

Report to the Congress • March 2017

The Medicare Payment Advisory Commission (MedPAC) is required by law to annually review Medicare payment policies and make recommendations to the Congress. The 2017 report includes payment policy recommendations for nine provider sectors in fee-for-service (FFS) Medicare. MedPAC also reviews the status of Medicare Advantage (MA) plans and Medicare's prescription drug plans (Part D).

FEE-FOR-SERVICE PAYMENT UPDATE RECOMMENDATIONS

To meet its legislative mandate, the principal focus of the March report is MedPAC's recommendations for annual rate adjustments (or "updates") under Medicare's various FFS payment systems. This year's report includes a recommendation in MA as well. MedPAC assesses payment adequacy by examining beneficiary access to care (supply of providers, service use, access surveys); quality of care; providers' access to capital; and provider costs and Medicare payments, where available. MedPAC's recommendations for the 2018 payment year are listed below.

Hospitals: Inpatient and outpatient services

- The Congress should update the inpatient and outpatient payments by the amounts specified in current law.
- The Secretary should require hospitals to add a modifier on claims for all services provided at off-campus stand-alone emergency department facilities.

Physicians and other health professionals.

- The Congress should increase payment rates for physician and other health professional services by the amount specified in current law for calendar year 2018.

Ambulatory surgical centers

- The Congress should eliminate the update to the payment rates for ambulatory surgical centers for calendar year 2018.
- The Congress should also require ambulatory surgical centers to submit cost data.

Outpatient dialysis

- The Congress should increase the outpatient dialysis base payment rate by the update specified in current law for calendar year 2018.

Post-acute care: The Congress and the Centers for Medicare & Medicaid Services (CMS) must act to implement recommended changes

- Post-acute care (PAC) providers (skilled nursing facilities, home health agencies, inpatient rehabilitation facilities, and long-term care hospitals) offer important recuperation and rehabilitation services to Medicare beneficiaries after an acute care hospital stay. In 2015, FFS program spending on PAC services totaled \$60 billion.

- For years, the Commission has noted that PAC payment systems do not encourage efficient care and are not equitable across different patient stays.
- The Commission has made several recommendations to reform PAC payment systems, with two goals in mind. First, payments should be adequate so that beneficiaries have access to needed services, while also preserving the long-run sustainability of the Medicare program. Second, payments should be based on patients' different care needs and provide consistent incentives across settings.
- To achieve these goals, the Commission has made several recommendations to lower aggregate payments to PAC providers. In June 2016, it recommended features of a unified system that would base payments on patient characteristics and redistribute payments more equitably across stays.
- The Congress and CMS must act to reform PAC payments. The Commission estimates that, across the four PAC settings, implementing its March 2017 recommendations would reduce FFS program spending by over \$30 billion over the next 10 years. Moreover, if the Congress had implemented the Commission's 2008 recommendations for skilled nursing facilities and home health agencies, spending would have been reduced by about \$11 billion over the period 2009 to 2016, all else being equal.

Skilled nursing facilities

- The Congress should eliminate the payment increases for 2018 and 2019 and direct the Secretary to revise the prospective payment system (PPS) for skilled nursing facilities.
- In 2020, the Secretary should report to the Congress on the impacts of the reformed PPS and make any additional adjustments to payments needed to more closely align payments with the costs of efficient providers.

Home health agencies

- The Congress should reduce home health payment rates by 5 percent in 2018 and implement a two-year rebasing of the payment system beginning in 2019.
- The Congress should direct the Secretary to revise the PPS to eliminate the use of the number of therapy visits as a factor in payment determinations, concurrent with rebasing.

Inpatient rehabilitation facilities

- The Congress should reduce the Medicare payment rate for inpatient rehabilitation facilities by 5 percent for fiscal year 2018.

Long-term care hospitals

- The Congress should eliminate the increase in payment rates under the long-term care hospital PPS for fiscal year 2018.

Hospice

- The Congress should eliminate the increase in hospice payment rates for fiscal year 2018.

STATUS OF THE MEDICARE ADVANTAGE PROGRAM

- In 2016, MA enrollment increased by 5 percent to 17.5 million beneficiaries (or 31 percent of all Medicare beneficiaries). Enrollment in HMO plans—the largest plan type—increased to 11.7 million enrollees.

- In 2017, 99 percent of Medicare beneficiaries have access to an MA plan, and 95 percent have access to a network-based coordinated care plan, which includes HMOs and PPOs. Eighty-one percent of beneficiaries have access to an MA plan that includes Part D drug coverage and charges no premium beyond the Medicare Part B premium. The average beneficiary was able to choose from 18 MA plan options in 2017.
- MA plans provide enrollees with additional benefits using rebates funded by Medicare. From 2016 to 2017, average rebates increased from about \$81 to about \$89 per month.
- In 2017, MA benchmarks (including the quality bonuses), bids, and payments will average 106 percent, 90 percent, and 100 percent of FFS spending, respectively. However, that comparison does not take into account differences in coding practices between MA and FFS. Our findings show that in 2015, a risk score for an MA enrollee tended to be about 4 percent higher than the risk score that beneficiary would have had in FFS (even after accounting for the adjustment for coding intensity, which was about -5.2 percent in that year). This suggests that payments to MA plans would be about 4 percent higher after accounting for differences in coding practices.
- MA enrollees are required to be enrolled in both Part A and Part B. However, MA benchmarks are currently based on the Medicare spending of all FFS beneficiaries. This creates a disconnect between the enrollment status of people in MA and the status of the beneficiaries used to calculate the MA benchmarks. 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 recommendation would increase spending in Medicare, but that added spending could be offset with many of the Commission's prior recommendations for the MA program.

RECOMMENDATION FOR THE MEDICARE ADVANTAGE PROGRAM

- The Secretary should calculate Medicare Advantage benchmarks using fee-for-service spending data only for beneficiaries enrolled in both Part A and Part B.

STATUS OF THE MEDICARE PRESCRIPTION DRUG PROGRAM (PART D)

- In 2016, about 72 percent of Medicare beneficiaries (41 million beneficiaries) were enrolled in Part D plans. An additional 3 percent received their drug coverage through employer-sponsored plans that receive Medicare's retiree drug subsidy. Among Part D plan enrollees, 12 million individuals received the low-income subsidy (LIS).
- In 2016, about 60 percent of Part D enrollees were in stand-alone prescription drug plans (PDPs); the rest were in Medicare Advantage-Prescription Drug plans (MA-PDs). For 2017, beneficiaries continue to have broad choice among plans, ranging from 18 PDPs to 24 PDPs depending on where they live, along with many MA-PDs that 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. Between 2007 and 2015, Part D spending increased at an average annual rate of more than 7 percent. Enrollees who incur spending high enough to reach the catastrophic phase of the benefit (high-cost enrollees) have started to drive Part D program costs, accounting for 53 percent of gross spending in 2015, up from about 40 percent before 2011. Spending for these high-cost individuals was driven primarily by increases in the average price per prescription filled (reflecting both price inflation and changes in the mix of drugs used).
- There are three types of payments Medicare makes to plan sponsors: direct subsidy payments (capitated monthly payments to plans that reduce premiums for all enrollees), low-income subsidy payments (which pay for most of the premiums and cost sharing for LIS enrollees), and reinsurance payments (which pay for 80 percent of spending in the catastrophic portion of the benefit). Spending on reinsurance became the largest component of program spending in 2014 and has remained the fastest growing component, at an

average annual growth rate of 20 percent between 2007 and 2015. Over that same period, spending on the direct subsidy grew by only 0.7 percent annually, and spending on low-income cost sharing grew by an average annual rate of 5.6 percent.

- During 2013 and 2014, there was an uptick in our overall index of Part D prices, even as the share of generic prescriptions in Part D rose to 85 percent. This is a dramatic shift from prior years when increased generic use had offset the increases in prices of brand-name drugs to keep overall prices stable, and it suggests brand price growth has begun to have a more dominating effect.
- In June 2016, the Commission recommended a combination of changes designed to address concerns over spending growth in Part D and improve the program for the future while maintaining the program's market-based approach.