MEDPAC Medicare Payment Advisory Commission

NEWS RELEASE

EMBARGOED FOR RELEASE UNTIL 1:00PM March 1, 2010

Contact: Jennifer Stolbach or Arielle Mir - (202) 220-3700

MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

Recommendations strive to assure beneficiary access and efficient use of resources

Washington, DC, March 1, 2010—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2010 *Report to the Congress: Medicare Payment Policy.*

The principal focus of the report is the Commission's recommendations for annual rate adjustments in fee-for-service (FFS) Medicare. These "updates" are based on an assessment of payment adequacy taking into account beneficiaries' access to care, supply of providers, the quality of the care they receive, and Medicare margins. The report also reviews the Medicare Advantage and Prescription Drug programs.

According to MedPAC Chairman Glenn Hackbarth, "Our goal is to strive for the best value for the program's expenditures, which means maintaining beneficiaries' access to high-quality services while encouraging efficient use of resources. Anything less does not serve the interests of the beneficiaries and taxpayers who finance Medicare through their premiums and taxes." The Commission's recommendations reflect its belief that Medicare updates should exert fiscal pressure on its providers—as long as doing so will not jeopardize providers' ability to offer care or keep Medicare beneficiaries healthy.

The Commission's payment update recommendations set the total amount of payments to a provider sector. In the skilled nursing facility (SNF) sector for example, Medicare margins are over 16 percent in 2008, with beneficiary access and provider supply stable, suggesting Medicare payments are more than adequate to cover a provider's costs of treating a Medicare beneficiary. For 2011, MedPAC recommends a zero update for SNFs.

Separate recommendations may redistribute payments within a sector to give providers incentives to provide high-value care. For example, while the aggregate level of SNF payments is adequate, Medicare's current payment system for SNFs appears to pay providers relatively more for therapy services than for patients with complex care needs. Therefore, MedPAC reiterates its recommendations to modify SNF payments to ensure that Medicare pays providers appropriately for all types of SNF-eligible patients. MedPAC also reiterates recommendations to create a quality incentive program for SNFs. These changes in the payment system would make payment more equitable among providers, and improve beneficiary access and quality of care.

Updates for other Medicare providers are specified in the accompanying fact sheet, as are related recommendations for nine FFS payment systems.

The Commission also reviews the status of the Medicare Advantage program, its plan offerings, quality outcomes, and payments. The Commission remains concerned that in 2010, Medicare's payments to MA plans will again exceed Medicare FFS spending for similar beneficiaries. MA plans will continue to provide enhanced benefits, but at a high cost to the Medicare program. This higher spending results in increased government outlays and higher Part B premiums for all beneficiaries (including those not in MA) at a time when both the Medicare program and its beneficiaries are under increasing financial stress. Therefore the Commission also reiterates its recommendation for financial neutrality between the MA and FFS payment systems.

The Commission recognizes that managing updates and relative payment rates will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. Therefore, these update recommendations should be considered in the context of the Commission's many prior recommendations to move beyond FFS to more comprehensive payment systems that would cross sectors and to pay for higher quality, for example, medical homes, readmissions penalties, and pilot testing of bundled payments.

The Commission's report also presents enrollment and plan characteristics of the more than 1,500 Part D drug plans. Most beneficiaries continue to participate in Part D and on average, beneficiaries have over 40 stand-alone drug plans to choose from, in addition to many Medicare Advantage plans that have drug benefits. Part D enrollees' monthly premiums increased on average by about $2 (6%) over the previous year to just over $30 (based on January 2010 enrollment). For 2010, approximately 1 million beneficiaries in the low income subsidy program had to switch to a different plan to avoid paying a premium.

Finally, in response to a legislative mandate in the Medicare Improvements for Patients and Providers Act of 2008, the Commission makes several recommendations to improve policymakers' and beneficiaries' ability to compare quality in the MA and FFS programs. The eight recommendations including expanding data collection, ensuring that electronic health records can be used to measure quality, and allocating financial resources to the Centers for Medicare and Medicaid Services to implement the proposed changes.

# # #

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