

## Report to the Congress: Medicare and the Health Care Delivery System - June 2012

The Commission's June 2012 report to the Congress focuses particular attention on the role of the Medicare beneficiary. The report includes chapters about Medicare's benefit design, care coordination in fee-for-service (FFS) Medicare, improving care for beneficiaries receiving both Medicare and Medicaid, and issues for risk adjustment in Medicare Advantage (MA).

The report also includes two congressionally mandated reports concerning Medicare in rural areas and home infusion therapy. Each of these reports has its own dedicated fact sheet available on the MedPAC [website](#). Finally, an appendix of the report reviews CMS's preliminary estimate of the 2013 update for physician and other health professional services.

### REFORMING MEDICARE'S BENEFIT DESIGN

- Medicare's benefit package under FFS has remained substantially unchanged since 1965.
- For several years, the Commission has been considering ways to reform the traditional benefit package so that it gives beneficiaries better protection against high out-of-pocket (OOP) spending and greater clarity on their OOP liability.
- Building flexibility into the design of the benefit is essential given the rapid evolution of the health care system. Allowing the Secretary to initiate changes in cost sharing as services become more or less valuable given new evidence and technological advances will allow the program to continually incentivize beneficiaries to make personal, value-based decisions about their care.
- About 90 percent of FFS beneficiaries receive supplemental coverage through medigap, employer-sponsored retiree plans, or Medicaid. While this additional coverage protects beneficiaries from unchecked OOP spending, it also reduces beneficiaries' incentives to weigh their decisions about use of discretionary services. The resulting increased utilization drives up costs to the Medicare program and to beneficiaries through higher premiums.

### Recommendation

The Congress should direct the Secretary to develop and implement a fee-for-service benefit design that would replace the current design and would include:

- an out-of-pocket 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 out-of-pocket maximum;
- no change in beneficiaries' aggregate cost-sharing liability; and
- an additional charge on supplemental insurance.

### CARE COORDINATION IN FEE-FOR-SERVICE MEDICARE

- Poor coordination of a patient's care can result in repeat testing, inconsistent medical instructions, poor transitions between sites of care, and unnecessary use of higher intensity services and settings.

- Gaps in care coordination exist because of the fragmentation of service delivery, a lack of tools to easily communicate across settings or providers, and a lack of financial incentive to coordinate. These gaps are particularly significant for the Medicare population because they are more likely to have multiple chronic conditions and to be participants in the health care system.
- Models to improve care coordination include physician practice transformation models to better deliver chronic care, care manager models, and models focusing on facilitating transitions between settings. A robust and well-supported primary care system is the linchpin of any care coordination model.
- 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. Many 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 care coordination intervention.
  - The approaches most likely to achieve significant improvement in care coordination are those that: create incentives to provide better, rather than more, care; give organizations the flexibility to use the best tools for their population; and support, facilitate, and permit innovation that will improve care for beneficiaries.
- Broad payment reforms, such as bundling and accountable care organizations, hold promise to improve care coordination but will likely take time to achieve major change. Interim steps may be necessary to improve care coordination and provide explicit payments for the related activities that primary care clinicians do but that are not currently paid for under the FFS system. These steps may 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 care coordination activities, or
  - using payment policy to reward or penalize outcomes resulting from coordinated or fragmented care.

## **CARE COORDINATION PROGRAMS FOR DUAL-ELIGIBLE BENEFICIARIES**

- Beneficiaries eligible for both Medicare and Medicaid, or dual-eligible beneficiaries, could particularly benefit from care coordination. These individuals are 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.
- CMS is working with states to test a capitated or a managed FFS model under an integrated care demonstration program. As these demonstrations develop, the Commission has a number of questions:
  - Is the scale of the demonstrations in some states too large? Will there be adequate comparison groups to determine the success of the demonstration? The Commission is particularly concerned that all dual-eligible beneficiaries in a state will be enrolled in the demonstration—in effect, a program change rather than a demonstration.
  - Are there plans with the requisite experience and capacity to handle the 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?
  - What plan standards will be required, considering that passive enrollment with opt-out could be construed as a restriction on freedom of choice?
- The Commission reviewed approaches to improve the care of dual-eligible beneficiaries, including dual-eligible special needs plans (D-SNPs) and the Program of All-Inclusive Care for the Elderly (PACE) model.
- D-SNPs are managed care plans that focus their enrollment on dual-eligible beneficiaries.

- *Quality*: Quality of care under D–SNPs is mixed. Due to lack of available quality data, we were unable to conclude whether D–SNPs provide better quality of care than FFS or other Medicare Advantage (MA) plans.
- *Bids and spending*: Bids for Medicare Part A and B services and Medicare spending on D–SNPs both exceed FFS spending.
- PACE is a provider-based integrated care program structured around a day care center. Most PACE sites operate on a small scale, and enrollment in PACE is generally slow. The Commission made a number of recommendations to increase enrollment in the PACE program and to revise payments to PACE providers.
  - *Quality*: Evidence suggests that the PACE program improves quality of care relative to FFS.
  - *Spending*: Medicare spending on PACE exceeds FFS spending for similar beneficiaries. PACE payments are based on MA payment rates in force prior to enactment of the Patient Protection and Affordable Care Act (PPACA) of 2010. Those rates are significantly higher than current law MA benchmarks.

## Recommendations

- Recommendation 1: The Congress should direct the Secretary to improve the Medicare Advantage (MA) risk-adjustment system to more accurately predict risk across all MA enrollees. Using the revised risk-adjustment system, the Congress should direct the Secretary to pay PACE providers based on the MA payment system for setting benchmarks and quality bonuses. These changes should occur no later than 2015.
- Recommendation 2: After the changes in Recommendation 1 take effect, the Congress should change the age eligibility criteria for PACE to allow nursing home–certifiable Medicare beneficiaries under the age of 55 to enroll.
- Recommendation 3: After the changes in Recommendation 1 take effect, the Secretary should provide prorated Medicare capitation payments to PACE providers for partial-month enrollees.
- Recommendation 4: After the changes in Recommendation 1 take effect, the Secretary should establish an outlier protection policy for new PACE sites to use during the first three years of their programs to help defray the exceptionally high acute care costs for Medicare beneficiaries.

The Secretary should establish the outlier payment caps so that the costs of all of this chapter’s recommendations do not exceed the savings achieved by the changes in Recommendation 1.

- Recommendation 5: 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.

## ISSUES FOR RISK ADJUSTMENT IN MEDICARE ADVANTAGE

- Health plans in the MA program receive a capitated payment for each of their Medicare enrollees equal to a base rate times a risk score. The risk score indicates how costly an enrollee is expected to be relative to the national average beneficiary.
- CMS uses the hierarchical condition category (CMS–HCC) model to risk-adjust each MA payment. The model uses demographics and medical conditions to predict a beneficiary’s costliness.
- An analysis of the CMS risk adjustment mechanism reveals systematic payment inaccuracies. For example, the model does not account for disease severity. Beneficiaries who have the same condition will have the same risk score, even though enrollees with a higher degree of disease severity will be more costly.
- For a given condition it is possible that plans can be financially advantaged or disadvantaged based on the disease severity of their enrollees.

- If the risk adjustment systematically favors the selection of some beneficiaries over others, it could create incentives for plans to design their benefit packages and focus their marketing to preferentially attract those beneficiaries.
- Likewise, 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.
- The Commission explored several methodological options to reduce these systematic errors and found:
  - 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 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 both 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.

#### **MANDATED REPORTS: SERVING RURAL BENEFICIARIES AND HOME INFUSION THERAPY**

Please see the separate fact sheets for MedPAC's reports on serving rural Medicare beneficiaries and home infusion therapy.