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

Washington, DC, March 13, 2020—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2020 *Report to the Congress: Medicare Payment Policy*. The report includes MedPAC’s analyses of payment adequacy in fee-for-service (FFS) Medicare and reviews the status of Medicare Advantage (MA) and the prescription drug benefit (Part D). As requested by the Congress, we report on health care provider consolidation and its effects on Medicare, its beneficiaries, and other aspects of the delivery system. Lastly, as mandated by the Balanced Budget Act of 2018, the report includes a preliminary analysis of expanding Medicare’s inpatient hospital post-acute care transfer policy to hospice.

**Fee-for-service payment rate update recommendations.** The report presents MedPAC’s recommendations for how Congress should update payment rates in FFS Medicare for 2021. 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.

Overall, these recommendations would reduce Medicare spending while preserving beneficiaries’ access to high-quality care. MedPAC recommends that payments be updated by the amount specified in current law for dialysis facilities and for physicians and other health professionals. For hospice services, MedPAC recommended no payment increase and that the aggregate hospice cap be wage adjusted and reduced by 20 percent. For long-term care hospitals, MedPAC recommends that payments be increased by 2 percent. MedPAC recommends no payment increase for 2020 for two FFS payment systems: ambulatory surgical centers and skilled nursing facilities. The Commission also recommends that ambulatory surgical centers report cost data. For home health agencies, MedPAC recommends reducing payments by 7 percent. For inpatient rehabilitation facilities, MedPAC recommends reducing payments by 5 percent. Lastly, for acute care hospitals, MedPAC recommends payments be increased by 2 percent; the Commission recommends the difference between our recommended 2 percent update and the payment increase specified in current law be used to increase the rewards hospitals receive under a hospital value incentive program.

**Medicare Advantage.** MA enrollment continued to grow in 2019, with 34 percent of all Medicare beneficiaries enrolled in MA plans. Medicare paid plans an estimated \$274 billion (not including Part D drug plan payments) in 2019 to manage beneficiaries’ care. In 2020, access to MA plans remains high; 99 percent of Medicare beneficiaries have access to an MA plan, and the average beneficiary has 27 available plans to choose from. In 2020, MA benchmarks, bids, and payments averaged 107, 88, and 100 percent of FFS spending, respectively, reflecting positive trends in the MA program. 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. We estimate that uncorrected coding intensity would add 2 percentage points to 3 percentage points to payments relative to FFS. The Commission previously recommended that CMS reduce excess payments stemming from plans’ intensive coding practices, which would improve equity across plans and produce savings for Medicare.

The Commission has also recommended curtailing the practice of MA plan consolidation to obtain unwarranted quality bonus payments. This concern was partly addressed in the Bipartisan Budget Act of 2018, which provides that, beginning at the end of 2019, the quality rating for consolidated contracts be based on an enrollment-weighted average of the results of each contract.

However, the Commission continues to have concerns with the MA star rating system, which serves as the basis for plan quality bonuses and public reporting of plan quality. MA star ratings continue to be determined at the contract level. Because contracts can cover wide (and discontinuous) geographic areas and quality results are often determined based on only a small sample of beneficiary medical records, Medicare and beneficiaries lack important information about the quality of care of MA plans in their market. As a result, the Commission can no longer accurately characterize the quality of care in MA. The Commission continues to work on developing a new value incentive program for MA.

**Part D.** Over 74 percent of Medicare beneficiaries (about 45 million beneficiaries) participated in private Medicare drug plans in 2019. Beneficiaries continue to have broad choice among plans in 2020. Beneficiaries' options range from 24 to 32 prescription drug plans (PDPs) depending on where they live, in addition to several MA plans that also offer prescription drug benefits (MA-PDs). In 2018, total Part D spending was nearly \$98 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 succeeded: 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, changes to Part D's benefit design, in combination with growth in the use of high-cost medicines, may be eroding plans' incentives to manage benefit costs. 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 to control spending). Between 2007 and 2018, reinsurance payments increased at an average annual rate of nearly 16 percent, while Medicare's fixed-dollar direct subsidy payments *decreased* 2.6 percent per year. As of 2019, brand-drug manufacturers provide a 70 percent discount in the coverage gap (an increase from the 50 percent discount provided between 2011 and 2018). This discount effectively makes the relative price of brand-name drugs less expensive than generic drugs and decreases what plan sponsors must cover in benefits, blunting sponsors' incentives to manage spending. A separate concern is that Part D's low-income subsidy creates plan and beneficiary incentives that increase program costs.

Policymakers are taking steps to give plans new flexibilities to manage drug spending. However, measures to increase the financial risk that sponsors bear (such as those recommended by the Commission in 2016) are essential to ensure plans have incentives to use their new management tools to reduce spending growth for Medicare and its beneficiaries.

**Congressionally requested report: Health care provider consolidation.** In 2018, the Chairman of the House Committee on Energy and Commerce requested that MedPAC report on the effects of hospital mergers and physician-hospital consolidation. The Chairman also asked the Commission to examine the incentives in the 340B Drug Pricing Program for hospitals to use more expensive Part B drugs.

In responding to this request, the Commission found that hospitals have been consolidating for many years, driven by factors beyond federal policies (including Medicare). By 2017, in most markets, a single hospital system accounted for more than 50 percent of hospital discharges. We found that greater hospital market power (a result of consolidation) has a statistically significant association with higher profit margins on non-Medicare patients and that higher non-Medicare margins have a statistically significant association with higher standardized costs per discharge. Medicare patients are initially insulated from the effect of hospital mergers because Medicare sets prices for the hospital services administratively. However, commercially insured patients appear to pay higher prices for care and higher prices for insurance in consolidated markets. In contrast to what we observe regarding hospital consolidation, federal (Medicare) payment policies have contributed to encouraging hospital acquisition of physician practices. When hospitals acquire physician practices, it increases Medicare spending and beneficiary

financial liability due to the introduction of hospital facility fees for physician services that are provided in hospital outpatient departments.

The Commission examined whether the 340B Drug Pricing Program is associated with greater average cancer drug spending in a market area. To examine the potential influence of the 340B Drug Pricing Program, we examined Medicare spending for certain cancer drugs which account for the majority of Part B drug spending. We analyzed drugs used to treat five types of cancer and found statistically significant higher costs potentially related to the 340B program for two of those drugs. Those 340B effects, however, were much smaller than the effects of the general trend in oncology spending. Given the relative size of the potential 340B effect, the overall effect on beneficiary cost sharing is likely to be modest and vary by beneficiaries' supplemental coverage.

**Mandated report: Expanding Medicare's hospital post-acute care transfer policy to hospice, preliminary results.** The Bipartisan Budget Act of 2018 expanded Medicare's hospital inpatient prospective payment system (IPPS) post-acute care (PAC) 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. Preliminary results from the first six months indicate that the policy change produced small savings without any significant changes in Medicare FFS beneficiaries' timely access to hospice care. As with any analysis of early data, caution should be taken in generalizing from these results. Our final evaluation report due in March 2021 will provide an assessment of experience over the first 18 months of the policy.

A list of recommendations is included in the accompanying fact sheet. The entire report is available online at <http://www.medpac.gov>.

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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.*