MedPAC Votes Major Changes to Part B Rx and Post Acute Payment Policies

April 7, 2017

On April 6th, 2017 the Medicare Payment Advisory Commission (MedPAC) voted on draft recommendations for Medicare Part B drug payment policies and a unified post-acute care (PAC) prospective payment system (PPS). The recommendations and discussion highlights are noted below**.** Click here to review meeting presentations.

Medicare Part B Drug Payment Policy Issues

- Part B drug spending was $26 billion in 2015 – up from $23 billion in 2014.
- The Commission voted unanimously to include the following package of recommendations in the June report to Congress:
  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 coast (WAC) based payments to WAC +3%;
     - Require manufactures to pay Medicare a rebate when the ASP for their product exceeds the inflation benchmark, and tie the beneficiary cost-sharing and the ASP add-on to the inflation-adjusted ASP; and
     - 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 would have the following elements:
     - Medicare contracts with a small number of private venders 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 would not exceed 100 percent of ASP; and
     - 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.
- If the following recommendations are implemented, MedPAC projects that program spending would have an estimated decrease of $250 million over one year and $1 billion over five years relative to current law.
- Several Commissioners, while ultimately voting to approve the overall package of recommendations, voiced concern over the binding arbitration component of the recommendation.
- Additional information regarding ASP inflation rebate, timing of the ASP add-on reduction, design options for binding arbitration under the DVP, among other items, will be included in the Chapter.

Implementing a Unified PAC Payment System

- Under a unified PAC PPS, payments would be based on patient characteristics; MedPAC believes this design feature would decrease incentives to treat patients with certain conditions over others.
- Responding to Commissioner inquiries from the March 2017 meeting, MedPAC staff investigated lowering the aggregate payments reduction by 5%, versus the 3% proposed in March. The staff found that even with a 5% reduction, the average payments would be 9% higher than the average cost of stays.
- MedPAC staff noted that the Centers for Medicare and Medicaid Services (CMS) could implement a PAC PPS as soon as 2021, but it is unlikely that a PAC PPS would be proposed before 2024.
- Commissioner Warner Thomas stated that he supported a quick implementation, but also suggested including the ability to pilot these models between now and 2021.
- The Commission voted unanimously to include the following recommendations in the June report to Congress:
    1. Implement a PAC PPS beginning in 2021 with a three year transition;
    2. Lower aggregate payments by 5%, absent prior reductions to the level of payments;
    3. Concurrently, begin to align setting-specific regulatory requirements; and
    4. Periodically revise and rebase payments, as needed, to keep payments aligned with the cost of care.