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**MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT  
ON MEDICARE PAYMENT POLICY**

Washington, DC, March 15, 2016—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2016 *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 2017 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 no payment update for 2017 for four FFS payment systems: ambulatory surgical centers, long-term care hospitals, inpatient rehabilitation facilities, and hospice. It recommends that payments be updated by the amount specified in current law for outpatient dialysis facilities and for physicians and other health professionals. For two types of providers, skilled nursing facilities and home health agencies, the Commission recommends reforming their prospective payment systems to more equitably distribute payments among providers and better maintain access for all beneficiaries. It also recommends two years of restraining and rebasing home health and skilled nursing facility payment rates.

**Increasing hospital payments and targeting uncompensated care payments to hospitals that provide the greatest shares of uncompensated care.** For inpatient and outpatient hospital services, the Commission recommends the payment increase specified in current law, concurrent with reductions to the payment rate for Part B drugs at 340B hospitals and changes to the size and distribution of the Medicare hospital uncompensated care pool (discussed below). Together, this package of recommendations will increase payments to hospitals by more than \$3 billion.

Nonprofit hospitals with high shares of Medicaid and low-income Medicare patients qualify for the 340B Drug Pricing Program. These hospitals receive substantial discounts from drug manufacturers for Part B drugs. The Office of Inspector General estimates that the discount across all 340B providers is 34 percent of the average sales price (ASP). Because Medicare does not currently adjust its payment rates

for the lower drug acquisition cost at 340B hospitals, it pays 340B hospitals much more than their costs for these drugs. Reducing the price that Medicare pays 340B prospective payment system hospitals for separately payable Part B drugs by 10 percent of ASP would accomplish two things. First, it would reduce beneficiary cost sharing. Second, it would reduce program spending for Part B drugs by approximately \$300 million—funds that we recommend be redirected to the Medicare-financed uncompensated care pool.

In addition to expanding the uncompensated care pool, we recommend distributing this pool on the basis of better data on uncompensated care (which hospitals report on Worksheet S-10 of their cost reports). This would better target additional payments to hospitals that provide above-average shares of uncompensated care.

**Examining inpatient rehabilitation facility (IRF) coding practices.** New Commission analysis finds that an IRF's mix of case types is correlated with its profitability under Medicare. In addition, we find that IRFs with high Medicare profit margins have patients who are, on average, less severely ill in their preceding acute care hospital stay but who then appear to be more functionally disabled upon admission to the IRF, compared with other IRFs. This discrepancy suggests the possibility that patient selection and assessment and coding practices may contribute to differences in costs—and profitability—across providers. The Commission recommends that the Secretary of Health and Human Services analyze IRF coding to determine whether it accurately reflects the rehabilitation needs of patients. This analysis should begin with focused medical record reviews of IRFs that have unusual patterns of case mix and coding. In the near term, we recommend that CMS better align IRF payments and costs through an expanded high-cost outlier pool.

**Medicare Advantage.** Current law requires that MA benchmarks be reduced over time to bring greater financial neutrality between MA and FFS. As a result, plan bids have come down in relation to FFS spending while enrollment in MA continues to grow. These benchmark changes have resulted in more competitive plan bidding, and MA plans continue to offer benefit packages that beneficiaries find attractive.

However, current law contains two adjustments to the county benchmarks that create inequity among MA plans. One adjustment places a cap on benchmarks in specified counties and can arbitrarily limit plans' quality bonuses. The other adjustment doubles quality increases in certain counties. We recommend eliminating both adjustments to make the benchmarks simpler and more equitable, while leaving overall payments at roughly the same level.

Recently, the Commission has expressed concerns about another source of inequity between MA and FFS payments: Analyses by MedPAC and others find that MA plan enrollees have higher risk scores than similar FFS beneficiaries because of plans' more intensive coding efforts. Higher risk scores translate into higher payments for plans. CMS makes an across-the-board adjustment to the scores to make them more consistent with FFS coding. We find that CMS would need to raise the coding adjustment (i.e., lower enrollees' risk scores) and change the way diagnoses are collected for use in the risk adjustment process to ensure the coding levels in aggregate are roughly equal between the FFS and MA programs. The report includes several recommendations to achieve better coding equity between MA and FFS and to better target plans that seem to engage in intensive coding practices.

**Part D.** Participation in the Medicare drug benefit remains quite high, with about 70 percent of Medicare beneficiaries (about 39 million beneficiaries) enrolled in Part D plans in 2015. The average beneficiary has between 19 and 29 stand-alone drug plans to choose from, in addition to many MA plans that offer the drug benefit.

Between 2007 and 2014, Part D program spending increased from \$46.7 billion to \$78 billion. Spending for Part D reflects two underlying trends. First, there has been a shift toward use of generic drugs, with generics accounting for 84 percent of all prescriptions filled in 2013 compared with 61 percent in 2007. This shift has mitigated the benefit spending on which plan sponsors base premiums and has helped keep enrollee premiums low. A second trend, however, is that Part D's reinsurance payments, or the largely program-financed payments to plans for the highest spending enrollees, have grown by an average of 19 percent per year. For the future, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. This change will put additional upward pressure on program spending in the catastrophic phase of the benefit.

A list of recommendations is included in the accompanying fact sheet. The entire report is available online at [http://medpac.gov/documents/reports/Mar16\\_EntireReport.pdf](http://medpac.gov/documents/reports/Mar16_EntireReport.pdf).

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*The Medicare Payment Advisory Commission is a congressional agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program.*