posed a question related to repackages and their effect on price, to which staff noted that repackages are much more prevalent in Part D than Part B. Staff noted that because there are relatively few in Part B, the effect on price is not significant in aggregate.

Commissioner Hoadley expressed support for the WAC policy proposal; in regards to the inflation rebate, he noted he believes putting the penalty onto the backs of the manufacturers rather than the providers makes sense. Hoadley noted that exempting the low cost drugs is sensible in order to keep it a simpler system.

Commissioner Bricker stated that she is in favor of consolidated billing codes. With respect to how to consolidate billing codes, she recommended relying on therapeutic classes, such as all beta-blockers. Bricker stated she is not in favor of arbitration due to the cost and burden associated with arbitration; she also expressed concern about the length of time being engaged in arbitration, versus nudging a manufacturer to come to market. She indicated a desire to see incentives being given to the manufacturers to bring drugs to the market.

Commissioner Hall questioned the goals of the Commission and whether any of the policies being proposed have a direct correlation to quality of care.

Commissioner Thomas provided his input on the WAC + 3 percent proposal, suggesting some sort of index to control any an increase in price going forward. He also questioned how to cap inflation in relation to arbitrary drug price increases.

Commissioner Ginsburg expressed his uneasiness about the notion that the DVP would be the entity to negotiate with manufacturers, and stated that he thinks this model will be extremely controversial. Ginsburg recommended that, instead, CMS should negotiate with manufacturers, assuming Congress gives the agency the authority to do so (which he acknowledged likely would not be anytime soon).

One Commissioner expressed concerns as to whether the proposed policies will actually achieve what the Commission hopes they will achieve. He is worried that the proposed policies simply scratch the surface and, at most, address the pricing issues but do not address other issues, such as access. He suggested strengthening the proposals.

Commissioner Coombs expressed strong concerns that the Commission is approaching the drug industry much differently than all other health care industries, such as hospitals. "Why we are tiptoeing around the base price of drugs…?" Coombs stated she feels very strongly that the Commission treat drug manufacturers as they do other industries.

Chairman Crosson concluded the discussion by stating "This is my ninth year on the Commission, and we've dealt, over that period of time, with a lot of issues. I can't think of one -- maybe there's some -- but I can't think of one that was a more serious issue, a more pressing issue, and a more complicated issue than this one, and I think our discussion bore that out." Chairman Crosson noted he intends to offer draft recommendations on these issues during the March meeting for the Commission to discuss, and vote on in April.

Next Steps in Primary Care

MedPAC staff opened the presentation by discussing how primary care services are underpriced in the fee schedule. Staff noted the fee schedule is not well-designed to support primary care, given that primary care requires ongoing, non face-to-face coordination. However, such care is crucial to a more coordinated and efficient health care system.

Staff then reviewed prior Commission recommendations related to improving payment for primary care:

1. Create budget-neutral bonus for primary care services
2. Repeal SGR and provide higher updates for primary care
3. Identify overpriced services and price them accurately
4. Establish per beneficiary payment for primary care
    a. This policy is intended to replace the expiring primary care incentive payment (PCIP) program
    b. Initially, funding for per beneficiary payments should be equal to PCIP payments
    c. Should be budget neutral
    d. Goal: Move primary care from service-based payment to beneficiary-centered payment

Subsequently, staff presented three options to better support primary care:

1. Maintain recommendation to establish per beneficiary payment for primary care based on amount of PCIP payments ($700 million).
    a. This would help rebalance the fee schedule between primary care and specialty care and would require no beneficiary cost sharing.
2. Increase per beneficiary payments to $1.2 billion ($700 million from option 1 + $500 million from MIPS exceptional performance bonus).
    a. This would require no beneficiary cost sharing.
3. Allow primary care practitioners in all two-sided ACOs to receive a portion of payments for primary care visits as an upfront payment, in addition to per beneficiary payment from option 2.
    a. Upfront payments would give providers more flexibility to invest in care coordination.
    b. No change in beneficiary cost sharing.

Staff noted the goals are to rebalance the fee schedule by increasing spending on primary care and giving primary care practitioners more resources and flexibility to invest in care coordination. MedPAC staff requested Commissioners discuss how large a per beneficiary payment should be, how it should be financed and whether Medicare should offer partial capitation for primary care to primary care providers in two-sided ACOs.

Looking Ahead

The Commission will not meet in February, but will reconvene March 2-3, 2017. To view the transcript associated with the January 2017 meeting, please visit: http://medpac.gov/docs/default-source/default-document-library/january-2017.pdf?sfvrsn=0

Note: MedPAC will be releasing its March Report to Congress in mid-March; be on the lookout!

The District Policy Group attends all public MedPAC meetings and also monitors Medicare policy actions by Congress and CMS. The District Policy Group assists clients in navigating the rapidly changing political and health policy world through lobbying and advocacy.

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