Focus Report

The Medicare Payment Advisory Commission (MedPAC) April 2016 Meeting

April 2016

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DEVELOPMENT

The Medicare Payment Advisory Commission (MedPAC) held its latest meeting on April 7 and 8. The meeting covered topics such as a unified post-acute care payment system, improving Part D, Medicare Part B drug and payment policy issues, risk-adjustment in MA, hospice spending, measuring low-value care, and preserving access to emergency care in rural areas and a status update on the duals demo. Additionally, MedPAC approved three Part D recommendation packages that were initially presented during the commission’s March meeting.

AVALERE’S TAKE

- **Life Sciences** / MedPAC also continues to focus on changing Part D plan risk sharing, which could impact plan benefit designs and ultimately access to Part D drugs. MedPAC’s recommendation to remove antidepressants and immunosuppressants from the protected classes under Part D could adversely impact coverage of these therapeutic areas. MedPAC’s recommendation to require more rigorous prescriber statements for exception requests and provide plans greater flexibility to use formulary management tools for specialty drugs could also impact patients’ ability to access their Part D drugs. Additionally, MedPAC’s recommendation to allow for implementation of management tools under Part D (split fills and use of two specialty tiers) could impact beneficiary access to outpatient drugs. In addition in addressing changes under Part D, MedPAC also explored changes to the Part B program. The recently released Part B Drug Demo cited and ended up using many of MedPAC’s Part B policy options as part of the Demo. The Demo seeks to reduce the average sales price (ASP) add-on fee and includes a flat per drug per day payment, as MedPAC recommends, however the amounts vary from MedPAC’s recommendations. Many of MedPAC’s other proposals—bundling payments under healthcare common procedural coding system (HCPCS) codes, the reinstatement of competitive acquisition program (CAP), risk-based contracting for oncology drugs, and episode-based payment for oncology drugs—have also been proposed as Part of Phase II of the Demo. It has yet to be seen if any of these proposals will be implemented or finalized, but it appears that MedPAC’s continued discussion around Part B drug payment was instrumental in developing the proposals for this rule. While there are still many unanswered questions about how the Demo will be implemented, these reforms could lead to reduced payments for Part B drugs, or could encourage physicians to be more efficient in the care they are providing by using lower cost drugs.

- **Plans** / MedPAC’s Part D recommendations, if implemented, could have significant impacts on how plans bid for Medicare Part D. In particular, plans would have to make significant bid adjustments as MedPAC recommends increasing the plan share of costs in the catastrophic phase to 80 percent. These changes may result in plans having to either increase their bids or reduce coverage. In addition, MedPAC showed support for estimating the Medicare Advantage (MA) risk adjustment model with encounter data. However, the commission noted that a model estimated on MA would violate financial neutrality in that payments to MA would not necessarily mirror the FFS payments. Finally, MedPAC expressed overall disappointment and concerns.
with the outlook of the Duals Demonstration. Plans may want to consider the role of Dual Eligible Special Needs Plans (D-SNPs) in a post-demonstration scenario in which dual eligibles would be transitioned out of Medicare-Medicaid Plans.

- **Providers** / As both MedPAC and the Part B Demo propose, moving to a Part B payment methodology that aligns reimbursement rates closer to 100 percent ASP plus a flat “add on” payment could increase the financial burden on providers, particularly providers with less purchasing power. Many other reforms discussed (reinstatement of CAP and implementation of pathway programs) could adversely impact physician prescribing autonomy for Part B drugs. Additionally, MedPAC’s proposal to require more rigorous prescriber statements for exception requests under Part D could place an administrative burden on providers.

- **Facilities** / The implementation of a unified post-acute care prospective payment system (PAC PPS) would narrow or reduce the variation of profitability for stays across providers and decrease the incentive for providers to selectively admit certain types of patients. It is likely that some PAC facilities may see decreases in revenue due to this new payment system, while others will see an increase.

**NEXT STEPS**

MedPAC will release its next report to Congress in June. MedPAC’s next meeting will be held September 8-9.

**HIGHLIGHTS**

- **Mandated Report: Developing a Unified Payment System for Post-Acute Care** / The Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 mandates MedPAC to submit a June report evaluating and recommending features of a unified post-acute (PAC) prospective payment system (PPS). The Commission continued their discussion and review of the PAC PPS and unanimously voted to forward their report to the Congress.

- **Improving Medicare Part D** / MedPAC voted in favor of all three recommendation packages presented during the March meeting, encouraging Congress and CMS to change policies regarding catastrophic coverage, low-income subsidy (LIS) copays, and formulary management. Many of the recommendations represent significant changes to the Part D benefit and mark a major pivot in MedPAC’s approach to Part D. The Congressional Budget Office (CBO) estimates the recommendations would reduce federal spending by more than $10 billion over five years. The recommendations will be included in the June report to Congress, though many of the proposals will face significant opposition across different stakeholder groups.

- **Medicare Part B Drug and Oncology Payment Policy Issues** / The Commission voted to recommend the Secretary to reduce the Medicare Part B dispensing and supplying fees to rates similar to other payers. They also reviewed additional policy options for both Part B drug and oncology payments for the June report. MedPAC identified areas of interest including oncology medical homes, oncology episodes-of-care and consolidated billing codes as areas of interest to further explore.

- **Using Encounter Data for Risk Adjustment in Medicare Advantage** / MedPAC reviewed the use of Medicare Advantage (MA) encounter data to estimate the CMS-hierarchical condition category (HCC) model used to determine risk scores for MA
capitated payments. They reviewed the current use of fee-for-service (FFS) cost data for the model development, issues related to using MA encounter data, and the current state of MA plan cost information in the encounter data. Many commissioners were in favor of further exploring the use of encounter data to estimate the risk model.

- **Hospice and Medicare Spending** / MedPAC reviewed the analysis they commissioned to examine the effects of hospice on Medicare spending and discussed potential policy implications as well as directions for future research.

- **Measuring Low-Value Care** / MedPAC presented an analysis that built on the work they conducted last year, applying additional measures of low-value care to Medicare claims data from 2012 and 2013. The Commission did not make formal recommendations, but will most likely continue to explore policy options when they reconvene in September.

- **Preserving Access to Emergency Care in Rural Areas** / MedPAC continued their discussion on addressing the need to sustain rural inpatient hospitals and preserve access to emergency care. The Commission reviewed current payment models and two new options for outpatient-only facilities. Overall, the commissioners favored the two models and will continue to develop new strategies and policy options.

- **Status Report on CMS’s Financial Alignment Demonstration for Dual-Eligible Beneficiaries** / MedPAC provided an update on health plan participation, enrollment trends and the delivery of care coordination of CMS’ financial alignment demonstration program for dual-eligible beneficiaries. The Commission expressed dissatisfaction with the lack of success of the demonstration program.
Report Summary by Session

MANDATED REPORT: DEVELOPING A UNIFIED PAYMENT SYSTEM FOR POST-ACUTE CARE

The Improving Medicare Post-Acute Care Transformation Act (IMPACT) of 2014 mandates MedPAC to submit a report evaluating and recommending features of a unified post-acute care (PAC) prospective payment system (PPS) in June. Following this report, the Secretary will provide a report on a prototype PPS design using uniform patient assessment data by 2020 on which MedPAC will develop a report by 2023. The PAC PPS would span across skilled nursing facilities (SNFs), home health agencies (HHAs), inpatient rehabilitation facilities (IRFs), and long-term care hospitals (LTCHs). MedPAC summarized their previous findings, provided final comments on the report and voted on recommending the full report to Congress in June.

RECOMMENDATIONS

- MedPAC made no formal recommendations.

TAKEAWAYS

MedPAC outlined the evaluation, recommendations and implications of a unified PAC PPS for the June report by the following topics:

- Feasibility of PAC PPS
  - The Commission reported that a unified PAC PPS is feasible and will include the following design features: common unit of service across provider types; common risk adjustment using patient characteristics; adjustment to align HHA payment to costs; separate models to establish payments for non-therapy ancillary services and routine + therapy services; and two outlier policies: high-cost and short-stay.
  - MedPAC noted there was no strong evidence to include adjustments for IRF teaching providers and rural providers. They also noted further areas of study including: low-volume, isolated providers; risk adjustment of highest-acuity patients; and providers with high shares of low-income patients.

- Impacts on Payments
  - The Commission suggested the estimated payments should be considered relative and directional and are not point estimates.
  - The model estimates that profitability across stays would be more uniform and would decrease the incentive to selectively admit certain types of patients. A The PAC PPS would shift payments between different types of stays, and overall, would lower payments to providers and settings with high costs unrelated to patient characteristics.

- Implementation Issues
  - The implementation of the PAC PPS would require a transition policy. To develop this policy, the level of payments relative to costs and the length of the transition from setting-based payments to the new model would need to be considered. MedPAC also discussed the possibility of implementing the system sooner using administrative data and refining the model when patient assessment information becomes available.
• One commissioner asked about the downside of accelerating this payment system prior to the availability of patient assessment data. The presenters identified potential issues for smaller facilities or providers that specialize in high acuity patients, however referred to potential short-term strategies that could alleviate these challenges.

• The Commission also discussed that the Secretary should periodically recalibrate the payment system to keep the payments aligned with costs.

### Possible Changes to Regulatory Requirements

• Given the extended timeframe of implementing the PAC PPS, MedPAC outlined short-term and longer-term strategies, which would give providers flexibility in offering a wide range of PAC services.
  
  • Short-term strategy: The Commission recommends that the Secretary evaluate waiving certain setting-specific requirements.
  
  • Longer-term strategy: The Secretary should develop “core” requirements for all providers, with additional requirements for providers opting to treat patients with highly specialized needs (e.g., ventilator care).

• Some commissioners expressed concerns in developing core requirements (e.g., prior hospital stays) uniform across settings that were based on patient characteristics.

### Companion Policies to Implement with PAC PPS

• The Commission recommends implementing companion policies in conjunction with the PAC PPS to protect beneficiaries and program spending.

• Specifically, the Commission recommends a readmission policy and including the PAC Medicare Spending per Beneficiary as part of a value-based purchasing. These policies would ensure quality and manage the use of service resources.

### Importance of Monitoring Provider Responses

• MedPAC reiterated the importance of monitoring provider responses with regards to quality of care, selective admissions, unnecessary volume, and adequacy of Medicare payments.

### Need to Move Toward Episode-Based Payments

• The Commission emphasized the need for Medicare to move towards episode-based payments.

• Episode-based payments would not only reduce the need for companion policies, but put providers at risk for quality and spending over an episode of care thereby incentivizing care coordination.

• MedPAC reiterated that the PAC PPS is not an end point but a good first step towards broader payment reforms. The Commission stated it will continue to work on a unified PAC PPS and related policies beyond the June report. MedPAC will continue to develop and track outcome and resource use measures across PAC settings, integrate their findings into annual update discussions and prepare to report on a prototype design by 2023, as required by IMPACT Act.

**AVALERE’S TAKE**
Commissioners were highly in favor of the report and discussed opportunities to expedite the implementation process including incentivizing providers to opt-in early or participate in demonstrations. However, statute outlines the PAC PPS report will be finalized in 2023 and the earliest transaction may not take place until 2026.

Commissioners discussed minor edits to the final report and unanimously voted in favor of forwarding the report to Congress.

**IMPROVING MEDICARE PART D**

MedPAC approved three recommendation packages that were initially presented during the commission’s March meeting. Overall, MedPAC supported these recommendations with the aim to better control spending growth in Part D. The final recommendations include the following changes:

- **Catastrophic Coverage** / Reduce Medicare’s individual reinsurance subsidy from 80 percent to 20 percent, exclude manufacturer coverage gap discounts from the calculation of beneficiaries’ true out-of-pocket (TrOOP) costs, and eliminate cost sharing in the catastrophic phase of the benefit;

- **LIS Cost Sharing** / Reduce low-income subsidy (LIS) cost sharing amounts to encourage use of generics, preferred multi-source drugs, and biosimilars and authorize Medicare to reduce or eliminate cost sharing for such drugs in appropriate therapeutic areas; and

- **Formulary Management** / Remove antidepressants and immunosuppressants from the protected classes, streamline formulary changes, require more rigorous prescriber statements for exception requests, and permit plans to use selected tools to manage specialty drugs.

**RECOMMENDATIONS:**

MedPAC voted unanimously to approve three recommendation packages regarding catastrophic coverage, low-income subsidy (LIS) copays, and formulary management. Details on each recommendation package can be found below. The Commission will publish these recommendations in the June report to Congress.

**TAKEAWAYS:**

MedPAC has demonstrated concern with Part D spending trends over the past year. MedPAC has specifically been focused on reinsurane payment growth, the impact of high cost drugs, and the costs associated with LIS beneficiaries. The recommendations put forth by the Commission propose changes to the Part D benefit to address these challenges while attempting to balance beneficiary access with financial sustainability.

**Catastrophic Coverage** recommendations encourage Congress to:

- Transition Medicare’s individual reinsurance subsidy to 20 percent while maintaining Medicare’s overall 74.5 percent subsidy of basic benefits;

- Exclude manufacturers’ discounts in the coverage gap from enrollees’ TrOOP spending; and

- Eliminate enrollee cost sharing above the out-of-pocket threshold.
The Commissioners believe that the reduction in the reinsurance subsidy from 80 percent to 20 percent would put greater pressure on plans to manage catastrophic spending and to negotiate lower prices. While this increase in financial risk to plans could lead to smaller plans increasing premiums, the Chairman estimates overall savings to the Medicare program and Part D enrollees.

The Chairman expects the exclusion of the brand discount from TrOOP will lead to higher cost sharing for non-LIS beneficiaries who would otherwise have reached the catastrophic phase and would now either fail to do so or would do so more slowly. MedPAC estimates that approximately half of high-cost non-LIS enrollees in 2013 would no longer have reached the catastrophic phase if this policy had been in place.

Commissioners expressed concern for the subset of beneficiaries that would no longer reach the catastrophic phase since they would have increased out-of-pocket costs but would fail to benefit from the cost sharing cap recommendation. The June Report will include language encouraging Congress to consider methods to protect this subgroup.

MedPAC highlighted the significant financial burden some non-LIS enrollees face in the catastrophic phase, despite the existing cost-sharing limitations. The Commissioners stated that the proposed cost-sharing cap is a priority to protect these beneficiaries from unlimited financial liability, particularly in light of the growth in high cost specialty drugs covered under Part D.

Presenters clarified that the combination of reducing the reinsurance subsidy and capping beneficiary cost sharing would lead to Medicare providing a 20 percent reinsurance subsidy and plans assuming full financial risk the remaining 80 percent of catastrophic spending.

This led many commissioners to question whether the package would place upward pressure on premiums. As a result, many Commissioners supported a transition period for the reinsurance subsidy recommendation and reiterated the need to monitor the impact of these provisions. One Commissioner cautioned against extending any transition period for the reinsurance proposal as the risk adjustment model would then need to be continuously recalibrated.

**LIS Cost Sharing** recommendations encourage Congress to:

- Modify copayments for Medicare beneficiaries with incomes at or below 135 percent of poverty to encourage the use of generic drugs, preferred multi-source drugs, or biosimilars when available in selected therapeutic classes.
  - Commissioners did not propose specific cost sharing amounts for generic drugs, preferred multi-source drugs, or biosimilars
- To implement the changes to LIS copayments, MedPAC recommends that Congress grant the Secretary the authority to direct changes at her discretion, as described here:
  - Direct the Secretary to reduce or eliminate cost sharing for generic drugs, preferred multi-source drugs, and biosimilars; and
  - Direct the Secretary to determine appropriate therapeutic classifications for the purpose of implementing this policy and review the therapeutic classes at least every three years.
• One Commissioner suggested the following amendment to replace the first implementation recommendation:

  • “Direct the Secretary to reduce or eliminate cost sharing for generic drugs, preferred multi-source drugs, and biosimilars, and increase cost-sharing for brand drugs.”

  • Many commissioners opposed the suggested amendment and favored moderate financial incentives to encourage the use of generics and biosimilars.

  • The amendment was withdrawn after discussion but the June Report will include language indicating that Congress could also achieve MedPAC’s aims by granting the Secretary the option to increase cost-sharing for brand drugs; however, MedPAC will not specifically recommend this action.

• During the presentation, staff stated that LIS copayments for biosimilars are the same as for branded reference biologics.

  • Commissioners asked for clarification on whether this was required in statute or was implemented through CMS guidance.

  • LIS copayments for biosimilars are not prescribed in federal statute; CMS issued guidance regarding LIS copayments for biosimilars on March 30, 2015 but could change its interpretation without Congressional action.

  • One Commissioner expressed concerns with the slow rate of biosimilars being approved and coming to market.

  • One Commissioner raised the topic of preferred cost sharing pharmacies and suggested developing a mechanism for implementing differential LIS cost-sharing between preferred and non-preferred pharmacies.

  • The Chairman indicated there was not sufficient data to understand the impact of such a proposal and suggested revisiting the topic at a later date.

• **Formulary Management** recommendations encourage the Secretary to:

  • Remove antidepressants and immunosuppressants for transplant rejection from the classes of clinical concern;

  • Streamline the process for formulary changes;

    • MedPAC suggested providing opportunities to apply for formulary changes between the time the plan submits its bid and annual open enrollment.

    • MedPAC also proposed allowing plans to put in place “maintenance” changes that CMS would normally approve – it is unclear whether MedPAC proposes to allow plans to make such changes before open enrollment or in January and February when maintenance changes are disallowed.

    • Presenters’ examples of maintenance changes that CMS normally approves included allowing a plan to add a new generic product and removing the brand drug counterpart.

  • Require prescribers to provide standardized supporting justifications with more clinical rigor when applying for exceptions; and
MedPAC stated this would create new exception requirements but would allow for a more predictable and simple process.

MedPAC indicated one of its aims for this proposal is to reduce delay for beneficiaries associated with exceptions and appeals.

Permit plan sponsors to use selected tools to manage specialty drug benefits while maintaining appropriate access to needed medications.

MedPAC presented two specific management tools for this recommendation: split fills (i.e., 15-day initial supply) and use of two specialty tiers (preferred and non-preferred).

The Commissioners clarified that these ideas would be presented in the June Report, but the Secretary would be charged with investigating and identifying the appropriate management tools.

Some Commissioners expressed concern regarding removing the two protected classes and questioned whether the benefits outweighed the risks. Staff and the Chairman relied heavily on the authority of CMS’ January 2014 proposal to remove these classes when supporting the appropriateness of this recommendation.

Due to the availability of multiple generics in this class, Commissioners expect multiple drugs in each class to remain available on plan formularies.

The Chairman commented that plan sponsors may be able to negotiate lower prices for drugs in protected classes if this recommendation is adopted, which could reduce premiums. However, some beneficiaries may need to switch medications or seek formulary exceptions.

The Chairman also indicated that enhanced formulary management could reduce costs and constrain enrollee premiums and cost sharing. He did note this could require more beneficiaries to apply to exceptions, redeterminations and appeals. Moreover, prescribers could find the transition to standardized reporting burdensome.

While MedPAC didn’t make any proposals, they did indicate support for improving the exceptions and appeals process. MedPAC will continue to test strategies for resolving issues at the point of sale and prescribing.

AVALERE’S TAKE:

- MedPAC voted unanimously for all three recommendation packages without amendment and will include all three packages in the June report to Congress.

- CBO estimates that the combined impact of the three recommendation packages will lead to more than $2 billion in one-year program savings relative to baseline spending, and more than $10 billion in savings over five years. MedPAC did not provide information on the dates used for these projections. In addition, MedPAC did not provide estimates of the impact of individual components of the recommendation packages. Recent estimates have indicated that similar LIS cost sharing proposals would save approximately $3.3 billion over five years and $9.6 billion over ten years.

- MedPAC’s approval of these recommendation packages marks a major shift in the Commission’s approach to Medicare Part D. While the LIS cost sharing
recommendation is consistent with previous MedPAC proposals, the catastrophic coverage and formulary management recommendation packages represent significant changes to the Part D benefit.

- In addition, MedPAC’s continued focus on drug spending trends in Medicare Part D and approval of these recommendation packages to address these trends represents another volley in the ongoing drug pricing debate. MedPAC has expressed concern regarding drug pricing trends and stated its intention that these proposals would act to create negative pressure on those trends.

- However, Congress is likely to face opposition to many of these proposals from stakeholders across the healthcare landscape. Manufacturers and patient advocacy organizations are likely to oppose all of MedPAC’s proposals except the cap on patient out-of-pocket costs. Payers will likely oppose the catastrophic coverage changes but will likely support the formulary management changes. Indeed, CMS has proposed some similar changes in the past, including reducing the number of protected classes, but was forced to withdraw the proposed changes in the face of strident opposition.

- It is unlikely that Congress or CMS will attempt to adopt any of these changes before the start of a new presidential administration but MedPAC’s formal recommendations may be incorporated into legislation or regulatory action in 2017 to help pay for other legislative proposals or as part of packages to address drug pricing.

MEDICARE PART B DRUG AND ONCOLOGY PAYMENT POLICY ISSUES

RECOMMENDATION:

MedPAC voted to include their recommendation to reduce Part B dispensing and supplying fees for the June report to Congress. They also continued their discussion on policy options to restructure and reform Part B drug and oncology payments.

TAKEAWAYS:

- Commissioners were in favor of the chapter for the June report to Congress and identified the following areas to further explore policy options for Part B and oncology drug payment after continuing their discussions from the March meeting: Consolidated billing codes, oncology medical homes, oncology episodes-of-care

- During the March meeting, the Commission reviewed various policy options to restructure the add-on to ASP payment methodology, to promote competition, and to apply downward price pressures to ASP. MedPAC continued to discuss the following policy options.

- Restructuring the ASP add-on to 103.5 percent of ASP + $5 per drug per day.

  - Using 2014 data, MedPAC expects savings of about 1.3 percent, or $270 million per year assuming no utilization changes. They also anticipate Part B drug payments to outpatient hospitals and specialists to decrease and payments to primary care physicians would increase.

  - Changing the ASP add-on payment could encourage beneficiaries to substitute low-priced drugs, but may hinder small purchasers from obtaining expensive drugs (e.g., oncology drugs). This may contribute toward the trend of hospital-based oncology care.
• Some commissioners sought to know the historical reason behind the 6 percent add-on payment. They also expressed concerns that reducing the add-on payment to 3.5 percent with a flat rate would not change the behaviors of prescribing higher cost drugs.

- Limiting the growth rate of Medicare’s ASP+6 payment for a drug.
  • Median ASP growth for the 20 highest-expenditure drug has exceeded inflation since 2010.
  • Limiting the growth of Medicare’s ASP+6 payment rate could be operationalized by shifting the financial risk towards manufacturers through rebates or to providers.
  • One commissioner was not in favor and did not believe limiting ASP growth would drive competitive pricing. Some commissioners expressed concern that limiting the ASP growth would lead to higher launch prices.

- Consolidating billing codes for products with similar health effects.
  • Single-source drugs and reference biologics receive their own billing code and are paid on their own ASP. Placing biosimilars and their reference products in one billing code could promote price competition.
  • One commissioner expressed opposition, stating that reference pricing could impact clinical decisions.

- Restructuring the Competitor Acquisition Program (CAP)
  • Between July 2006–December 2008, Medicare supported a voluntary CAP program where in physicians ordered prescriptions prior to a patient’s visit and received reimbursement for the administration. Medicare paid the contracted vendor for the drug and the vendor collected drug cost-sharing from beneficiaries.
  • To encourage physician enrollment, the Commission recommends offering shared savings for physicians, reducing or eliminating the ASP add-on in traditional buy-and-bill system, and restructuring CAP to be a stock replacement model or a group purchasing organization (GPO) model. MedPAC also suggested permitting vendors to operate a formulary and provide them with shared savings opportunities.
  • Some commissioners expressed concerned about delivering untimely care through CAP.
  • One commissioner suggested taking a look at the DEM competitive bidding to and draw parallels to the CAP program.

- Reducing Part B dispensing and supplying fees
  • The dispensing and supplying fee rates for Part B drugs were set in 2006 and based on limited data. In 2014, dispensing fees for Part B drugs could range from $33 per 30-day supply for inhalation drugs to $24 for a 1st script of oral anticancer drugs.
  • The OIG reports that Medicare Part D and Medicaid paid dispensing fees of less than $5 per script in 2011.
To generate Medicare program savings and decrease beneficiary cost-sharing, MedPAC voted in favor of this recommendation during the March meeting.

The Commission voted unanimously to include this recommendation in the June report to Congress.

The Commission also continued their discussion of four potential options to improve efficiencies in oncology care under FFS Medicare including:

- Risk-sharing agreements to improve the value of drug spending.
  - Some commissioners were not in favor of risk-sharing agreements because measures could be based on surrogate outcomes.
- Clinical pathways to reduce prescribing variability, improve quality of care, and reduce costs of care.
  - Commissioners questioned the proprietary nature of clinical pathways and expressed concern about the evidence used to develop the pathways.
  - Some commissioners also questioned the succession of new drugs into clinical pathways.
- Oncology medical homes to improve health outcomes, enhance patient care experiences, improve timeliness and coordination of care, and reduce costs of care.
  - Commissioners expressed the most interest in exploring this option in the future.
- Oncology episodes-of-care to remove revenue incentive to prescribe one drug over another and strengthen incentive to prescribe on quality bases.

**AVALERE’S TAKE:**

- The Commission was in favor of the chapter on Part B and oncology payment for the June report to congress. They voted unanimously to recommend the Secretary to reduce dispensing and filling fee rates similar to other payers.
- MedPAC reviewed potential policy options for both Part B drug and oncology drug payments introduced during the March meeting and identified consolidated billing codes, oncology medical homes, oncology episodes-of-care as areas to further explore.
- A number of the initiatives discussed during this session have tentatively been proposed as part of the Part B demo – including modifications to the ASP add-on payment, episodes of care payments and risk-sharing agreements. MedPAC did not discuss or make reference to the Part B demo and it has yet to be seen if any of the initiatives will be finalized.

**USING ENCOUNTER DATA FOR RISK ADJUSTMENT IN MEDICARE ADVANTAGE**

The Commission discussed the use of Medicare Advantage (MA) encounter data to calibrate the risk adjustment.

The Medicare program currently uses the Medicare FFS data in the CMS hierarchal condition category (CMS – HCC) model to determine risk scores for MA capitated payments. Since 2012, plans have submitted detailed claim data for their members to
CMS. These data are called encounter data. Using MA encounter data could be more appropriate to estimate the model because the current model disease weights are based on FFS provider coding patterns. Research has shown that MA plan providers code differently than FFS providers because MA plan payments depend on conditions coded, whereas FFS payments do not. Because the cost of treating conditions may be different in MA and FFS, the relative disease weights associated in the risk model could reflect these differences as well. As a result, MA plans may be incentivized to avoid conditions costly conditions which could create differentials in the cost of treating patients between MA and FFS.

Using encounter data instead of FFS could address coding intensity, but would create new issues (e.g., plans creating new condition-specific incentives). Because FFS coding is incomplete and variable, it can impact MA risk scores and lead to overpayment. The Affordable Care Act (ACA) requires a mandatory coding intensity adjustment that increases each year to account for the difference in coding practices. Once the risk model is estimated on MA encounter data, however, the coding intensity adjustment would no longer be required as per the statute.

Although MedPAC considers the MA encounter data is considered to be good quality based on the prevalence of the HCCs in the dataset, there are gaps in the encounter data. Encounter data do not include administrative cost and profits, and it is difficult to determine provider capitation or salary because capitated encounters show $0 payment in the data. In 2013, an aggregate 30 percent of provider payments were not available in encounter data when compared to overall Medicare payments. MedPAC reviewed the current use of FFS cost data, issues related to using MA plan cost data, and the current state of MA plan cost information in the encounter data. They identified methods to address shortcomings on the encounter data and discussed next steps in developing the model on encounter data.

**RECOMMENDATION:**

MedPAC made no formal recommendations.

**TAKEAWAYS:**

- MedPAC noted that the current risk adjustment methodology allows for financial neutrality between MA and FFS payments. The commission has consistently supported MA payments being equal to the expected cost in FFS and recognized using encounter-based risk adjustment would cause payments to move away from financial neutrality.
- Some commissioners questioned the value in attaining financial neutrality in comparison to the efficiency of using encounter-based risk adjustments.
- The staff presented three methods to address capitated encounter payments:
  - Use FFS Medicare price information to estimate the cost of each MA encounter
  - Use only MA enrollees with complete (i.e., FFS) encounter payment information
  - Allocate each plan’s MA capitated payment amounts to MA enrollees
- Some commissioners were in favor of the first method in using FFS data and requested additional data to better understand this proposal. One commissioner
expressed concerns not only with using the encounter data, but also the issues in moving forward with the three methods above.

- MedPAC identified next steps to further explore MA encounter data: assess the feasibility of allocating capitated payments and calibrate an MA-based model and compare MA utilization with FFS.
- Many commissioners were in favor of both next steps to better understand and were open to discussing risk adjustments and additional approaches to address the issues during their July internal retreat (note – this retreat is not open to the public).

**AVALERE’S TAKE:**

- Using encounter data for the HCC model can resolve coding intensity concerns and establish cost competition among MA plans. However, there are gaps in the data set, and using encounter data will result in MA payments no longer being financially neutral with FFS payments.
- Commissioners appeared in favor or further exploring encounter data due to the HCC model inaccuracies, but expressed concerns about the gaps in data. Four commissioners spearheaded the discussion, focusing on the value-add of using encounter data and the implications of removing financial neutrality from MA payments.
- The Commission asked staff to provide additional information to help them better understand the differences between MA and FFS and the differences within MA patient populations (e.g., patient characteristics, differences in treatment). MedPAC also requested information on cases where MA plans are underpaid and the associated FFS data.
- Although they will not make recommendations on this issue in the June report to Congress, MedPAC will likely revisit this topic during their internal meeting in July and again in their public meeting in September to further explore the use of encounter data in the risk adjustment model for MA beneficiaries. CMS’ timeline of using encounter data to more accurately capture patient health and adequately risk adjust is unknown at this time, although CMS did indicate in the final Call Letter for 2017 their intention to estimate the risk model on encounter data in the future.

**HOSPICE AND MEDICARE SPENDING**

The hospice benefit includes palliative and supportive services for beneficiaries with terminal illness. Enrollees that choose to enroll must meet certain eligibility criteria and agree to forgo conventional care for their terminal condition and related conditions.

When Congress enacted the Medicare hospice benefit, it was presumed to cost less than conventional care and therefore lead to Medicare program savings. In recent years, there have been concerns that providers may pursue revenue generation strategies in hospice, further driving program spending. To better understand the impact of hospice spending on Medicare, MedPAC commissioned a contractor to report on national trends, replicate and evaluate existing literature, and provide a market-level analysis.

**RECOMMENDATIONS**

- MedPAC made no formal recommendations.
TAKEAWAYS

- The Commission noted current literature on hospices’ effect on Medicare spending presents mixed results and presented the contractor report analysis to clarify the impact of hospice on spending.

National Trends

- Between 2002–2012, hospice use and Medicare spending in the last year of life both increased. The share of elderly fee-for-services (FFS) decedents who used hospice nearly doubled from 2002 to 2012 (26 percent to 47 percent respectively).
- In 2012, approximately one-third of hospice spending was for care prior to the last year of life.

Replicating and Evaluating Studies

- MedPAC’s contractor replicated two types of studies that showed different results:
  - Fixed period study: This study compared spending for hospice and non-hospice users 6-12 months prior to death and found small costs or small savings for hospice users depending on the time period and population studied.
  - Enrollment/pseudo-enrollment: This study looked at the period of hospice enrollment and compared it to a pseudo-enrollment period for non-hospice enrollees which demonstrated large cost savings for hospice decedents. However, the savings found in pseudo-enrollment approach could be artifact of the methodology.

Market-level Analysis

- The relationship between hospice use in a market and decadent cost was measured by the ratio of per person decedent costs to survivor costs. Overall, higher hospice penetration in the market was modestly associated with higher costs per decedent.
- High costs were attributable to patients with long hospice stays and hospice use among non-cancer decedents.

Report Conclusions and Implications

- Hospice’s main benefits are its effect on patient care rather than costs
- Hospice does not appear to result in a reduction of aggregate Medicare spending relative to conventional end of life care.
- Overall, hospice may result in less spending for cancer patients, but higher spending for non-cancer patients and patients with very long stays, which could have significantly influenced the aggregate results.
- MedPAC conducted an analyses to examine the beneficiary and provider characteristics that accounted for hospice spending for care prior to the last year of life.
• In 2013, 35 percent of hospice payments were for care prior to the last year of life, however, the percent varied by the level of hospice care, patient diagnosis and provider characteristics.
  • Level of hospice care: 38 percent of routine home care (RHC) payments, but only 8 percent-9 percent of general inpatient care and continuous home care payments
  • Patient diagnosis: 16 percent of hospice payments prior to last year of life were for cancer and 40 percent for non-cancer diagnoses
  • Provider characteristics: 40 percent of hospice payments were for for-profit hospices and 29 percent were for nonprofit centers.
  • MedPAC reported that 20 percent of hospices received 46 percent or more of their total RHC payments for care provided prior to the last year of life
• Commissioners were most interested in the payment differentials between for-profit and nonprofit hospice centers. They also questioned the certification of hospice beneficiaries and whether the certifying physicians are affiliates of the hospice center.
• Some commissioners requested data on the case mix of patient characteristics and conditions in hospice over a period of time because diagnoses and pharmaceutical advancements may have affected cost and length of hospice stays. They also requested data on MA plans as MA enrollees are more likely to use hospice.
• Many commissioners were in favor of exploring and developing policies around quality programs, value-based adjustors for different conditions and informed-decision making to encourage the opportunity for hospice at an earlier timeframe.

AVALERE’S TAKE
- The MedPAC commissioned report on hospice and Medicare spending demonstrated that hospice may result in less spending for certain patient groups, but the benefit does not reduce Medicare spending relative to conventional care at the end of life. This conclusion was consistent with previous studies.
- Commissioners were highly in favor of further exploring the impact of hospice on Medicare spending and potential policy options to reduce long hospice stays and inappropriate stays for certain conditions.

MEASURING LOW-VALUE CARE
MedPAC presented an analysis that builds on the work published by Schwartz and colleagues in *Jama Internal Medicine* in 2014 and 2015. MedPAC applied 31 measures of low-value care to Medicare claims data from 2012 and 2013 to calculate the number of low-value services per 100 beneficiaries, the share of beneficiaries who received at least one low-value service, and total spending for each service.

RECOMMENDATION:
MedPAC made no formal recommendations.
TAKEAWAYS:

- MedPAC reiterated their motivation in examining low-value care by citing recent studies and the Choosing Wisely campaign in addition to the Commission's support of value-based insurance design.

- MedPAC clarified that low-value care can be defined as services with little or no clinical benefit, or when risk of harm from a service outweighs potential benefit.

- Last year, MedPAC applied 26 measures to 2012 claims data using narrow and broad versions of measures based on Schwartz et al.'s 26 low-value measures.

- Applying a similar methodology, researchers analyzed 2012 and 2013 Medicare claims data using narrow and broad versions of measures based on Choosing Wisely, U.S. Preventive Services Task Force (USPSTF), literature (e.g., Schwartz et al.) and other sources. Specific results for 2012 claims data were not included in the presentation as they were similar to the findings for 2013.

- Results for broad measures: Researchers found 74 low-value services per 100 beneficiaries, 38 percent of beneficiaries received at least one low-value service, and Medicare spending on low-value care was $7.1 billion.

- Results for narrower measures: Researchers found 35 low-value services per 100 beneficiaries, 23 percent of beneficiaries received at least one low-value service and Medicare spending on low-value care was $2.6 billion.

- Under both measures, cardiovascular tests/procedures, other surgical procedures, and imaging accounted for the most spending on low-value care. In addition, imaging, cancer screening and diagnostics and preventative testing accounted for the most volume of low-value care.

- MedPAC and researchers estimate the results understate the volume and spending on low-value care due to challenges in identifying low-value care with claims data and the lack of claims-based measures of low-value care. Furthermore, the spending estimates do not account for downstream services that result from the initial service (e.g., PSA tests account for 28 percent of spending whereas biopsies and pathology account for 50 percent and 19 percent of spending, respectively).

- MedPAC staff presented four potential policy directions:

  - Payment/delivery system reform (e.g., ACOs)
    - MedPAC presented information from an article published by Schwartz et al. in 2015 on pioneer ACOs reducing low-value care. After applying 31 measures, researchers found ACOs had greater reduction in volume and spending for low-value care relative to control groups.
    - One commissioner suggested exploring low-value care measures in MA encounter data.

  - Quality measurement

  - Medicare coverage policy
    - Some commissioners discussed the various challenges associated with creating or modifying Medicare coverage policy.
    - One commissioner suggested creating a coverage policy that would provide oversight of low-value care, but not specify service that may be low-value.
Increase beneficiary engagement (e.g., cost sharing, shared decision making).

- Some commissioners suggested the engagement should be more directed at providers.

Three additional policy directions were suggested by commissioners: prior authorization, decision support integration tools, and contracting a third party organization to function in a relationship similar to CMS and USPSTF.

- There were mixed reactions to applying prior authorization as it could add administrative burdens to the program.
- One commissioner described CMS’ work of integrating a decision support system into electronic health records for imaging. According to the commissioner, providers would be required to go through a series of prompts when using imaging services. Other private payers have already integrated this function and tied it to payment.
- One commissioner suggested further exploring the work of PCORI and CER and the potential of contracting with an evidence group to identify low-value services to support CMS in moving forward to address this issue.

**AVALERE’S TAKE:**

- The Commission continued to express interest in reducing low-value care and identified potential policy directions. Commissioners identified payment/delivery system reform, benefit engagement, in addition to their own ideas as areas they would like to further explore.
- MedPAC’s research regarding low-value care measures highlights how measures can be used to review the value of services. No final recommendations are likely to appear in MedPAC’s June report and it is likely that MedPAC will revisit this topic and continue to discuss and develop potential policy options when they reconvene in September.

**PRESERVING ACCESS TO EMERGENCY CARE IN RURAL AREAS**

MedPAC continued their discussion on two proposed models to address the need for sustainability of rural inpatient hospitals and preserving access to emergency care in rural areas. The first option proposes hospitals to convert to an outpatient-only model with a 24/7 emergency Department (ED). The second model restructures struggling hospitals to function as primary care clinics with a 24/7 ambulance service. Commissioners reviewed current payment models for rural hospitals and discussed payment options for the new models.

**RECOMMENDATION:**

MedPAC made no formal recommendations.

**TAKEAWAYS:**

- Currently, several strategies to supplement inpatient rates in rural settings exist.
- Sole-Community Hospital (SCH) – an add-on to inpatient rates
- Medicare-Dependent Hospital (MDH) – an add-on to inpatient rates
Low-volume adjustments – an add-on to inpatient rates (can also be MDG/SCH)

Critical Access Hospital (CAH) – cost-based reimbursement that requires inpatient services

Rural hospitals are also limited by cost-based payments and payments only for inpatient services. Cost-based payments favor higher-cost hospitals and encourage non-emergency services, both leading to excess cost growth. In-patient focused payments can also drive high costs and raises concerns about quality when there are lower volumes.

These limitations have placed rural hospitals at financial risk, a problem compounded and perpetuated by low-volume and declining admission rates. MedPAC reported 41 rural closures between 2013 to March, with variation in distance to the nearest hospital among the closures.

Commissioners continue to discuss two outpatient-only models of care:

- **Model 1: 24/7 Emergency Department** / This option would involve converting inpatient hospitals to 24/7 emergency departments that also provide primary care outpatient services. Participating hospitals would be paid hospital outpatient PPS rates per service and receive a fixed grant to help fund stand-by costs. To qualify for the fixed grants, hospitals cannot offer acute inpatient services or provide post-acute SNF services at the PPS rates.

- **Model 2: Clinic + Ambulance** / Under this model, a hospital would convert to a primary care clinic with an ambulance available 24/7. The clinic would receive PPS rates per unit of service (e.g., Federally Qualified Health Center (FQHC) rates) and a fixed grant to help pay for the ambulance stand-by capacity and uncompensated care costs.

Under the two models, beneficiaries and providers would experience different effects. Emergency access for rural beneficiaries would be maintained, however patients would need to travel for inpatient care. Furthermore, outpatient services would be paid PPS rates, and have lower coinsurance than at CAHs. Although the change is optional for providers, it could create financial viability and support the recruitment of additional physicians. The cost structures would be lower making the hospital more compatible with ACOs and the shift towards value care.

Commissioners were in favor of both options and did not lean more towards one or the other. They reiterated the importance of allowing hospitals the flexibility to revert back to inpatient facilities and discussed the option of requiring matching grant funds from the county or local community. Some commissioners were in favor of this proposition as it would shift responsibility and accountability towards the community. However, other members expressed concern that matching grant funds could create additional barriers for communities unable to secure these funds.

In addressing access, commissioners agreed that telemedicine would play an important role in providing the breadth of services required and addressing some of the staffing issues in rural settings. MedPAC was in favor of continuing the discussion of access to rural emergency care services to their sessions on telehealth in the future.

Commissioners suggested incentivizing larger providers to partner with rural clinics to address resource allocation and staffing issues. MedPAC was in favor of further exploring this issue.
MedPAC revisited the issue of love-volume isolated providers and the definition of “isolated”. They discussed the pros and cons of using time versus distance, but did not provide a conclusive proposal.

AVALERE’S TAKE:

The Commission’s discussion continued to highlight the lack of access to services in rural areas. MedPAC favored both models presented by staff and will most likely continue to develop the strategies to launch as a pilot. MedPAC was also in favor of integrating their discussion of telehealth and rural care in future sessions. Although there were no recommendations made for the June report to Congress, they will most likely revisit this topic in the future and continue to discuss policy options and implications.

STATUS REPORT ON CMS’S FINANCIAL ALIGNMENT AND DEMONSTRATION FOR DUAL-ELIGIBLE BENEFICIARIES

CMS’ financial alignment demonstration is in its second year of testing two models of care (capitated and managed fee-for-service (FFS)) for dual-eligible beneficiaries. MedPAC staff provided an update on health plan participation, enrollment trends, and the delivery of care coordination based on a series of site visits and interviews. Because the majority of states are using capitated models, the analysis focuses mostly on those demonstrations.

Enrollment Trends / About 450,000 dual eligible are currently enrolled in the financial alignment demonstration. Participation rate is approximately 30 percent of the eligible population across all states, but enrollment varies from state to state.

- States can use passive enrollment, but many beneficiaries have opted out or disenrolled, citing satisfaction with existing care, lack of information about the demonstration, or resistance from providers.
- Stakeholders reported additional outreach of the demonstration and a slower roll-out of passive enrollment could have resulted in a higher rate of participants.

Site Visit and Interview Results /

- Delivery of Care Coordination: During the site visits, stakeholders reported the following challenges in caring for dual eligible beneficiaries:
  - Challenges for plan coordinators in developing trusting relationships with beneficiaries,
  - Lack of adequate/stable housing,
  - Shortage of outpatient treatment options, and
  - Providing interdisciplinary care while adhering to federal rules that restrict sharing of patient information
- Service Use and Quality of Care: Plans interviewed by MedPAC have not seen significant changes in service use and do not expect to see modified utilization patterns for another 2-3 years. CMS is currently collecting quality data for plans, but they have not yet made this information publicly available.
Many states reported they do not expect to see changes or savings for an additional 2-3 years as they continue to work through some of the challenges associated with dual-eligible populations. They also described CMS’ goals and expected savings as unrealistic.

- MedPAC staff will continue to evaluate the financial alignment demonstration by conducting additional site visits, comparing MMP enrollees to beneficiaries who opted out or later disenrolled, examining payment methodology for Part A/B compared to MA plan payment rates and assessing usefulness of quality data when it becomes available.

**RECOMMENDATION:**

MedPAC made no formal recommendations.

**TAKEAWAYS:**

- The Commission stated that it is too early in the demonstration to observe substantial outcomes given the challenges plans face with this subpopulation. MedPAC acknowledged the barriers to working with the duals population and questioned whether plans were ready to take on the responsibility of providing both medical and social services.

- One commissioner expressed concerns with the success of these programs if they could not demonstrate savings despite entering its second or third year. Another commissioner questioned whether or not looking at savings was the right outcome measure for the success of the program.

- Some commissioners questioned the identity of dual-eligible and whether they were considered Medicaid or Medicare beneficiaries. They discussed issues with oversight that may arise if the population was not well defined.

- Two commissioners expressed concerns about housing issues and the association of inadequate housing with the inability to locate beneficiaries.

- A few commissioners made reference to the Program of All-inclusive Care for the Elderly (PACE) and discussed the feasibility of restructuring this as a model for the demonstration. MedPAC staff highlighted that PACE did not lead to savings for Medicare, and although it is considered successful it would be difficult to apply on a broad scale.

**AVALERE’S TAKE:**

- In general, the Commission expressed dissatisfaction with the direction of the duals demonstration, particularly with respect to enrollment being below expectations. Furthermore, MedPAC highlighted their concerns with what will happen after the demonstration ends. They questioned how states would transition their dual-eligible participants and discussed potential models. Commissioners suggested exploring Dual Eligible Special Needs Plans (D-SNPs) and developing a model to shift management of the population to these plans. Another commissioner suggested restructuring the program to align with best practices of care coordination, quality and payment as seen in MA plans.
MedPAC staff will continue to conduct additional site visits to evaluate and analyze the financial alignment program. The Commission will most likely revisit this issue within the next year.