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

Washington, DC, June 13, 2014—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2014 *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.

Synchronizing policy across Medicare. This report outlines a set of questions for the Medicare program as it develops new ways of financing and organizing care for beneficiaries. Medicare currently finances care through traditional fee-for-service (FFS), through Medicare Advantage (MA) health plans, and more recently through accountable care organizations (ACOs), which are a variation of FFS. In each model, Medicare has different—and sometimes conflicting—policies concerning payment, risk adjustment, quality measurement, and other issues.

According to MedPAC Chairman Glenn Hackbarth, “This report represents the beginning of a dialogue within MedPAC about how Medicare’s policies across FFS, MA, and ACOs might evolve and how these differing policies might affect beneficiaries, providers, and taxpayers.”

- *Payment benchmarks.* One chapter compares the way payment benchmarks are set in MA and ACOs and how those compare with FFS. Commission analysis shows that no one payment model will be the lowest cost model in all areas of the country. Rather, which model is least costly in a given area would be sensitive to how benchmarks are set.
- *Risk adjustment.* A second chapter considers how Medicare’s tools for risk adjustment could be improved. Appropriate risk adjustment is an important part of paying providers and plans fairly and equitably for the care of patients with different clinical needs.
- *Quality measurement.* A third chapter examines Medicare’s approach to measuring and paying for health care quality. MedPAC raises concerns about Medicare’s current focus on quality measures that reflect processes rather than outcomes and explores what measures may be appropriate for quality measurement in the various payment models.

Fee-for-service reforms. In the report, MedPAC identifies several areas within FFS for which restructuring payments to support quality and efficiency may be warranted and for which MedPAC may consider recommendations to the Congress in the future.

- *Supporting primary care.* Medicare currently pays bonus payments to primary care practitioners to recognize the important role that primary care plays in care coordination for Medicare beneficiaries. In this report, the Commission discusses the idea of transforming the bonus payment—which is currently paid as an add-on to primary care claims—into a per beneficiary payment that could be paid monthly or annually. To develop the policy concept of such a payment, the Commission considers several design issues: practice requirements, method for attributing patients to the practice, and funding.
- *Post-acute care payments across settings.* When Medicare beneficiaries get rehabilitation care after a hospitalization (post-acute care services) in skilled nursing facilities (SNFs) or inpatient rehabilitation facilities (IRFs), Medicare often pays different rates, even when patients in both settings are similar with respect to their diagnoses, care needs, and risk profiles. The Commission examines three conditions that patients frequently recover from in IRFs and SNFs—major joint replacement, other hip and femur procedures, and stroke—and assesses the feasibility of paying IRFs the same rates as SNFs for these conditions.

Other policy analysis. MedPAC’s June report also contains chapters on other topics of interest to the Congress.

- *Financial assistance for low-income beneficiaries.* In 2012, MedPAC recommended the Congress change the traditional FFS benefit package to protect beneficiaries against high financial burden and introduce incentives to make beneficiaries more cost conscious. In this report, MedPAC discusses how changing income eligibility for the Medicare Savings Programs (MSPs) could help low-income Medicare beneficiaries afford out-of-pocket costs under a redesigned benefit package.
- *Impact of medication adherence on health spending.* Clinicians and researchers frequently cite the importance of patient adherence to medication regimens in reducing poor health outcomes and health care spending. MedPAC examines the impact of medication adherence on medical spending in the Medicare population and shows that while better adherence to an evidence-based regimen for certain beneficiaries is associated with lower medical spending, the effects likely vary by beneficiary characteristics (e.g., age), and the effects diminish over time.

The full report is available at MedPAC’s website: http://medpac.gov/documents/Jun14_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.