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

**Washington, DC, June 15, 2017**—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2017 *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. This year’s report includes:

**Implementing a unified payment system for post-acute care (PAC).** The Commission recommends moving to a unified PAC prospective payment system (PPS) that spans the four settings—skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals. In 2015, Medicare fee-for-service (FFS) spending on these services totaled \$60 billion. A unified PAC PPS would redistribute payments more equitably across patient conditions; payments would decrease for rehabilitation care unrelated to patient characteristics and increase for medically complex care. Greater equity in payments means providers would have less incentive to select certain patients over others. The implementation of the new PAC PPS should begin 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 the aggregate level of payments be lowered by 5 percent to more closely align with the cost of care. The Secretary should align regulatory requirements across the PAC settings when the PPS is implemented.

**Reforming Medicare payment for drugs under Part B.** The Medicare payment system for Part B drugs raises a number of concerns, including the price Medicare Part B pays for drugs, the lack of price competition among drugs with similar health effects, and the rapid growth in spending. The Commission recommends a series of regulatory and market-based reforms to improve Medicare payment for Part B drugs. The Commission’s recommendation would reform the “buy-and-bill” system, including an inflation rebate that would protect against rapid price increases, create greater head-to-head competition between biosimilars and reference drugs, gradually reduce the average sales price (ASP) add-on payment, and other changes. Under the recommendation, Medicare also would develop a voluntary alternative market-based program that would allow providers to use private vendors to negotiate drug prices with manufacturers. This alternative would offer participants a range of tools to promote competition, including the authority to create a formulary and also the opportunity to share in Medicare program savings.

**Redesigning the Merit-based Incentive Payment System (MIPS) and strengthening advanced alternative payment models (A-APMs).** MIPS, as presently designed, is unlikely to help beneficiaries choose clinicians, help clinicians change practice patterns to improve value, or help the Medicare program reward clinicians based on value. To address these challenges, the Commission discusses an alternative construct for MIPS in which Medicare would withhold a portion of payments from clinicians. Clinicians could get back this withhold through performance on quality metrics or by participating in an A-APM. The current set of MIPS quality

measures could be eliminated and replaced with a smaller set of population-based outcome measures. The chapter also discusses two policies to encourage clinicians to participate in A-APMs. The \$500 million fund for “exceptional performance” in MIPS could be reprogrammed to support A-APMs with asymmetric risk. Also, we discuss a possible design for an A-APM that might be more attractive to small practices.

**Using premium support in Medicare.** Under a premium support model, the government would pay a fixed dollar amount for each beneficiary’s Medicare coverage. As a result, beneficiaries’ premiums would reflect the choices they make to receive Medicare benefits through the fee-for-service (FFS) program or a managed care plan. The Commission makes no recommendations about premium support. Rather, we examine key design issues that policymakers would want to resolve 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 the impact of potentially higher premiums and to protect low-income beneficiaries?

**The relationship between clinician 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 the total service use and expenditures under Part A, Part B, and Part D of Medicare. Our findings suggest that clinician services and other services neither substitute for nor complement each other, which suggests a weak relationship.

**Payments from drug and device manufacturers to physician and teaching hospitals in 2015.** Under the Open Payments program, drug and device manufacturers and group purchasing organizations report information to the Centers for Medicare & Medicaid Services (CMS) about payments they make to physicians and teaching hospitals (those payments totaled over \$7 billion in 2015). This program has increased the transparency of financial interactions between manufacturers, physicians, and teaching hospitals, and it should be expanded to include other providers and organizations receiving payments.

**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. We provide an introduction to the industry, discuss its role in Medicare, and provide possible directions for policy.

**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. We discuss policies that could be considered in response to this trend.

**Hospital and skilled nursing facility use by Medicare beneficiaries who reside in nursing facilities (NFs).** 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. We found wide variation across facilities in their risk-adjusted rates of hospital use, which suggests opportunities for reductions in unnecessary Medicare spending.

**Provider consolidation: The role of Medicare policy.** We discuss the implications for the Medicare program of consolidation in the health care industry. There is evidence that consolidation among and between hospitals and physicians has increased prices without increasing quality. The Commission has made recommendations to address those issues. In addition, we discuss consolidation of provider functions and insurer functions by accountable care organizations and Medicare Advantage plans and implications for Medicare.

The full report is available at MedPAC's website (<http://www.medpac.gov>).

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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.*