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

Report focuses on changing payment system incentives to reward value, not volume

Washington, DC, June 15, 2009—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2009 *Report to the Congress: Improving Incentives in the Medicare Program*. MedPAC's report focuses on how incentives in the Medicare payment systems could be changed to strengthen the Medicare program and promote quality care for Medicare beneficiaries.

“To achieve better care coordination and efficiency, Medicare must change the way it pays health care providers,” said Glenn Hackbarth, chair of the Commission. “Current incentives reward volume instead of value and costly care instead of efficient, effective care. When providers don't work together, quality suffers and costs increase—which benefits neither the patient nor the Medicare program.”

In the report, the Commission discusses several opportunities for modifying incentives to change the way care is delivered in the Medicare program:

- ***Graduate medical education:*** Medicare is the largest financial supporter of graduate medical education. The report reviews medical education and residency training programs and reflects the Commission's discussions of possible ways to use graduate medical education to better support the future needs of the Medicare program by promoting coordinated care, quality improvement, and judicious use of resources.
- ***Accountable care organizations:*** Current incentives in traditional Medicare reward volume and discourage coordination among providers. The report explores how accountable care organizations (ACOs) could promote care coordination and potentially increase quality and lower cost growth.
- ***Physician resource use measurement:*** In 2005, MedPAC recommended that Medicare share information with physicians about the resources they use to provide patient care. The Congress passed legislation directing CMS to begin measuring and reporting physician resource use in 2008. This report describes principles that should guide CMS as it implements this legislation.

The report also presents findings on three additional areas that shed light on the role of incentives—both for providers and beneficiaries—in the Medicare payment system. These include:

- ***Self-referral in imaging:*** Rapid technological progress in diagnostic imaging over the last decade has enabled physicians to more effectively diagnose and treat illness. At the same time, use of and spending on imaging has grown in certain areas of the country, without a clear linkage to higher quality. Findings presented in this report show that when physicians have a financial interest in imaging equipment, they are more likely to order imaging tests and incur higher overall spending on their patients' care.
- ***Follow-on biologics:*** A regulatory pathway for follow-on biologics (FOBs) will be necessary to create price competition among biologic products and the report discusses the policy issues that need to be addressed to establish such a pathway. The report also presents the Commission's perspective on how, as a large payer for pharmaceuticals, Medicare may need to change in order to extract greater value from its spending on biologics, while ensuring appropriate clinical use and patient safety.
- ***Benefit design in traditional Medicare:*** Medicare's significant cost-sharing requirements and its lack of catastrophic protection have been important catalysts behind the widespread use of supplemental coverage. Yet coverage that fills in most or all of Medicare's cost sharing can lead to higher use of services and Medicare spending, frequently without corresponding gains in quality of care. The report reflects the Commission's discussion of traditional Medicare benefit design, and whether cost sharing can be used as a tool for increasing the value of care while ensuring beneficiary access to needed services.

This report also fulfills two of the Commission's mandated reports to the Congress, both required by the Medicare Improvement for Patients and Providers Act of 2008:

- ***Medicare Advantage payments:*** MedPAC reports on different approaches to reforming Medicare Advantage payment. Under the current system, in 2009 Medicare is paying about \$12 billion more for the beneficiaries enrolled in MA plans than it would have spent if they were in FFS Medicare. The report discusses options that encourage efficient plans and reward quality.
- ***Chronic care management:*** The report describes the current the state of Medicare's demonstration research on care management for beneficiaries with chronic conditions, including the impacts of these care management programs on quality and costs in Medicare. MedPAC found that although managing chronic conditions is crucial to constraining costs, and that many such programs have shown improvements in quality, attempts to produce cost savings have been less successful. The report discusses strategies that may enable the Medicare program to accomplish this cost saving goal more effectively.

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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.