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

Recommendations strive to assure beneficiary access to quality care and efficient use of resources

Washington, DC, March 15, 2011—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2011 *Report to the Congress: Medicare Payment Policy*.

The report presents the Commission's recommendations for 2012 rate adjustments in fee-for-service (FFS) Medicare. These "updates" 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. The report also reviews the Medicare Advantage and prescription drug programs.

According to MedPAC Chairman Glenn Hackbarth, "the Commission's goal is to achieve a Medicare program that assures beneficiary access to high-quality care, pays health care providers and health plans fairly, and spends tax dollars responsibly."

The Commission recommends updates—that is, how much Medicare payment rates should change—for ten Medicare fee-for-service payment systems (e.g., the physician fee schedule or the inpatient hospital prospective payment system). As an example, for 2012, the Commission recommends a 1 percent increase in payments for physician services to ensure beneficiaries have continued access to these services. In contrast, the Commission recommended no update to payments for home health care services, as the number of home health agencies has increased to an all-time high and Medicare's payments have exceeded their costs by nearly 18 percent—the 10th consecutive year they have been in this range.

Separate recommendations may redistribute payments within a payment system to pay providers more accurately and fairly. For example, MedPAC finds that Medicare's current payment system for skilled nursing facilities (SNFs) appears to pay providers relatively more for patients who need therapy services than for patients with complex care needs. Therefore, MedPAC reiterates its recommendations to modify SNF payments to ensure that Medicare pays providers appropriately for all types of SNF-eligible patients. MedPAC also reiterates recommendations to create a quality incentive program for SNFs. These changes in the payment system would make payment more equitable among providers, and improve beneficiary access and quality of care.

Policies affecting the level and distribution of payments to providers may not always be enough to achieve our objectives. In some cases, recommendations may also be warranted to guard against fraudulent or abusive practices. For example, the Commission recommends the Secretary of Health and

Human Services review counties with aberrant home health utilization and suspend provider enrollment and payment in counties with widespread fraud.

The Commission recognizes that managing updates and relative payment rates will not solve the fundamental problem with current Medicare FFS payment systems—that providers are paid more when they deliver more services without regard to the quality or value of those additional services. Therefore, these update recommendations should be considered in the context of the Commission’s many prior recommendations to move beyond FFS to more comprehensive payment systems that would cross sectors and pay for higher quality (e.g., medical homes, readmissions penalties, and pilot testing of bundled payments).

The Commission also reviews the status of the Medicare Advantage (MA) program, its plan offerings, quality outcomes, and payments. In 2010, MA enrollment increased to 11.4 million beneficiaries (24 percent of all Medicare beneficiaries). Enrollment in HMOs, the dominant form of MA plan, grew by 7 percent. In 2011, virtually all Medicare beneficiaries have access to an MA plan and 99 percent have access to a network-based coordinated care plan. Ninety percent of beneficiaries have access to an MA plan that includes Part D drug coverage and has no premium (beyond the Medicare Part B premium). Beneficiaries can choose from an average of 12 plans, including 8 coordinated care plans.

The Commission supports private plans in the Medicare program; beneficiaries should be able to choose between the traditional FFS Medicare program and the alternative delivery systems that private plans can provide. Private plans have greater potential to innovate and to use care management techniques and, if paid appropriately, would have more incentive to do so.

The Commission’s report also presents enrollment and plan characteristics of the Part D program. Most beneficiaries continue to participate in Part D and, on average, beneficiaries have over 30 stand-alone drug plans to choose from, in addition to many Medicare Advantage plans that have drug benefits. CMS estimates the average monthly premium in 2011 will be \$30, a \$1 increase over the 2010 average.

A full list of recommendations is included in the accompanying fact sheet. The full report is available online at http://medpac.gov/documents/Mar11_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.