MEDPAC Medicare Payment Advisory Commission

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EMBARGOED FOR RELEASE UNTIL 1:00 PM March 15, 2017

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

Washington, DC, March 15, 2017—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2017 *Report to the Congress: Medicare Payment Policy.* The report includes MedPAC's analyses of payment adequacy in fee-for-service (FFS) Medicare and provides a review of Medicare Advantage (MA) and the prescription drug benefit, Part D.

Fee-for-service payment rate recommendations. The report presents MedPAC's recommendations for 2018 rate adjustments in FFS Medicare. These "update" recommendations—which MedPAC is required by law to submit each year—are based on an assessment of payment adequacy that examines beneficiaries' access to and use of care, the quality of the care they receive, supply of providers, and providers' costs and Medicare's payments.

In this year's report, MedPAC continues to make recommendations to ensure high-quality care for Medicare beneficiaries at lower costs to the program. In light of its payment adequacy analyses, MedPAC recommends that payments be increased by the amount specified in current law for hospitals, dialysis facilities, and for physicians and other health professionals. MedPAC also recommends no payment increase for 2018 for three FFS payment systems: ambulatory surgical centers, long-term care hospitals, and hospice. MedPAC recommends no payment increase for both 2018 and 2019 for skilled nursing facilities. For home health agencies and inpatient rehabilitation facilities, MedPAC recommends reducing payments by 5 percent. Lastly, for skilled nursing facilities and home health agencies, MedPAC recommends reforming their prospective payment systems to more equitably distribute payments among providers and better maintain access for all beneficiaries. Overall, these recommendations are expected to reduce spending in the Medicare program without harming beneficiaries' access to care.

Encouraging the Congress and CMS to implement MedPAC's recommended changes to post-acute care (PAC) payments. PAC providers offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. However, the Commission has long observed the shortcomings of the separate FFS payment systems for PAC. The current systems create incentives for providers to treat certain types of patients over others; contribute to wide variation in program spending across different geographic areas, with an unclear effect on quality; and do not align payments with the costs of treating patients.

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The Commission has said that PAC payment reform should follow several principles, including that payments should be adequate to provide beneficiaries with access to needed services, that payments should be set to preserve the long-run sustainability of Medicare, and that payments should focus on the costs of treating patients with different care needs. To follow those principles, the Commission has made recommendations that would both update payment rates and revise payment systems. In June 2016, the Commission recommended features of a unified PAC payment system that would base payments on patient characteristics and redistribute Medicare payments more equitably across stays.

The costs of failing to implement the Commission's PAC recommendations are substantial. We estimate that if this year's recommendations were implemented, FFS spending would be reduced by more than $30 billion over 10 years, all else being equal. Moreover, because FFS payments form the basis of financing in other areas of Medicare, overpayments and misaligned incentives distort payments in Medicare Advantage (MA) and accountable care organizations (ACOs).

Medicare Advantage. Reductions to MA benchmarks to more closely align them with FFS spending have been phased in since passage of the Patient Protection and Affordable Care Act (PPACA) in 2010, and were completed in 2017. MedPAC estimates that MA benchmarks are about 2 percent above FFS (6 percent after quality bonuses are included). That results in payments to MA plans that are now on average about 100 percent of FFS spending, assuming that risk adjustment in the Medicare program adequately adjusts payments for the differences in health status between enrollees in MA and FFS. However, for several years the Commission and others have documented that enrollees in MA plans have higher risk scores than similar beneficiaries in FFS because of plans' more intensive coding practices. Those higher risk scores result in higher payments to plans relative to what those beneficiaries would have cost in FFS.

The Commission also discusses another inequity in MA payment policy and makes a recommendation to address it. MA enrollees are required to enroll in both Part A and Part B. However, MA benchmarks are currently based on the Medicare spending of all FFS beneficiaries (including those who do not enroll in both Part A and Part B). To ensure equity between FFS and the MA program, and equity across MA plans, the Commission recommends calculating MA benchmarks using average FFS spending only for beneficiaries enrolled in both Part A and Part B. This would increase spending under the Medicare program, which could be offset by many of the Commission's previous recommendations for MA.

Part D. Participation in the Medicare drug benefit increased to about 72 percent of Medicare beneficiaries (about 41 million beneficiaries) in 2016. Beneficiaries continue to have broad choice among plans, ranging from 18 to 24 prescription drug plans (PDPs) depending on where they live, along with many MA plans that also offer drug benefits. In 2015, Medicare spent $80 billion for the Part D benefit on an incurred basis. In addition, beneficiaries paid about $27 billion in premiums and cost-sharing. Since 2014, reinsurance payments have been the largest and fastest growing component of spending. These payments have grown at an average annual rate of 20 percent since 2007. Also, during 2013 and 2014, there was an uptick in our overall index of Part D prices. In June 2016, the Commission recommended a combination of changes designed to address these concerns and improve Part D for the future while maintaining the program's market-based approach.

A list of recommendations is included in the accompanying fact sheet. The entire report is available online at http://www.medpac.gov.

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