MEDPAC Medicare Payment Advisory Commission

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

Commission identifies opportunities and challenges for how Medicare pays for care

Washington, DC, June 14, 2013—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2013 *Report to the Congress: Medicare and the Health Care Delivery System.*

According to Commission Chair Glenn Hackbarth, "This report can inform a dialogue about future directions for the Medicare program, as well as about technical refinements to existing Medicare payment policy. Whether broad or narrow, the Commission's work aims to balance the interests of Medicare beneficiaries, health care providers, and tax payers."

Redesigning the Medicare benefit. In the report, the Commission continues its discussion of possible ways to redesign the Medicare benefit by focusing on the concept we refer to as competitively determined plan contributions (CPC). Under CPC, Medicare beneficiaries could receive care through either a private plan or traditional fee-for-service (FFS), but the premium paid by the beneficiary might vary depending on the coverage option they choose. How much the federal government pays for a beneficiary's care would be determined through a competitive process comparing the costs of available options for coverage. The report identifies key issues to be addressed if the Congress wishes to pursue a policy option like CPC. These include how benefits could be standardized for comparability, how to calculate the Medicare contribution, the role FFS, and the structure of subsidies for low-income beneficiaries.

Reducing Medicare payment differences across sites of care. Medicare's payment rates often vary for similar services provided to similar patients, simply because they are provided in different sites of care. For example, Medicare pays 141 percent more for one type of echocardiogram when done in a hospital outpatient department than when it is done in a freestanding physician's office. If Medicare pays a higher rate for a service in one setting over another, program spending increases and beneficiaries pay more in cost sharing without a corresponding increase in quality of care.

The Commission previously recommended reducing the rate Medicare pays for basic office visits from the payment rate in the outpatient setting to the physician office rate. Using similar criteria, this report identifies additional services that may be eligible for equalizing or narrowing payment differences across settings.

Bundling post-acute care services. Each year, about one-quarter of Medicare beneficiaries receive care following a hospitalization from a post-acute care provider, such as a skilled nursing facility, home health agency, or inpatient rehabilitation facility. However, nationwide the use of these services varies widely, for reasons not explained by differences in beneficiaries' health status. Under traditional Medicare, the program pays widely varying rates for different settings and—characteristic of FFS—pays based on the volume of care provided, without regard to quality or resource use.

Medicare has begun to explore the possibility of bundling services as a way to encourage providers to coordinate and furnish needed care more efficiently. In this report, the Commission explores the implications for quality and program spending for different design features of the bundles, such as the services included, the length of time covered by the bundle, and the method of payment.

Reducing hospital readmissions. In 2008, the Commission recommended a hospital readmissions reduction program to improve patient experience and reduce Medicare spending. In 2012, Medicare began such a program, penalizing hospitals that have high rates of Medicare beneficiaries being readmitted to the hospital within 30 days of discharge. The readmission penalty has given hospitals a strong incentive to improve care coordination across providers, and for that reason Medicare should continue to implement the policy. In this report, the Commission suggests further refinements to improve incentives for hospitals and generate program savings through reduced readmissions rather than higher penalties.

Payments for hospice services. The Medicare hospice benefit provides beneficiaries an important option for end-of-life care. At the same time, the Commission has identified several problems in the way Medicare pays for hospices that may lead to inappropriate use of the benefit. The report presents information on the prevalence of long-stay patients and the use of hospice services among nursing home patients—both of which may inform policy development in the hospice payment system in the future. It also presents further evidence to support the Commission's March 2009 recommendations to revise the hospice payment system.

Improving care for dual-eligible beneficiaries. Beneficiaries eligible for both Medicare and Medicaid—many of whom have complex medical and social needs—often have trouble accessing services and receive little care coordination, resulting in poorer health outcomes and higher spending relative to other beneficiaries. Programs that coordinate dual-eligible beneficiaries' Medicare and Medicaid benefits have the potential to improve care for this population. In the report, the Commission notes that federally qualified health centers and community health centers may be uniquely positioned to coordinate care for dual-eligible beneficiaries because they provide primary care, behavioral health services, and care management services, often at the same clinic site.

Mandated reports. The report includes three chapters that fulfill Congressional mandates: one on Medicare ambulance add-on payments, a second on geographic adjustment of fee schedule payments for the work effort of physicians and other health professionals, and a third on Medicare payment for outpatient therapy services. In each case, the Commission considers the existing policies—which are not permanent statutory provisions—and examines the effect of their continuation or termination on program spending, beneficiaries' access to care, and the quality of care beneficiaries receive, as well as their potential to advance payment reform.

The three congressionally mandated reports are described in further detail in separate fact sheets, posted on MedPAC's website. The full report can be downloaded from MedPAC's website: http://medpac.gov/documents/Jun13_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. 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.