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**MEDICARE PAYMENT ADVISORY COMMISSION
RELEASES REPORT ON MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM
*Commission makes recommendations on quality improvement,
payments for ancillary services***

Washington, DC, June 15, 2011—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2011 *Report to the Congress: Medicare and the Health Care Delivery System*. This latest report focuses on some of the key challenges facing the Medicare program today.

This report builds on MedPAC's previous recommendations to change Medicare's payment systems to reward quality and efficiency in the delivery of health care services, instead of rewarding increased volume and intensity. Examples of such payment reforms include making a single payment for larger bundles of health care services and linking payments to quality. According to MedPAC chairman Glenn Hackbarth, "The Commission believes payment reform is a necessary, although not sufficient, condition for reform of the health care delivery system."

In *Medicare and the Health Care Delivery System*, the Commission complements those payment reforms with a set of recommendations to help motivate and support quality improvement among health care providers who treat Medicare patients. These recommendations would fundamentally restructure Medicare's Quality Improvement Organization (QIO) program. In doing so, MedPAC seeks to ensure that providers whose quality of care is lagging receive well-targeted and effective technical assistance.

The Commission also makes a set of recommendations concerning ancillary services, such as diagnostic imaging and other tests. In the last decade, ancillary services have reached high levels of use, fueled at least in part by unduly high payments. These recommendations improve payment accuracy to reduce providers' financial incentives to order more ancillary services, while strengthening clinical support tools to improve appropriate use of these services.

In this report, the Commission examines the sustainable growth rate system (SGR), Medicare's expenditure target system designed to link updates to Medicare's physician fee schedule to service volume. For 2012, the SGR prescribes a 30 percent reduction to physician fee schedule payments, unless Congress intervenes.

The Commission is concerned that the magnitude of this payment reduction, coupled with repeated short-term "fixes" to prevent the cut, undermine provider and beneficiary confidence in Medicare and raise concerns about beneficiaries' access to physician services. The SGR in its current form is unworkable and this report describes a series of policies for further consideration that could collectively replace the SGR, reduce the volume incentives under fee-for-service, and increase Medicare's valuation of primary care.

The report addresses other issues, including:

- ***Medicare's fee-for-service benefit design:*** This chapter reviews the elements of the fee-for-service benefit structure and its impact on beneficiary out-of-pocket spending. The Commission is exploring options to better protect beneficiaries against high out-of-pocket (OOP) spending while at the same time encouraging them to weigh their use of discretionary care without forgoing needed care.
- ***Coordinating the care of dual-eligible beneficiaries:*** The Commission is interested in improving care for dual-eligible beneficiaries, a population whose care is both costly and frequently uncoordinated, resulting in poor outcomes. This chapter describes the characteristics of provider-based and managed care programs that have the potential to integrate and coordinate services provided to their enrollees.
- ***Federally Qualified Health Centers:*** FQHCs are community-based organizations that provide comprehensive primary care and preventive care to persons of all ages, regardless of their ability to pay. This chapter describes their structure, funding, and services, including how FQHCs are paid by Medicare, and their potential role in providing primary care to Medicare beneficiaries.
- ***Variation in private sector payment rates:*** This chapter examines the differences in private sector payment rates for hospital and physician services across and within U.S. markets.

The report can be downloaded from MedPAC's website: http://medpac.gov/documents/Jun11_EntireReport.pdf

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The Medicare Payment Advisory Commission is a Congressional agency that provides independent, non-partisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is to achieve a Medicare program that assures beneficiary access to high-quality care, pays health care providers and health plans fairly, rewarding efficiency and quality, and spends tax dollars responsibly.