

**Report to the Congress • June 2009**  
***Improving Incentives in the Medicare Program***

The Medicare Payment Advisory Commission (MedPAC) envisions a strong Medicare program in which beneficiaries have access to high-quality health care, providers are paid equitably to efficiently supply health care services, and taxpayers' dollars are spent responsibly. To achieve this, the Commission works to shape Medicare payment policies that reward health care value rather than volume, encourage coordination among and across providers, and constrain cost growth.

As required by law, each June MedPAC submits a report to the Congress that examines issues affecting the Medicare program, health care delivery in the U.S., and the market for health care services on the Medicare program. In addition, the Commission reviews the preliminary estimate of the following year's payment update for physician services.

In our June 2009 report, the Commission discusses a number of issues and challenges for Medicare payment and delivery system reform. The issues range broadly but focus on how incentives in the current Medicare payment systems could be changed to reward value, not volume. The following are summaries of the eight chapters and appendix:

**Graduate medical education.** Medicare is the largest financial supporter of graduate medical education. Despite this spending, a number of reports and articles have expressed concern that our health professionals are not learning certain skills necessary to work optimally in delivery systems that focus on care coordination, quality, or judicious resource use.

- In a study of internal medicine residency programs, the Commission found that formal curricula are not well aligned with the objectives of delivery system reform. Of particular concern is the relative lack of formal training and experience in multidisciplinary teamwork, cost awareness in clinical decision making, comprehensive health information technology, and patient care in ambulatory settings.
- Residency experience in nonhospital and community-based settings is important because most of the medical conditions that practicing physicians confront should be managed in nonhospital settings. However, inherent financial incentives and Medicare regulations strongly encourage teaching hospitals to confine their residents' learning experiences to within the hospital.

**Accountable care organizations.** Current incentives in traditional Medicare reward volume and do not encourage coordination among providers. The chapter explores how accountable care organizations (ACOs) have the potential to promote care coordination, increase quality, and lower cost growth.

- The Commission defines an ACO as a set of providers held responsible for the quality and cost of health care for a population of Medicare beneficiaries. An ACO could consist of primary care physicians, specialists, and at least one hospital. It could be formed from an integrated delivery system, a physician-hospital organization, or an academic medical center.
- If the ACO achieves both quality and cost targets, its members could receive a bonus. If it fails to meet both quality and cost targets, its members could face lower Medicare payments. Ideally, these financial incentives would lead the ACO to judiciously constrain the use of health care services and capacity in contrast to the incentive in the fee-for-service (FFS) payment systems to always increase the volume of services.
- The chapter discusses two variations on the ACO model, one in which providers volunteer to form an ACO and one in which participation is mandatory. In a voluntary, bonus-only ACO model, FFS rates throughout the program would be restrained in order to fund the bonuses for those providers undertaking the difficult tasks of organizing care and changing practice patterns.

**Physician resource use measurement.** In 2005, the Commission recommended that Medicare measure physician resource use and share the results with physicians in a confidential manner to address variation in physician practice patterns and Medicare's unsustainable rate of spending growth. The Congress directed CMS to implement such a program and CMS has begun a phased implementation.

- In this chapter, the Commission proposes several policy principles to guide Medicare's physician resource use measurement program. These principles include ensuring that physicians are able to actively modify their behavior on the basis of the feedback provided, risk adjusting clinical data to ensure fair comparisons among physicians, obtaining feedback from the physician community, and adopting a methodology that is transparent to all physicians.
- The chapter also examines several technical aspects of measuring physician resource use. We find a high degree of stability in the measurements of physicians' resource use over time, suggesting that outlier physicians can be identified consistently across years.
- The Commission also finds that various methods for attributing episodes to physicians have both advantages and drawbacks, suggesting that Medicare may want to consider more than one attribution method when its physician resource use measurement program is fully implemented in the future.

**Impact of physician self-referral on use of imaging services within an episode.** 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 without a clear linkage to higher quality.

- This chapter expands upon earlier research by analyzing whether physician self-referral is related to higher use of imaging by type of clinical episode. Controlling for all other factors, self-referral episodes had higher use of imaging than non-self-referral episodes.
- We also investigated whether greater use of imaging within an episode is associated with higher or lower total episode spending, since some studies suggest that use of imaging can save money by preventing expensive interventions. Although in specific cases imaging may substitute for other services, our findings suggest that greater use of imaging is associated with greater overall resource use during an episode for the 13 types of episodes we examined (adjusting for patient severity and other factors).

**Medicare payment systems and follow-on biologics (FOBs).** Medicare spending on biologics was about \$13 billion in 2007. The top six biologics account for 43 percent of spending on separately billed drugs in Medicare Part B. Biologics account for a relatively small—but rapidly growing—share of Part D spending. Medicare spending on biologics is substantial and is expected to grow significantly. The establishment of a process to approve FOBs is necessary to promote price competition and has spending implications for Medicare.

- The chapter summarizes key issues that are being discussed as policymakers and stakeholders consider the potential establishment of a regulatory pathway for FOBs. While the FDA would have jurisdiction over approval of FOBs, Medicare as a large payer for biologics has a strong incentive to ensure that it gets value for the money it spends on these products.
- The chapter also discusses coding and payment strategies that could be pursued to ensure that Medicare Part B realizes the maximum benefit from competition between FOBs and innovator biologics. The Part D benefit may also need to be restructured to take advantage of the potential savings offered by FOBs. While Medicare Part D should achieve savings on FOBs for older biologics, the current benefit structure is likely to limit savings for newer products.

**Improving traditional Medicare's benefit design.** 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 and prevents cost sharing from being used as a policy tool.

- Research commissioned by MedPAC examines more closely the impact of supplemental coverage on Medicare spending and finds that spending for beneficiaries with supplemental insurance is significantly higher than for those without such coverage.
- The Commission also finds that beneficiary spending for premiums and cost sharing varies as a function of supplemental coverage.

- Beneficiaries with high health care costs and no supplemental coverage generally spend a larger share of their incomes on health care than those with supplemental coverage.
- In the future, cost sharing may be used as a tool to complement various policy goals such as: improving financial protection for Medicare beneficiaries and distributing cost-sharing liability more equitably among individuals with differing levels of health care costs, encouraging use of high-value services and discouraging use of low-value ones, and reinforcing payment system reforms that seek better value for health care expenditures.

**Medicare Advantage payment.** As mandated by the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008, the Commission reports on different approaches to reforming the Medicare Advantage (MA) program. Under the current payment 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. Options are discussed that encourage efficient plans and reward quality.

- The chapter presents analysis of four options for setting MA payment benchmarks administratively—all financially neutral to FFS Medicare in the first year. For example, one option would set the benchmark using a blend of local and national spending levels. Another would use local input prices to determine county benchmarks. For each scenario, the chapter offers insight into the options' first year impact on availability of plans by type and quality and the level of extra benefits.
- The Commission also discusses an approach to setting benchmarks through competitive bidding. The chapter presents the fundamental decisions that would have to be made when designing a competitive bidding system and outlines some possible ways that plans might respond.

**Improving Medicare chronic care demonstration programs.** The Congress and CMS have initiated a number of demonstration and pilot programs to test different approaches to improve care coordination for Medicare beneficiaries. The Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 required MedPAC to evaluate feasibility and advisability of establishing a Medicare Chronic Care Practice Research Network (MCCPRN) for testing new models of care coordination and other approaches to care for chronically ill patients.

- The Commission reviewed results of CMS demonstrations and found some modest gains in quality, but no real cost savings (and indeed some increases in spending).
- The chapter reviews a specific proposal from a group of 12 organizations called the Medicare Chronic Care Practice Research Network. The network would be financed by Medicare and its purpose would be to develop, implement, and evaluate the effects of evidence-based chronic care interventions. The Commission expresses concerns about the specific MCCPRN proposal, but shares the goal the proposal attempts to address—to find innovative ways to change the misaligned cost and quality incentives in the health care delivery system.
- The results of our review also suggest larger issues with the structure and funding of research and development in Medicare. Funding levels for Medicare research activities are low relative to the overall size of the program, CMS often has constraints on redirecting research funding as program needs and priorities shift, and administrative process requirements are time-consuming.

**Review of CMS's preliminary estimate of the physician update for 2010.** In CMS's annual letter to the Commission on the update for physician services, the agency's preliminary estimate of the 2010 update is a reduction of 21.5 percent. The reduction is a combination of three factors.

- The first factor is the Medicare Economic Index, which CMS is estimating to be 1.0 percent.
- The second factor is the expiration of temporary bonuses enacted over several years; this factor will not change. (The bonuses were overrides of negative payment updates for 2007, 2008, and 2009 under the sustainable growth rate formula.)
- The third factor is the update adjustment of -7.0 percent for 2010. We have analyzed CMS's calculations and have concluded that these factors are unlikely to change significantly before the publication of the final rule, and thus conclude that CMS's preliminary estimate of -21.5 percent, is accurate.