MEDPAC Medicare Payment Advisory Commission

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# MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE PAYMENT POLICY

**Washington, DC, June 15, 2007**—Today, the Medicare Payment Advisory Commission (MedPAC) releases its June 2007 *Report to the Congress: Promoting Greater Efficiency in Medicare.*

The report describes the changing beneficiary profile in Medicare and its preliminary implications for the program, and examines several approaches to promote greater efficiency in the Medicare program. Medicare program efficiency becomes ever more important as the baby-boom generation enters the ranks of Medicare beneficiaries.

Efficiency should include not only getting more for a set amount of inputs, but getting more effective care. One way the report recommends to do so is to develop information on the comparative effectiveness of alternative treatments. Comparative-effectiveness analysis compares the clinical effectiveness of a service with its alternatives. The report finds that not enough credible, empirically based information is available for providers, patients, and payers to make informed decisions about alternative services for diagnosing and treating most common clinical conditions. Moreover, because the information can benefit all users and is a public good, it is underproduced by the private sector; a federal role is necessary. Consequently, the Commission recommends that the Congress charge an independent entity to sponsor credible research on comparative effectiveness of health care services and disseminate this information to patients, providers, and public and private payers. The entity would:

- be independent and have a secure and sufficient source of funding (the Commission prefers a public–private option to reflect the benefits to all payers and patients);
- produce objective information and operate under a transparent process;
- seek input on agenda items from patients, providers, and payers;
- reexamine comparative effectiveness of interventions over time;
- disseminate information to providers, patients, and public and private health plans; and
- have no role in making or recommending coverage or payment decisions for payers.

Private plans have the potential to promote greater efficiency in the delivery of health care and improved outcomes for enrollees; hence, the Commission supports their participation in Medicare. However, the report finds that the Medicare Advantage (MA) payment system does not promote efficiency, primarily because inflated, administratively-set county benchmarks—which are the basis of payment for MA plans—exceed Medicare fee-for-service (FFS) expenditure levels. Benchmarks averaged 116 percent of

expected FFS spending in 2006, and those high benchmarks enabled plans to offer extra benefits to attract enrollees, resulting in significant enrollment growth in MA. Enrollment growth has been greatest in private fee-for-service (PFFS) plans rather than coordinated care plans. Yet, on average, PFFS plans provide the basic Medicare benefit package at a cost that is higher than the traditional FFS program while HMOs do so for less. In other words, PFFS plans are providing extra benefits because of the higher payment rates; not because of greater efficiency. Current MA payment policy is inconsistent with MedPAC's principle of payment equity between MA and the traditional FFS program.

Efficiency encompasses quality as well as quantity and cost, and in response to a Congressional mandate, the report develops a design for a home health pay-for-performance (P4P) system that illustrates the issues and possible solutions in P4P programs in Medicare. The design includes four key aspects: how to fund the reward pool, setting thresholds for performance using use a test of statistical significance, balancing rewards for attainment and improvement, and determining the size of the reward.

Another aspect of efficiency is getting the right amount of care over an entire episode of care. One possibility discussed in the report is to decrease the number of avoidable hospital readmissions. Medicare's hospital payment system provides no penalty for hospitals that have high readmission rates. Yet research shows that hospital-based initiatives can avert many readmissions—to the benefit of beneficiaries and the program. The report explores a two-step policy option to encourage hospitals to adopt strategies to reduce readmissions. The first step is public reporting of hospital-specific readmission rates for a subset of conditions. The second step is an adjustment to the underlying payment method to create incentives for lower readmission rates.

The report considers several improvements to payment accuracy. In response to a Congressional mandate, the Commission recommends a new approach for computing the hospital wage index. The wage index is used to adjust payments for differences in labor costs across geographic areas. The Commission recommends first, that the Congress should repeal the existing hospital wage index statute including reclassifications and exceptions, and give the Secretary authority to establish new wage index systems. Second, the Secretary should use this new authority to establish a hospital compensation index that: uses wage data representing all employers and industry-specific occupational weights; is adjusted for geographic differences in the ratio of wages to benefits; adjusts market-level indexes for county-level wage differences and smoothes large differences between counties; and is implemented so that large changes in wage index values are phased in over a transition period. Third, the Secretary should use that hospital compensation index for the home health and SNF prospective payment systems and evaluate its use in the other Medicare FFS prospective payment systems.

Another source of inefficiency in the program is the overlap between the new Part D program for prescription drugs and the previous limited drug coverage in the program under Part B. The report makes three recommendations to sort out these overlaps and promote efficiency and convenience for beneficiaries. First it recommends that the Congress change the law to allow CMS to identify selected overlap drugs that are covered under Part D most of the time and are low-cost, and direct plans always to cover them under Part D. Second, for drugs that continue to be covered by Part B and Part D, it recommends that the Congress authorize prescription drug plans to approve transition supplies while coverage is being determined. Third, it recommends that the Congress should permit coverage for appropriate preventive vaccines under Part B instead of Part D. The report also examines three potential options for providing Part D benefits in long-term care settings.

The report describes potential reforms to the payment system for skilled nursing facilities (SNFs) and introduces new quality measures. The current design of the prospective payment system results in

impaired access for certain beneficiaries who require expensive nontherapy ancillary (NTA) services and encourages providers to furnish therapy even when the services are of little or no value. The report concludes that options can be designed that better target payments for NTA and therapy services and for stays with unusually high costs. It also notes that two proposed measures of SNF quality declined at the same time publicly reported SNF quality measures improved. This difference in trend, combined with previous concerns about the publicly reported measures, leads the Commission to urge CMS to report community discharge rates and rehospitalization rates for Medicare patients and to change the timing of the patient assessment so that changes in health status are gathered for all patients.

Finally, the report discusses changes to physicians' practice expense (PE) payments—which account for almost half of Medicare spending under the physician fee schedule. CMS is using new methods to calculate PE payments that will substantially redistribute PE payments across services. It examines CMS's new method for calculating indirect practice expense and explores other methods to pay indirect practice costs. It finds PE payments would be more accurate if the payment system's geographic adjustment did not apply to the portion of PE payment covering equipment and supplies—inputs whose costs do not differ by geography.

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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.*