

EMBARGOED FOR RELEASE UNTIL 8:30 AM JUNE 13, 2008

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

Washington, DC, June 13, 2008—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2008 *Report to the Congress: Reforming the Delivery System*.

A reformed Medicare payment system should pay for care that spans across provider types and time (encompassing multiple patient visits and procedures) and hold providers accountable for the quality and cost of that care. The Commission finds that fundamental reforms in payment and delivery systems are needed to improve quality, coordinate care, and reduce cost growth. To increase value for beneficiaries and taxpayers, the Medicare program must overcome the limitations and incentives for volume growth in its current payment systems. We make specific recommendations in three areas: primary care, care provided around a hospitalization, and skilled nursing facility (SNF) payments.

The Commission recommends two initiatives for promoting primary care. The first is a budget-neutral adjustment that increases fee schedule payments for primary care services furnished by clinicians focused on delivering primary care. The second establishes a medical home pilot program in Medicare. A medical home is a clinical setting that serves as a central resource for a patient's ongoing care. The medical home pilot would include monthly, per beneficiary payments to qualifying medical practices based on criteria involving infrastructure and activities that promote ongoing comprehensive care management. Beneficiaries would not incur cost sharing for the medical home fees and would retain their ability to see specialists and other practitioners of their choice. Beneficiaries with multiple chronic conditions would be eligible to participate.

We recommend three changes in Medicare payment for care provided around a hospitalization to encourage care coordination and efficiency:

- First, that the Secretary confidentially report to hospitals and physicians information about resource use around a hospitalization (e.g., the inpatient stay plus 30 days postdischarge) and readmission rates. After two years of confidential disclosure to providers, this information should be reported publicly.
- Second, reducing payments to hospitals with relatively high readmission rates for select conditions. This payment change should be made together with a change in law, which MedPAC recommended previously, to allow hospitals and physicians to share in the savings that result from providing care more efficiently. (In contrast, the current payment system rewards increasing the volume of medical services, not improving efficiency. The report discusses how hospitals and physicians in some cases

have responded with financial and organizational arrangements that encourage volume growth.) Recognizing that readmissions account for only part of the variation in practice patterns around an admission, we recommend that the Secretary also explore other payment changes to encourage efficiency around hospitalization episodes and report back to the Congress within two years.

- Third, we recommend that CMS conduct a voluntary pilot program to test bundled payment for all services around a hospitalization for select conditions. A pilot would allow CMS to resolve design and implementation issues, while giving providers who are ready the chance to start receiving a bundled payment.

The Commission recommends revising the payment system for SNFs to incorporate a nontherapy ancillary (NTA) payment component, a therapy payment component, and an outlier policy based on exceptionally high ancillary costs per stay. Compared with the existing payment system, these changes better calibrate payments for stays that incur those costs. Because the revised payment system would establish more accurate payments, SNFs would be less likely to avoid patients who hospital discharge planners have difficulty placing. We also recommend CMS require SNFs to report on patient diagnoses, service use during the SNF stay, and nursing costs.

In addition to these specific recommendations, the report explores three other important topics. First, it examines issues in creating a comparative effectiveness entity. The Commission supports a dedicated, broad-based, public and private financing mechanism because it will help ensure the entity's stability and independence, and because the entity's research will benefit all users. The report also explores issues related to the structure and governance of the entity.

Second, we observe that physicians influence the health care services Medicare beneficiaries receive, but may have financial relationships with drug and device manufacturers and facilities that could compromise their independence and objectivity. Payers, plans, patients, and the general public are often not aware of these potential conflicts of interest. The report examines options for collecting data on physicians' financial relationships with manufacturers, hospitals, and ambulatory surgical centers.

Third, we find that hospice care has changed significantly in the 25 years since Medicare implemented the hospice benefit, yet Medicare's payment system for hospice care has changed relatively little. We find spending increases have been driven by more beneficiaries using the hospice benefit and increases in hospice length of stay. Part of this increase reflects a change in the mix of patients electing hospice; but part of the increase reflects incentives in Medicare's hospice payment system that financially reward longer lengths of stay. For-profit hospices have a length of stay about 45 percent longer than nonprofit hospices. (For-profit hospices are now a majority and account for most of the new entrants since 2000.) These incentives run counter to the intent of Medicare's hospice benefit—to provide an end-of-life alternative that is less intrusive and costly than conventional treatment. Overall, Medicare payments to hospices appear adequate, but this assessment masks considerable variation. In 2005, nonprofit and provider-based hospices had small negative margins, while for-profit and freestanding hospices had large positive margins.

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The Medicare Payment Advisory Commission is an independent Congressional advisory body charged with providing policy analysis and advice concerning the Medicare program and other aspects of the health care system. Its 17 Commissioners represent diverse points of view and include health care providers; payers; beneficiary representatives; employers; and individuals with expertise in biomedical, health services, and health economics research.