MEDPAC Medicare Payment Advisory Commission

TESTIMONY

Report to the Congress: Medicare and the Health Care Delivery System

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Statement of

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Before the
Subcommittee on Health
Committee on Ways and Means
U.S. House of Representatives

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Chairman Herger, Ranking Member Stark, distinguished Subcommittee 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 MedPAC's June Report to the Congress and our recent recommendations on Medicare payment policy.

The Medicare Payment Advisory Commission is a Congressional agency that provides independent, nonpartisan 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, rewarding efficiency and quality; and spends tax dollars responsibly. As part of its mandate from the Congress, each June the Commission reports on issues affecting the Medicare program, including changes in health care delivery in the U.S. and the market for health care services. In this year's report, we examine several issues central to beneficiaries' experience of the Medicare program. While much of the Commission's work focuses on providers and their payment incentives, how beneficiaries view the Medicare program and how they make decisions about their health care are vital to the program's success. Aligning incentives for beneficiaries and providers and the design of the program has the potential to improve health, to improve the experience of health care provided through Medicare, and to control costs for the beneficiary and the taxpayer alike. In our June report we review:

- The design of the fee-for-service (FFS) Medicare benefit package, which has remained essentially unchanged for Part A and Part B since the creation of the program in 1965. We recommend creating an out-of-pocket maximum cost-sharing amount to protect beneficiaries against high medical expenses; replacing coinsurance with fixed-dollar copayments; giving the Secretary authority to adjust cost sharing according to the value of the service; and including a charge on supplemental insurance to account, in part, for the additional cost supplemental coverage imposes on Medicare.

- Care for beneficiaries in rural areas of the United States, including access to care for rural beneficiaries, the quality of the care they receive, special rural payments, and the adequacy of payments for rural providers. We also develop and bring forward several principles to help formulate and guide rural policies in the future.

- Improving care coordination for beneficiaries dually eligible for Medicare and Medicaid, a population that may benefit the most from improved care coordination, including recommendations to make the Program of All-Inclusive Care for the Elderly (PACE) program more effective and available. We also discuss issues involving forthcoming demonstrations to integrate Medicare and Medicaid's care for the dual-eligible population, including subgroups of dual-eligibles with special needs.

- Risk adjustment for Medicare payments to Medicare Advantage (MA) plans. Accurate risk adjustment is essential to pay plans correctly. Although not a central issue for beneficiaries themselves, risk adjustment can create incentives for MA plans to select beneficiaries with certain characteristics because a plan's financial performance will be determined by the mix of beneficiaries it enrolls.

- An assessment of care coordination for beneficiaries in FFS Medicare with an emphasis on the results of past Medicare care coordination demonstration projects and a review of new models.

- Medicare's payment for home infusion. We examine issues related to Medicare payment for infusion of drugs in the beneficiary's home and the circumstances under which enhanced coverage could better meet the beneficiary's needs and save money for the program.

In an appendix, as required by law, we review CMS's preliminary estimate of the update to payments under the physician fee schedule for 2013.

Reforming Medicare's benefit design

Medicare's FFS benefit package under Part A and Part B has remained substantially unchanged since 1965. During that time, insurance products in the private sector have undergone numerous changes, medical technology has evolved radically, and Medicare payment systems have changed as well. Because Medicare FFS prices and the amount of services beneficiaries receive have grown dramatically, some beneficiaries may now incur very large cost-sharing liability (i.e., medical bills remaining after Medicare has paid its share). The fact that no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur under the current benefit design is thus a great concern. Although the chance of a beneficiary

experiencing catastrophic liability in any one year may be relatively low, as shown in Table 1, the probability of a beneficiary experiencing very high liability increases over multiple years. For example, while only 6 percent of beneficiaries would see $5,000 or more in annual cost sharing liability in any one year, 13 percent could expect to see that much liability in any one of four years.

Table 1. More beneficiaries would be better off with an out-of-pocket maximum over time

Fee-for-service beneficiaries who had:	2009	2006–2009
1 or more hospitalizations	19%	46%
2 or more hospitalizations	7	19
$5,000 or more annual cost sharing liability	6	13
$10,000 or more annual cost sharing liability	2	4

Source: MedPAC analysis based on data from CMS.

In part due to the limitations of the FFS benefit design, about 90 percent of FFS beneficiaries receive supplemental coverage through medigap, employer-sponsored retiree plans or Medicaid. This additional coverage protects beneficiaries from unlimited out-of-pocket (OOP) spending, but it also reduces their incentives to weigh decisions about the use of care because many supplemental plans cover all or nearly all of Medicare's cost-sharing requirements. Moreover, most of the costs of the resulting increased utilization are borne by the Medicare program. As a matter of equity among beneficiaries and fiscal sustainability, Medicare should recover at least some of those additional costs.

The Commission recommends reforming the traditional benefit package so that it would:

- Protect beneficiaries better against high and unpredictable OOP spending by including an OOP cap and substituting fixed copayments for coinsurance that varies with the price of a service. The OOP cap would also increase equity among beneficiaries by giving all beneficiaries protection against catastrophic expenses. Now only those who can afford to purchase supplemental insurance (or receive it through an employer or Medicaid) have this essential protection.

- Not increase average beneficiary cost-sharing liability, nor reduce the actuarial value of the Medicare benefit package to achieve these beneficiary protections.

- Give the Secretary flexibility to change cost-sharing rules, which would provide a way to recognize that services can be of different and changing value to the program and its beneficiaries. Current law makes it difficult to change Medicare's benefit design as our health care system evolves. Congress would retain ultimate control over the benefit package and its design.

To pay for the increased protection in this design while keeping average beneficiary liability unchanged, we included an additional charge on supplemental insurance (we have excluded MA plans—because the MA plan, not Medicare, is at risk for benefit designs that increase costs relative to their capitation payments—and Medicaid; thus the charge is only on medigap or employer-sponsored retiree plans). That charge funds the OOP cap and is designed to recover some of the cost of the increased utilization resulting from supplemental insurance that is now borne by the program. Beneficiaries who now have supplemental insurance would have the option of retaining it and paying the additional charge, choosing a less expensive plan, or dropping supplemental insurance entirely. The latter options would be more attractive than they were previously because of the increased protection in the reformed Medicare benefit. They would also have the additional salutary effect of creating stronger incentives for beneficiaries to make better decisions about their use of discretionary care. Beneficiaries would also continue to have the option of joining an MA plan.

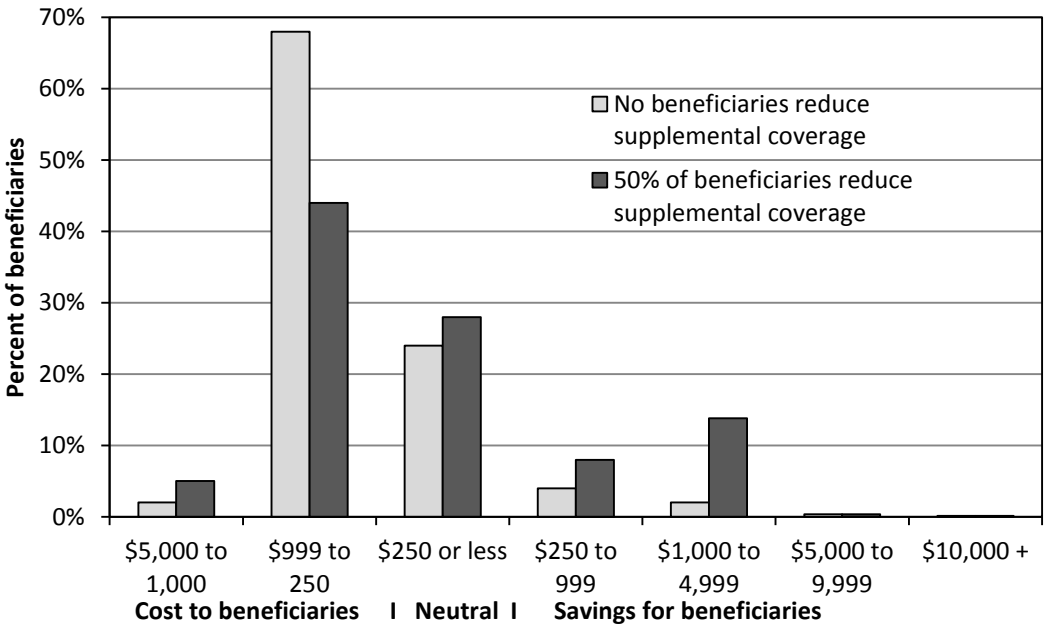
Some have proposed prohibiting first dollar coverage in supplemental policies, which would require beneficiaries to pay a copayment or coinsurance for every service they receive. However, the Commission believes that such an unwieldy regulatory approach may unduly limit beneficiary choice; we believe that risk-averse beneficiaries should be allowed to purchase supplemental insurance, but at a price that better reflects the increased costs to Medicare induced by such insurance.

In the report, for illustration, we demonstrate how a benefit design meeting those goals could result in a cap on beneficiaries' OOP liability while leaving the average cost-sharing liability of beneficiaries unchanged. The illustrative design incorporates a $5,000 per year OOP maximum

and a schedule of copayments including $20 for a primary care visit and $40 for a specialist visit. It includes an additional charge of 20 percent on supplemental insurance, which yields modest net savings to Medicare under the reformed benefit package. The specific amount of savings depends on how many beneficiaries choose to scale back or no longer purchase supplemental insurance.

The analysis that follows helps illustrate how beneficiaries under different circumstances might fare under a reformed benefit design. In Figure 1 we look at two scenarios. In the first scenario (the light colored bars) no beneficiaries decide to reduce supplemental coverage. Many would see an increase in combined OOP costs and supplemental premiums because of the 20 percent additional charge, with almost 70 percent seeing additional costs of $250 or more. For just over 20 percent the change would be about neutral with savings or costs of $250 or less. Few would see savings.

Figure 1. More beneficiaries would see savings as they reduce supplemental coverage



Source: MedPAC based on CMS data.

In the second scenario (the dark bars), half of the beneficiaries are assumed to reduce supplemental coverage because of the greater protection against unpredictable OOP costs. Fewer beneficiaries than in the first scenario see higher costs (for example, the percentage with additional costs of $250 to $999 declines from about 70 percent to just over 40 percent) and more would see savings, with over 20 percent seeing savings of $250 or more.

There would be more beneficiaries seeing significant savings because many would no longer be paying supplemental premiums (the percentage with savings between $1,000 and $4,999 increases from 2 percent to almost 14 percent) and some would see very large savings because of the OOP maximum. It is important to note that premiums for supplemental insurance exceed the expected value of supplemental benefits. Beneficiaries are willing to pay these premiums because they are risk averse and value the additional insurance protection. The illustrative benefit package would provide a sense of security by protecting against unpredictable OOP costs and some beneficiaries would reduce supplemental coverage. Those beneficiaries would very likely see savings as a result. Figure 1 is limited to one year of data. More beneficiaries would be likely to see savings over multiple years, because, as shown in Table 1, more beneficiaries are exposed to the risk of a catastrophic expense over a longer period of time.

Under this illustrative benefit design, some beneficiaries will see an increase in their OOP costs. This increase funds the catastrophic protections for beneficiaries with expenses exceeding $5,000 and keeps the average beneficiary's financial liability unchanged.

We have simulated the effects of the particular design outlined in the report to illustrate how a reformed benefit design could work. Because of the many tradeoffs and considerations in any benefit design, we are not recommending a particular detailed design. Rather, the Commission recommends that the Congress should direct the Secretary to develop and implement a FFS benefit design that would replace the current design and would include:

- an OOP maximum;
- deductible(s) for Part A and Part B services;
- replacing coinsurance with copayments that may vary by type of service and provider;
- Secretarial authority to alter or eliminate cost sharing based on the evidence of the value of services, including cost sharing after the beneficiary has reached the OOP maximum;

- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on individually purchased and employer-provided supplemental insurance.

Serving rural Medicare beneficiaries

The Patient Protection and Affordable Care Act of 2010 required that the Commission report to the Congress on:

- rural Medicare beneficiaries' access to care,
- quality of care delivered by rural providers,
- special rural Medicare payments, and
- the adequacy of Medicare payments to rural providers.

In addition to the findings presented on each of those four topics, we also present a set of principles that are designed to guide expectations and policies with respect to rural access, quality, and payments. By following this set of principles, Medicare policy can be refined to more efficiently provide access to high-quality care for rural beneficiaries.

Methods

We realize that there is great diversity in rural America and tailored our data collection and analysis to address that. We used multiple sources for our data, including:

- Beneficiary focus groups, site visits to providers in rural areas, meetings with associations representing rural beneficiaries and providers, and input from our own Commissioners with extensive experience as rural providers and/or serving rural Medicare beneficiaries,
- Beneficiary survey data, including the Commission's national telephone survey,
- Examination and analysis of claims data to evaluate beneficiaries' service use and certain outcomes (such as mortality and readmissions), and
- Examination and analysis of cost report data to evaluate providers' costs and the profitability of serving Medicare beneficiaries.

In the analysis, where possible, we subdivide rural areas into categories based on proximity to urban areas and population:

- Metropolitan (urban)

- Rural micropolitan: counties with a city of 10,000 to 50,000 people
- Rural adjacent: counties without a town of 10,000 or more people that are adjacent to urban areas
- Rural nonadjacent: counties that are not adjacent to an urban area and do not have a town of 10,000 or more people
- Frontier: counties with a population density of six or fewer people per square mile. (The Commission makes this distinction where possible.)

These detailed analyses are available in our June report.

Access

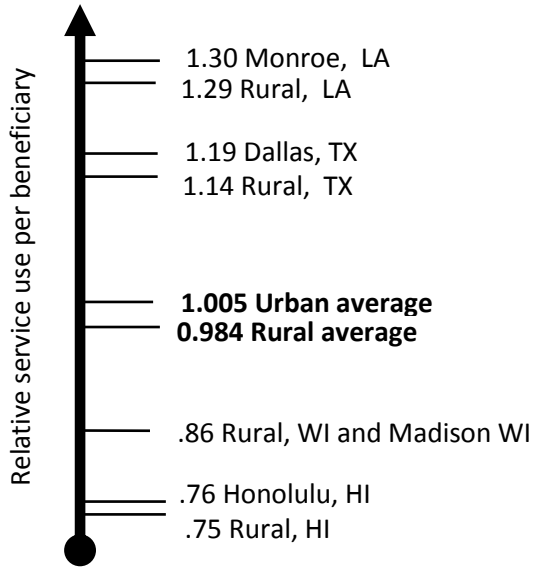
When evaluating access, we focus on beneficiary-centered indicators rather than provider-centered ones. These indicators include patient claims data, beneficiary surveys, and beneficiary focus groups.

Looking at utilization of health care services, we find that despite lower physician-to-population ratios and difficulties of recruiting physicians to practice in rural areas, beneficiaries in urban and rural areas used comparable amounts of health care in every service we examined and across the spectrum of rural areas (from those adjacent to urban areas to those in sparsely populated frontier counties). For example, beneficiaries in urban areas have about 10.1 office or outpatient visits per year, and beneficiaries in the five categories of rural areas have between 10.7 and 9.8. Similarly, they experience very similar rates of hospital admissions, averaging from 0.31 to 0.35 per year in the five rural areas and 0.33 in urban areas. This might seem counterintuitive given that there is a lower ratio of physicians to beneficiaries in rural areas than in urban areas. However, rural beneficiaries travel for care and obtain about 30 percent of their care in urban areas. As a result they have somewhat longer travel times. One study found that 41 percent of rural residents traveled more than 30 minutes for medical care, compared with 25 percent for urban residents.

Although we find very similar use of health care services across the urban and rural spectrum at the national level, there are significant differences in health care service use by Medicare beneficiaries across regions of the country. However, there is little difference between rural and urban beneficiaries' service use within those regions. In Figure 2, we see that at the national level service use in urban areas relative to the national average is 1.005 and in rural areas 0.984, a very

small difference. However there are large differences between regions of the country, ranging from 0.76 to 1.30 relative to the national average in urban areas. Looking at regions where service use is high, such as Louisiana, service use is high for both urban beneficiaries (1.30) and for rural beneficiaries (1.29). Similarly, in low-use regions such as Hawaii, service use is low for urban beneficiaries (0.76) and also for rural beneficiaries (0.75).

Figure 2. Urban and rural service use is similar within states, but wide regional variation exists



Source: MedPAC analysis of beneficiary-level Medicare spending from the Beneficiary Annual Summary File and Medicare inpatient claims data.

Beneficiaries in rural and urban areas also report similar levels of satisfaction with access to care, even if some rural beneficiaries have to travel outside their area to obtain care. In Table 2, we display several measures of patient experience. The results are very similar across all of these measures in both urban and rural areas with slight differences. For example, slightly fewer urban beneficiaries (78 percent) report no problem getting a new primary care physician than rural beneficiaries (83 percent), while the reverse is true for specialists.

Table 2. Urban and rural satisfaction with access is similar

Selected patient experience questions	Urban	Rural
Never experience unwanted delay in getting an appointment		
• For routine care	76%	72%
• For illness or injury	83	83
No problem getting a new physician		
• Primary care	78	83
• Specialist	88	85
Rate their hospital highly	67	67
Rate their hospital poorly	9	8
Definitely would recommend hospital	70	67
Definitely would not recommend hospital	6	5

Source: MedPAC telephone survey conducted from May to September 2010 on physician access and MedPAC analysis of Hospital Consumer Assessment of Healthcare Providers and Systems data, accessed July 2011.

We find the volume of care is comparable with and without adjustments for health status. Notwithstanding, some are concerned that rural populations have a significantly greater illness burden than urban populations that is not detected by Medicare claims data. However, we see no clear evidence that rural Medicare beneficiaries are older, are sicker, or consistently live in communities with greater levels of poverty. For example, rural beneficiaries' self-reported indicators of health are not consistently lower or higher than those in urban counties, as indicated by limitations in activities of daily living (ADLs), self-reported health, and several clinical conditions. Although some rural areas tend to have poor and sick populations (looking across Medicare beneficiaries and others), differences in health status and wealth appear to differ far more among regions of the country than across the rural/urban continuum.

Considering these findings, the Commission has determined this ***principle for access: All beneficiaries, whether rural or urban, should have equitable access to health care services. However, equitable access does not necessarily mean equal travel times for all services or that all services are available locally.***

Beneficiaries in small rural communities often have to travel farther to see specialists because there are too few local residents to support some specialties, but that does not mean they do not have access to those services. We evaluate whether beneficiaries have equitable access by

examining the volume of services received, as well as beneficiaries' reported satisfaction with access to all services.

Quality

With respect to quality of care, we do not find major differences in quality between urban and rural providers in most sectors. Patient satisfaction is similar, and quality measures for skilled nursing facilities, home health agencies, and outpatient dialysis facilities do not show major differences between urban and rural providers or across the rural spectrum. For example, the average rate of potentially avoidable hospitalizations from skilled nursing facilities is 19 percent in urban areas and the same or lower in rural areas. Similarly, hospital readmission measures do not point to major differences based on rural or urban location. However, we do find that rural hospitals do not perform as well as urban hospitals on most process measures and on condition-specific 30-day mortality rates—consistent with long-standing findings in the literature—even after adjusting for the effect of low-volume.

We have determined the following ***principles for quality: Quality metrics should be reported by even the smallest providers. Expectations for quality of care in rural and urban areas should be equal for nonemergency services rural providers choose to deliver. By contrast, emergency services may be subject to different quality standards to account for different levels of staff, patient volume, and technology between urban and rural health care providers.***

When measuring the quality of emergency care, for example, low-volume rural hospitals' performance on quality of emergency care could be compared to the average for other small hospitals, rather than the average for all hospitals. Alternatively, a small hospital's quality outcomes for emergency care could be compared to the expected outcomes if that hospital no longer offered emergency care and patients had to travel longer distances for emergency services.

Payment

With respect to payment, we find that in general the adequacy of FFS payments to rural providers does not differ systematically or significantly from the adequacy of urban providers' payments. On average, freestanding rural skilled nursing facilities and home health agencies have margins for Medicare patients similar to those of urban providers, with some rural and

urban agencies having relatively high margins. When we examined the adequacy of physician payments, we found similar service use rates, similar ability to obtain appointments with existing and new physicians, and similar satisfaction with access. These indirect indicators suggest that payments to rural physicians are at least as adequate as those made to urban physicians. In addition, physician incomes per hour are comparable in rural and urban areas. However, the Commission has raised concerns about the adequacy of payments to primary care physicians relative to payments to subspecialists—concerns that apply to physicians in both rural and urban areas. A greater share of physicians in rural areas are primary care physicians.

Medicare payments are as adequate for rural hospitals as for urban hospitals, in part due to implementation of certain increases in rural hospital payments that followed from previous Commission recommendations. As a result, the number of rural hospital closures has declined dramatically in recent years. However, when we look at the current array of rural payment adjusters through our analytic framework, we find some problems. For example, the critical access hospital program has grown to more than 1,300 hospitals, and 16 percent of them are less than 15 miles from the nearest hospital. The low-volume adjustment (originally designed to take into account a hospital's total volume because that is what determines economies of scale) is now based only on the number of Medicare admissions, and thus perversely favors hospitals with larger non-Medicare shares. Looking at these and other examples, the Commission has determined the following ***principles for special payments:***

- ***Payments should be targeted toward low-volume isolated providers—that is, providers that have low patient volume and are at a distance from other providers.***

- ***The magnitude of special rural payment adjustments should be empirically justified. That is, the payments should increase to the extent that factors beyond the providers' control increase their costs.***

- ***Rural payment adjustments should be designed in ways that encourage cost control on the part of providers.***

Care coordination programs for dual-eligible beneficiaries

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits and, given the medical complexity of some sub-populations, could particularly benefit from improved care coordination. In 2010, there were approximately 9.9 million dual-eligible beneficiaries—accounting for about 18 percent of Medicare FFS enrollment and 31 percent of Medicare FFS spending. They also account for about 15 percent of Medicaid enrollment and 40 percent of Medicaid spending. These individuals are often high cost; require a mix of medical, long-term care, behavioral health, and social services; and have more limited financial resources than the general Medicare population. Programs that help dual-eligible beneficiaries access and coordinate services could improve their quality of care and may have the potential to reduce Medicare and Medicaid spending.

We reviewed the two main integrated care programs for dual-eligible beneficiaries—PACE and dual-eligible special needs plans (D–SNPs)—and examined the structure of their care coordination models, quality outcomes, and Medicare payments. We also examined a set of demonstration programs in development by the states and CMS.

PACE is a provider-based integrated care program structured around day care centers, which serve about 21,000 beneficiaries this year. PACE makes it possible for frail beneficiaries to remain in the community, and there is evidence that the program improves the quality of care relative to FFS. We also found that: PACE sites operate on a small scale, enrollment in the PACE program is generally slow, PACE providers reported that they were able to reach positive margins after a few years of operation, and Medicare spending on PACE exceeds FFS spending for similar beneficiaries. PACE payments are based on the MA payment rates in force before enactment of the Patient Protection and Affordable Care Act of 2010; those rates are significantly higher than current law MA benchmarks, which govern payment for D–SNPs.

To make the PACE program accessible to more beneficiaries and to pay more accurately, the Commission recommends that the Congress should direct the Secretary to improve the MA risk-adjustment system. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay PACE providers based on the current MA payment system for setting

benchmarks and quality bonuses. These changes should occur no later than 2015. After these changes are made:

- the Congress should change the age eligibility criteria for PACE to allow nursing home–certifiable Medicare beneficiaries under the age of 55 to enroll, and

- the Secretary should provide prorated Medicare capitation payments to PACE providers for partial-month enrollees and establish an outlier protection policy for new PACE sites to use during the first three years of their programs.

In addition, the Congress should direct the Secretary to publish select quality measures on PACE providers and develop appropriate quality measures to enable PACE providers to participate in the MA quality bonus program by 2015.

In contrast to the provider-based PACE program, D–SNPs are managed care plans that focus their enrollment on dual-eligible beneficiaries. D–SNPs enrolled about 1.16 million beneficiaries for plan year 2012. Some have state contracts to cover all of a state's Medicaid benefits, including long-term care, and some do not. We were not able to conclude whether D–SNPs provide better quality of care than FFS or other MA plans because of a lack of available quality data. Using the measures that are available for D–SNPs, we found that their quality of care is generally mixed. We found that plan bids for Medicare Part A and Part B services and Medicare spending on D–SNPs both exceed FFS spending, which raises the question of whether these plans can provide Part A and Part B services at a cost that is equal to or below FFS.

CMS is in the process of working with states to promote the development of integrated care demonstration programs. CMS has offered states the opportunity to test a capitated model or a managed FFS model. As the demonstrations are developed, a number of issues must be addressed:

- Is the scale of the demonstration in some states too large? Will the size of the demonstrations leave adequate comparison groups, and is there an orderly process for disenrollment if the demonstration fails?

- Are there plans with the requisite experience and capacity to handle the large scale of the demonstration?

- How will beneficiaries be matched to care delivery organizations that are appropriate to meet their needs under passive enrollment models, and can an opt-out enrollment policy be structured to accommodate beneficiaries with cognitive and other limitations?

The Commission's greatest concern is that all dual-eligible beneficiaries in a state will be enrolled in the demonstration—in effect, a program change rather than a demonstration. The Commission will continue to consider this and other concerns as we move forward.

Issues for risk adjustment in Medicare Advantage

Health plans that participate in the MA program receive monthly capitated payments for each Medicare enrollee. Each capitated payment is the product of: a base rate, which reflects the payment if an MA enrollee has the health status of the national average beneficiary, and a risk score, which indicates how costly the enrollee is expected to be relative to the national average beneficiary. If Medicare's risk-adjustment for MA systematically favors the selection of beneficiaries with less complex conditions over others, it could create incentives for plans to design their benefit packages and focus their marketing to preferentially attract those beneficiaries. Alternatively, if a plan's care delivery strategy focuses on patients who require the most complex care, such as those enrolled in D–SNPs, it could be disadvantaged. We examined the performance of the risk-adjustment system in the MA program and offer alternatives for improving its performance.

CMS uses the CMS–hierarchical condition category (CMS–HCC) model to risk-adjust each MA payment. This model uses enrollees' demographics and medical conditions collected into 70 HCCs to predict their costliness. It is a much better predictor of a beneficiary's costliness than the demographic-based model that preceded it. The demographic model explained only about 1 percent of the variation in costliness among individual beneficiaries, whereas the CMS–HCC model explains about 11 percent—about half of the variation predictable from past spending.

Nonetheless, systematic payment inaccuracies remain. For example, for all beneficiaries who have the same condition, the CMS–HCC model adjusts MA payments by the same proportion.

But disease severity can vary across beneficiaries with a given condition, and those with greater severity tend to be more costly. Therefore, for a given condition it is possible that plans can be financially advantaged or disadvantaged based on the disease severity of their enrollees.

Not only can systematic payment inaccuracies in the CMS–HCC result in opportunities for favorable selection in the MA program, plans that focus on high-risk populations, such as SNPs and PACE, may be adversely affected. If high-risk populations—such as those who have many conditions—are systematically underpaid, then plans specializing in high-risk populations will be at a financial disadvantage.

We explored several policy options for reducing these errors. We found that:

- Including beneficiaries' race and measures of income does not improve payment accuracy.
- Including the number of medical conditions a beneficiary has in the model improves payment accuracy.
- Using two years of diagnoses to identify beneficiaries' conditions improves payment accuracy for high-risk beneficiaries (but to a lesser extent than adding the number of conditions) and also reduces year-to-year fluctuations in beneficiaries' risk scores—which would result in more stable revenue streams for MA plans.
- Adding the number of conditions and two years of diagnosis data to the model results in more accurate payments and smaller year-to-year fluctuations in beneficiaries' risk scores.

Care coordination in fee-for-service Medicare

The lack of care coordination in the health care delivery system can negatively impact patients. Negative outcomes include unnecessarily repeated medical histories and tests, inconsistent medical instructions, poor transitions between sites of care, and unnecessary use of higher intensity settings. Gaps exist in care coordination because of the fragmentation of service delivery, the lack of tools to easily communicate across settings and providers, and the lack of a financial incentive to coordinate care. These gaps are particularly important for Medicare

beneficiaries because they are more likely to have multiple chronic conditions than younger patients and thus more involvement with the health care system.

Findings from recent Medicare demonstrations on care coordination and disease management models have not shown systematic improvements in beneficiary outcomes or reductions in Medicare spending. Despite those findings, many health care providers and researchers still see significant potential for care coordination programs to improve care. The most successful model in the Medicare demonstrations emphasized restructuring systems to support a care coordination intervention. This finding supports the conclusion that successful care coordination cannot be a "plug-in module" but must be an integral part of the system providing the care.

Ideally, as more integrated payment and delivery systems evolve, the incentives for greater care coordination inherent in such systems will develop as well, leading to greater care coordination. However, in the interim, additional methods for encouraging care coordination may need to be pursued, including those that make explicit payments for related services to primary care clinicians—the linchpin of more coordinated care and eventual system redesign.

Policy options to improve care coordination in the current FFS system could include creating a per beneficiary payment for care coordination, adding codes or modifying existing codes in the fee schedule that would allow practitioners to bill for selected care coordination activities, and using payment policy to reward or penalize outcomes resulting from coordinated or fragmented care.

Medicare coverage of and payment for home infusion therapy

The Congress requested the Commission to conduct a study on home infusion therapy. Home infusion involves the intravenous administration of drugs to an individual at home. Home infusion involves several components (drugs, supplies, equipment, and nursing). Medicare FFS covers some or all components of home infusion, depending on the circumstances, with total program spending of about $1 billion in 2009. The Commission was asked to assess the benefits and costs associated with providing infusions in the home versus alternative settings, including whether savings could be achieved from broader Medicare coverage of home infusion. In addition, the Commission was asked to examine sources of data that could be used for setting

home infusion payment rates, coverage and payment for home infusion by commercial insurers and MA plans, and potential abuse of a home infusion benefit.

We found that the most common payment method used by private health plans included a payment for drugs; a separate payment for nursing as needed; and a per diem amount covering supplies, equipment, pharmacy services, and additional services. Providers we interviewed described a wide range of payment levels for per diem services. All plans use utilization management techniques, particularly prior authorization, to ensure that home infusion is provided appropriately.

Whether home infusion yields Medicare savings or costs for an individual beneficiary depends on the setting where the beneficiary otherwise would have received infusions, how payments compare between infusion in the home and the alternative setting, how frequently the drug is infused, and how often home nurse visits are needed. Some opportunities likely exist to achieve savings for beneficiaries who would otherwise be admitted to skilled nursing facilities for the sole purpose of receiving infusions; savings from moving infusions from other sectors to the home may also be possible under certain circumstances. Home infusion would likely cost the program more if a beneficiary moved from receiving infusions in an outpatient department and required a nurse at the home for all infusions.

For expanded home infusion coverage to realize overall savings for Medicare, any savings from shifting infusion to the home would need to exceed the additional costs to Medicare of home infusion services and supplies, or those that would otherwise have been paid by other insurers or beneficiaries. The cost implications of broader home infusion coverage vary by drug. Thus, a targeted expansion of home infusion coverage focusing on a subset of drugs would have a greater likelihood of savings than a broad expansion. However, we cannot draw conclusions about net savings or costs with the data currently available.

Collecting the data needed for constructing a home infusion payment system would be difficult. Current data on the cost associated with providing home infusion services are very limited; options for additional data might include Medicare payment rates for similar services—such as the rate for a home health visit—or information gleaned from competitive bidding. Alternatively,

the feasibility of obtaining data on providers' acquisition costs or manufacturers' sales prices for equipment and supplies could be explored.

In the report, we discuss two approaches for increasing access to home infusion: filling in the gaps in current coverage and setting up a demonstration project for beneficiaries who need infused antibiotics. In general, Medicare has had less ability to monitor care provided in the home than in facility settings and it has been more difficult to create payment systems with incentives for appropriate utilization. While private payers have not reported fraud to be a problem in the home infusion industry, a broad, unmanaged expansion of Medicare FFS coverage could lead to fraudulent actors entering the field. To ensure appropriate utilization of such a benefit, management controls such as prior authorization would likely be needed. The demonstration project could test Medicare's ability to administer a targeted prior authorization policy designed to improve quality of care and reduce costs. A successful program in the specific context of home infusion could be expanded to other candidate components of FFS Medicare.