

Report to the Congress: Medicare and the Health Care Delivery System · June 2017

The Commission's June 2017 report examines a variety of Medicare payment system issues. In the ten chapters of this report, we consider: implementing a unified payment system for post-acute care, Medicare Part B drug payment policy issues, using premium support in Medicare, the relationship between physician and other health professional services and other Medicare services, redesigning the Merit-based Incentive Payment System and strengthening advanced alternative payment models, payments from drug and device manufacturers to physicians and teaching hospitals in 2015, the medical device industry, stand-alone emergency departments, hospital and skilled nursing facility (SNF) use by Medicare beneficiaries who reside in nursing facilities, and provider consolidation and the role of Medicare policy.

IMPLEMENTING A UNIFIED PAYMENT SYSTEM FOR POST-ACUTE CARE

- The Commission recommends a unified prospective payment system (PPS) for post-acute care (PAC) services. Although the types of cases treated in the four main PAC settings (SNF, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) overlap, Medicare's payments for similar patients can differ substantially, in part because Medicare uses separate systems to pay for stays in each setting.
- Given the overlap among PAC settings in the patients they treat, the Commission has long promoted the idea of moving to a unified PAC PPS that spans the four settings, with payments based on patient characteristics rather than the site of service. In a June 2016 report mandated by the Improving Medicare Post-Acute Care Transformation Act of 2014 (IMPACT), the Commission set out the necessary features of a PAC PPS and considered the effects on payments of moving to such a system.
- Using available data on patient characteristics, the Commission's PAC PPS design predicts the costs of stays for a broad range of conditions. The PAC PPS would redistribute payments across patient conditions. Payments would decrease for rehabilitation care unrelated to patient needs and increase for medically complex care. Equity in payments would increase, and providers would have less incentive to selectively admit certain types of patients over others.
- The Commission recommends that the Centers for Medicare & Medicaid Services begins to implement a new PAC PPS in 2021, with a three-year transition. The Commission finds that Medicare payments exceed providers' costs by 14 percent across the PAC settings and recommends that payments be lowered by 5 percent to more closely align payments with the cost of care. The Secretary should align setting-specific regulations as the PPS is implemented to ensure that all providers can compete on a level playing field. In addition, the Secretary should have the authority to revise and rebase PAC PPS payments over time, to keep payments aligned with the cost of care.

Recommendation:

The Congress should direct the Secretary to:

- implement a prospective payment system for post-acute care beginning in 2021 with a three-year transition;
- lower aggregate payments by 5 percent, absent prior reductions to the level of payments;
- concurrently, begin to align setting-specific regulatory requirements; and
- periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.

MEDICARE PART B DRUG PAYMENT POLICY ISSUES

- Chapter 2 presents the Commission’s recommendation to improve Medicare payment for Part B drugs. Medicare Part B covers drugs administered by infusion or injection in physician offices and hospital outpatient departments, and drugs furnished by suppliers. In 2015, Medicare and its beneficiaries paid about \$26 billion for Part B–covered drugs and biologics, two-thirds of which was accounted for by biologics. Since 2009, Medicare Part B drug spending has grown at an average rate of about 9 percent per year.
- The Commission is concerned about the overall price Medicare pays for Part B–covered drugs, the lack of price competition among drugs with similar health effects, and the rapid growth in Part B drug spending. Medicare pays for most Part B–covered drugs based on the average sales price plus 6 percent (ASP + 6 percent). It also assigns generic drugs and their associated brand products to a single billing code, which creates price competition. By contrast, Medicare pays for most single-source drugs and biologics under separate billing codes—which does not create price competition among products with similar health effects. In addition, the 6 percent add-on to ASP may create incentives for providers to choose higher priced drugs over lower priced drugs.
- The Commission’s recommendation improves the current ASP system. The Commission’s recommendation would reform the buy-and-bill system by including an inflation rebate that would protect the Medicare program and beneficiaries from rapid price increases, gradually reduce the ASP add-on payment, consolidate reference biologic and biosimilar drugs into a single billing code, and other changes.
- Over the longer term, the Commission recommends that Medicare develop a market-based program that we refer to as the Part B Drug Value Program (DVP). The DVP would allow providers to voluntarily enroll and would use private vendors to negotiate drug prices with manufacturers. The intent of the DVP would be to obtain lower prices for Part B drugs by permitting private vendors to use tools such as a formulary to negotiate prices with manufacturers and by improving incentives for provider efficiency through shared savings opportunities.

Recommendation:

The Congress should change Medicare’s payment for Part B drugs and biologicals (products) as follows:

(1) Modify the average sales price (ASP) system in 2018 to:

- Require all manufacturers of products paid under Part B to submit ASP data and impose penalties for failure to report.
- Reduce wholesale acquisition cost (WAC)-based payment to WAC plus 3 percent.
- Require manufacturers to pay Medicare a rebate when the ASP for their product exceeds an inflation benchmark and tie beneficiary cost sharing and the ASP add-on to the inflation-adjusted ASP.
- Require the Secretary to use a common billing code to pay for a reference biologic and its biosimilars.

(2) No later than 2022, create and phase in a voluntary Drug Value Program (DVP) that must have the following elements:

- Medicare contracts with a small number of private vendors to negotiate prices for Part B products.
- Providers purchase all DVP products at the price negotiated by their selected DVP vendor.
- Medicare pays providers the DVP-negotiated price and pays vendors an administrative fee, with opportunities for shared savings.
- Beneficiaries pay lower cost sharing.
- Medicare payments under the DVP cannot exceed 100 percent of ASP.
- Vendors use tools including a formulary and, for products meeting selected criteria, binding arbitration.

(3) Upon implementation of the DVP or no later than 2022, reduce the ASP add-on under the ASP system.

USING PREMIUM SUPPORT IN MEDICARE

- Under a premium support model, the amount that the government pays for each beneficiary's Medicare coverage in a given market area could be changed to a fixed dollar amount that would remain the same whether the beneficiary enrolled in the fee-for-service (FFS) program or in a managed care plan. Beneficiaries would pay premiums that equal the difference between the overall cost of providing the Medicare benefit package and the government contribution. As a result, premiums for FFS and managed care plans in different parts of the country would vary based on the underlying differences in their overall costs.
- The Commission makes no recommendation on whether premium support should be used in the Medicare program. Given the Commission's role in providing analysis and guidance on Medicare issues, Chapter 3 examines some of the key design issues that policymakers would need to address if they decide to use premium support in Medicare, including:
 - What would be the role of the FFS program, which covers about 70 percent of Medicare beneficiaries?
 - How much should the coverage offered by the FFS program and managed care plans be standardized under a premium support system?
 - What method would be used to calculate the Medicare contribution and beneficiary premiums?
 - How would high-quality care be rewarded under premium support?
 - What steps could be taken to mitigate or delay the impact of potentially higher premiums and protect low-income beneficiaries?

MANDATED REPORT: RELATIONSHIP BETWEEN PHYSICIAN AND OTHER HEALTH PROFESSIONAL SERVICES AND OTHER MEDICARE SERVICES

- The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) directs the Commission to submit a report to the Congress on the relationship between the use of and expenditures for services provided by clinicians and total service use and expenditures under Part A, Part B, and Part D of Medicare.
- A positive correlation between services provided by clinicians and all other services would suggest that the services might be complements. Alternatively, a negative correlation would suggest clinician services and all other services could be substitutes for one another. We find a weak correlation suggesting that clinician services and other services are neither clear complements nor clear substitutes.

REDESIGNING THE MERIT-BASED INCENTIVE PAYMENT SYSTEM AND STRENGTHENING ADVANCED ALTERNATIVE PAYMENT MODELS

- MACRA repealed the sustainable growth rate system and established a new approach to updating payments to clinicians. It established two paths—a path for clinicians who participate in advanced alternative payment models (A-APMs) and a path for other clinicians, the Merit-based Incentive Payment System (MIPS).
- As CMS has begun to implement these two paths, it has become clear that MACRA sets up a complex system in which some signals to improve value may not be well aligned. Although it is difficult to judge what sort of program will eventually result, the Commission is concerned by the direction the program is taking. Therefore, in this chapter the Commission outlines ideas for improvement but does not make specific recommendations.
- Chapter 5 discusses an alternative model for MIPS, which would start with the institution of a quality payment withhold for all services under the physician fee schedule (i.e., payment rates are reduced by a set percentage and then returned or not, depending on performance on quality). It would eliminate the

current set of MIPS measures and instead would rely on a much smaller set of population-based outcome measures. The proposed outcome measures would be calculated from claims or surveys and would thus minimize burdensome clinician reporting. Clinicians could get the quality withhold back if they join a virtual group or an A-APM.

- Currently, MACRA requires clinicians to reach a threshold of revenue through an A-APM to qualify for the 5 percent incentive payment, but the incentive payment is then calculated as a percentage of all of a clinician's revenues. We discuss making the reward based solely on the revenue coming through the A-APM. We would eliminate the threshold and instead make the incentive payment proportional to A-APM involvement. This would create more equity and would serve as an incentive for clinicians to participate in A-APMs.
- MACRA creates a fund of \$500 million per year for MIPS (from 2019 to 2024) to reward clinicians with "exceptional performance" on their MIPS scores. Moving this fund from MIPS to A-APMs would shift clinician incentives toward A-APMs by making MIPS less attractive. We discuss using this money to fund an asymmetric risk corridor for two-sided-risk accountable care organizations (ACOs) that qualify as A-APM entities. We also discuss a possible design for an A-APM that would be more attractive to small practices that may be reluctant to take on a large amount of risk relative to their revenue.

PAYMENTS FROM DRUG AND DEVICE MANUFACTURERS TO PHYSICIANS AND TEACHING HOSPITALS IN 2015

- Under the Open Payments program, drug and device manufacturers and group purchasing organizations report information to CMS about payments to physicians and teaching hospitals. This program has shed light on industry ties to these providers. The Open Payments database contains information on financial interactions that were worth \$7.3 billion in 2015. The Commission's analysis of the Open Payment database reported in this chapter indicates that payments for research accounted for just over half of the total; general payments accounted for 35 percent; and physician ownership or investment interests accounted for 11 percent.
- The Open Payments program has increased the transparency of financial interactions between manufacturers and physicians and teaching hospitals, and the Commission believes it should be expanded to include advance practice and registered nurses, physician assistants, and patient organizations. In addition, the Secretary should make information reported by manufacturers on free drug samples available to oversight agencies, researchers, payers, and health plans. We also believe companies should report whether they are group purchasing organizations (GPOs) or manufacturers, what type of products they make, whether they are physician-owned distributors (PODs), and the portion of each research payment that is related to physician compensation.

AN OVERVIEW OF THE MEDICAL DEVICE INDUSTRY

- The medical device industry makes a wide range of products—from surgical gloves to artificial joints to imaging equipment—and plays an important role in developing new medical technologies. Chapter 7 provides a brief introduction to the industry and its role in the Medicare program. The industry has a relatively small number of large, diversified companies and many smaller companies that are mainly engaged in research and development of new devices for specific therapeutic areas. Medicare does not pay for medical devices directly. Instead, the average cost of medical devices is bundled into Medicare's overall payment rate for many services.
- Future policy could focus on improving the availability of device- and provider-specific information and aligning provider incentives. Such improvements could include adding more device-specific information to administrative claims, improving reporting by PODs under the Open Payments program,

limiting the number of PODs, and more broadly allowing initiatives like gainsharing that encourage hospital–physician collaboration to reduce device costs.

STAND-ALONE EMERGENCY DEPARTMENTS

- The number of health care facilities devoted primarily to emergency department (ED) services and located apart from hospitals—referred to as “stand-alone EDs”—has grown rapidly in recent years. This growth has been driven by payment systems that reward treating lower severity cases in the higher paying ED setting, competition for patient market share, and an exemption in law that allows stand-alone EDs to receive higher hospital outpatient payments for non-ED services. In 2016, most were in metropolitan areas that have existing ED capacity. They also tended to be in more affluent ZIP codes, with higher household incomes and higher shares of privately insured patients.
- In our June 2016 report to the Congress, the Commission discussed stand-alone EDs in the context of rural areas and suggested that rural stand-alone EDs could have a role in the Medicare program. In our March 2017 report, in response to the concern about a lack of Medicare claims data specific to stand-alone EDs, the Commission recommended that the Secretary require hospitals to add a modifier on claims for all services provided at stand-alone EDs. In this chapter, we discuss possible directions for policy. In the future, policymakers could consider reducing payment rates for off-campus emergency departments; encouraging the development of stand-alone EDs in areas with inadequate access to ED services; and eliminating policy exceptions to site-neutral payment for ambulatory (i.e., hospital outpatient and physician) services.

HOSPITAL AND SNF USE BY MEDICARE BENEFICIARIES WHO RESIDE IN NURSING FACILITIES

- In Chapter 9, we consider the use of hospitals by long-stay nursing facility (NF) residents. Transferring Medicare beneficiaries who are long-stay NF residents to a hospital for conditions that could have been prevented or treated by the NF exposes beneficiaries to health risks and unnecessarily increases Medicare program spending. Although Medicare does not pay for the long-term portion of NF care, it does pay for hospital use by long-stay NF residents. High rates of hospital use may indicate poor care coordination between the NF staff and physicians or poor quality of care provided within the NF.
- The Commission developed facility-level measures to track use of hospitals by long-stay NF residents. We found wide variation in the rates of hospital and SNF use across facilities. Some of the variation in the measures of hospital use was explained by the frequency of physician visits and access to on-site X-ray capabilities. Differences in state Medicaid policies explain some of the variation observed across states, but we also observed high within-state variation. This variation indicates potential disparities in quality across facilities and suggests opportunities for reductions in hospital and SNF use for long-stay NF residents, which would reduce potential harm to beneficiaries and unnecessary Medicare spending.

PROVIDER CONSOLIDATION: THE ROLE OF MEDICARE POLICY

- In Chapter 10, we outline the implications for the Medicare program of consolidation in the health care industry. We discuss the current level of provider consolidation and its effect on prices and quality. The chapter also discusses the vertical consolidation of provider functions and insurer functions by ACOs or Medicare Advantage plans. We find that consolidation among and between hospitals and physicians has increased prices without any increase in quality.
- Chapter 10 makes no new recommendations but discusses how the Commission’s previous recommendations address provider consolidation. In response to horizontal consolidation, the Commission has recommended restraining Medicare prices rather than following increases in commercial prices. In response to vertical provider consolidation, the Commission has recommended

site-neutral pricing policies. By creating true “site-neutral” payments, the Medicare program could be further insulated from the cost of physician–hospital consolidation. Integration that improves care and generate efficiencies would still occur, but consolidation that is driven primarily by capturing new facility fees would be discouraged. In response to consolidation of provider and insurance functions, the Commission has discussed synchronizing payments across Medicare Advantage plans, ACOs, and FFS so that they could compete more equitably.