Executive summary

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As part of its mandate from the Congress, each June the Commission reports on Medicare payment systems and on issues affecting the Medicare program, including changes in health care delivery and the market for health care services. In this report, we examine several issues central to the 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 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. In the first four chapters of this report we consider:

- The design of the fee-for-service (FFS) Medicare benefit package, which has remained essentially unchanged 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, reforming other aspects of the package, and including a charge on supplemental insurance to account, in part, for the additional cost supplemental coverage imposes on Medicare.
- Care coordination for beneficiaries in FFS Medicare with an emphasis on the results of past Medicare care coordination demonstration projects and a review of promising new models. Near-term methods to encourage care coordination within the current FFS system—such as explicit payments for related services to primary care clinicians—may need to be pursued until more integrated payment and delivery systems evolve.
- 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) more effective and more widely 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 invisible to beneficiaries, risk adjustment can dictate their desirability to MA plans because the mix of beneficiaries a plan enrolls can help determine the plan's financial performance.

We also include in-depth reports on two congressionally mandated topics:

- 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. 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 benefit package under FFS 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. Over the years, Medicare FFS prices and the amount of services beneficiaries receive have grown dramatically; as a result, some beneficiaries may now incur very large cost-sharing liability because under the current benefit design no upper limit exists on the amount of Medicare cost-sharing expenses a beneficiary can incur. 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 creates incentives for them to make better decisions about their use of discretionary care.

In part due to the gaps in coverage in 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 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 recoup at least some of those additional costs.

Current law makes it difficult to change Medicare's benefit design as our health care system evolves. Although the practice of medicine and medical technology change rapidly, fairly rigid statutory parameters give Medicare's program managers little flexibility to change its benefit design in response, even as other insurers change their benefit packages. Giving the Secretary some flexibility to change cost-sharing rules, within budget-neutrality parameters established by the Congress, would provide at least some way to recognize that services can be of different and changing value to the program and its beneficiaries.

Therefore, in Chapter 1, we recommend 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.

For illustration, we demonstrate how one such design could result in a cap on beneficiaries' OOP liability while leaving the cost-sharing liability of all beneficiaries taken together unchanged. It includes an additional charge on supplemental insurance (designed to recover some of the cost of the increased utilization borne by the program) and would yield modest savings to Medicare. However, we are not recommending a particular detailed design but rather that the Secretary develop one that adheres to the above principles.

Care coordination in fee-for-service Medicare

In Chapter 2, we consider care coordination in FFS Medicare. Poor care coordination can result in beneficiaries having to repeat medical histories and tests and receiving 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.

Care coordination programs for dual-eligible beneficiaries

Dual-eligible beneficiaries are eligible for both Medicare and Medicaid benefits and are a population that 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 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 have the potential to reduce Medicare and Medicaid spending.

In Chapter 3, we look at the two main integrated care programs for dual-eligible beneficiaries—PACE and dual-eligible special needs plans (D–SNPs)—and examine the structure of their care coordination models, quality outcomes, and Medicare payments. We also examine 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 in 2012. 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 most PACE sites operate on a small scale, that enrollment in the PACE program is generally slow, that most PACE providers were able to reach positive margins after a few years of operation, and that 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 to more accurately predict risk across all MA enrollees, which would make payments more appropriately reflect the costs of the population PACE programs enroll (see Chapter 4 for an analysis of 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 in 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?
- 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'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 the risk-adjustment system 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, it could be disadvantaged. In Chapter 4, we examine 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 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 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. We compared the costliness in 2007 of those who enrolled in an MA plan in 2008 (joiners) and those who stayed in FFS Medicare in 2008 (stayers). We found that within nearly all the disease categories in the CMS–HCC, the joiners were less costly than the stayers, meaning that MA enrollees are systematically lower cost than their FFS counterparts, even though the aggregate HCC risk score for all MA plans is about equal to the aggregate risk score for FFS Medicare.

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 a beneficiary's medical conditions 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.

Serving rural Medicare beneficiaries

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

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

In Chapter 5, in addition to the findings presented on each of those four topics, we present a set of principles that are designed to guide expectations and policies with respect to rural access, quality, and payments. By consistently following this set of principles, Medicare policy can be refined to more efficiently provide access to high-quality care for rural beneficiaries.

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). We find significant differences in health care service use by Medicare beneficiaries across regions of the country but little difference between rural and urban beneficiaries' service use within those regions. Rural service use is high in regions where urban use is high, and rural service use is low in regions where urban use is low. In Texas and Louisiana, for example, where service use is high for urban beneficiaries, it is also high for rural beneficiaries. Similarly, in Minnesota and Hawaii, where service use is low for urban beneficiaries, it is also low for rural beneficiaries.

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. 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. 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 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. Whether access is equitable and results in beneficiaries receiving equal services can be evaluated by examining the volume of services received as well as beneficiaries' reported satisfaction with access to all services.

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. Similarly, hospital readmission measures do not point to major differences based on rural or urban location. However, we do find that rural hospitals continue to 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.

We have determined the following principles for quality: 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 areas. Quality metrics should be reported by even the smallest hospitals, and all hospitals should be expected to practice evidence-based medicine.

The relevant quality benchmark for emergency care should be other small hospitals or the expected outcomes if the small rural hospital no longer offers emergency care and patients must travel farther for emergency services.

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.

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, some rural special payments have been enacted that go beyond the Commission's recommendations, and some of those special payments are not consistent with the set of payment principles we establish below:

- 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.

Medicare coverage of and payment for home infusion therapy

The Congress requested the Commission to conduct a study on home infusion therapy; we report our findings in Chapter 6. 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.

For expanded home infusion coverage to realize overall savings for Medicare, any net savings from shifting infusion to the home would need to exceed the additional costs to Medicare of home infusion services that would otherwise have been paid by other insurers or beneficiaries and more beneficiaries using intravenous drugs instead of other therapies. 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 more 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 is very limited; options for additional data might include Medicare payment rates for similar services or competitive bidding. Alternatively, the feasibility of obtaining data on providers' acquisition costs or manufacturers' sales prices for equipment and supplies could be explored.

In Chapter 6, 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.

Review of CMS's preliminary estimate of the 2013 update for physician and other professional services

In CMS's annual letter to the Commission on the calculation of the proposed update for physician and other professional services, the agency's preliminary estimate of the 2013 update is –27.0 percent. The prescribed reduction is due to a series of temporary increases enacted over several years that—under current law—expire at the end of 2012. Those increases prevented a series of negative updates under the sustainable growth rate (SGR) formula—the statutory formula for annually updating Medicare's payment rates for physician and other health professional services. If the temporary increases expire, the physician fee schedule's conversion factor must decrease by 27.5 percent. The SGR formula's update—specific to 2013—of 0.7 percent would then be applied to the reduced conversion factor yielding the estimated update of –27.0 percent.

In the appendix, we provide the Commission's mandated technical review of CMS's estimate. We find that CMS's calculations are correct and that—absent a change in law—the expiration of the temporary increases and the formula's update for 2013 are very unlikely to produce an update that differs substantially from –27.0 percent. The temporary increases—by far, the largest factor influencing the payment reduction—were specified in law. The estimate of the SGR formula's update of 0.7 percent for 2013 could change between now and when CMS would implement the update in January, but any such changes are likely to be small compared with the total reduction prescribed by law.

While the appendix is limited to technical issues, the Commission has concerns about the SGR formula as a payment policy. The SGR may have resulted in lower updates, but it has failed to restrain volume growth and, in fact, for some specialties may have exacerbated it. In addition, the temporary increases, or "fixes," to override the SGR are undermining the credibility of Medicare by engendering uncertainty and frustration among providers, which may be causing anxiety among beneficiaries. In an October 2011 letter to the Congress, the Commission recommended repealing the SGR and replacing it with specified updates that would no longer be based on an expenditure-control formula. These updates would include a 10-year freeze in current payment levels for primary care where potential access problems are most readily apparent and, for all other services, annual payment reductions of 5.9 percent for 3 years, followed by a freeze for the remainder of the 10-year window. ■