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

Washington, DC, March 15, 2021— Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2021 *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). As mandated by the Balanced Budget Act of 2018, the report includes an analysis of expanding Medicare’s inpatient hospital post-acute care transfer policy to hospice. Lastly, we report on an option for Medicare’s coverage of telehealth services after the coronavirus pandemic.

In 2020, the global coronavirus pandemic had catastrophic consequences for many Medicare beneficiaries and affected health care delivery for all. In the report, we begin to discuss some of the preliminary effects of the pandemic on beneficiary access to care and service use, as well as its financial effects on health care providers. A fuller discussion of the pandemic’s effects on beneficiaries and providers, including lessons learned, will require analysis of data that are still being collected and is beyond the scope of the report.

Fee-for-service payment rate update recommendations. The report presents MedPAC’s recommendations for how Congress should update payment rates in FFS Medicare for 2022. 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. Because of standard data lags, the most recent complete data we have are from 2019. Where relevant, we have considered the effects of the 2020 coronavirus pandemic on our indicators and whether those effects are likely to be temporary or permanent. To the extent that the effects of the COVID-19 public health emergency (PHE) are temporary or vary significantly across providers in a sector, they are best addressed through targeted temporary funding policies rather than permanent increases in the payment rates for all providers in 2022 that would get compounded over time.

Overall, these recommendations would reduce Medicare spending while preserving beneficiaries’ access to high-quality care. For acute care hospitals, we recommend payment updates of 2 percent for both inpatient and outpatient services and note that this update should be accompanied by our 2019 recommendation to revise Medicare’s hospital quality incentive programs. MedPAC recommends that payments be updated by the amount specified in current law (no update) for physicians and other health professionals. We also recommend no payment increase for 2022 (lower than current law) for four FFS payment systems: ambulatory surgical centers, outpatient dialysis facilities, skilled nursing facilities, and hospice services. The Commission also recommends that the aggregate hospice cap be wage adjusted and reduced by 20 percent, and that ambulatory surgical centers be required to report cost data to CMS. For home health care agencies and inpatient rehabilitation facilities, MedPAC

recommends reducing payments by 5 percent. Lastly, for long-term care hospitals, MedPAC recommends payment rates be increased by 2 percent.

Medicare Advantage. Overall, many indicators continue to point to an increasingly robust MA program. MA enrollment (43 percent of all Medicare beneficiaries with both Part A and Part B coverage enrolled in MA plans in 2020); beneficiary access to MA plans (99 percent of Medicare beneficiaries have access to an MA plan, and the average beneficiary has 32 available plans from which to choose in 2021); and levels of rebates that fund extra benefits (\$1,668 per enrollee, on average, in 2021) have all reached record highs in recent years.

However, Medicare paid plans an estimated \$317 billion (not including payments to cover the Part D drug benefit provided by Medicare Advantage Prescription Drug Plans (MA-PDs)) in 2020 to manage beneficiaries' care. This level of payment reflects Medicare payments that were higher for MA enrollees than the program would have spent for similar beneficiaries in traditional FFS Medicare, continuing a long-standing trend. Using plan bid data for 2021, we estimate that MA payments will be 101 percent of FFS spending. However, for several years, the Commission has expressed concern that enrollees in MA plans have higher risk scores than similar beneficiaries in FFS because of plans' more intensive coding practices that result in excess payments to plans. Accounting for coding intensity, in 2021, we estimate that Medicare payments to MA plans actually average 104 percent of FFS spending (quality bonuses in MA account for an estimated 2 to 3 percentage points of MA payments in 2021). Medicare payments to MA plans continue to exceed FFS spending levels, despite the fact that plan bids in 2021 decreased to 87 percent of FFS, in aggregate—a record low.

In prior work, we identified some MA policies that need immediate improvement. The Commission previously recommended in 2017 that CMS reduce excess payments stemming from plans' coding practices, which would improve equity across plans and produce savings for Medicare. In 2020, the Commission also recommended replacing the MA quality bonus program with a value incentive program that would more accurately characterize the quality of care in MA. Currently, the Commission is assessing an alternative MA benchmark policy that would improve equity and efficiency in the MA program.

Part D. Over 74 percent of Medicare beneficiaries (about 47 million beneficiaries) participated in private Medicare drug plans in 2020. Beneficiaries continue to have broad choice among plans in 2021. Beneficiaries' options range from 25 to 35 prescription drug plans (PDPs) depending on where they live, in addition to several MA plans that also offer prescription drug benefits (MA-PDs). In 2019, total Part D spending was over \$102 billion. Plan enrollees paid about \$14 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 14 percent between 2018 and 2019, while Medicare's fixed-dollar payments declined about 14 percent. In addition, though our overall index of Part D prices declined in 2019, owing to increased use of, and competition among, generic drugs, prices continued to rise in therapeutic classes dominated by brand-name drugs or biologics. Despite deceleration in overall price growth, inflation in prices of drugs taken by high-cost enrollees will continue to drive their

spending upward. In 2019, over 483,000 enrollees (11 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.

Telehealth in Medicare after the coronavirus public health emergency. During the COVID-19 PHE, the Congress and CMS have temporarily expanded Medicare's coverage of and payment for telehealth services, giving providers broad flexibility to furnish telehealth services to ensure that beneficiaries continue to have access to care and reduce their risk of exposure to COVID-19. Hospitals, physicians, and other providers have responded by rapidly adopting telehealth to provide continued access to medical care for their patients. Without legislative action, many of the changes will expire at the end of the PHE.

In the report, we present a policy option for expanded coverage for Medicare telehealth policy after the PHE is over. Under the policy option, policymakers should temporarily continue some of the telehealth expansions for a limited duration of time (e.g., one to two years after the PHE) to gather more evidence about the impact of telehealth on beneficiary access to care, quality of care, and program spending to inform any permanent changes. During this limited period, Medicare should temporarily pay for specified telehealth services provided to all beneficiaries regardless of their location, and it should continue to cover certain newly-covered telehealth services and certain audio-only telehealth services if there is potential for clinical benefit.

The policy option also specifies that after the PHE ends, Medicare should return to paying the physician fee schedule's facility rate for telehealth services and collect data on the cost of providing those services. In addition, providers should not be allowed to reduce or waive beneficiary cost sharing for telehealth services after the PHE. CMS should also implement other safeguards to protect the Medicare program and its beneficiaries from unnecessary spending and potential fraud related to telehealth.

Mandated report: Expanding Medicare's hospital post-acute care transfer policy to hospice. The Bipartisan Budget Act (BBA) of 2018 expanded Medicare's hospital inpatient prospective payment system post-acute care transfer policy, which reduces payments to hospitals for certain cases that are transferred to post-acute care providers, to include transfers to hospice beginning in fiscal year 2019. The BBA of 2018 mandates that the Commission evaluate and report on the effects of this policy change. Results from fiscal year 2019 and the first three months of fiscal year 2020 indicate that the policy change produced savings of about \$382 million over the first five quarters of the policy without any discernable changes in Medicare FFS beneficiaries' timely access to hospice care.

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.