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

Washington, DC, March 15, 2013—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2013 *Report to the Congress: Medicare Payment Policy*. The report includes the Commission’s analyses of payment adequacy in fee-for-service (FFS) Medicare; Medicare Advantage (MA), including MA special needs plans; and Part D.

Fee-for-service payment rate recommendations. The report presents the Commission’s recommendations for 2014 rate adjustments in fee-for-service (FFS) Medicare. These “update” recommendations—which MedPAC is required by law to submit each year—are based on an assessment of payment adequacy taking into account beneficiaries’ access to care, the quality of the care they receive, supply of providers, and providers’ costs and Medicare’s payments.

In this year’s report, the Commission continues to make recommendations to find ways to provide high-quality care for Medicare beneficiaries at lower costs to the program. In light of its payment adequacy analyses, MedPAC recommends no update for 2014 for five fee-for-service payment systems and a 1 percent update for the hospital inpatient and outpatient payment systems. For two sectors, skilled nursing facilities and home health agencies, it reiterates previous recommendations calling for an array of reforms including rebasing (lowering the base rate), creating incentives to improve quality, and increasing program integrity. For the physician and other health professional payment system it calls for making the system fairer and for repeal of the sustainable growth rate system (SGR), which governs physician fee schedule payments.

Addressing the sustainable growth rate system. The sustainable growth rate system—Medicare’s policy for updating physicians’ fees based on overall expenditure growth—is fundamentally flawed. It has not restrained volume growth, and the deep cuts called for by the SGR formula, combined with temporary stop-gap fixes, have undermined beneficiaries’ and providers’ confidence in Medicare. The Commission’s October 2011 letter to the Congress recommended repealing the SGR and replacing it with legislated updates that would no longer be based on an expenditure-control formula. The scheduled updates would favor primary care over specialty services to help correct the undervaluation of primary care.

The need to repeal the SGR is urgent. Deferring repeal of the SGR will not leave the Congress with a better set of choices, as the array of new payment models is unlikely to change in the near-term, and SGR fatigue is increasing. CBO’s most recent budget projections have substantially lowered the budget score for SGR repeal and may present an opportunity for the Congress to act. However, the budget score

is volatile. The score depends on the relationship between growth in the volume of services and growth in the GDP. In each of the last three decades there have been periods of rapid volume growth and periods of slower growth.

Medicare Advantage. In the Medicare Advantage (MA) program, enrollment continues to grow, beneficiaries continue to have wide access to plans (with an average of 12 plans to choose from in 2013), and the MA benchmarks and plan payments have moved closer to FFS levels. This is important because the Commission has stressed the concept of imposing fiscal pressure on providers to improve efficiency and reduce Medicare program costs. The Commission has recommended that payments for MA plans relative to FFS be brought down from previous high levels and set so that the payment system is neutral and does not favor either MA or the traditional FFS program.

Special needs plans. Special needs plans (SNPs) are MA plans that can limit their enrollment to one of three categories of special needs individuals. SNP authority expires at the end of 2014. In response to several inquiries from the Congress, the Commission evaluated each type of SNP on how well they perform on quality-of-care measures and whether they encourage a more integrated delivery system than is currently available in traditional FFS Medicare. In brief, the Commission recommends that the Congress:

- permanently reauthorize institutional SNPs (I-SNPs), which are plans for beneficiaries residing in nursing homes or beneficiaries living in the community that require a nursing home level of care.
- allow the authority for chronic condition SNPs (C-SNPs)—plans for beneficiaries with certain chronic conditions—to expire, with the exception of C-SNPs for a small number of conditions, including end-stage renal disease, HIV/AIDS, and chronic and disabling mental health conditions. Also, increase flexibility for standard MA plans so that they can, in effect, incorporate the models of care targeted to specific conditions.
- permanently reauthorize SNPs for beneficiaries dually eligible for Medicare and Medicaid (D-SNPs) that assume clinical and financial responsibility for Medicare and Medicaid benefits—either at a plan or organizational level—and allow the authority for all other D-SNPs to expire.

Part D. Participation in the Medicare drug benefit remains quite high, and the average beneficiary has over 30 stand-alone drug plans to choose from, in addition to many MA plans that have drug benefits. CMS estimates the average monthly premium in 2013 will be \$31, as it was in 2012. While average costs for basic Part D benefits are expected to remain stable between 2012 and 2013, plan sponsors are expecting significant changes in costs for individual components: a decrease for the direct subsidy and an increase for the reinsurance component.

A full list of recommendations is included in the accompanying fact sheet. The full report is available online at http://medpac.gov/documents/Mar13_EntireReport.pdf.

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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.