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

Washington, DC, March 13, 2015—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2015 *Report to the Congress: Medicare Payment Policy*. The report includes MedPAC’s analyses of payment adequacy in fee-for-service (FFS) Medicare and provides a review of Medicare Advantage (MA) and the prescription drug benefit, Part D.

Fee-for-service payment rate recommendations. The report presents MedPAC’s recommendations for 2016 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 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.

In this year’s report, MedPAC 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 2016 for five fee-for-service payment systems: ambulatory surgical centers, outpatient dialysis, long term care hospitals, inpatient rehabilitation facilities, and hospice. For two sectors, skilled nursing facilities and home health agencies, it reiterates previous recommendations calling for an array of reforms including more equitably distributing payments among providers to ensure access for all beneficiaries, rebasing (lowering the base rate), creating incentives to improve quality, and increasing program integrity.

For the physician and other health professional payment system, MedPAC again calls for repeal of the sustainable growth rate system (SGR), which governs physician fee schedule payments, and reducing the disparity in payments between primary care providers and proceduralists. For inpatient and outpatient hospitals, MedPAC recommends a 3.25 percent update to payment rates, concurrent with two changes that would institute site neutral payments between settings (discussed below).

Examining Medicare’s payments for services provided in different care settings. MedPAC also makes recommendations on improving payment accuracy by examining payment rates for similar types of care frequently provided in different care settings. Basing payment on the rate in the most efficient setting would save money for Medicare, reduce cost sharing for beneficiaries, and reduce the incentive to provide services in the higher paid setting.

This year, we are recommending site-neutral payments to inpatient rehabilitation facilities (IRFs) for select conditions treated in both skilled nursing facilities and IRFs. MedPAC previously recommended site neutral payments for non-chronically critically ill cases between LTCHs and acute care hospitals, and for certain services provided in the hospital outpatient department and the freestanding physician office.

Paying differently for primary care. MedPAC also makes recommendations on new payment models that help support primary care and move Medicare away from purely fee-for-service payments. In this report, MedPAC discusses the Primary Care Incentive Payment (PCIP) program, which is scheduled to expire in 2015. The PCIP provides a 10 percent bonus payment on fee schedule payments for primary care services provided by certain primary care practitioners. The Commission recommends that the additional payments to primary care practitioners should continue on a budget neutral basis; however, they should be in the form of a per beneficiary payment as a step away from the fee-for-service payment approach and toward beneficiary-centered payments that encourage care coordination.

Medicare Advantage. In the Medicare Advantage (MA) program, enrollment continues to grow and beneficiaries continue to have wide access to plans (with an average of 9 plans to choose from in 2015). Medicare's MA benchmarks and payments to plans have moved closer to FFS levels, with payments averaging approximately 102 percent of FFS, down from a high of 112 percent in 2009. While plan payments have declined relative to FFS, the average extra benefits provided to plan enrollees has stayed stable at approximately \$75 per month. MedPAC has recently recommended including the hospice benefit in MA and changing the bidding process for employer plans.

Part D. Participation in the Medicare drug benefit remains quite high, with about 69 percent of Medicare beneficiaries (over 37 million beneficiaries) enrolled in Part D plans in 2014. The average beneficiary has between 24 and 33 stand-alone drug plans to choose from, in addition to many MA plans that offer the drug benefit. Average beneficiary premiums remain stable from 2014 to 2015 at about \$30 per month.

Between 2007 and 2013, Part D spending increased from \$46.7 billion to \$64.9 billion. Program spending for Part D reflects two underlying trends. First, there has been a shift toward use of generic drugs, with generics accounting for 81 percent of all prescriptions filled in 2012 compared with 61 percent in 2007. This has mitigated the benefit spending on which plan sponsors base premiums and helped keep enrollee premiums low. A second trend, however, is that Part D's reinsurance payments, or payments to plans for the highest spending enrollees, have grown by an average of 16 percent per year. For the future, the pharmaceutical pipeline is shifting toward greater numbers of biologic products and specialty drugs, many of which have few therapeutic substitutes and high prices. This will put additional upward pressure on program spending in the catastrophic phase of the benefit.

A list of recommendations is included in the accompanying fact sheet. The entire report is available online at http://medpac.gov/documents/reports/Mar15_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.