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Top Five Takeaways from MedPAC's Meeting on Medicare Issues and Policy Developments – October 2018

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The Medicare Payment Advisory Commission ("MedPAC") met in Washington, D.C., on October 4-5, 2018. The purpose of this and other public meetings of MedPAC is for the commissioners to analyze existing challenges and issues within the Medicare program and to provide future policy recommendations to Congress. MedPAC issues these recommendations in two annual reports, one in March and another in June. These meetings offer a comprehensive perspective on the current state of Medicare as well as future outlooks for the program.

We monitor MedPAC developments to determine how regulations and policies will impact the health care marketplace. Here are our five biggest takeaways from the October meeting:

Managing Prescription Opioid Use in Medicare Part D

MedPAC provided an informational overview of opioid use and polypharmacy as an update to its work in prior years. MedPAC first discussed the use of opioids by Medicare beneficiaries. Since the 1990s, aggressive marketing of extended-release opioid formulations and liberal prescribing of these drugs for acute and chronic pain due to ambiguous clinical guidelines for safe prescribing contributed to the "opioid crisis." The Centers for Disease Control and Prevention ("CDC") reported over 17,000 prescription opioid overdose deaths in 2016. Due to their age and accompanying pain and "illness burdens," Medicare beneficiaries are especially prone to the toxicity and harm associated with even low-dosage opioid prescriptions. In its 2016 guideline, CDC generally addressed safe opioid prescribing for acute and chronic pain, including its preference for non-pharmacologic therapy and non-opioid pharmacologic therapy and recommendation that "additional caution" be used "when initiating opioids for patients age 65 and older."

MedPAC then presented updated data on patterns of opioid use in Medicare Part D. From 2012 to 2016, opioid analgesic (i.e., pain-relief drugs) prescriptions per 1,000 Medicare Part D enrollees have declined about 18 percent. While it recognized this positive trend, MedPAC expressed continued concern that (1) "opioid use in Part D continues to be widespread, with nearly one-third of enrollees filling at least one opioid prescription in a given year"; (2) most opioid use did not relate to hospice care or cancer treatment; and (3) gross spending on opioids is among the highest in Part D, totaling $4.1 billion in 2016. MedPAC also discussed varying "opioid-related adverse drug events" ("ADEs"), defined narrowly by MedPAC as "diagnosis codes specifying poisoning by opioid in inpatient and

outpatient claims, including emergency department visits that resulted in inpatient stays." MedPAC found that "high-intensity users"—17% of Part D beneficiaries defined as those with higher average dosage and treatment lasting longer than three months—had nearly seven times the ADE rate of "low-intensity opioid users," defined by MedPAC as beneficiaries with "50 [morphine milligram equivalents ("MME")] per day or less and treatment lasting three months or less." MedPAC also stressed that polypharmacy, or beneficiaries using multiple drugs, is another key contributor to ADEs.

Lastly, MedPAC described steps that the Centers for Medicare & Medicaid Services ("CMS") and Part D plan sponsors have been taking to monitor opioid use and manage opioid misuse. In 2013, CMS required plan sponsors to identify enrollees who were at "high risk of opioid abuse or misuse," monitor high cumulative enrollee dosages, and notify pharmacists to coordinate with the enrollee's prescriber. CMS uses its Overutilization Monitoring System ("OMS") to supervise these plan sponsors' compliance. In 2019, Part D plan sponsors will now have the authority to limit at-risk beneficiaries' access to frequently abused drugs using a tailored approach. For example, plans must limit opioid quantity to a seven-day prescription for post-surgery patients. Plans may also limit access through a drug management program. Examples of restrictions include placing restrictions on beneficiaries' fills, locking beneficiaries into seeking prescriptions from certain prescribers, and prescriber "safety checks" once cumulative daily dosage reaches 90 MME. Through Medicare Drug Integrity Contractors ("MEDIC"), CMS also monitors providers or opioids to ensure they are not prescribing inappropriately. In 2019, offending prescribers may ultimately be placed on CMS's "preclusion list," where Part D plan sponsors must reject their pharmacy claims.

Opioids and Alternatives in Hospital Settings

Under the new SUPPORT for Patients and Communities Act, MedPAC is required to report on the following opioid issues in inpatient and outpatient hospital settings by March 2019: (1) how Medicare pays for opioid and non-opioid alternatives, (2) incentives under prospective payment systems for prescribing opioids versus opioid alternatives, and (3) how Medicare claims data tracks opioid use. MedPAC addressed each issue in succession.

Reporting on the first issue, MedPAC stated that Medicare uses bundled payments for inpatient and outpatient hospital settings via the inpatient prospective payment system ("IPPS") and outpatient prospective payment system ("OPPS"), respectively. The IPPS bundles *all* goods and services together, including drugs supplied during the hospital stay, whereas the OPPS pays for *integral* goods and services that are bundled into categories based on clinical and cost similarity. Medicare Part B pays for analgesics, including opioids, that are integral to the procedure or treatment for the beneficiary. For example, post-surgical opioid prescriptions are considered integral by CMS. Non-integral opioids may or may not be paid by Medicare Part D.

Although MedPAC acknowledged that patient-specific and clinical factors play a role in a provider's prescribing choices, MedPAC focused on the financial incentives that guide prescribers' opioid administration. Both IPPS and OPPS incentivize hospital prescribers to select the lowest-cost goods and services while adhering to Medicare's quality measurement and reporting programs and clinical professionalism. MedPAC then stated it has "begun an analysis of the differences in prices between opioid and non-opioid drugs commonly used . . . [a]nd . . . options about non-drug alternatives."

MedPAC lastly described how Medicare tracks opioid use. As described in the earlier section, CMS monitors Part D opioid use through OMS; ensuring plan sponsors implement opioid overutilization policies effectively. CMS also uses quality measures to track trends in opioid overuse and publicizes providers' prescribing data through its online Part D Opioid Prescribing Mapping Tool. MedPAC then

stated that CMS does not yet track opioid use in inpatient and outpatient hospital settings (Medicare Parts A and B). MedPAC listed multiple reasons for CMS initiating opioid monitoring in hospital settings, including the severity of the opioid epidemic and the need to understand the extent to which beneficiaries are exposed to opioids while in the hospital. It also acknowledged some challenges to implementation, including questions about how to interpret the "appropriateness of opioid prescriptions identified by a tracking program" and how Parts A and B do not have plan sponsors on which to rely for reporting data.

Medicare Payment Policies for APRNs and PAs

In response to Commissioner interest on rebalancing the physician fee schedule, MedPAC discussed Medicare payment polices for advanced practice registered nurses ("APRNs") and physician assistants ("PAs"). APRNs include four types of licensed practitioners: nurse practitioners ("NPs"), certified nurse anesthetists ("CNAs"), clinical nurse specialists ("CNSs"), and certified nurse midwives ("CNMs"). While individual states determine the services and responsibilities that APRNs and PAs have, their authority and independence have substantially increased nationwide over time. Based on its review of existing literature, MedPAC concluded that "NPs and PAs provide roughly equivalent care in terms of quality and patient experience" at a lower cost for their provider-employers (although evidence of lower payer costs is mixed).

MedPAC then addressed Medicare payment for APRNs and PAs, whose services are generally covered if medically necessary. Medicare pays APRNs and PAs directly through their national provider identifier ("NPI") at 85% of the physician fee schedule. Under this direct billing, MedPAC noted substantially increasing trends in total Medicare FFS allowed charges for APRNs and PAs—NPs total allowed charges billed have increased 158% from 2010–2016. MedPAC also pointed to rapidly growing (149% from 2010–2016) APRN/PA primary care patient visits, especially compared to the decline in traditional primary care physicians (-13% change from 2010–2016). Medicare also pays NPs and PAs under "incident to" billing at 100% of the physician fee schedule: the physician NPI is used instead of the NP or PA NPI. Certain circumstances (e.g., hospital settings, new patients, new *problems* for existing patients) require that NPs bill directly to Medicare; however, the rapid expansion of NPs and PAs suggests that incident to billing will also expand, especially in "evaluation and management" services ("E&M") according to MedPAC. Based on its analysis, MedPAC concluded that for E&M office visits performed for established patients, NPs likely utilized incident to billing practices roughly 40% of the time, and PAs billed this way roughly 30% of the time. MedPAC then concluded with two policy options: (1) to eliminate incident to billing for APRNs and PAs—potentially reducing Medicare and beneficiary expenditures and (2) improving Medicare's specialty designations for APRNs and PAs to indicate primary care as a field of practice.

Medicare's Role in the Supply of Primary Care Physicians

MedPAC discussed Medicare's role in the supply of primary care physicians (PCPs), focusing on beneficiaries' current access to PCPs, factors influencing physicians' choice of specialty, and methods for recruiting more medical students or graduates into primary care. Recent statistics have shown that though most Medicare beneficiaries report that they are able to obtain care when needed, there was a small share who reported trouble finding a doctor. This was a concern to the MedPAC committee given that the absolute number of primary care physicians treating beneficiaries between 2011 and 2016 had increased.

It was reported that physicians focusing on primary care were generally trained in family medicine, geriatric medicine, internal medicine and pediatrics. Whereas family medicine residents usually

ended up practicing primary care, internal medicine residents have increasingly decided to enter subspecialties (e.g., cardiology, gastroenterology), instead of practicing primary care. The percentage of internal medicine residents going into primary care dropped 6% between 2001 and 2010.

One of the key factors influencing physician choice of specialty was educational debt load. Medical students with high debts levels were found to be less likely to choose primary care. The committee found this very concerning because education debt has been rising over time. For instance, median debt among medical school graduates rose roughly $15,000 between 2010 and 2016.

MedPAC is currently seeking input on ideas to increase the supply of PCPs. One of the proposed routes was creating a scholarship or loan repayment program for medical students and/or graduates who commit to providing primary care to Medicare beneficiaries. Design issues to consider include size of programs in terms of dollars and the number of physicians, financing a Medicare program, determining type of medical student eligibility, physician requirement for treating Medicare beneficiaries, and the length of the service commitment.

Episode Based Payments and Outcome Measures Under a Unified Payment System for Post-Acute Care

MedPAC provided an overview regarding 2019 plans for the unified post-acute care prospective payment system (PAC PPS) and the quality measures being developed for PAC providers. MedPAC has been developing a unified PAC PPS that would extend across four settings – home health agencies, skilled nursing facilities long-term care hospitals, and inpatient rehabilitation facilities – and provide base payments solely on patient characteristics. The committee sees the system as having an impact in terms of redistributing payments, thus making payments more equitable "across different patient conditions compared with current policy." With payments increasing for medically complex patients and decreasing for patients receiving rehabilitative care unrelated to their clinical conditions, the belief is that providers would have less financial incentives to prefer various patients over others.

The committee discussed their initial work regarding patient stays, emphasizing that a stay-based payment system would encourage stays while discouraging providers from "offering a continuum of care." The committee proposes an episode-based PPS, where a single payment would cover both stays in the episode of PAC care (this would pertain only to post-acute care and others services like hospital or physician services). MedPAC believes that such a model provides several advantages such as encouraging institutional PAC providers to offer a continuum of care as well as lower program spending and beneficiary cost sharing.

Finally, the Commission discussed their development of uniform measures to be utilized for measuring quality of care across providers. In conjunction with the PAC PPS, the Commission recommended implementing a unified value-based payment (VBP) program, which would hopefully discourage shifting of care to other providers as well as overuse of care. Some of the uniform measures discussed for a PAC VBP include Medicare spending per beneficiary, combined admissions and readmissions, hospital readmissions, and discharge to the community. The Commission hopes to develop a combined measure of admissions and readmissions that will include admissions to hospitals for both community and inpatient admitted beneficiaries.

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