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MedPAC April 2017 Meeting Report

By Tony L. Mitchell

Overview

The Medicare Payment Advisory Commission (MedPAC) met for its third and the final time before its summer hiatus. The Commissioners revisited a number of topics from the March meeting, provided draft recommendations centered on Part B drug payments and post-acute care payment reform, and began exploration of provider consolidation and its impact on Medicare costs and access.

The District Policy Group attended the meeting. To provide you with the meeting's key takeaways, we developed a memo and recorded our second "Unpacking MedPAC" podcast.



Key Takeaways

Medicare Part B Drug Payment Policy Issues

With Part B drug spending steadily on the rise, MedPAC continues to look for ways to reduce the incentive to use high-priced drugs. Picking up where they left off in March, the Commissioners made recommendations to change Part B drug payments by modifying the average sales price (ASP) system starting in 2018. Under the recommendations, all manufacturers with products paid under Part B would be required to report ASP data, wholesale acquisition costs (WAC) based-payments would be reduced by 3 percentage points, manufacturers would be required to pay a Medicare rebate when their product exceeds a certain ASP benchmark, and the Secretary of Health and Human Services (HHS) would be required to use a common billing code to pay for a reference biologic and its biosimilar. Of particular interest was the Commissioners' recommendation to create and phase in a voluntary Drug Value Program (DVP) by 2022. Operated by private vendors, DVP drug prices would be limited to no more than 100 percent of ASP to increase negotiating leverage. Providers would have incentives

to join DVPs given the Commissioners' plan to phase in ASP reductions of 3 percent for providers opting to remain in the ASP system. Approved by a unanimous vote, the recommendations are estimated to decrease program spending by \$250M to \$750M over one year and by \$1B to \$5B over five years relative to the current law.

Post-Acute Care (PAC) Unified Payment System

Concerned that reform has occurred too slowly, MedPAC Commissioners unanimously agreed on recommendations that would speed the implementation of a unified payment system across all four PAC settings (Skilled Nursing Facilities, Inpatient Rehabilitation Facilities, Home Health Agencies, and Long-Term Care Hospitals), beginning in 2021. The approved draft recommendation lowers aggregate payments by 5 percent, while giving the Secretary power to periodically revise and rebase payments as needed to maintain alignment with the cost of care. The Commissioners also agreed that efforts should begin to align setting-specific regulatory requirements. By implementing the PAC perspective payment system (PPS) beginning in 2021, through a three-year transition window, providers will have the opportunity to phase out of the current setting-specific PPS into the unified new system. Because providers will have the option to bypass this transition period and start in 2021, savings will depend significantly on the number of providers who opt-in to the new system. MedPAC estimates these changes could lower PAC spending between \$5B-\$10B over a five year timeframe.

An Overview of the Medical Device Industry

MedPAC began a conversation around the medical device industry to gauge the Commissioners' interest in potential policy issues and future work. The Commission touched on a number of topics, including unique device identifiers (UDIs), gainsharing, implantable medical device (IMD) price transparency, and physician owned distributorships (PODs). Revisiting its 2005 recommendation, the Commission agreed that gainsharing has the ability to reduce costs while allowing hospitals and physicians to share cost savings. Commissioner Warner Thomas was in line with the 2005 recommendation on gainsharing, but

warned that transparency would be needed considering that inappropriately quick discharges are a major concern. A number of individuals voiced their concern with PODs, given overwhelming evidence of induced demand. Because minimal POD reporting occurs under the [Open Payments Program](#) and a [2013 Office of the Inspector General \(OIG\) Special Fraud Alert](#) classified them as “inherently suspect” under anti-kickback statute, the Commissioners agreed they would revisit ways to improve reporting and potential hospital-level POD policies going forward.

Using Premium Support in Medicare

Following up on the March discussion, the Commission revisited premium support, this time focusing on premium subsidies for low-income individuals. Staff indicated there would be a chapter on the topic in the upcoming June report, with a focus on the key issues to consider if policymakers choose to use premium support for Medicare beneficiaries. Staff also presented new material on premium subsidies for low income beneficiaries noting that such subsidies would help “ensure that low-income beneficiaries can obtain coverage.” Commissioner Brian DeBusk noted that while this was an intricate topic to unravel, the conversation was extremely important considering the individuals it affects. When discussing ways to finance premium subsidies, Commissioners discussed the pros and cons of a shared federal-state Medicaid-type approach and a Medicare federally dominated approach, like the current Low-Income Subsidy under Part D. Commissioners noted that the latter would increase federal spending and providing subsidies as a Medicaid benefit would be a shared federal and state government cost. Commissioners agreed to look at this further down the road given the effect financing of such subsidies would have on state and federal budgets.

Medicare Part D Payment and Plan Incentives

In response to rising Part D spending in a follow up from the June 2016 report, the Commission considered a proposal on biosimilars, and another related to cost sharing between Medicare and insurance plans. Currently, in the coverage gap level or “doughnut hole,” reference (or brand name) biologics receive a 50 percent discount, and this discount adds to the beneficiary’s total spending, leading him or her closer to the catastrophic coverage level. At the meeting, two MedPAC commissioners proposed that biosimilars receive a similar discount that reference biologics receive in order to lower beneficiary costs. The Commission as a whole then supported this recommendation. Commissioners also cited additional growth in direct and indirect remuneration (DIR), including manufacturer rebates, pharmacy fees, and additional payments, which help reduce overall Medicare program costs, but do not reduce the out-of-pocket costs for drugs when beneficiaries purchase them. Additionally, the Commission discussed that the manner in which these discounts are calculated moves more beneficiaries to the catastrophic coverage level, where Medicare must

pay a greater share of drug costs for beneficiaries. Two commissioners recommended a change in how these discounts, rebates, etc. are calculated in order to shift risk and cost to the plans, and away from Medicare. However, there was no agreement on how to make such a change, so the Commission tabled this specific recommendation and decided to continue to discuss the issue generally.

Provider Consolidation: The Role of Medicare Policy

The two-day meeting closed with a discussion on provider consolidation, which was a follow-up to two previous discussions the Commission has had regarding physician consolidations and other health care consolidations and their impact on price increases due to market power. Staff indicated they are considering the topic for a possible chapter in the June 2017 report. The four topics were: horizontal hospital consolidation; horizontal physician consolidation; vertical consolidation (where hospitals employ physicians) and vertical consolidation of provider functions; and insurance risk (provider take on insurance risk and insurers purchase provider groups). Staff indicated that “consolidation can lead to higher hospital prices, without clear evidence of quality improvement” and “on average commercial prices are about 50% above costs, well above Medicare.” Staff highlighted that when hospitals buy physician practices they then bill physician services as hospital outpatient department (HOPD) services and receive a facility fee in addition to a physician service fees, resulting in higher overall Medicare spending.

The second portion of the session was an examination of insurer-provider consolidation and effects on quality and cost. The staff discussed the impact of different models of delivery and financing (Medicare Advantage, Accountable Care Organizations, etc.) on quality, efficiency, and outcomes. The staff proposed two policy responses: (1) supporting policies that favor one model over another (paying more for certain structure or process) or (2) maintaining “financial neutrality” and paying fee-for-service and all types of Medicare Advantage plans the case base rates.

The Commission then had a robust discussion regarding the impact of Medicare payment policy on consolidation, Medicare costs, commercial prices, access to care, and delivery system reform. As part of the discussion, the Commissioners acknowledged their earlier work on recommending site neutral payments for physician services between independent physician practices and physician services provided under hospital outpatient department. Commissioners expressed concern that the growing differential between commercial reimbursement rates and Medicare could create an access problem for beneficiaries.

After lengthy discussion about consolidation, the Commissioners agreed that provider consolidation needed to be considered separately from discussions about delivery system structure tied to insurer-provider consolidation. They decided that additional discussion was warranted on both, with additional future elucidation of the “problem we are trying to solve.”

Looking Ahead

MedPAC will issue its report to Congress in June and will not meet again until September 7-8, 2017. Currently pending at the Office of Management and Budget (OMB) for review are the payment rules for:

- Hospital Inpatient Prospective Payment System for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System and FY 2018 Rates (CMS-1677-P) (received at OMB March 8, 2017);
- FY 2018 Inpatient Rehabilitation Facility (IRF) Prospective Payment System (CMS-1671-P) (received at OMB March 9, 2017);
- FY 2018 Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities (SNFs) (CMS-1679-P) (received at OMB March 14, 2017);

- CY 2018 Updates to the Quality Payment Program (CMS-5522-P) (received at OMB March 22, 2017);
- FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements (CMS-1675-P) (received at OMB March 23, 2017); and
- CY 2018 Changes to the End-Stage Renal Disease (ESRD) Prospective Payment System, Quality Incentive Program, and Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) (CMS-1674-P) (received at OMB April 5, 2017).

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