MEDPAC Medicare Payment Advisory Commission

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MEDICARE PAYMENT ADVISORY COMMISSION RELEASES REPORT ON MEDICARE AND THE HEALTH CARE DELIVERY SYSTEM

Commission makes recommendations on improving the Medicare benefit

Washington, DC, June 15, 2012—Today the Medicare Payment Advisory Commission (MedPAC) releases its June 2012 *Report to the Congress: Medicare and the Health Care Delivery System.*

In this report, the Commission focuses particular attention on the role of the individuals who receive the Medicare benefit. While much of the Commission's work has focused on providers and their payment incentives, how beneficiaries view the Medicare benefit and how they make decisions about their health care are both vital to the program's success.

According to Commission Chair Glenn Hackbarth, "Aligning the beneficiary, the provider, and 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."

This focus on the beneficiary is highlighted in three chapters: (1) reforming Medicare's benefit design, (2) care coordination in fee-for-service Medicare, and (3) care coordination programs for dual-eligible beneficiaries.

Medicare's benefit design. The fee-for-service (FFS) Medicare benefit package has remained essentially unchanged since the creation of the program in 1965. In this report, the Commission recommends reforms to Medicare's benefit design to give beneficiaries better protection against high out-of-pocket spending and to create incentives for them to make better decisions about their use of discretionary care. The package of reforms would include a cap on beneficiary out-of-pocket spending, a deductible, and a schedule of copayments for services to allow beneficiaries to anticipate their costs for the medical care they receive. Taken together, these changes would keep aggregate beneficiary financial liability the same.

To be informed consumers, Medicare beneficiaries need accurate price signals to understand the services and products they are buying in Medicare. Currently, beneficiaries who choose supplemental plans to cover cost sharing do not face the real cost of such plans; they pay a premium for the policy, but its price does not reflect the costs of the additional medical services that individuals with supplemental coverage tend to use. To address this issue, the Commission recommends placing an additional charge on Medicare supplemental plans. If beneficiaries preferred to avoid the higher costs of supplemental plans, they could choose either to switch to a different plan or to forgo a supplemental policy—which may be a more viable option once the FFS benefit package is enriched.

Care coordination. Under the current Medicare program, beneficiaries with significant care needs often face gaps in care or poor outcomes due to lack of care coordination. In FFS, where services are paid on a piece-meal basis, this is particularly true. To explore possibilities to improve care coordination in FFS, the Commission provides an assessment of different care coordination models, with an emphasis on the results of past Medicare care coordination demonstration projects and a review of promising new models.

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. The most successful program in the Medicare demonstrations emphasized developing a care coordination intervention, as well as restructuring providers' administrative and care delivery processes so that they would work well around the intervention. Restructuring the way care is provided may be necessary to achieve good care coordination, but such restructuring is difficult in a FFS environment.

Beneficiaries receiving both Medicare and Medicaid. Individuals eligible for both Medicare and Medicaid represent a diverse group of beneficiaries—some aged, some disabled, and allwith a variety of care needs. In general, these individuals 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 have the potential to reduce Medicare and Medicaid spending.

In this report, the Commission looks at the two main programs designed to integrate care for dual-eligible beneficiaries—the Program of All-Inclusive Care for the Elderly (PACE) and dual-eligible special needs plans (D–SNPs)—and examines the structure of their care coordination models, quality outcomes, and Medicare payments. The Commission makes a set of recommendations for changes to the Medicare program to improve the PACE program and remove barriers to greater enrollment.

The report also includes two chapters that fulfill Congressional mandates:

- 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.

- Medicare's payment for home infusion. As requested by the Congress, we examine issues related to Medicare payment for infusion of drugs in the beneficiary's home and the circumstances under which enhanced coverage could benefit the beneficiary and the program.

These chapters and others are included in the full report, which can be downloaded from MedPAC's website: http://medpac.gov/documents/Jun12_EntireReport.pdf

The two congressionally mandated reports are described in further detail in separate fact sheets, posted on MedPAC's website.

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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, rewards efficiency and quality, and spends tax dollars responsibly.