Medicare Adopts More Medical Management Tools to Improve Patient Health

To improve consumers' experience with their coverage and care, health insurance providers in the commercial market work with doctors, nurses, and patients to find ways to make care more efficient, effective, and affordable. Medical management helps us deliver on that promise. Examples of medical management tools include: evidence-based medical necessity/medical appropriateness reviews; tiered formulary and provider network designs; prior authorization and concurrent review; step therapy; and quantity and dosing limits. These tools are increasingly being relied upon by government-sponsored health care programs like Medicare.

PATIENT CARE SHOULD BE BASED ON PROVEN EVIDENCE

- Significant gaps have long existed between evidence-based practices and care being delivered to patients.[1]
- 65% of physicians reported that at least 15-30% of care is unnecessary.[2]
- Needless medical tests waste billions of dollars every year – between $760-$935 billion is wasted annually on excessive testing and treatment, accounting for approximately 25% of total health care spending.[3]
- Medicare fee-for-service beneficiaries receive a significant amount of "low-value" care, with conservative estimates of cost ranging from $2.4-$6.5 billion per year.[4]

EXAMPLES OF HOW MEDICAL MANAGEMENT PROMOTES SMART PATIENT CARE

- Promoting opioid prescribing consistent with federal recommendations to prevent addiction and abuse.
- Protecting patients from unnecessary exposure to potentially harmful radiation from inappropriate diagnostic imaging, such as CT scans for headaches.
- Encouraging the use of equally effective, more affordable generic medications.
- Promoting care delivered by high value, experienced providers and facilities, such as centers of excellence.
- Supporting use of medications for approved indications where there is evidence of safe and appropriate use.

1 Crossing the Quality Chasm: A New Health System for the 21st Century. Institute of Medicine, Committee on Quality of Health Care in America. Academy Press, 2001 and To Err is Human: Building a Safer Health System. Institute of Medicine. Committee on Quality of Health Care in America. National Academy Press, 1999.
2 Overtreatment in the United States. Lyu H, et al. PLOS One. Sept. 6, 2017
3 Waste in the U.S. Health Care System: Estimated Costs and Potential for Savings. Shrank, WH, et al. JAMA. 2019; 322(15): 1501-1509.
4 Report to the Congress: Medicare and the Health Care Delivery System. MedPAC. June 2018

EXAMPLES OF HOW MEDICARE PROGRAM VALUES MEDICAL MANAGEMENT

- Traditional Medicare fee-for-service uses a "reasonable and necessary" standard when deciding to cover a service or item.
- Traditional Medicare has used prior authorization since 2017 for certain durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) that are frequently subject to unnecessary utilization.
- Traditional Medicare has also implemented a number of prior authorization demonstration programs for specific services. A recent GAO report recommended that Medicare continue prior authorization efforts to reduce spending, estimating that savings from prior authorization demonstrations through March 2017 could be as high as $1.1 to 1.9 billion.[5]
- Medicare's prior authorization demonstrations include repetitive, scheduled non-emergent ambulance transports; non-emergent hyperbaric oxygen therapy; home health services; and power mobility devices. CMS recently announced plans to expand the non-emergent ambulance prior authorization demonstration across the country.[6]
- Traditional Medicare is also in the process of implementing an evidence-based guideline and prior authorization program for advanced diagnostic imaging.
- For the Medicare Part D program, CMS recently codified its policy allowing Medicare Advantage plans to use step therapy for Part B drugs.[7]
- In 2020, CMS added a prior authorization requirement in the traditional Medicare program for certain outpatient department services that are primarily cosmetic and recently expanded those services to include additional services where there has been an unnecessary increase in volume.[8]

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5 CMS Should Take Actions to Continue Prior Authorization Efforts to Reduce Spending. Government Accountability Office (GAO). April 2018.
6 CMS to Expand Successful Ambulance Program Integrity Payment Model Nationwide. September 22, 2020.
7 Modernizing Part D and Medicare Advantage to Lower Drug Prices and Reduce Out-of-Pocket Expenses (84 FR 23832, 5/23/19)
8 Hospital Outpatient Prospective Payment Final Rule for CY2021 (85 FR 85866, 12/29/20)