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**CONTACT: Stephanie Cameron** (202) 220-3700  
scameron@medpac.gov

## MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT TO CONGRESS ON MEDICARE PAYMENT POLICY

**Washington, DC, March 15, 2022**—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2022 *Report to the Congress: Medicare Payment Policy*. The report includes MedPAC’s analyses of payment adequacy in traditional fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and the prescription drug benefit (Part D). This report also satisfies four additional legislative mandates that address: a payment adjustment for certain low-volume acute care hospitals, recent changes to the home health payment system, the performance of certain specialized MA plans, and a value-based payment program for post-acute care services.

The Commission is acutely aware of the ongoing coronavirus pandemic. Medicare beneficiaries—particularly those who reside in nursing homes, have end-stage renal disease, are dually eligible for Medicaid, or are members of racial or ethnic minority groups—have been disproportionately affected by the pandemic. The health care workforce continues to experience extreme stress and heavy and unpredictable workloads given the multiple “waves” or surges in hospital admissions and impacts on other providers (e.g., nursing facilities) over the past two years. In the report, we discuss some of the effects of the pandemic and pandemic-related policies on beneficiaries and providers. However, our statutory charge is to evaluate available data to assess whether Medicare payments, in aggregate, are sufficient to support the efficient delivery of care and ensure access to care for Medicare’s beneficiaries. Therefore, while we have considered the effects of the coronavirus pandemic on our payment adequacy indicators, we continue to make recommendations aimed at finding ways to provide high-quality care for Medicare beneficiaries while giving providers incentives to constrain their cost growth and thus help control program spending. To the extent that the effects of the pandemic are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than permanent changes to payment rates in 2023 and beyond.

**| Fee-for-service payment rate update recommendations.** The report presents MedPAC’s recommendations for how FFS Medicare provider payment rates should be updated for 2023. These “update” recommendations, which MedPAC is required by law to submit each year, are based on an assessment of payment adequacy for each provider type 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.

Overall, these recommendations would reduce Medicare spending while preserving beneficiaries’ access to high-quality care. MedPAC recommends positive (consistent with current law or policy) payment updates in 2023 for acute care hospitals, long-term care hospitals, and outpatient dialysis facilities; no update for clinicians paid under the physician fee schedule (consistent with current law), ambulatory surgical centers, and hospice providers; and negative updates (reductions in base payment rates) for skilled nursing facilities, home health agencies, and inpatient rehabilitation

facilities. We also include recommendations to improve payment accuracy by requiring ambulatory surgical centers to report cost data and by wage adjusting the hospice aggregate cap and reducing it by 20 percent.

In addition, we recommend that the Secretary require physicians and other health professionals, home health agencies, and hospices to provide more information on the telehealth services they provide, to help policy makers assess the impact of these services on access, quality, and costs.

**Medicare Advantage.** Overall, many indicators point to an increasingly robust MA program. Forty-six percent of eligible beneficiaries were enrolled in MA in 2021, a reflection of the value that Medicare beneficiaries see in MA. Virtually all beneficiaries have access to at least one MA plan in 2022, with the average beneficiary having 36 plans from which to choose. Further, the level of rebates that fund extra benefits reached a record high of nearly \$2,000 per enrollee, on average, in 2022.

For 2022, the average MA plan bid to provide Medicare Part A and Part B benefits was 15 percent less than FFS Medicare would spend for those enrollees. However, the efficiencies reflected in these low bids are shared exclusively by the companies sponsoring MA plans and MA enrollees (in the form of extra benefits). The taxpayers and FFS Medicare beneficiaries (who help fund the MA program through Part B premiums) do not realize any savings from MA plan efficiencies. Instead, we estimate that Medicare spends 4 percent more for MA enrollees than it would have spent if those enrollees remained in FFS Medicare. In aggregate, for the entire duration of their Medicare participation, private plans have never produced savings for Medicare.

The Commission remains committed to including private plans in the Medicare program and allowing beneficiaries to choose among Medicare coverage options, including the alternative delivery systems that private plans can provide. However, Medicare should not continue to overpay MA plans. Indeed, under current policies, doing so will further worsen Medicare's fiscal sustainability as MA enrollment continues to grow. In the past few years, the Commission has made recommendations to address coding intensity, replace the quality bonus program, and establish more equitable benchmarks, which are used to set plan payments, all of which will stem Medicare's excess payments to MA plans, helping to preserve Medicare's solvency and sustainability, while maintaining beneficiary access to MA plans and the extra benefits they can provide. It is imperative that the Congress and the Secretary make such policy improvements.

**Part D.** Over 76 percent of Medicare beneficiaries (about 49 million beneficiaries) participated in private Medicare drug plans in 2021. Beneficiaries continue to have broad choice among plans in 2022. Beneficiaries' options range from 19 to 27 prescription drug plans (PDPs) depending on where they live, in addition to several MA plans that also offer prescription drug benefits (MA-PDs). In 2020, total Part D spending was \$105.3 billion. Plan enrollees paid about \$13.6 billion of that amount in plan premiums (enrollees also paid additional amounts in cost sharing).

In several ways, Part D has been a success: Part D has improved beneficiaries' access to prescription drugs, generic drugs now account for nearly 90 percent of the prescriptions filled, and enrollees' average premiums for basic benefits have remained steady for many years (around \$30 per month). However, over time, a growing share of Medicare's payments to plans have taken the form of cost-based reinsurance instead of fixed-dollar payments (which provide incentives for plans to control spending). Medicare's cost-based reinsurance continues to be the largest and fastest growing component of Part D spending, rising by 3.7 percent from 2019 to 2020 (an aberrantly lower rate compared to the historical annual average of 15.7 percent from 2007 to 2019), while Medicare's fixed-dollar payments declined by 13.6 percent.

In 2020, over 443,000 enrollees (11.6 percent of high-cost enrollees) filled a prescription for which a single claim was sufficient to put them into the catastrophic phase of the Part D benefit, up from just 33,000 enrollees in 2010. To help address these issues, in 2020 the Commission recommended substantial changes to Part D's benefit design to limit enrollee out-of-pocket spending; realign plan and manufacturer incentives to help restore the role of risk-based, capitated payments; and eliminate features of the current program that distort market incentives.

**| Mandated report: Interim report on effects of home health payment reform.** The Bipartisan Budget Act (BBA) of 2018 required the elimination of therapy as a payment factor in the home health prospective payment system in 2020 and shortening the unit of payment under the PPS from 60 days to 30 days. CMS implemented these changes through a new case-mix system known as the Patient-Driven Groupings Model (PDGM). The BBA of 2018 mandates that the Commission provide an interim analysis of the impact of these changes.

Assessing the initial impact of the PDGM on home health care in 2020 is confounded by the disruptions associated with the coronavirus public health emergency (PHE). However, the payment adequacy indicators for 2020 point to the stability of Medicare home health care in the first year of the PDGM. Though the number of 30-day periods and the number of beneficiaries served in 2020 were lower than in 2019, the monthly pattern in home health care volume for 2020 signals that the declines were mostly attributable to the PHE and not the PDGM. We will continue to monitor the home health sector in the upcoming years and will make a more comprehensive assessment of the impacts of the PDGM in 2026, as required by the BBA of 2018.

**| Mandated report: Extension of the increased inpatient hospital payment adjustment for low-volume hospitals.** The BBA of 2018 temporarily extended and modified the low-volume hospital (LVH) payment adjustment in the inpatient prospective payment system for 2019 through 2022. The legislation mandates that the Commission report on the effects of the changes on Medicare inpatient stays, Medicare spending, LVHs' financial status, and other relevant analyses.

We find that in 2019, the BBA of 2018 policy change raised the number of LVHs by 5 percent but increased LVH payments by about 19 percent. This growth in payments was due to increases in the number of LVHs, the average number of FFS Medicare stays per LVH, and the average LVH payment adjustment. With the expiration of the BBA 2018 changes in 2023, the LVH policy will become more consistent with the Commission's earlier recommendation with respect to adjusting payments to LVHs, but we remain concerned that the LVH policy is not well targeted to isolated hospitals and is duplicative for many LVHs paid based on costs.

**| Mandated report: Performance of dual-eligible special needs plans (D-SNPs).** The BBA of 2018 permanently authorized dual-eligible special needs plans (D-SNPs), and starting in 2021, required them to meet new standards for integrating the delivery of Medicare and Medicaid services. The BBA of 2018 also mandates that the Commission periodically compare the performance of different types of D-SNPs and other plans that serve dual-eligible beneficiaries.

In our first report in response to this mandate, we find that the most readily available data to make such comparisons—Healthcare Effectiveness Data and Information Set (HEDIS®) data—are insufficient to make robust and meaningful comparisons of the relative performance of D-SNPs. In future analyses, we anticipate evaluating the utility of other data, such as Medicare Advantage encounter data, or Consumer Assessment of Healthcare Providers and Systems (CAHPS) data in making such comparisons.

**| Mandated report: Establish a prototype value-based purchasing program under a unified post-acute care prospective payment system.** The Consolidated Appropriations Act, 2021, mandates that the Commission develop a prototype value-based purchasing payment program under a unified prospective payment system (PPS) for post-acute care (PAC) services and analyze the impacts of such a design. The prototype that we discuss in this report (the PAC Value Improvement Program, or PAC VIP) would include five design elements: a small set of performance measures, strategies to ensure reliable measure results, a system to distribute rewards with minimal “cliff” effects, an approach to account for differences in patients’ social risk factors using a peer-grouping mechanism (if necessary), and a method to distribute the entire provider-funded pool of dollars. We modeled a PAC VIP design that includes four of the five design elements; additional work is needed before determining whether an approach to account for the social risk of a post-acute care provider’s patient population is always needed.

The Commission concludes that implementing a PAC VIP would involve many steps and would be a multiyear endeavor beginning with the implementation of a PAC PPS and the alignment of regulatory requirements for PAC providers so that setting-specific practice patterns would begin to converge. With the PAC PPS as a foundation, CMS could then begin developing a PAC VIP consistent with our prototype discussed in this report.

The full report is available at MedPAC’s website (<http://www.medpac.gov>).

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*The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission’s goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.*