

EMBARGOED FOR RELEASE UNTIL 1:00 PM June 15, 2015
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**MEDICARE PAYMENT ADVISORY COMMISSION
RELEASES REPORT ON MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM**

Washington, DC, June 15, 2015—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2015 *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.

Hospital short-stay policy issues. Short hospital inpatient stays have been scrutinized by Medicare’s auditors because Medicare generally pays more for short inpatient stays than similar outpatient stays, these inpatient stays are highly profitable, and Medicare’s guidelines for when to admit a patient are open to interpretation. As a result, hospitals have increased their use of outpatient observation stays, which can have implications for beneficiaries’ financial liability. Over the last year, the Commission has undertaken extensive work to understand these issues, including analyses of data on trends in inpatient and outpatient stays and conversations with a broad range of stakeholder groups. Through the course of this work, the Commission developed a set of recommendations that are designed to provide greater protections for beneficiaries and reduce administrative burden for hospitals, while ensuring that the program is not paying too much for hospital care.

Medicare payment for drugs under Part B and Part D. Four chapters in this report examine policy issues related to how Medicare pays for drugs under Part B and Part D. Medicare pays for most Part B drugs at payment rates set at the average sales price plus 6 percent. In 2013, Medicare and its beneficiaries paid more than \$19 billion for those drugs, which are furnished by physicians, hospital outpatient departments, and suppliers. Medicare Part D pays private plans a capitated monthly rate to provide a prescription drug benefit to Medicare beneficiaries. In 2013, Medicare spent almost \$65 billion for the Part D benefit.

- *Payment policies for Part B drugs.* One chapter explores two topics related to Medicare payment policy for Part B drugs: (1) converting all or part of the 6 percent add-on to a flat-fee add-on to dampen the potential financial incentive to prescribe higher cost drugs and (2) estimating the discount on Part B drugs received by hospitals under the 340B Drug Pricing Program, and the implications for Medicare program expenditures and beneficiary out-of-pocket costs.
- *Value-based incentives.* A second chapter considers how Medicare payment policy could be used to ensure that beneficiaries and the program are getting a good value for their Part B drug spending. Currently, Medicare’s payment policies for Part B drugs do not give clinicians incentives to consider evidence of a drug’s clinical effectiveness compared with its alternatives. MedPAC examines several ideas for linking Part B payment for drugs to comparative clinical effectiveness evidence that could reduce spending for beneficiaries and taxpayers.

- *Polypharmacy and opioid use.* A third chapter examines how the use of multiple prescription drugs (polypharmacy) can affect patients' medical conditions and lead to additional service use. Studies have found a positive association between polypharmacy and adverse events, such as hospitalization and emergency department visits, and nonadherence to appropriate medications. To this point, chronic opioid use among Medicare beneficiaries is substantial and is inappropriate in many cases. When opioids are included as part of a multiple-drug regimen, problems related to adherence and adverse drug events are more likely.
- *Risk-sharing in Part D.* A fourth chapter discusses the potential need for reforms to insurance risk-sharing structures in Medicare Part D. The Medicare program shares a substantial portion of Part D enrollees' insurance risk, in part because when Part D was created, one goal was to attract plans to enter the program. Now that the program is established, risk sharing may need to be redesigned. As an initial step, MedPAC examines the ways in which Medicare shares insurance risk with Part D plans and the patterns of bidding and spending that have resulted.

Synchronizing policy across Medicare. This report continues a discussion that MedPAC began last year about aligning Medicare's policies across its three payment models. Medicare currently finances care through traditional fee-for-service (FFS), through Medicare Advantage health plans, and more recently through accountable care organizations, which currently receive variations of FFS payment. In each model, Medicare has different—and sometimes conflicting—policies concerning payment, risk adjustment, quality measurement, and other issues.

- *Synchronizing across models.* In this report, the Commission presents further evidence that the payment model that is least costly varies among markets. In order to maximize the value of the Medicare program for its beneficiaries and taxpayers, Medicare may need to determine how to set payment rules that reward the most efficient model of care in a market and how to encourage beneficiaries to choose that model. To that end, the Commission also considers several different ways to calculate beneficiaries' Part B premiums and how premiums might vary in each market for each model as a result.
- *Next steps in measuring quality.* In its June 2014 report to the Congress, the Commission put forth a concept for an alternative to Medicare's current quality measurement system that would use a small set of population-based outcome measures that could be compared across the three payment models. In this report, we examine a "healthy days at home" measure to determine whether it could eventually be used as such a measure.

The next generation of Medicare beneficiaries. The Medicare population is projected to increase from 54 million beneficiaries today to over 80 million beneficiaries by 2030 as the baby-boom generation ages into Medicare. The baby-boom population is unique in terms of its health status, socioeconomic level, and historical experience with private insurance. We examine what the entrance of this population means for the Medicare program.

The full report is available at MedPAC's website: http://medpac.gov/documents/reports/Jun15_EntireReport.pdf

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The Medicare Payment Advisory Commission is an independent, nonpartisan Congressional agency that provides 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.