

EMBARGOED FOR RELEASE UNTIL 8:30 AM MARCH 1, 2007

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

Washington, DC, March 1, 2007—Today, the Medicare Payment Advisory Commission (MedPAC) releases its March 2007 *Report to the Congress: Medicare Payment Policy*.

The report reviews the context for Medicare, its fee-for-service payment systems, and their updates. It also reviews recent findings and past recommendations on Medicare Advantage (MA) plans, and findings on the private plans offering the new prescription drug benefit (Part D).

The trend of increasing Medicare spending without a commensurate increase in value to the program, combined with the retirement of the baby boomers and Medicare's new prescription drug benefit, will, if unchecked, result in the Medicare program absorbing unprecedented shares of the GDP and of federal spending. Medicare should exert financial pressure on providers to control their costs, much as would happen in a competitive marketplace. In all sectors, Medicare should also adjust payments for quality, paying more for high quality and less for poor quality.

MedPAC makes updates and policy recommendations for eight Medicare payment systems for 2008. The update is the amount by which the base payment for all providers in a prospective payment system is changed. In most cases where payments are adequate, some amount representing productivity improvement should be subtracted from the initial update value, which is an estimate of the change in input prices. MedPAC's policy goal for improvement in productivity is the ten year average of productivity gains in the general economy, 1.3 percent for 2008. This factor links Medicare's expectations for efficiency to the gains achieved by the firms and workers who pay taxes that fund Medicare. MedPAC recommends:

- For both inpatient and outpatient services, updates equal to the hospital market basket (a measure of input prices), implemented *concurrently* with a quality incentive payment program. This recommendation balances positive indicators of financial performance, access, and quality against negative payment margins. Although separately computed and paid, a hospital's quality performance payment would likely determine whether its net increase in payments in 2008 would be above or below the market basket increase. Part of the funding for a quality incentive payment policy should come from reducing indirect medical education (IME) payments. More than half of the IME add-on payment is unrelated to the additional cost of care that results from the intensity of a hospital's teaching program. The Commission recommends that the Congress reduce the IME adjustment by 1 percentage point to 4.5 percent per 10 percent increment in the resident-to-bed ratio, concurrent with implementation of a system for adjusting payments for severity of illness.
- For the physician fee schedule, an update equal to the increase in input prices less the expectation for productivity growth. Beneficiary access to physicians is generally good and per beneficiary service volume

grew with small improvements in quality. The sustainable growth rate (SGR) formula continues to call for substantial negative updates through 2015. The Commission is concerned that consecutive annual cuts would threaten beneficiary access to physician services over time. As a mechanism for volume control, the current national SGR has several problems, which the Commission examines in its mandated report to the Congress: *Assessing Alternatives to the Sustainable Growth Rate System*.

- For the outpatient dialysis payment system, an update equal to the projected change in input prices less the Commission's expectation for productivity growth. The report also suggests bundling all dialysis-related services, including drugs, into a single payment and continued efforts to improve dialysis quality.
- For three of the four post-acute care payment systems—skilled nursing facilities, home health agencies, and long-term care hospitals—no increases in the payment rates. Considering current margins, increased spending and volume, stable access and quality, and good access to capital, these providers can accommodate next year's cost increases without an increase in base payments.
- For inpatient rehabilitation facilities an increase of 1 percent, recognizing that they are transitioning from a period of historically high margins and growth to lower margins and volume declines brought about by a major change in Medicare policy—CMS's modification of the 75 percent rule.

The report finds that all beneficiaries will be able to join an MA plan in 2007, and enrollment in MA plans grew in 2006 to 17 percent, a level close to its all-time high. Almost half the growth in 2006 was in private fee-for-service MA plans. In addition, the benchmarks (which are the reference level for plan bids and the maximum program payment) now average 116 percent of traditional Medicare fee-for-service (FFS) levels, and payments average 112 percent. The Commission has always supported a private plan option in Medicare, and has recommended a policy of financial neutrality between private plans and traditional Medicare fee-for-service. Financial neutrality includes setting payment benchmarks at 100 percent of fee-for-service costs and removing duplicative payments for indirect medical education. In addition to financial neutrality between MA and FFS, the Commission has also recommended neutrality between types of MA plans, including eliminating the stabilization fund for PPO plans and making bidding rules consistent across plan types. Further, the Commission has recommended a pay for quality performance program for MA plans, and calculating clinical measures for the FFS program that would permit CMS to compare quality in the FFS program with that in MA plans.

Part D plan offerings for 2007 shows that about 30 percent more plans entered the market for 2007 than in 2006 and that the typical beneficiary has a choice of over 50 stand-alone drug plans. More plans are including coverage in the gap for generic drugs. Average premiums unweighted by plan enrollment are lower in 2007 than in 2006 for basic plans, and higher for plans with enhanced coverage.

CMS chose not to fully enrollment weight plan bids in 2007, using its general demonstration authority. This means enrollees will pay lower premiums and more low-income enrollees will be able to remain in their current plan. However, it also does not allow the full benefits of competition to be realized and thus, the cost to Medicare will increase. The Commission has previously recommended that the Secretary should use his demonstration authority to test innovations in the delivery and quality of healthcare, not as a mechanism to increase payments. The Commission has also previously recommended that the Secretary have a process for timely delivery of Part D data to Congressional support agencies. CMS has proposed a regulation that supports the intent of that recommendation. MedPAC supports that proposed regulation and urges CMS to make it final.

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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.

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**MEDICARE PAYMENT ADVISORY COMMISSION
RELEASES REPORT ON SUSTAINABLE GROWTH RATE**

Washington, DC, March 1, 2007— The Deficit Reduction Act of 2005 (DRA) required the Medicare Payment Advisory Commission (MedPAC) to examine alternative mechanisms for controlling physician expenditures under Medicare. Today, MedPAC will deliver its report, *Assessing Alternatives to the Sustainable Growth Rate System*, to the Congress.

Currently, Medicare attempts to limit expenditures for physician services using a statutory formula known as the sustainable growth rate (SGR). The SGR determines the annual update to the physician payment rate consistent with an expenditure target that is tied to growth in the gross domestic product (GDP). The SGR is widely considered to be flawed; it neither rewards physicians who restrain volume growth nor punishes those who prescribe unnecessary services. Further, when the SGR calls for cuts to physician payment rates because expenditure growth exceeds the target, the Congress has usually overridden it. However, some observers believe that, despite its flaws, the SGR has helped restrain the increase in Medicare spending for physician services by focusing Congressional attention when expenditures exceed the target. The subsequent debate may also compel providers to support payment reforms they otherwise might find objectionable.

As required by the DRA, the Commission examined five alternative mechanisms for establishing expenditure targets—geographic area, type of service, group practice, hospital medical staff, and physician outliers—and considered the feasibility of each. We also considered adjustments to the current SGR (e.g., softening or eliminating the cumulative formula or applying target corridors). Policymakers should recognize that each of these alternatives attempts to control total expenditures, not volume. As the report outlines, each alternative has advantages and disadvantages, but without accompanying payment policies that change the inherent incentives of fee-for-service (FFS) payment, the ability to influence the behavior of individual physicians will be limited.

Any effort to relax the current SGR will be costly. For any of the alternatives, details of the formula—including where the target is set, how to deal with the existing difference between the target and spending, and whether the target is applied only to physician services or is extended more broadly—are the most important determinants of projected total spending. But the Congress may be able to maintain some spending control by retaining the expenditure target in some form.

We outlined two possible paths for the Congress to follow. One path would repeal the SGR and not replace it with a new expenditure target. If it pursues this path, the Congress would need to make explicit decisions about how to update physician payments.

Alternatively, the Congress could replace the SGR with a new expenditure target system. If the Congress chooses to pursue this path, the Commission has concluded that the target system should not apply solely to physicians. Rather, it should ultimately apply to all providers. Controlling total Medicare expenditures and producing the optimal mix of services requires that all types of providers work together, not at cross purposes, to keep costs as low as possible while increasing quality. Rewards and penalties should be applied on a geographic basis, since different parts of the country contribute differentially to volume and expenditure growth. Moreover, high-spending areas have not demonstrated higher quality of care. Medicare would provide data measuring resource use to individual physicians and groups of physicians so that providers would be informed of their practice patterns. Finally, Medicare would provide opportunities to selected groups of providers (e.g., physician organizations and hospital and physician collaboratives) who practice as a network and share the savings they generate.

We did not recommend a specific path because significant disagreement exists within the Commission about the utility of expenditure targets. Nevertheless, the Commission is united on this: Regardless of which path is chosen, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to improve the value of the program to beneficiaries and taxpayers. Payment policies should reward providers for efficient use of resources and create incentives to increase quality and coordinate care. Policies such as pay for performance that link payment to the quality of care physicians furnish should be implemented. At the same time, Medicare should encourage coordination of care and provision of primary care, allow gainsharing arrangements, bundle and package services where appropriate to reduce overuse, ensure that its prices are accurate, and rethink the program's benefit design and the effects of supplemental coverage. To reduce unwarranted variation in volume and expenditures, Medicare should collect and distribute information about how providers' practice styles and use of resources compare with those of their peers. Ultimately, this information could be used to adjust payments to physicians. Findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Finally, concerted efforts should be made to identify and prevent misuse, fraud, and abuse by strengthening provider standards, ensuring that services are furnished by qualified providers to eligible recipients, and verifying that services are appropriate and billed accurately and that payments for those services are correct.

The Congress needs to provide CMS with the necessary time, financial resources, and administrative flexibility to make these improvements. CMS will need to invest in information systems; develop, update, and improve quality and resource use measures; and contract for specialized services. In the long run, failure to invest in CMS will result in higher program costs and lower quality of care.

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