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

Recommendations aim to make Medicare a more prudent purchaser of health care services

Washington, DC, March 15, 2012—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2012 *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 and Part D, as well as the Commission’s assessment of the sustainable growth rate (SGR) system for physician payment.

According to Glenn Hackbarth, MedPAC chairman, “This report recommends steps toward one of the Commission’s goals for the Medicare program—to make Medicare a prudent purchaser of health care services, while ensuring access to high-quality care for Medicare beneficiaries.”

Fee-for-service payment rate recommendations. The report presents the Commission’s recommendations for 2013 rate adjustments in 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.

For example, for skilled nursing facilities (SNFs), the Commission observed adequate access to care for beneficiaries, stable quality outcomes, and Medicare margins exceeding 10 percent for the tenth year in a row (2010 margins were 18 percent). Taken together, those indicators led the Commission to recommend bringing down payments to SNFs to a level more consistent with the costs of treating Medicare patients. The Commission also reasserted its recommendation to revise the payment system to pay SNFs more equitably. In addition, the Commission recommended reducing Medicare’s payments to SNFs with relatively high rates of rehospitalization.

Aligning payment rates across health care settings. In the past, the Commission has recommended delivery system reforms to help Medicare move beyond traditional FFS and encourage quality, coordination, and judicious use of resources. However, while those new payment systems are being developed and refined, the Commission is also committed to finding ways to overcome the challenges of the FFS payment systems’ “silos.”

Because Medicare's FFS payment systems were developed independently, the program can pay very different amounts for similar services. For example, Medicare pays about 80 percent more for a 15-minute evaluation and management office visit provided in a hospital outpatient department than in a freestanding physician's office. This difference creates a financial incentive to provide services in the higher paid setting and raises costs for both the beneficiary and the Medicare program. In this report, the Commission recommends equalizing the payment rates for these office visits. Going forward, MedPAC will explore other opportunities to align payment rates for similar services provided in other settings.

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 report reprints the Commission's October 2011 letter to the Congress in which it recommended repealing the SGR and replacing it with specified 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. Despite the high budget score associated with a full repeal of the policy, the Commission concluded that the risks of retaining the SGR outweigh the benefits and offered a list of options for defraying the cost of repeal.

Medicare Advantage. In the Medicare Advantage (MA) program, enrollment continues to grow, beneficiaries continue to have wide access to plans, and plan performance on quality measures is mixed, but improving. Additionally, the MA benchmarks and plan payments have moved closer to FFS levels and many plans' bids are below FFS. Those promising trends should be continued by encouraging efficiency and innovation in MA plans through financial pressure and ensuring that Medicare spending is controlled, beneficiary choice is preserved, and quality of care is high.

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 2012 will be \$31, a slight decrease from 2011.

At the same time, the Commission reports that costs for enrollees receiving the low-income subsidy (LIS) are growing rapidly. High-spending LIS enrollees tend to fill more prescriptions, fill more costly prescriptions, and take more brand-name drugs. Unlike other Part D enrollees, LIS beneficiaries' cost sharing for brand-name drugs does not differ significantly from the generic co-pays. Therefore, LIS enrollees do not have an incentive to choose the generic option when one is available. In this report, the Commission recommends modifying the copayments for LIS enrollees to encourage the use of generics—a strategy that has been successful in encouraging greater use of generic drugs among non-LIS enrollees.

A full list of recommendations is included in the accompanying fact sheet. The full report is available online at http://medpac.gov/documents/Mar12_EntireReport.pdf.

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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.