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Top Five Takeaways from MedPAC's Meeting on Medicare Issues and Policy Developments – November 2017

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The Medicare Payment Advisory Commission ("MedPAC") met in Washington, DC on November 2-3, 2017. The purpose of this and other public meetings of MedPAC is for the commissioners to review the issues and challenges facing the Medicare program and then make policy recommendations to Congress. MedPAC issues these recommendations in two annual reports, one in March and another in June. MedPAC's meetings can provide valuable insight into the state of Medicare, the direction of the program moving forward, and the content of MedPAC's next report to Congress.

As thought leaders in health law, Epstein Becker Green monitors MedPAC developments to gauge the direction of the health care marketplace. Our five biggest takeaways from the November meeting are as follows:

Article By Olivia Seraphim
Daniel KimEpstein Becker & Green, P.C.
Health Law Advisor

Health Law & Managed Care
All Federal

1. **MedPAC refines an alternative to MIPS.**

MedPAC discussed the potential implementation of a new value-based program, described as a voluntary value program ("VVP"), for clinicians in Medicare fee-for service ("FFS") if the Merit-based Incentive Payment System ("MIPS") is eliminated, as was proposed by MedPAC in its October meeting. The VVP would encourage clinicians to form voluntary groups that would receive payment depending on the group's overall performance. MedPAC did not anticipate recommending restrictions on the size or markup of the voluntary group beyond a minimum threshold, which would depend on specific quality measures, clinician specialties, and attribution rules. MedPAC also discussed the potential of a CMS-established voluntary fallback group for isolated or low-volume clinicians who want to join a group. With respect to different quality measures on which the VVP would reward payments, MedPAC proposed that Congress focus on measuring population-based outcomes, patient experience, and cost. Lastly, to incentivize clinicians to switch from the Medicare FFS, MedPAC proposed that any policy should cap the total value payment as to make it less attractive than an alternative payment model.

2. **MedPAC recommends rebalancing Medicare's physician fee schedule towards primary care services.**

MedPAC expressed concern that the current physician fee schedule disfavors primary care practice, often underpricing primary care relative to other Medicare health care services, and thus potentially contributing to the decrease of primary care clinicians. In response, MedPAC proposed two approaches towards rebalancing the fee schedule in favor of primary care services. The first approach would increase fee schedule payments for primary care clinicians and psychiatric services provided by all specialties and clinicians. The payment increase would be distributed on a per service basis, to achieve the goal of spreading the increased dollars among clinicians. Eligible primary care services would include: evaluation and management codes for office visits, home visits, and visits to patients in long-term care settings; chronic care management and transitional care management codes;

and “Welcome to Medicare” visits and annual wellness visits.

The second approach would increase fee schedule payments for primary care and psychiatric services provided only by certain specialties and certain clinicians within those specialties. Payment increases could be distributed either on a service-by-service basis or on a per beneficiary basis. While the former may incentivize more discrete primary care visits, the latter would encourage non-face-to-face care coordination and would be consistent with MedPACs 2015 recommendation to Congress. However, as the size of a per beneficiary payment increases, questions would arise about how to attribute patients and whether to risk-adjust the payments.

3. **MedPAC makes payment policy recommendations for non-competitively bid DMEPOS.**

MedPAC discussed the proposed recommendations it intends to make to the Centers for Medicare and Medicaid Services (“CMS”) to address the durable medical equipment, prosthetics, and orthotics (“DMEPOS”) fee schedule rates, which MedPAC finds to be excessive. As proposed, the recommendations would shift more DMEPOS products currently paid on a fee schedule basis to a competitive bidding program (“CBP”). MedPAC’s recommendations also call for immediate reduced payment rates for certain non-CBP products while CMS works on incorporating them into the CBP. Alternatively, MedPAC recommends a policy option that aligns balance billing and participation rules for DMEPOS suppliers with the rest of Medicare and that further protects beneficiaries. This policy option would have CMS consider capping balance billing at a percentage of the fee schedule rate and reducing the allowed amount by five percent for non-participating suppliers.

4. **MedPAC makes coverage-gap discount policy recommendations for biosimilars in Medicare Part D.**

Consistent with its 2016 recommendations and the Chairman’s draft recommendation, MedPAC’s proposed policy for Part D would have the manufacturing coverage gap discount apply to both originator biologics and biosimilars, which currently applies only to originator biologics. However, the discount would no longer apply to the beneficiary’s out-of-pocket spending for either originator biologics or biosimilars. MedPAC believes that the standardized use of the coverage gap discount will better align the incentives. Because the discount would no longer distort price signals between the two products, there would be slightly lower plan liability for biosimilars than originator biologics, therefore incentivizing sponsors to put the lower-priced biosimilars on their formulary. This change would also result in Medicare paying lower reinsurance. Although some enrollees would have higher cost sharing, cost sharing above the out-of-pocket threshold would be eliminated, creating a hard cap. Because prices for biologics have been outpacing Part D as a whole, MedPAC anticipates the hard cap would become more valuable over time.

5. **MedPAC provides principles for evaluating the expansion of Medicare’s coverage of telehealth services.**

This month is MedPAC’s third and last address to Congress’ mandate concerning telehealth expansion under Medicare. MedPAC discussed three principles that policy makers should consider when evaluating telehealth services or policies for potential incorporation into the FFS Medicare program: 1. increased access; 2. improved quality; and 3. reduced costs. Through examples, MedPAC appears to recommend (1) expanding telehealth services into urban areas; and (2) covering direct-to-consumer (“DTC”) services across all areas and for all beneficiaries. According to MedPAC, Medicare’s coverage of urban telehealth and DTC services would increase beneficiary access and convenience, especially in areas with certain service coverage shortages (*i.e.*, stroke specialists, mental practitioners). For programs like telestroke, MedPAC notes that expanding access would likely improve quality by reducing mortality or more serious disability. MedPAC acknowledges that expanding telehealth services may increase costs, and noted that policy makers would need to decide whether the benefits in access and quality that result from telehealth services justify the extra costs of those services.

MedPAC also briefly reported its take on FFS Medicare’s telehealth service expansion for Medicare Advantage (“MA”). Rather than changing the MA program or its payment policy, MedPAC focuses on addressing the question of whether the Medicare benefit should be the same regardless of whether a beneficiary enrolls for FFS Medicare or MA. One option would keep the benefit between FFS Medicare and MA the same. Another option would allow MA plans to include telehealth services in their bids, thereby making the Medicare payment for telehealth services included in the program’s base payment and not financed by rebate dollars. This would mean all plan members would have access to the telehealth benefits, but not be able to opt out in exchange for lower premiums.

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