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**MEDICARE PAYMENT ADVISORY COMMISSION
RELEASES REPORT ON MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM**

Washington, DC, June 15, 2018—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2018 *Report to the Congress: Medicare and the Health Care Delivery System*. As part of its mandate from the Congress, each June MedPAC reports on issues affecting the Medicare program as well as broader changes in health care delivery and the market for health care services. This year's report includes:

Mandated report: The effects of the Hospital Readmissions Reduction Program. In this mandated report, the Commission concludes that the Hospital Readmissions Reduction Program (HRRP) contributed to a significant decline in readmission rates without causing a material increase in emergency department (ED) visits or observation stays and without having an adverse effect on mortality rates. As a result, beneficiaries endured fewer returns to the hospital, and the Medicare program saved roughly \$2 billion per year.

Using payment to ensure appropriate access to and use of hospital emergency department services. The Commission makes two recommendations to ensure appropriate access to and use of hospital emergency department (ED) services. One recommendation would establish a new voluntary option—the outpatient-only hospital—for isolated rural communities to maintain access to needed ED services. The second recommendation would address the proliferation of off-campus EDs (OCEDs) in certain urban locations, where growth in OCEDs appears to be driven more by Medicare payment policy than by unmet need for ED services. That recommendation would reduce Medicare's payments to certain OCEDs, saving money for both beneficiaries and the Medicare program.

Rebalancing Medicare's physician fee schedule toward ambulatory evaluation and management services. The Commission is concerned that ambulatory evaluation and management (E&M) services, such as office visits, are underpriced relative to other services in the Medicare fee schedule for physicians and other health professionals. We describe an approach to rebalance the fee schedule that would increase payment rates for ambulatory E&M services while reducing payment rates for other services (e.g., procedures, imaging, and tests), without increasing Medicare spending.

Paying for sequential stays in a unified prospective payment system for post-acute care. We consider refinements to a unified post-acute care (PAC) prospective payment system, focusing on increasing the accuracy of payment for cases that involve sequential stays in one episode of PAC.

Encouraging Medicare beneficiaries to use higher-quality post-acute care providers. Helping beneficiaries to identify better quality PAC providers should be a goal of a reformed hospital discharge planning process. The selection of a PAC provider can be crucial because the quality of care varies widely among providers. We

discuss approaches to giving hospitals greater ability to assist beneficiaries in finding higher-quality PAC providers after an acute hospital stay.

Issues in Medicare’s medical device payment policies. We explore two distinct topics related to Medicare’s policies on medical devices. First, we look at ways to improve Medicare’s payment policies for durable medical equipment, prosthetic devices, prosthetics, orthotics, and supplies (DMEPOS) by potentially expanding the use of competitive bidding for more products. Second, the Commission examines physician-owned distributors (PODs) of devices and medical equipment, and we discuss ways to constrain the potential program integrity risks PODs pose, by making them more transparent to beneficiaries, enforcement agencies, and others.

Applying the Commission’s principles for measuring quality: Population-based measures and hospital quality incentives. The Commission formalizes a set of principles to guide quality measurement and applies them to two population-based outcome measures that may be used to evaluate quality of care for different populations. We also apply the principles to the design of a new hospital value incentive program (HVIP) that would streamline the four existing hospital quality programs and combine a small set of measures including patient outcomes, experience, and Medicare spending per beneficiary.

Medicare accountable care organization models: Recent performance and long-term issues. We review the current Medicare accountable care organization (ACO) models and examine their performance on cost and quality thus far. We find that some models—predominantly two-sided models at risk for both savings and losses—are producing small savings relative to the benchmarks set by CMS, and all are maintaining or improving quality. Based on this review, we raise six issues that are important for the sustainability of two-sided-risk ACOs in the long term.

Managed care plans for dual-eligible beneficiaries. Individuals who receive both Medicare and Medicaid (known as dual-eligible beneficiaries) often have complex health needs but can experience fragmented or low-quality care because of the challenges in obtaining care that is covered (and paid for) by two distinct programs. While some have argued that managed care plans can provide better integration between the two programs, these plans have been difficult to develop. We consider three potential policies to encourage the development of plans that integrate care for individuals who receive both Medicare and Medicaid.

Medicare coverage policy and use of low-value care. We review the coverage processes used in FFS Medicare, Medicare Advantage plans, and Part D sponsors, and discuss how Medicare covers many items and services without an explicit coverage policy. We find that the FFS coverage process does not prevent the use of low-value services and that the use of such services is prevalent in Medicare. We describe six tools that Medicare could consider to reduce the use of low-value care in the program.

The full report is available at MedPAC’s website (<http://www.medpac.gov>).

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides policy and technical advice to the Congress on issues affecting the Medicare program. The Commission’s goal is to achieve a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewards efficiency and quality, and spends tax dollars responsibly.