

Assessing Alternatives to the Sustainable Growth Rate System

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Statement of
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Chairman Baucus, Ranking Member Grassley, distinguished Committee members, I am Glenn Hackbarth, Chairman of the Medicare Payment Advisory Commission (MedPAC). I appreciate the opportunity to be here with you this morning to discuss alternatives to the sustainable growth rate (SGR) system used in Medicare's physician payment system.

Medicare pays for physician services on a fee-for-service basis using a resource-based relative value scale. Each service is assigned a weight reflecting the resources needed to furnish it. Payment is determined by multiplying a service's weight by a national physician payment rate, called the conversion factor.

Currently, as specified in statute, the annual update to the conversion factor is determined under the SGR, based on 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. Some critics contend the SGR may actually stimulate volume growth. Other observers believe that, despite its flaws, the SGR has helped curb the increase in Medicare spending for physician services by alerting policymakers that spending is rising more rapidly than anticipated and constraining the ability of policymakers to increase fees.

Slowing the increase in Medicare outlays is important; indeed it is becoming urgent. Medicare's rising costs, particularly when coupled with the projected growth in the number of beneficiaries, threaten to place a significant burden on taxpayers. Rapid growth in expenditures also directly affects beneficiary out-of-pocket costs through higher Part B and supplemental insurance premiums as well as higher copayments.

The Deficit Reduction Act of 2005 (DRA) requires MedPAC to examine alternative mechanisms for establishing expenditure targets. We also considered ways to reconfigure the existing SGR to improve its performance. We have reviewed the pros and cons of the different alternatives and outlined two possible paths for the Congress to follow. Significant disagreement exists within the Commission about the utility of expenditure

targets. Moreover, the complexity of the issues makes it difficult to recommend any option with confidence. Absent careful development and significant investment, the risk that a formulaic expenditure target will fail and have unintended consequences is substantial.

Despite disagreement about expenditure targets, the Commission is united on this: Whether or not the Congress elects to retain some form of expenditure target, a major investment should be made in Medicare's capability to develop, implement, and refine payment systems to change the inherent incentives in the fee-for-service system to reward quality and efficient use of resources while improving payment equity. Examples of such reforms include pay-for-performance programs for quality, improving payment accuracy, developing incentives to coordinate care, using comparative-effectiveness information, and bundling payments to reduce overutilization.

An expenditure target, however designed, cannot substitute for improvements to Medicare's payment systems; at best, it may be a useful complement. An expenditure target alone will not create the proper incentives for individual physicians or other providers; indeed, there is a risk that—in the absence of other changes—constraint on physician fees will stimulate inappropriate behavior, including the very increases in volume and intensity that the target system purports to control. It is better to think of an expenditure target as a tool for altering the dynamic of the policy process than as a tool for directly improving how providers deliver services. An expenditure target alerts policymakers that spending is rising more rapidly than anticipated and leads to an annual debate over the update to the physician payment rate. That debate may also influence the behavior of providers: To avoid rate decreases, they could be compelled to support payment reforms that they might otherwise find objectionable.

The Congress, then, must decide between two paths. One path would repeal the SGR and not replace it with a new expenditure target. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and

other providers to furnish higher quality care at a lower cost. 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. A new expenditure target would not reduce the need, however, for a major investment in payment reform. Regardless of the path chosen, Medicare should develop measures of practice styles and report the information to individual physicians. Medicare should also create opportunities for providers to collaborate to deliver high quality care while restraining resource use.

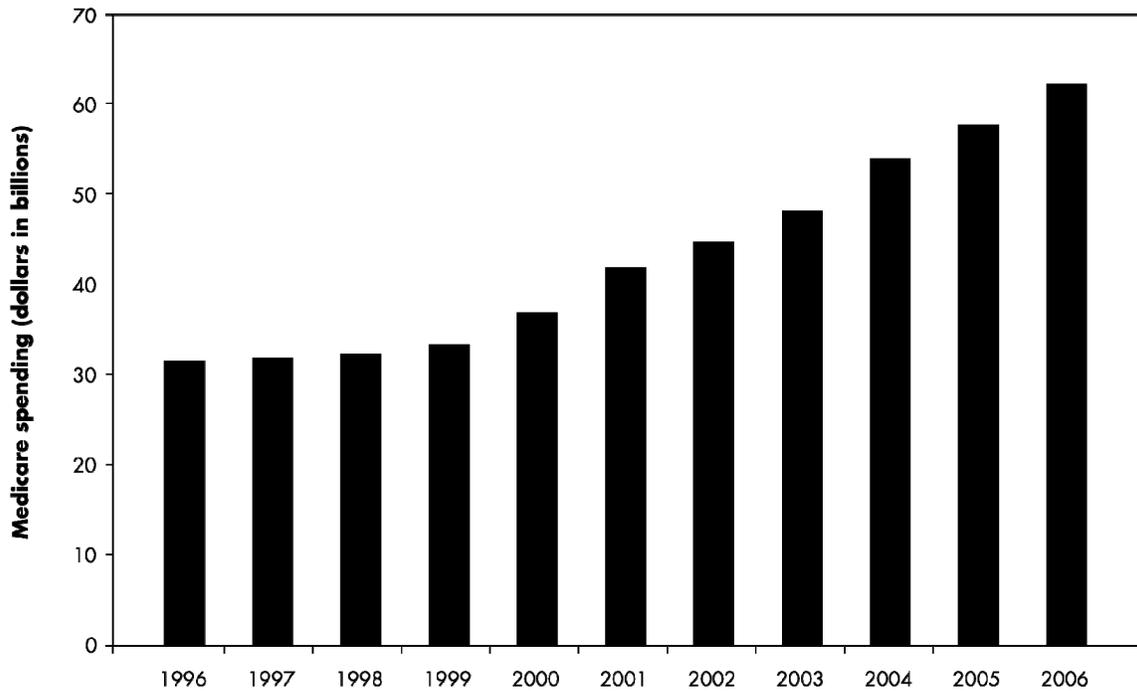
If the Congress chooses to use expenditure targets, the Commission has concluded that such targets should not apply solely to physicians. Rather, they should ultimately apply to all providers. Medicare has a total cost problem, not just a physician cost problem. Moreover, producing the optimal mix of services requires that all types of providers work together, not at cross purposes. For example, physicians and hospitals must collaborate to reduce unnecessary admissions and readmissions. If used, an expenditure target should be designed to encourage all types of providers to work together to keep costs as low as possible while increasing quality. The Congress may also wish to apply targets on a regional 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.

The sustainable growth rate system

Each year, CMS follows the statutory formula to determine how to update fees for physician services to help align spending with the SGR's expenditure target. The SGR allows growth in spending due to factors that one would expect to affect the volume of physician services: inflation in physicians' practice costs, changes in enrollment in fee-for-service Medicare, and changes in spending due to laws and regulations. In addition, the SGR includes an allowance for growth above these factors based on growth in real GDP per capita. Growth in GDP—the measure of goods and services produced in the

United States—is used as a benchmark of how much additional expenditure growth society can afford.

Figure 1. FFS Medicare spending for physician services, 1996–2006



Note: FFS (fee-for-service). Dollars are Medicare spending only and do not include beneficiary coinsurance.

Source: 2006 annual report of the Boards of Trustees of the Medicare trust funds.

The SGR system has been widely criticized. In recent years expenditures for physician services have grown substantially, suggesting that the SGR does not provide a strong check on spending (Figure 1). It does little to counter the inherently inflationary nature of fee-for-service payment. In addition, the SGR is inequitable, treating all providers—regardless of their behavior—and all regions of the country alike.

The SGR also fails to distinguish between desirable increases in volume and those that are not. Some volume growth may be desirable. For example, growth arising from technology or changes in medical protocols that produce meaningful improvements to patients, or growth in services that are currently underutilized, is beneficial. But research

suggests that some portion of volume growth does not advance the health and well-being of beneficiaries. In geographic areas with more providers and more specialists, research has found that beneficiaries receive more services but do not experience better quality of care or better outcomes, nor do they report greater satisfaction with their care.

Table 1. Cumulative actual expenditures for SGR-related services exceeded SGR-allowed expenditures starting in 2002

Year	Cumulative expenditures (in billions)		Difference (in billions)
	Allowed	Actual	
1996	\$36.6	\$36.6	N/A
1997	86.6	85.9	\$0.7
1998	138.7	135.8	2.9
1999	194.1	188.4	5.7
2000	253.4	246.4	7.0
2001	315.4	312.7	2.7
2002	382.5	383.6	-1.1
2003	454.5	461.8	-7.3
2004	531.2	548.9	-17.7
2005	611.3	640.0	-28.7
2006	693.0*	734.9*	-41.9*

Note: SGR (sustainable growth rate), N/A (not applicable). Cumulative allowed and actual expenditures are as of calendar year end. Pursuant to the Balanced Budget Refinement Act of 1999, the SGRs for 2000 and all subsequent years are estimated and then revised twice by CMS, based on later data.
* Estimated.

Source: CMS 2006. Estimated sustainable growth rate and conversion factor, for Medicare payments to physicians in 2007. November. <http://www.cms.hhs.gov/SustainableGRatesConFact/Downloads/sgr2007f.pdf>.

Medicare spending for physician services has exceeded targeted spending for several years, resulting in the SGR calling for cuts in physician payment rates (Table 1). The Congress has repeatedly prevented these cuts from being implemented without changing the SGR formula or the target. As a result, the cumulative SGR formula calls for larger fee cuts in multiple years. The Medicare trustees project that the SGR will call for annual cuts of about 5 percent well into the next decade. The trustees characterize this projected series of negative updates to physician fees as “unrealistic” because the Congress is unlikely to allow them. But the federal budget’s baseline includes the large fee cuts,

making it costly from a budgeting perspective to give zero updates, much less increase fees. If they were implemented, large cumulative cuts would likely compromise access to care. They might also have the unintended consequence of spurring volume growth as physicians attempt to maintain their income.

Using Medicare’s physician and other payment systems to improve value

Medicare should institute policies that improve the value of the program to beneficiaries and taxpayers (see text box, p.17). Those 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.

DRA-mandated alternatives to the SGR

The DRA requires that we examine the potential for volume controls using five alternative types of sub-national targets—geographic area, type of service, group practice, hospital medical staff, and physician outliers—and consider the feasibility of each. Policymakers should recognize that, by their very nature, these alternatives can only attempt to control total expenditures, not volume. Each alternative has advantages and disadvantages, but without accompanying payment policies that change the inherent incentives of fee-for-service payment, the ability to influence the behavior of individual physicians will be limited.

The Commission has not provided budgetary scores for the alternatives. MedPAC does not produce official scoring estimates. Further, many of the alternatives' administrative implications are unknown. 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 important determinants of projected total spending. Efforts to relax the current SGR (e.g., softening or eliminating the cumulative formula) will be costly under current baseline assumptions. However, the Congress may be able to maintain some expenditure control by retaining the expenditure target in some form.

Geographic area alternative

The geographic area alternative would apply targets to subnational geographic areas. Setting different fee update amounts by region acknowledges that regional practice patterns vary and contribute differentially to overall volume and expenditure growth. Use of different regional updates would improve equity across the country and over time could help reduce geographic variation. However, it is not clear what the optimum geographic unit would be. Choosing the unit involves tradeoffs between physician accountability, year-to-year volatility, and administrative feasibility. Using smaller units, such as hospital referral regions, might increase physician accountability but would also increase year-to-year volatility and be difficult to administer. Large units, such as states

or Part D regions, are more stable and are easier to administer but include too many physicians to encourage accountability.

Using different regional updates would not entirely address the inequities of the current system; for example, a physician who practices conservatively in a high-volume region would still be penalized. Using different regional updates could also create wide disparities in payment rates by area. Beneficiaries crossing the boundaries of geographic areas to seek care also would be an issue that would have to be resolved.

Type-of-service alternative

A type-of-service alternative would set expenditure targets for different types of services, as was done under the volume performance standard (VPS), which preceded the SGR. (Under the VPS, three targets were established—for evaluation and management services, surgical procedures, and all other services.) A type-of-service expenditure target recognizes that expenditure growth differs widely across types of services. Some might prefer this type of target because it would differentiate between services with the greatest growth in volume and expenditures and those with the smallest. This alternative also could be designed to boost payments for primary care services, which some believe are undervalued.

But service-specific targets present a number of difficulties. One problem is that, under such targets, inequities across services and specialties could arise. In addition, setting service-specific targets would implicitly require Medicare to know the optimal mix of services. This would be difficult, since the optimal mix of services will evolve with changes in the population served, patterns of illness, and medical knowledge and technology.

Multispecialty group practice alternative

The Congress asked MedPAC to analyze an alternative to the SGR that might adjust payment based on physicians' participation in group practices, since some studies suggest

that physicians in multispecialty group practices may be more likely to use care management processes and information technology and to have lower overall resource use. But considering the small share of physicians in multispecialty groups (20 percent), and that not all group practices engage in activities that improve quality and manage resource use, payment policies focusing solely on group status may not effectively elicit the desired behavior. Further, using separate targets for group and nongroup physicians could be viewed as inequitable, since efficient physicians in smaller nongroup practices would be ineligible for the payment updates that physicians in multispecialty groups would receive. In addition, rural physicians may have few, if any, opportunities to join group practices. Such small groups of physicians would also increase year-to-year volatility and could be difficult to administer. Establishing payment incentives for performing specific activities associated with better care and lower resource use would likely be more effective than using separate targets based on group practice status.

While the Commission has not recommended a multispecialty group alternative for an expenditure target, such groups may still be an important locus for many of the policy changes that MedPAC believes are important. For example, these groups could serve as accountable care organizations (ACOs), together with independent practice associations (IPAs), hospital medical staffs, and other organized groups of physicians. The Commission's preliminary research has found that beneficiaries who regularly see physicians in multispecialty groups appear to use fewer resources than other beneficiaries. Multispecialty groups may be more likely to incorporate incentives to control resource use and monitor and influence practice styles, which may encourage providers to better coordinate care and ensure that patients are appropriately monitored and receive necessary follow-up care.

Hospital medical staff alternative

A hospital medical staff target system would use Medicare claims to assign physicians and beneficiaries to one type of ACO based on the hospitals they use most. Even if some physicians have little or no direct interaction with a hospital, they can be assigned to the

group based on the hospital most of their patients use. This option creates a virtual physician group using the extended hospital staff as the organizational focal point. Initially, Medicare could collect and distribute information about the practice patterns of different groups. Ultimately, that information could be used to adjust payments for differences in resource use and quality.

Using hospital medical staffs as ACOs could better align incentives to control expenditures. The hospital could provide an organizational locus for physicians in the area to come together to monitor and influence practice styles. Although the size of the groups would vary substantially, each of them would be much smaller than the current national pool. Individual physicians could therefore more readily see a link between their own actions and their group meeting its target. Over time, this alternative is intended to induce physicians and other providers to practice more as a system, optimizing care delivery and reducing overall expenditures.

There are significant barriers to this alternative. Some argue that hospitals and physicians are competitors who will not easily collaborate with one another, making this type of ACO an unlikely vehicle for change. Such small groups of physicians would increase year-to-year volatility and could be difficult to administer. Physicians may resist having Medicare assign them to an entity to which they may feel little or no affinity. Physicians who rarely refer patients for hospital care may be particularly resistant. Finally, there may be additional legislative changes to allow sharing of funds that would be required to implement this alternative.

Outlier alternative

Medicare could identify physicians with very high resource use relative to their peers. CMS could first provide confidential feedback to physicians. Then, once greater experience and confidence in resource-use measurement tools were gained, policymakers could use the results for additional interventions such as public reporting, targeting fraud and abuse, pay for performance, or differential updates based on relative performance.

The major advantage of this alternative is that it would promote individual accountability and would enable physicians to more readily see a link between their actions and their payment. However, a number of technical issues would need to be resolved.

Implementation of an outlier system based on episode groupers may prove difficult if physicians cannot be convinced of the validity of episode grouping tools. Physicians will need to be confident that their scores reflect the relative complexity of their patient mix and that they are being compared to an appropriate set of peers. There would likely be considerable controversy around initial physician scores as some physicians realized that their practice patterns were not in line with those of their peers.

Reconfiguring the national target system

We also considered a reconfiguration of the current national target. For example, the current system could be changed to moderate or eliminate the cumulative aspect of the spending targets. Another option is to implement an additional allowance corridor around the allowed spending target line. Both options would relieve some of the budget pressure and result in more favorable updates but also would increase total expenditures and would not change the inflationary incentives inherent in fee-for-service payment.

Other changes could be made to the physician payment system to address services that are growing quickly. Such growth may signal that relative prices for those services do not reflect the time and complexity of furnishing them. In examining such services, the Secretary would need to take into account changes in both the number of physicians furnishing the services to Medicare beneficiaries and the number of hours physicians worked. CMS could use the results from these analyses to flag services for closer examination of their relative work values. Alternatively, the Secretary could automatically correct such mispriced services and the Relative Value Scale Update Committee could then evaluate these changes during its regular five-year review.

Choices for the Congress on expenditure targets

There are two paths the Congress could take. The Commission did not reach a consensus on which path is best. The issues surrounding the use of expenditure targets are complex, the information requirements are many, and the full effects are almost unknowable; in addition, the risk of failure and unintended consequences is high. Nevertheless, some Commissioners believe it is prudent to retain an expenditure target to limit rate increases and to provide leverage with providers to encourage them to embrace reforms they might otherwise oppose. At the same time, other Commissioners fear that undue restraint on rates may impede access to care in the long run. Moreover, across-the board restraint that fails to distinguish between good performers and poor performers may encourage providers to engage in undesirable behavior to maintain their profitability—for example, ordering services of marginal value or seeking to furnish services with payments that are high relative to costs.

Despite disagreement about the utility of expenditure targets, the Commission is united on this key point: Whether or not the Congress elects to retain some form of expenditure target, a major new investment should be made in Medicare’s capability to develop, implement, and refine fee-for-service payment systems to reward quality and efficient use of resources while improving payment equity, as discussed below. An expenditure target, however designed, is not a substitute for improving Medicare’s payment systems; at best, it may be a useful complement. An expenditure target by itself cannot create the proper incentives for individual physicians or other providers. A target is a tool for improving the dynamics of policymaking, not health care delivery.

Following are two alternative paths for the Congress to consider.

Path 1

The first path would repeal the SGR. No new system of expenditure targets would be implemented. Instead, the Congress would accelerate development and adoption of approaches for improving incentives for physicians and other providers to furnish lower

cost and higher quality care (see text box, p. 17). Increasing the value of Medicare in this way will require:

- ***Changing the payment incentives.*** Policies must be implemented that link payment to the quality of care physicians and other providers furnish. MedPAC's pay-for-performance recommendations would move toward correcting the problem of lack of incentives for quality care. At the same time, Medicare needs to encourage coordination of care and provision of primary care, ensure that its prices are accurate, allow gainsharing arrangements, and bundle and package services where appropriate to reduce overuse. ACOs like physician groups and other combinations of providers can be encouraged as a means to improve quality and reduce inappropriate use of resources. Medicare should also rethink the program's benefit design and the effects of supplemental coverage.
- ***Collecting and disseminating information.*** Variation in practice patterns may reflect geographic differences in what physicians and other providers believe is appropriate care. To reduce this variation, providers need information about how their practice styles compare with those of their peers. Ultimately, such information could be used to adjust payments to physicians. In addition, findings from comparative-effectiveness research should be used to inform payment policy and furnished to beneficiaries and providers to inform decisions about medical care. Both of these are activities in which collaborating with the private sector could lead to wider adoption and greater impact.
- ***Redoubling efforts to identify and prevent misuse, fraud, and abuse.*** This effort includes supporting quality through the use of 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.

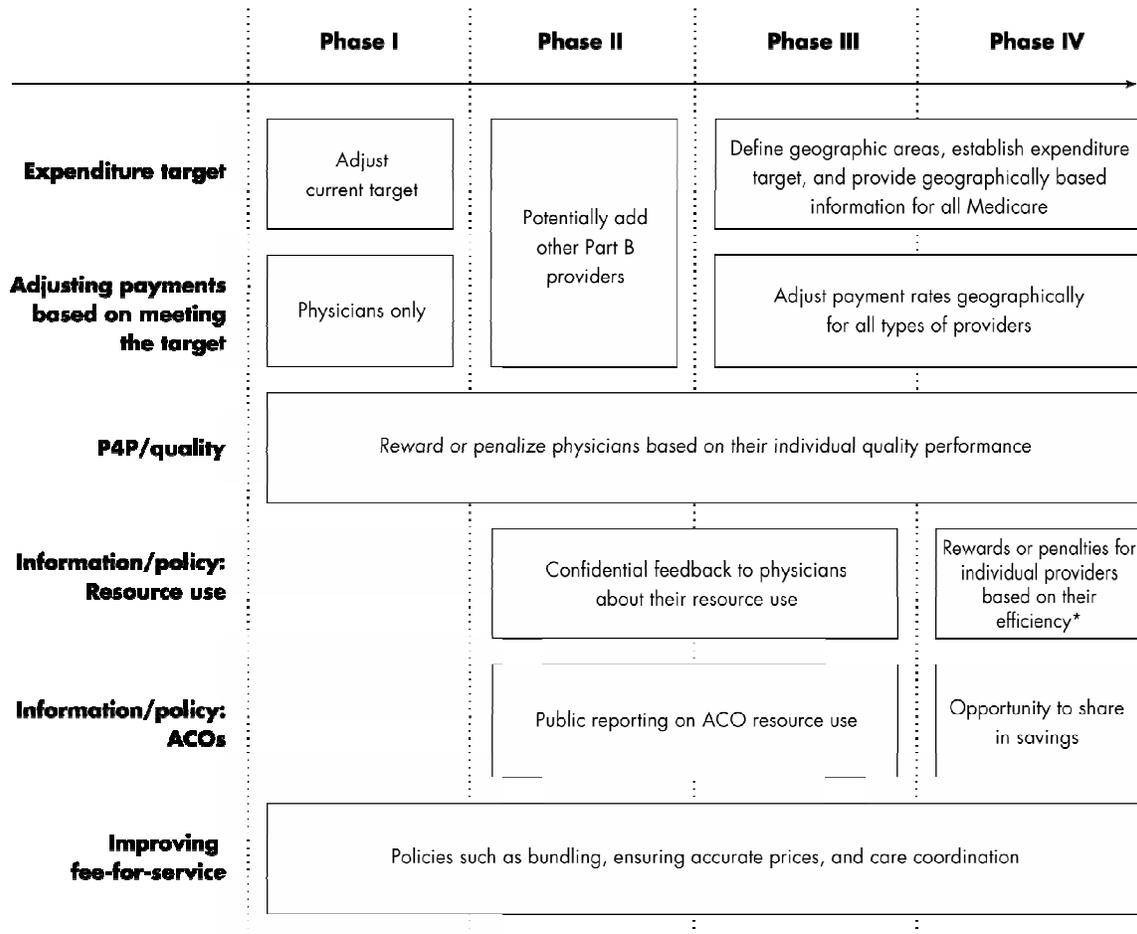
Path 2

The second path would pursue the approaches outlined in path 1 but would also include a new system of expenditure targets (Figure 2). As policymakers grapple with the budgetary consequences of volume and expenditure growth, the presence of an expenditure target may prompt more rapid adoption of the approaches in path 1, since it will put financial pressure on providers to change. If the Congress determines that a target is necessary to ensure restraint on fee increases, the Commission has concluded that such a target should embody the following core principles:

- encompass all of fee-for-service Medicare,
- apply the most pressure in the parts of the country where service use is highest,
- establish opportunities for providers to share savings from improved efficiency,
- reward efficient care in all forms of physician practice organization, and
- provide feedback with the best tools available and in collaboration with private payers.

In keeping with these principles, the expenditure target should not be borne solely by physicians. Rather, it should ultimately be applied to all providers to encourage different providers to work together to keep costs as low as possible while increasing quality. The Congress should also consider applying any expenditure target on a geographic basis, since different parts of the country contribute differentially to volume and expenditure growth. If an expenditure target reflects the limits of what society wants to pay, the greatest pressure should be applied to those areas of the country with the highest per beneficiary costs and the greatest contribution to Medicare expenditure growth.

Figure 2. Timeline for path 2



Note: P4P (pay for performance), ACO (accountable care organization).
 * Providers receive rewards or penalties if they are not part of ACOs.

Geographically adjusted targets, even if applied at the level of metropolitan statistical areas, are still too distant from individual providers to create appropriate incentives for efficiency. Creating proper incentives for improved performance—whether for physicians or other providers—will require much more targeted incentives. Rewards and penalties must be based on the performance of provider groupings that are small enough for the providers to be able to work together to improve. Therefore, within each geographic area, measurement of resource use would show how physicians compare with their peers and would reveal outliers. The comparisons could show the resource use of

individual physicians and of groups of physicians belonging to ACOs, such as integrated delivery systems, multispecialty physician groups, and collaborations of hospitals and physicians. ACOs, in turn, would have to meet eligibility criteria but would then be able to share savings with the program if they furnish care more efficiently than the trend in their area. Episode groupers and per capita measures are tools for measuring resource use, and they could become tools that define payment adjustments for physicians who remain committed to solo or small practice outside the confines of larger organizations.

This expenditure target system would address three goals simultaneously. First, it would address geographic disparities in spending and the volume of services. Second, by departing from the existing national SGR and allowing providers to organize into ACOs, it would improve equity and encourage improvements in the organization of care. Third, providers would receive actionable information to change their practice style.

Improving Medicare's value

Medicare should change payment incentives by:

- *Linking payment to quality by basing a portion of provider payment on performance.* The Commission has found that two types of physician measures are ready to be collected: structural measures associated with information technology (such as whether a physician's office tracks patients' follow-up care) and claims-based process measures, which are available for a broad set of conditions. To implement pay-for-performance, CMS must be given the authority to pay providers differentially based on performance. Such a program should be budget neutral, with monies set aside redistributed to providers who performed as required.
- *Encouraging coordination of care and use of care management processes, especially for chronic care patients.* There are a number of care coordination and care management models Medicare could implement. For example, beneficiaries with chronic conditions could volunteer to see a specific physician or care provider for the complex condition that qualifies them to receive care coordination/care management. That physician would serve as a sort of medical home for the patient. Payment for services to coordinate care would be contingent on negotiated levels of performance in cost savings and quality improvements.
- *Ensuring accurate prices by identifying and correcting mispriced services.* CMS should reduce its reliance on physician specialty societies to identify misvalued services so that overvalued services are not overlooked in the process of revising the physician fee schedule's relative weights. CMS should also update the assumptions it uses to estimate the practice expenses associated with physician services. Further, CMS should initiate reviews of services that have experienced substantial changes in volume, length of stay, site of services, practice expense, or other factors that may indicate changes in physician work.
- *Allowing shared accountability arrangements, including gainsharing, between physicians and hospitals.* Such arrangements might increase the willingness of physicians to collaborate with hospitals to lower costs and improve care.
- *Bundling services.* Bundling puts providers at greater financial risk for the services provided and thus gives them an incentive to furnish and order services judiciously. Candidates for bundling include services typically provided during the same episode of care. Bundling the hospital payment and the physician payment for given DRGs could also increase efficiency and improve coordination of care.
- *Promoting primary care, which can lower costs without compromising quality.* Medicare should create better incentives for providers to furnish primary care (e.g., by ensuring accurate prices for primary care services) and for beneficiaries to seek it (e.g., by changing Medicare's cost sharing structure).
- *Rethinking Medicare's cost-sharing structure and its ability to steer beneficiaries to lower cost and more effective treatment options.*

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Improving Medicare's value (continued)

Medicare should collect and disseminate information by:

- *Measuring physicians' resource use over time and sharing results with physicians.* Physicians would then be able to assess their practice styles, evaluate whether they tend to use more resources than their peers (or what available evidence-based research recommends), and revise their practice styles as appropriate. Once greater confidence with the measurement tool was gained, Medicare could use the results for payments—for example, as a component of a pay-for-performance program that rewards both quality and efficiency. CMS could also use the measurement tool to flag unusual patterns of care that might indicate misuse, fraud, and abuse.
- *Encouraging the development and use of comparative-effectiveness information to help providers and patients determine what constitutes good quality, cost-effective care.* Comparative-effectiveness information could also be used to prioritize pay-for-performance measures, target screening programs, and prioritize disease management initiatives. Given the potential utility of this information to Medicare, and given concerns about the variability in methods and the potential bias of researchers conducting clinical- and cost-effectiveness research, a public-private partnership may be warranted. For example, the federal government could help set priorities for research, while funding could come in part from drug manufacturers, health plans, and pharmacy benefit managers.

Medicare should improve program integrity and provider standards by:

- *Using standards, where appropriate, in physician offices to ensure quality.* MedPAC has recommended that CMS impose quality standards as conditions of payment for imaging services. Other types of services may be candidates for standards as well.
- *Continuing to improve program integrity, capitalizing on the opportunity presented by administrative contractor reform.* Contractor reform may also provide an opportunity for Medicare to enhance its ability to measure performance, improve quality of care, and encourage coordination of care.