

The Medicare Program
An Instrument for Change

Prepared by:

Bostrom

and

Old Creekside Consulting

Prepared on Behalf of

THE PHYSICIANS FOUNDATION

Physicians Committed to a Better Health Care System for All Americans

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The Medicare Program

An Instrument for Change


The Physicians Foundation’s mission is to help educate physicians on the important systemic changes that impact upon the private practice of medicine. In this report, we examine the Medicare program as a recent *instrument* of systemic reform, and then consider reforms that might be ahead for the Medicare program, itself. In so doing, we consider implications for physicians and the larger health care system.

CHAPTER I > **The Medicare Program: An Instrument for Change**—We open with a brief examination of two themes. First, we introduce the concept of the Medicare program as an instrument for reforms in the health care system. A summary of past major legislative actions affecting the Medicare program highlights the continual reshaping of the program in its nearly 50 years of existence.

Second, we discuss the allure of competition as a future means to foster efficiencies in Medicare. We suggest more neutral terminology that may better capture the distinction between the administration of traditional Medicare and proposals that would rely exclusively upon competing health plans to provide Medicare benefits. We highlight the Patient Protection and Affordable Care Act (ACA) plan competition model, and the confused (and confusing) political party cross-signals over private plan competition. Why is it good sometimes and not others—for both parties?

Specifically for physicians, we highlight emerging issues on Medicare billing data releases, site-neutral payment policy recommendations and a new Inspector General’s report on evaluation and management codes. In addition, we highlight a new release from

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the Medicare Payment Advisory Commission concerning how Medicare risk-adjustment methods' inaccuracies affect equity among Medicare Advantage plans, Fee-For-Service Medicare and Accountable Care Organizations. These issues have potential implications for physician payment and practice models.

CHAPTER II > A Primer on Medicare's Origins and Current Characteristics—To set the stage for reform discussions, we visit the Social Security Administration's historical archives to bring readers a *brief* history of the Medicare program's origins and its private health insurance building blocks. We touch on the early role of organized medicine and an alternative plan advocated by the American Medical Association, and characterize the program that was enacted instead. An awareness of Medicare's history is indeed surprisingly interesting and relevant to consideration of the program's future.

We highlight the Centers for Medicare and Medicaid Services' (CMS's) many responsibilities today and provide a current organizational chart. We examine the sheer scale and centrality of Medicare contracting to operation of the program, and the evolving roles of private health plans in supporting the Medicare program from its inception. This extends to all current Medicare models: traditional, Part C-Medicare Advantage and Part D-drug benefit plans. We prepared an abstract of recent General Accountability Office testimony on major contracting changes occurring in traditional Medicare today—it's a different form of competition and accountability.

The second part of Chapter II provides what we think are essential data, mainly in chart form, to be aware of in considering Medicare's future.


These data focus on the larger parameters of the program and beneficiary characteristics, including education and income levels, health services utilization, disability prevalence and end-of-life care. These realities are especially important to consider in crafting not just a cost-effective, but a practical and humanely structured Medicare program for the future.

CHAPTER III > An Update on Medicare as an Instrument of Health Care Reform—In Chapter III, we take a brief look at key interventions in Medicare over the years and leading into the ACA. (The latter were covered at length in the Physicians Foundation's first ACA-related report titled *A Roadmap to Health Care Reform*, released in May 2012, and tracked in several subsequent reports.)

Separately, we invite attention to the recently updated CMS Strategic Plan, which provides striking insight into how the Agency perceives its role in reforming the U.S. health care system. We also detail the broad policy reach of the Agency in the public and private sectors, and provide a personal author's note on the culture of the Agency.

For physicians, we focus on important new developments such as the recent, major, physician billing data release and recommendations to the Congress for site-neutral payments for select medical services.

CHAPTER IV > Looking to the Future—Medicare Modernization and Competition—In our closing chapter, we first summarize the major elements of the Medicare Advantage and Part D plan contracting models functioning in Medicare



today, both of which are voluntary enrollment models. Then we look “around the corner” and consider total replacement of today’s direct federal administration of the traditional Medicare program and Parts C and D, by a single “supervised private plan administration” model in which private health plans compete within a federal framework to provide coverage and benefits to the *entire* Medicare population.

The key switch is to a compulsory private plan enrollment model in Medicare. Is that feasible given the characteristics of the Medicare population? We ask whether this is a de facto “Medicare Exchange” concept (raised by economist Alice Rivlin and colleagues in 2011) and ask “What If?” That is, what if the basic plan competition and marketplace design elements of the ACA prove to be successful and adaptable to Medicare? What might be different? What changes might such an approach imply, and what basic issues must be addressed to help decide such a strategy?

In closing, we trust you will find this report to be informative and thought provoking as we consider what the future of Medicare might hold. As always, **The Physicians Foundation** thanks you for your time and attention.



Chapter I

The Medicare Program—An Instrument for Change

Part I: Introduction

Overview—In this report, the Physicians Foundation is pleased to provide an examination of two broad themes of reform with respect to the Medicare program. The first relates to Medicare as a channel or instrument for changes policymakers seek in the organization, delivery, quality and cost of services rendered to patients system-wide. The Patient Protection and Affordable Care Act of 2010 (ACA) is a major recent example of provisions added to Medicare that have an impact on the broader health system.

The second relates to current and future reforms in the benefit design and administration of Medicare, itself. These are linked—due to Medicare’s size and economic power, changes to Medicare’s benefits and the means by which the benefits are administered reverberate throughout the nation’s health care system.

We need to establish terms and clear distinctions right up front. By benefits, we refer to the structure of the benefit package itself: defined benefits, covered services, premiums,

copays, and other standard parameters of any health insurance plan.

By administration, we refer to “direct federal administration,” i.e. traditional Medicare, as compared to “supervised private plan administration,” as occurs under the Medicare Advantage and Part D drug benefit programs today. Under the latter two models, private plans bid to provide benefits in Medicare, and assume program responsibilities and financial risk, all under federal supervision. Over the last fifteen years, numerous organizations and individuals have proposed restructuring Medicare by relying upon competing private plans to deliver all benefits to all beneficiaries. The term “premium support” has become familiar, but we find it has been degraded as though it meant an abdication of federal responsibilities toward Medicare and its beneficiaries.

While not advocating one model over another, we think it is useful to dial-down the temperature in order to have a more careful consideration of the real issues facing Medicare’s sustainability in the future. We suggest more neutral

terminology that reflects what such models fundamentally are—a different policy and contracting approach for delivering Medicare benefits to beneficiaries, and one that could and should be properly shaped and supervised by the federal government. We examine the scale and centrality of contracting for administration of the Medicare program in all its incarnations throughout this report.

CMS: The Nation's Largest Health Insurer—In carrying out this select review of near-term reforms, and reforms in the future, we take a close look at the Centers for Medicare and Medicaid Services (CMS), its history, responsibilities, strategic plan, organization, and critically important contracting roles used to support the traditional Medicare program, and separately, the competition models under Part C and Part D of Medicare.

The future of Medicare reform is inextricably linked to the nuts and bolts of how benefits get delivered to beneficiaries, and to the authorities granted to the federal government to carry out these enormous tasks. Medicare support operations across the entire Medicare benefit spectrum (Parts A, B, C, and D) are largely performed not by federal employees, but by private contractors. Private contractors not only must carry out Medicare program regulations, as applicable, but also must comply with federal contracting requirements and policies. It is difficult to overstate how important flexible, highly competitive, performance-based contracting authorities are to Medicare's future. We find this to be a critical, yet rarely analyzed or discussed feature of reform discussions in the past.

Lest contracting tools sound distinctly unexciting, consider the following synopsis from the General Accountability Office.

"In fiscal year 2014 the Medicare program will cover more than 50 million elderly and disabled beneficiaries at an estimated cost of \$595 billion [est./benefit payments only]. In order to administer benefits to Medicare beneficiaries, CMS relies extensively on contractors to assist in carrying out its responsibilities, including program administration, management, oversight, and benefit delivery. In fiscal year 2014, approximately 38 million Medicare

beneficiaries will be enrolled in original FFS Medicare and more than 1.2 billion claims will be processed and paid for those beneficiaries by claims administration contractors. In February 2014, Medicare had 571 contracts with MA organizations to provide medical benefits and offer prescription drug benefits to over 15.3 million beneficiaries, and an additional 85 contracts with organizations that provide prescription drug benefits outside of the MA program. (Source: Medicare: Contractors and Private Plans Play a Major Role in Administering Benefits. GAO-14-417T. March 2014).

Federal contract authorities are central whether one is discussing the federal government's direct administration of the traditional fee-for-service program or its' oversight of the largest private health plan competition models in traditional Medicare, the Medicare Advantage (Part C) and Medicare Part D drug benefit programs.

Correspondingly, authorizing legislation shapes the competition models and contracting terms under Parts C and D, which in turn may be shaping the future of the Medicare program. These models, their legislative and regulatory parameters, design issues, successes and perceived shortcomings, are the practical stepping-stones to future competition models for Medicare. We will explore the nexus of such contracting authorities and ideas for Medicare reform later in this report.

Part II: The Harnessing of Medicare's Market Power

Overview—Returning to our opening theme of Medicare as an instrument of reform, since enactment in 1965, the Medicare program has driven major changes in health care in America. These changes include financing and coverage, health care services organization and delivery, quality, technological innovations and, of course, health care costs. The dynamism of the health care system has been so profound over the 49 years since Medicare's enactment that there no longer is a counter-factual state—what once was is no more. The future starts from where we are now.

Since the program's enactment, numerous legislative and regulatory changes have

Medicare support operations across the entire Medicare benefit spectrum (Parts A, B, C, and D) are largely performed not by federal employees, but by private contractors.

occurred to address *Medicare-specific* concerns in benefits, coverage and provider payment policies (see Appendix A for a modest compilation of legislative changes). Medicare's regulatory and purchasing powers in the health care marketplace have also been harnessed to drive more *systemic reforms* in health care.

The ACA is the most recent example of federal policymakers' drive to effect changes in the health care system. The ACA's private health insurance market and Medicaid *coverage expansions* have temporarily dominated public discourse, especially during the initial 2013-2014 implementation of those provisions.

However, the ACA also initiated or extended other reform concepts that strike at the heart of the practice of medicine in this country, and at how care is organized and delivered to patients by the full array of health care providers. These reforms range across physicians' practices, hospital systems, outpatient clinics, skilled nursing facilities, rehabilitation facilities, home health agencies, end-stage renal disease facilities, federal health centers and hospice care organizations.

It is important to note that ongoing changes to Medicaid, the State Children's Health Insurance Program (S-CHIP), and other health programs are also material in their impact. However, our focus in this report is on Medicare as the federal government's most centralized, and most economically powerful health care financing program.

Physician-Oriented Issues—The ACA's "programmatically" changes to Medicare's traditional program broadly support the goal of "value-based purchasing" of health care services. To policymakers, this concept simultaneously links evidence-based improvements in quality of care for patients to parallel strategies to bend the cost curve downward.

The Physicians Foundation highlighted over two dozen major such changes wrought by the ACA in a major report released in May 2011 and titled "A Roadmap for Physicians to Health Care Reform." That was followed by a series of several reports on the unfolding implementation of the ACA. Each report contained a chapter devoted

to physician-oriented policies and issues. The most recent was released in April 2014, and titled "The Patient Protection and Affordable Care Act, Beyond the Horizon into 2015: ACA Critical Issues—Part II. In the physician section, we provided important details on new Network Adequacy guidelines issued for exchange plans by CMS and the Office of Personnel Management (OPM), and new law passed this spring affecting the fee schedule, radiology services, codes and other matters. (The entire series is available at www.thephysiciansfoundation.org).

In this report, we consider emerging policy discussions of import to physicians and to how they practice in Chapter III: An Update on Medicare as an Instrument for Change. In addition to a broad examination of CMS as an Agency and its policy and operational reach, we examine emerging Medicare developments relating to:

- Implications of Medicare's national release of identifiable physician billing information,
- Site-neutral payment concepts for physician services advocated by the Medicare Payment Advisory Commission,
- The Health and Human Services Inspector General's report on large excess costs to Medicare due to over-billing involving evaluation and management codes.

Controversy in the U.S. Congress over the ACA's private insurance and Medicaid coverage provisions, and the pending 2014 mid-term elections, has impeded action on many fronts, including the more typical array of Medicare program policies that need further action. Few are as central to physicians as reforms to the Medicare physician fee schedule that have been left unresolved, thus far. When that deadlock breaks, we expect these issues to get legislative attention.

Part III: The Allure of Competition in the Private Health Insurance Market to Meet Medicare Program Goals

Medicare Competition Models—Competition, as a major tool by which to foster systemic efficiencies and improvements in health

The dynamism of the health care system has been so profound over the 49 years since Medicare's enactment that there no longer is a counter-factual state—what once was is no more. The future starts from where we are now.

Many Americans and current health policy leaders are steeped in the ideals and design of today's Medicare program and are deeply concerned about possible changes. Future changes must evolve from this history.

care services, has had a challenging history in Medicare. In many quarters, competition among private health insurance plans is viewed as a means to achieving patient care and cost management improvements for Medicare beneficiaries. Private plan competition to lower costs and improve benefits is an active principle guiding the competitive private plan design of both the Medicare Advantage Part C program and the Medicare Part D drug benefits program. However, these two models differ in significant ways that we consider later in this report.

While Medicare's future modernization continues to be debated, Medicare's traditional fee-for-service (FFS) program is currently being modified selectively through various tools such as public disclosure of provider data, bundled payments and accountable care organizations (ACOs). Also, within the FFS program, a third and different competitive bidding model is employed by CMS in establishing approved suppliers and payment levels for durable medical equipment (DME). In May 2014, CMS announced it is adding a prior authorization initiative relating to DME. The provider and supplier communities are both affected by such initiatives in the present.

The Affordable Care Act Private Insurance Competition Model—The ACA extends health insurance coverage to individuals and small businesses nationwide through competing private health insurance plans that are regulated under federal and state regulations. The ACA's federal and state regulatory frameworks encompass the operation of publicly administered health insurance exchanges under which plans offer their pre-approved products to consumers. Common requirements are set for benefit design and plan offerings, plans' market conduct and the means by which exchanges operate and enrollment shall occur. A legislated set of income-related subsidies to help defray some of the premium cost of securing a plan is also administered through this framework.

Some elements of the ACA have been rescinded, delayed or subject to legal challenges; some of the latter are not yet fully resolved in the federal courts. The initial private plan coverage rollout beginning in October 2013 suffered famously

challenging technical website enrollment and other issues. We expect these early implementation issues to gradually resolve and stabilize. Regardless of where one stands on the merits of the ACA as social policy, the law provides a competition model that offers ideas for Medicare in the future.

Conclusion—Competition and benefit package reforms in Medicare are complicated issues and we attempt to clarify the basic concepts in Chapter IV: A Look to the Future—Medicare Modernization and Competition. In that chapter, we provide an overview of the Part C and Part D contracting models, and ask whether benefit package modernization should precede additional other reforms. We conclude by raising other fundamental questions that would need to be considered regarding new Medicare competition models going forward.

Finally, many Americans and current health policy leaders are steeped in the ideals and design of today's Medicare program and are deeply concerned about possible changes. Future changes must evolve from this history. In order to discuss Medicare's future, it is essential to first understand key elements of the program's origins, history and characteristics today. Our next chapter provides a thumbnail history of Medicare and CMS, and spending and demographic parameters of Medicare today. To set the stage, we turn now to Chapter II: A Primer on Medicare's Origins and Current Characteristics.

Appendix A: Key Milestones in CMS Programs

An Overview: 1965 – 2010

Overview—The following material was sourced from two major documents, cited at the conclusion of this Appendix. The period 1965 to 2000 was developed by CMS as part of its Medicare history archives. The concluding entries, 2003-2010, were adapted from material developed by the Congressional Research Service.

While not exhaustive (relatively less significant legislative changes have occurred since 2010), this list illustrates the continual attention that Medicare and associated major programs, such as Medicaid and the State Children’s Health Insurance program (SCHIP), among others, receive on an ongoing basis by the U.S. Congress. Such legislative changes, to varying degrees, not only change programs, but also:

- 1) require beneficiary education and outreach,
- 2) repeatedly affect the responsibilities, workload and organization of CMS, and other agencies,
- 3) require extensive new regulations and educational documents, many with significant impact upon providers of health services, and
- 4) repeatedly impact upon States and private contractors that are carrying out diverse actions to support the affected programs.

Of particular significance to physicians, earlier in 2014, the Congress again passed a temporary patch to the Medicare physician fee schedule update, deferring action on deeper reform of the fee schedule.

From CMS:

Below are some of the key legislative milestones that have shaped our programs—Medicare, Medicaid, CLIA, HIPAA and SCHIP

1965: Medicare and Medicaid were enacted as Title XVIII and Title XIX of the Social Security Act, extending health coverage to almost all Americans aged 65 or older (e.g., those receiving retirement benefits from Social Security or the Railroad Retirement Board), and providing health care services to low-income children deprived of parental support, their caretaker relatives, the elderly, the blind, and individuals with disabilities. Seniors were the population group most likely to be living in poverty; about half had insurance coverage.

1966: Medicare was implemented and more than 19 million individuals enrolled on July 1.

1967: An Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) comprehensive health services benefit for all Medicaid children under age 21 was established.

1972: Medicare eligibility was extended to individuals under age 65 with long-term disabilities and to individuals with end-stage renal disease (ESRD). Medicare was given the authority to conduct demonstration programs. Medicaid eligibility for elderly, blind and disabled residents of a state could be linked to eligibility for the newly enacted Federal Supplemental Security Income program (SSI).

1973: The HMO Act provided for start-up grants and loans for the development of health maintenance organizations (HMOs); HMOs meeting Federal standards relating to comprehensive benefits and quality were given preferential treatment in the marketplace.

1977: The Health Care Financing Administration (HCFA) was established to administer the Medicare and Medicaid programs.

1980: Coverage of Medicare home health services was broadened. Medicare supplemental insurance, also called “Medigap,” was brought under Federal oversight.

1981: Freedom of choice waivers (1915b) and home and community-based care waivers (1915c) were established in Medicaid; states were required to provide additional payments to hospitals treating a disproportionate share of low-income patients (i.e., DSH hospitals).

1982: The Tax Equity and Fiscal Responsibility Act made it easier and more attractive for health maintenance organizations to contract with the Medicare program. In addition, the Act expanded the Agency’s quality oversight efforts through Peer Review Organizations (PROs).

1983: An inpatient acute hospital prospective payment system for the Medicare program, based on patients’ diagnoses, was adopted to replace cost-based payments.

1985: The Emergency Medical Treatment and Labor Act (EMTALA) required hospitals participating in Medicare that operated active emergency rooms

to provide appropriate medical screenings and stabilizing treatments.

1986: Medicaid coverage for pregnant women and infants (up to 1 year of age) to 100 percent of the Federal Poverty Level (FPL) was established as a state option.

1987: The Omnibus Budget Reconciliation Act of 1987 (OBRA87) strengthened the protections for residents of nursing homes.

1988: The Medicare Catastrophic Coverage Act, which included the most significant changes since enactment of the Medicare program, improved hospital and skilled nursing facility benefits, covered mammography, and included an outpatient prescription drug benefit and a cap on patient liability.

Medicaid coverage for pregnant women and infants to 100 percent FPL was mandated; special eligibility rules were established for institutionalized persons whose spouses remained in the community to prevent "spousal impoverishment"; Qualified Medicare Beneficiary (QMBs) program was established to pay Medicare premiums and cost sharing charges for beneficiaries with incomes and resources below established thresholds.

The Clinical Laboratory Improvement Amendments (CLIA) strengthened quality performance requirements for clinical laboratories in order to assure accurate and reliable laboratory tests and procedures.

1989: The Medicare Catastrophic Coverage Act of 1988 was repealed after higher-income elderly protested new premiums. A new Medicare fee schedule for physician and other professional services, a resource-based relative value scale, replaced charge-based payments. Limits were placed on physician balance billing above the new fee schedule. Physicians were prohibited from referring Medicare patients to clinical laboratories in which their physicians, or physicians' family members, have a financial interest.

Medicaid coverage of pregnant women and children under age 6 to 133 percent FPL was mandated; expanded EPSDT requirements were established.

1990: Phased in Medicaid coverage of children ages 6 through 18 under 100 percent FPL was established; Medicaid prescription drug rebate program was established; Specified Low-Income Medicare beneficiary eligibility group was established (SLMBs) for Medicaid programs to pay Medicare premiums for beneficiaries with incomes at least 100 percent but not more than 120 percent of the FPL and limited financial resources.

Additional federal standards for Medicare supplemental insurance were enacted.

1991: Medicaid Disproportionate Share Hospital (DSH) spending controls were established, and provider-specific taxes and donations to states were capped.

1996: Welfare Reform—The Aid to Families with Dependent Children (AFDC) entitlement program was replaced by the Temporary Assistance for Needy Families (TANF) block grant; the welfare link to Medicaid was severed; a new mandatory low income group not linked to welfare was added; and enrollment/termination of Medicaid was no longer automatic with receipt/loss of welfare cash assistance.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) had several provisions. First, it amended the Public Health Service Act, the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 to provide for new Federal rules improving continuity or "portability" of coverage in the large group, small group and individual health insurance markets. CMS implements HIPAA provisions affecting the small group and individual markets. Second, it created the Medicare Integrity Program which dedicated funding to program integrity activities and allowed CMS to competitively contract for program integrity work. Third, it created national administrative simplification standards for electronic health care transactions. Fourth, it required HHS to issue privacy regulations if Congress failed to enact substantive privacy legislation.

1997: Balanced Budget Act of 1997 (BBA)—State Children's Health Insurance Program (SCHIP) was created; limits on Medicaid payments to disproportionate share hospitals were revised; new Medicaid managed care options and requirements for states were established.

Medicare changes included:

- Establishing an array of new Medicare managed care and other private health plan choices for beneficiaries, offered through a coordinated open enrollment process;
- Expanding education and information to help beneficiaries make informed choices about their health care;
- Requiring CMS to develop and implement five new prospective payment systems for Medicare services (for inpatient rehabilitation hospital or unit services, skilled nursing facility services, home health services, hospital outpatient department services, and outpatient rehabilitation services);
- Slowing the rate of growth in Medicare spending and extending the life of the trust fund for 10 years;
- Providing a broad range of beneficiary protections;

- Expanding preventive benefits; and
- Testing other innovative approaches to payment and service delivery through research and demonstrations.

1998: The internet site *www.medicare.gov* was launched to provide updated information about Medicare.

1999: The toll-free number, 1-800-MEDICARE (1-800-633-4227), became available nationwide. The first annual Medicare & You handbook was mailed to all Medicare beneficiary households.

1999: The Ticket to Work and Work Incentives Improvements Act of 1999 (TWWIIA) expanded the availability of Medicare and Medicaid for certain disabled beneficiaries that return to work. Established optional Medicaid eligibility groups and allowed states to offer a buy-in to Medicaid for working-age individuals with disabilities.

The Balanced Budget Refinement Act of 1999 (BBRA) increased payments for some Medicare providers and increased the amount of Medicaid DSH funds available to hospitals in certain States and the District of Columbia. Other related legislation improved Medicaid coverage of certain women's health services.

2000: The Benefits Improvement and Protection Act (BIPA) further increased Medicare payments to providers and managed health care organizations, reduced certain Medicare beneficiary co-payments, and improved Medicare's coverage of preventive services.

BIPA created a new Medicaid prospective payment system for Federally Qualified Health Centers and Rural Health Clinics and it modified the amount of Medicaid DSH funds available to hospitals, while it provided a one-year extension on the sunset of transitional medical assistance provided to families eligible for welfare.

From CRS:

2003: Congress enacted the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108-173), which included a major benefit expansion and placed increasing emphasis on the private sector to deliver and manage benefits. The MMA included provisions that (1) created a new voluntary outpatient prescription drug benefit to be administered by private entities; (2) replaced the Medicare+Choice program with the Medicare Advantage (MA) program and raised payments to plans in order to increase their availability for beneficiaries; (3) introduced the concept of income testing into Medicare, with higher-income persons paying larger Part B premiums beginning in 2007; (4) modified some provider payment rules; (5) expanded

covered preventive services; and (6) created a specific process for overall program review if general revenue spending exceeded a specified threshold.

2005-08: During the 109th Congress, two laws were enacted that incorporated minor modifications to Medicare's payment rules. These were the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432). In the 110th Congress, additional changes were incorporated in the Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173) and the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275).

2010: Comprehensive health reform legislation was enacted that, among other things, made statutory changes to the Medicare program. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148), enacted on March 23, 2010, included numerous provisions affecting Medicare payments, payment rules, covered benefits, and the delivery of care. The Health Care and Education Affordability Reconciliation Act of 2010 (the Reconciliation Act, or HCERA; P.L. 111-152), enacted on March 30, 2010, made changes to a number of Medicare-related provisions in the ACA and added several new provisions.

Included in the ACA, as amended, are provisions that (1) constrain Medicare's annual payment increases for certain providers; (2) change payment rates in the Medicare Advantage program so that they more closely resemble those in fee-for-service; (3) reduce payments to hospitals that serve a large number of low-income patients; (4) create an Independent Payment Advisory Board (IPAB) that will make recommendations to adjust Medicare payment rates; (5) phase out the Part D prescription drug benefit "doughnut hole"; (6) increase resources and enhance activities to prevent fraud and abuse; and (7) provide incentives to increase the quality and efficiency of care, such as creating value-based purchasing programs for certain types of providers, allowing accountable care organizations (ACOs) that meet certain quality and efficiency standards to share in the savings, creating a voluntary pilot program that bundles payments for physician, hospital, and post-acute care services, and adjusting payments to hospitals for readmissions related to certain potentially preventable conditions.

Sources:

1) Centers for Medicare and Medicaid Services. *CMS: Our History*. Prepared for a major anniversary of the Medicare program.

2) Congressional Research Service, *A Medicare Primer* (R40425), pages 4-5. February 7, 2014.

Who Makes Social Welfare Policy?

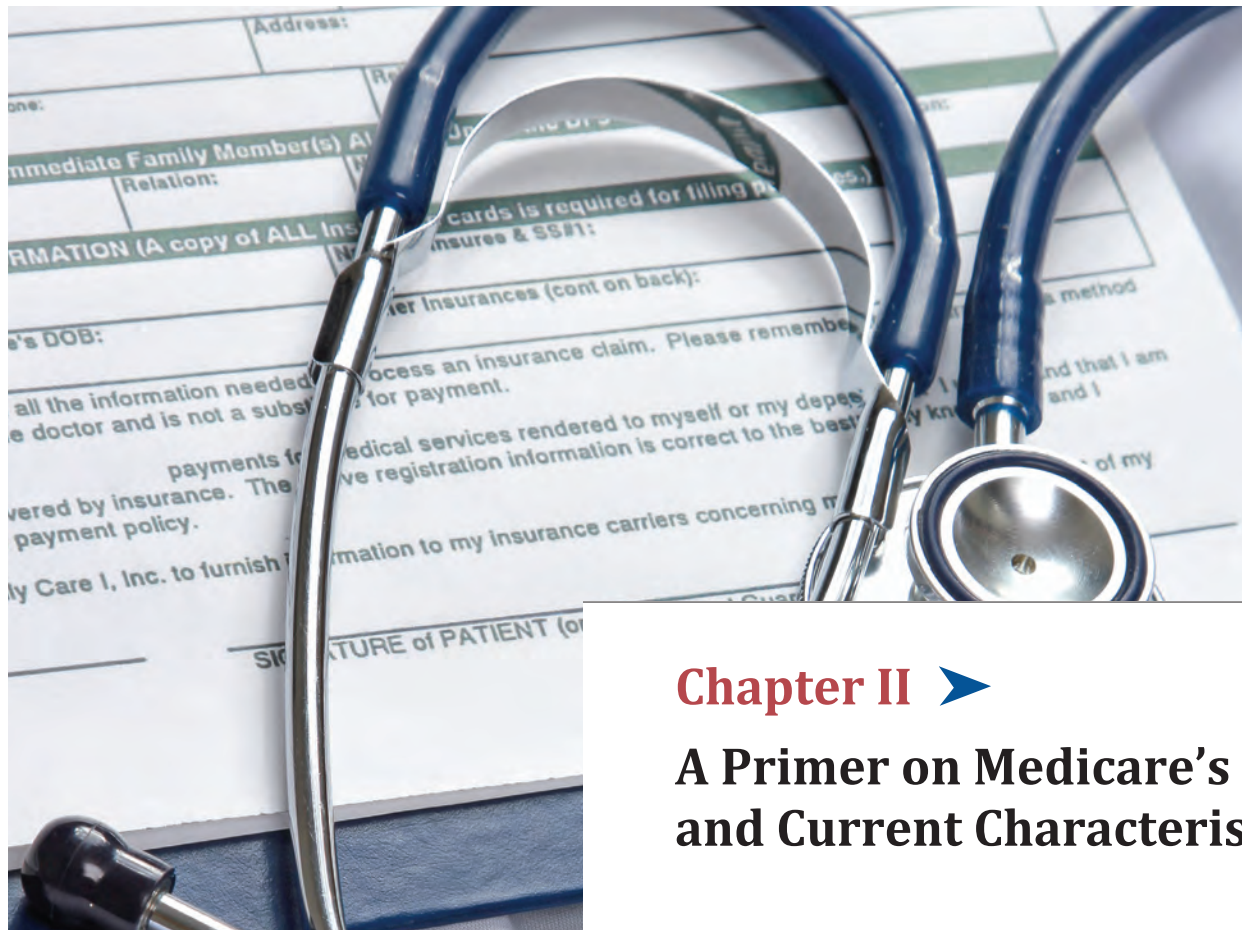
“Democracy is expensive—but it is a time-tested way of resolving conflicts.”

In American society, as in most others, a delicate balance always exists between *conflict and consensus*. Without a relatively high degree of agreement on fundamentals, no orderly social and political life is possible. On the other hand, our diverse interests and ways of pursuing happiness—as individuals and as organizations—frequently come into conflict with one another.

“...Conflict was an important and highly visible aspect of the Medicare debate. Yet the contending parties also displayed a high degree of consensus. Both sides agreed to “play by the rules of the game” and accepted the decisions of the legislative process as binding. This is often taken for granted in our society, but it is no small achievement.”

[Among President Johnson’s Medicare signing ceremony remarks]...“The final victory of Medicare, he had said, was not attributable to the efforts of any one [person]. It was attributable to the joint efforts of many—to at least a score of Congressmen and Senators (some of whom had died before seeing the fruit of their work), to dozens of departmental officials and technicians, to congressional staff people, to the leaders and staffs of the many interest groups and organizations which supported the measure, to newspaper and magazine editors who had endorsed it, to philanthropists, courageous physicians, committed intellectuals, dedicated pamphleteers, and self-effacing political organizers. All of these people and more contributed their ideas, their money, their labor, and their influence to the cause.”

(Source: Abstract from *Evolution of Medicare*, Chapter 5, Peter A. Carney, 1969)



Chapter II ➤

A Primer on Medicare's Origins and Current Characteristics

Part I. A Primer on Medicare's Origins

Former U.S. Senator "Hubert H. Humphrey once calculated that a bill might have to surmount as many as 28 separate obstacles before becoming the law of the land. "At each stage of the legislative highway," he noted, "a few legislators lurk, like the pirates of Tripoli, and take toll of the passing traffic..."

(Source: Peter A. Corning)

A Little History—Sometimes in social policy, as in life, it's important to check your premises and revisit what you think you know. In that spirit, we paid a (virtual) visit to the Social Security Administration's (SSA) History Archives to highlight facets of Medicare's origins. We discovered a treasure trove of American cultural, political and social programs history. We highlight how inextricably linked private health plans (PHPs) have been to Medicare's structure and functioning, right from the beginning. We also note some interesting aspects of the role of organized medicine, most prominently represented at the time by the American Medical Association's "Eldercare" proposal.

In visiting the history archives, we draw particularly upon the extensive work of Peter A.

Corning. Mr. Corning's report, titled *Evolution of Medicare*, is an extensive documentation of the social, political and legislative history and early implementation of the Medicare program developed under contract to the Social Security Administration, the Agency that first administered the new law (www.socialsecurity.org/history/corning.html. Accessed April 26, 2014.)

The report was originally published in 1969, later archived, and then re-issued more recently by SSA as a foundational document regarding the origins and initial implementation challenges of

A Digression on Implementation Failures

We were very interested in Peter Corning's descriptions of Medicare's initial implementation challenges in light of the recent upheavals over the ACA coverage rollout. In Medicare's initial implementation, enrollment wasn't the problem since SSA already had the retirement benefit database to draw upon for enrollment. Rather, contractors (private health plans) were initially overwhelmed in 1966-67 and unable to handle the onslaught of provider claims, leading to mounting piles of unpaid claims. Their technology and staffing were inadequate to the sheer scale of the Medicare start-up of about 19 million enrollees. The problems became so severe that a number of Social Security Administration district office workers (federal employees), were deployed on-site to private contractors to help process claims and handle other tasks until the initial crisis was resolved.

the Medicare program. A professional journalist at the time, Mr. Corning began the project while working with the Oral History Research Office at Columbia University on the early history of Social Security. We commend his richly detailed and fascinating account of Medicare's inception and early implementation to any student of social or health care history in the United States. The following is drawn from Chapter 4 of his document. Any faults of omission in the interest of focusing on highlights are our own.

Early Days in the U.S. Health Insurance Debate—

Beginning in the early 1900's, Americans considered numerous ideas relating to financial protection against the cost of illness or injury. The debate ranged across national health insurance, to smaller scale proposals such as government-sponsored health insurance for veterans, for the indigent and/or disabled, and for the aged, and many other smaller-scale private options. The debates were rich in cultural, social and political nuances and spanned several Presidents' Administrations.

The debate over health insurance for the aged surged during the Kennedy/Nixon 1960 Presidential election debates leading to the election of Senator John F. Kennedy. The health care community was divided, with the American Medical Association and many insurers and business organizations actively campaigning against a federal government program, and for alternatives. The American Hospital Association campaigned in favor of a federal program, along with, in general, many unions, church organizations and representatives for the aged.

Initial "Medicare" Defeat—After years of intense national debate and episodic Congressional debate and unsuccessful legislative activity, a major, initial "Medicare" bill was defeated in 1962 in the U.S. Senate. It was a signal legislative defeat for President Kennedy, for whom health care for the aged had been a major priority before and after the 1960 election. The issue came to the fore again after President Kennedy's tragic death, led by former Vice-President Lyndon B. Johnson. Public opinion shifted slowly in favor, but significant opposition remained. Yet, as summarized by Peter Corning:

"If there were still any lingering doubts about the prospects for Medicare, they were dispelled by the outcome of the 1964 election. President Johnson was returned to office by the largest plurality in history, carrying in on his coattails the biggest congressional majorities since New Deal days. In the House, the Democrats picked up 38 seats, to give the Party a margin of 295-140. In the Senate, where the Democrats already had held a lopsided 66-34 majority, the party gained two more seats."

AMA Role and "Eldercare" Private Plan Approach—

Notably, however:

"Just after the [1964] election, in fact, the AMA (American Medical Association, *supplied*) held a high level strategy meeting at its Chicago headquarters, at which it was decided to fight on to the very end. Another publicity campaign was mapped. Then, in early January, AMA leaders announced they would support an alternative to Medicare based on the principle of the original Taft-Smith-Ball bill and its many successors—that is, a program operated through private insurance carriers (and the States), with premiums for the low-income elderly subsidized out of Federal and State revenues. "Eldercare," as the AMA's proposal was called, was promptly introduced by two Ways and Means Committee members, A. S. Herlong, Jr. of Florida and Thomas B. Curtis of Missouri (H.R. 3727 and H.R. 3728), and given wide publicity."

Perspectives—We draw attention to the AMA's role for two reasons. First, it's useful for physicians today to be aware of the historic role of medicine's most prominent organization, at that time, in landmark social efforts to address the financing of health care services for Americans. That historical role is infinitely more extensive and nuanced than we can do justice to in this report. We note that after enactment of the Medicare program, the AMA's position evolved into strong defense of the program's importance, even when the AMA has strongly critiqued certain features or shortcomings.

More important for our purposes are some of the *ideas* encapsulated in the “Eldercare” proposal. Conceptually, at a top-tier level, it resembles certain elements of the ACA model (i.e., income-related premium subsidies to support the purchase of private health insurance plans.) Keep in mind that under the ACA, state health insurance exchanges were expected to be primary, and the current federal exchange model (Healthcare.gov), was intended to be a default option to be relied upon by few states, if any. The failure in 1965 of the AMA’s state-based, private health plan, Eldercare proposal for the aged, begs a hypothetical question: What would have happened to aged persons in the targeted Medicare population under an Eldercare-type model had it been enacted assuming state participation, and their state of residence declined to participate?

Certain of the Eldercare elements also resemble certain top-level aspects of “premium support” ideas for private plan coverage as a reform approach to the current Medicare program. It suggests a strong persistence in certain ideas regarding approaches to equitable health care financing in this country, at least for public programs.

Enactment of Medicare—Long-time observers of the workings of the U.S. Congress are acutely aware of the labyrinthine politics and processes that lead more often to defeat than success of legislative bills. Congressional watchers can read between the lines of the following excerpt and imagine both the fierce politics, public and private, and the enormous effort conveyed by the span of time, and the roster of amendments and votes, required to bring the Medicare legislation to successful completion.

“Finally, on March 23, 1965, the Ways and Means Committee voted 17-8 to substitute a drastically revised committee bill for King-Anderson. (The committee bill, 296 pages long, had 102 separate sections.) The next day, Chairman {Wilbur} Mills introduced this “Mills bill” (H.R. 6675) on the House floor, and on April 8, after 1 day of floor debate, the Mills bill passed—without amendment-by 313-115. It was all very anti-climatic—indeed, almost perfunctory. By mid-1965 public attention had shifted to other issues—the growing

racial crisis, the war on poverty and the war in Vietnam. Nonetheless, approval of Medicare by the House of Representatives was a momentous occasion, and President Johnson paused briefly to hail it: “This is a landmark day in the historic evolution of our social security system.”

The Mills bill then went to the Senate, where the Finance Committee held hearings in late April and early May, followed by extended executive sessions. The bill was finally reported out—with 75 committee amendments—on June 24 (by a vote of 12-5). During 3 days of debate on the Senate floor, some 250 additional amendments were considered.

Then, on July 9, the Senate passed the measure by a 68-21 vote. A Senate-House conference committee labored for over a week in mid-July to reconcile a total of 513 differences between the two chambers, after which the final bill was approved in the House and Senate, on July 27 and 28, respectively. Thus, America finally joined the many other nations that provided health insurance protection for the aged—in Winston Churchill’s phrase, bringing “the magic of averages to the rescue of millions.”

The final Medicare act (officially part of the “Social Security Amendments of 1965”) established a two-part insurance program. The “basic” (Part A) program of hospital and related benefits was financed through social security taxes. Benefits included 90 days of hospital care, 100 days of nursing-home care, 100 home-nursing “visits” in each “spell” of illness, and hospital outpatient service—all subject to “deductibles,” “coinsurance,” and other features, as well as certain other conditions. The second part (Part B) consisted of a voluntary program of “supplementary” benefits, covering 80 percent (above an annual deductible of \$50) of physicians’ fees, additional home-nursing services, in-hospital diagnostic and laboratory work, certain kinds of therapy, ambulance services, surgical dressings, and so forth. This supplementary plan would be financed initially through a \$3 monthly premium from each beneficiary, with a matching

The failure in 1965 of the AMA’s state-based, private health plan, Eldercare proposal for the aged, begs a hypothetical question: What would have happened to aged persons in the targeted Medicare population under an Eldercare-type model had it been enacted assuming state participation, and their state of residence declined to participate?

Looking back, what actually occurred in the passage of Medicare? First, it reflected the defeat, at least indirectly, of the concept of a national health insurance system resembling the one that Britain passed into law in the early 1900's. Equally, it represented the defeat of competing proposals to offer "Medicare" benefits directly through private health plans (PHPs), with various income-related government subsidies to defray the costs of those plans.

amount paid by the Government out of the general revenues. In addition, the act provided for a substantially expanded Kerr-Mills program extending "medical indigency" benefits (Medicaid) to other age groups besides those over age 65. Of course, many other changes in the social security system were also included in the act."

The Medicare program today stands on the shoulders of its founders' ideas and purposes, on its original design, and on the steady flow over nearly fifty years of legislative and regulatory alterations. The Social Security Amendments of 1965, which added Medicare (Title XVIII) and Medicaid (Title XIX) to the Social Security Act, were signed into law on July 30, 1965, by President Lyndon B. Johnson in the presence of former President Harry A. Truman in a large ceremony held at the Truman Presidential Library (see archival photo).



President Johnson's trip to the Truman library was a gracious acknowledgement of the material contributions President Truman's administration made in the late 1940's, to examining and ultimately advocating health insurance benefits for Social Security beneficiaries and assistance for the indigent.

The Medicare Compromise—Looking back, what actually occurred in the passage of Medicare? First, it reflected the defeat, at least indirectly, of the concept of a national health insurance system resembling the one that Britain passed into law in the early 1900's. Equally, it represented the defeat of competing proposals to offer "Medicare" benefits directly through private health plans (PHPs), with various income-related government subsidies to defray

the costs of those plans. There were four key elements that have endured:

➤ **Social Security System Framework**—It was agreed to rely upon the existing Social Security system to bring a minimum level of basic financial security to targeted populations, primarily the elderly and permanently disabled. The incorporation of Medicare into the Social Security framework reflected the evolving view that most retirees' income and savings, including Social Security cash benefits, failed to protect the program's beneficiaries against their greatest financial vulnerability, the high economic cost of serious illness.

➤ **Federal Oversight and Regulatory Role**—Medicare's enactment reflected acceptance of a major new role for the federal government in financing, oversight and regulation of a program of health benefits. In retrospect, due to the increasing enrollment and efforts to manage costs, quality and program integrity, the government was drawn even more deeply into the specifics of the provision of health care in the U.S. than even early detractors may have envisioned. Early on, this occurred primarily through the establishment of rules for providers governing conditions of participation, program integrity, coverage and payment for services. Over the years, these and related policies became powerful tools that have impacted significantly upon health services delivery in the U.S.

➤ **Political Consensus and Compromises**—The program's ultimate passage and program design reflected important *political consensus and compromises*, which included accommodations to major stakeholders, including organized medicine and PHPs. For medicine, it was the decision to make enrollment in Part B medical insurance benefits "supplementary" and voluntary. Part A "hospital insurance" benefits were mandatory. For all providers, and for PHPs (and in recognition that the government lacked sufficient operational infrastructure), it was decided to rely upon private health plans accustomed to working with providers to serve as the original fiscal agents for the government. (Author's note: For a period of time, the original Bureau of Health Insurance within SSA created and operated a "direct

intermediary” option for providers that elected *not* to interact with Medicare through private health plans—this option was phased out some years later. In this option, the government served as its own fiscal agent.)

➤ **Key Early, but Evolving, Roles for Private Health Plans**—The Blue Cross and Blue Shield plans were the most dominant, but not the only large private health insurers in the U.S. in the early 1960’s. Such plans had a deep history of their own in working with hospitals, physicians, and other providers as the private health insurance system developed in the U.S. Therefore, the government contracted with them from Medicare’s operational beginnings to establish coverage; process claims and for some provider classes, cost reports; pay claims; determine beneficiary cost-sharing liabilities; and, establish oversight controls and provide assistance to providers and beneficiaries.

It took many years, as explained later, for the role of PHPs to change, both functionally and with respect to the terms under which they could contract with the government. This relates both to administration in the traditional program, and to emerging new roles for health plans such as we see today in the Medicare Advantage and Medicare Part D programs.

Part II: The Origins and Powers of CMS

The Evolution of an Agency—Historically, the Bureau of Health Insurance (BHI) was created within SSA to implement the Medicare program. Several top managers in the original agency, including Thomas Tierney, the original Bureau Director, and Mildred Tyssowski, an operations Chief, were hired due to their executive skills and expertise in private health insurance operations. BHI later 1) merged with another federal agency, and in so doing, 2) added responsibilities for Medicaid administration, and 3) became a freestanding agency that separated from SSA and was re-named the Health Care Financing Administration (HCFA). HCFA was later reorganized as new responsibilities were legislated into being and renamed the Centers for Medicare and Medicaid Services (CMS). CMS has also re-organized internally over time as responsibilities shifted,

modernized and grew (see page 20 to view CMS’s current organizational chart.)

CMS Policy and Operational Responsibilities—CMS now has the primary policy and operational responsibilities at the federal level for Medicare, Medicaid, and the State Children’s Health Insurance Program (SCHIP). CMS has significant responsibilities relating to implementation of the ACA’s Medicare, Medicaid and SCHIP program changes, as well as federal oversight of private insurance market oversight provisions, major coverage expansions, and health insurance exchanges and related matters. (Several other federal agencies also have important collaborative roles in implementing the ACA, such as the Social Security Administration, the Department of Labor, the Department of the Treasury, and Homeland Security.)

CMS also carries out other responsibilities under laws such as the Clinical Laboratory Improvement Amendments (CLIA) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), among others. Under CLIA, CMS regulates all laboratory testing (except research) performed on humans in the U.S. and covering about 244,000 laboratory entities. CMS currently has about 6,100 employees, the majority of whom are employed in the Agency’s national headquarters in Baltimore, Maryland. There are regional locations, as well, organized under a management Consortia model.

Part III: Contracting Support of the Traditional Medicare Program

Introduction—We opened this report with an advisory that any program changes and reforms must be carried out within a well-designed federal contracting framework. Yet this framework gets minimal attention. It is important to understand that it took the U.S. Congress 38 years before it enacted fundamental changes (in 2003) to the non-competitive Medicare contracting model of 1965, despite repeated HCFA/CMS requests to put operational support of the program on a more competitive, rigorous footing.

We drew upon recent Government Accountability Office testimony to the Congress to prepare an abstract on this topic noting some

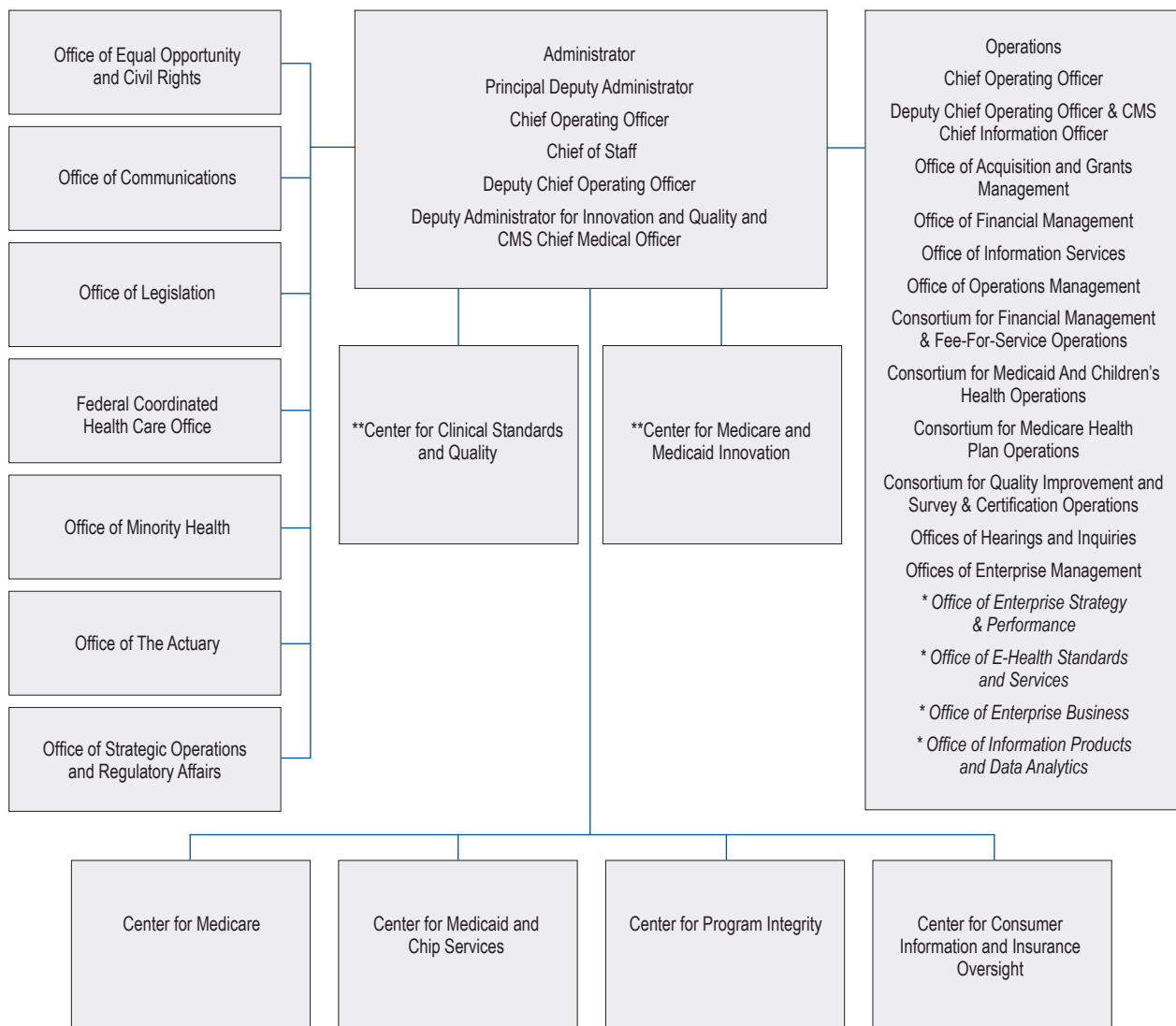
It took the U.S. Congress 38 years before it enacted fundamental changes (in 2003) to the *non-competitive* Medicare contracting model of 1965, despite repeated HCFA/CMS requests to put operational support of the program on a more competitive, rigorous footing.

of the crucial changes in contracting terms and organization that are occurring today in CMS's management of the traditional FFS program.

The traditional Medicare program's troubling contracting reform story is an important cautionary tale to the extent that it highlights some of the hidden costs of the differences in perspectives and roles between Executive and Legislative Branches of government. From

a public policy perspective, it is especially problematic when the Congress fails to grant authorities needed to correct long-simmering policy or operational problems in Medicare. A recent notable example is the failure of the Congress, over multiple years, to address the well-recognized and costly issues in the current Medicare physician fee schedule's sustainable growth rate (SGR) formula.

DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE & MEDICAID SERVICES



APPROVED

* Reports to Offices of Enterprise Management ** Reports to Deputy Admin. for Innovation and Quality

SOURCE: WWW.CMS.GOV/ORGANIZATION CHART. ACCESSED 06/04/14.

For purposes of traditional Medicare, or any future competition model reforms, it is crucial to ensure that contracting models specified in the law and to be utilized by federal managers, in turn, grant those managers the tools necessary to properly carry out the objectives of the law.

Today, private health plans and other types of contractors continue to support major functions in the Medicare traditional fee-for-service program. However, many PHPs now compete under the Medicare Advantage program to attract beneficiaries out of the traditional program into their privately managed, Medicare-approved, insurance products. Other PHPs compete to offer drug benefits to Medicare beneficiaries under the Part D benefit enacted in 2003. These evolving Medicare options form the foundation for examining benefit modernization and new plan competition models for the future.

Medicare Contracting History

Medicare’s Private Health Plan Contracting History—Medicare’s private health plan contracting history under the traditional program (and separately under Part C) is a case study in how politics can distort federal government administrative operations and goals. **In 1965, by law, the government was required to select Medicare claims contractors on a non-competitive basis from among private health insurers that were experienced in processing hospital and medical claims in their own lines of business.**

As noted in our brief history of Medicare section, these arrangements were set by the Congress in order to achieve political and legislative acceptance of the Medicare program in the medical and private health plan (PHP) communities. Such a “favored nation” structure would presumably not even be considered in today’s federal contracting environment. However, once these favorable terms were written into the Medicare law, we note that it took *thirty-eight years* for such terms to be abandoned by the Congress in favor of more flexible, performance-based, competitive contracting for Medicare administration.

Today, the original plans that served as Part A intermediaries and Part B carriers are referred to as the “legacy” contractors. As the chronology (abbreviated) derived below from the General Accountability Office (GAO) makes clear, in recent years the Congress has become increasingly concerned with the overall growth in Medicare spending and in improper payments to providers. This is reflected both in the changing authorities granted to CMS regarding contracting, and in new types of contracting focused particularly on addressing improper payments to providers.

GAO Summation—As noted recently by the GAO in a Report to the Congress (Medicare: Contractors and Private Plans Play a Major Role in Administering Benefits. GAO-14-417T. March 2014.):

“By law, CMS [in 1965, it was actually the Bureau of Health Insurance] was required to select carriers from among health insurers or similar companies and to choose fiscal intermediaries from organizations that were first nominated by associations representing providers, *without the application of competitive procedures* [emphasis supplied]. In addition, CMS could not terminate these contracts unless the contractors were first provided an opportunity for a public hearing, whereas the contractors themselves were permitted to terminate their contracts, unlike other federal contractors. The contractors were paid based on their allowable costs and generally did not have financial incentives that were aligned with quality performance (p. 3.)”

As further described by GAO:

“Beginning in the 1980s, the Department of Health and Human Services (HHS) asked Congress to amend its authority related to the selection of claims administration contractors, citing several reasons. HHS wanted greater flexibility to administer the program and improve services to beneficiaries and providers. In addition, HHS wanted to promote competition by opening up the contracting process to a broader set of contractors, achieve cost

From a public policy perspective, it is especially problematic when the Congress fails to grant authorities needed to correct long-simmering policy or operational problems in Medicare. A recent notable example is the failure of the Congress, over multiple years, to address the well-recognized and costly issues in the current Medicare physician fee schedule’s sustainable growth rate (SGR) formula.

savings, and increase CMS's ability to reward contractors that performed well. Congress included such reform in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA).

Specifically, the MMA repealed limitations on the types of contractors CMS could use and required that CMS:

- use competitive procedures to select new contracting entities to process medical claims;
- provide incentives for contractors to provide quality services;
- develop performance standards (including standards for customer satisfaction);
- comply with the Federal Acquisition Regulation (FAR), except where inconsistent with provisions of the MMA;
- implement contractor reform by October 2011; and
- recompute the contracts at least once every 5 years.

CMS implemented the MMA contracting reform requirements by shifting claims administration tasks from 51 legacy contracts to new entities called Medicare Administrative Contractors (MACs). Originally, CMS selected 15 MACs to process both Part A and B Medicare claims (known as A/B MACs) and 4 MACs to process durable medical equipment (DME) claims (known as DME MACs). CMS also selected 4 A/B MACs to process claims for home health care and hospice services. CMS began awarding the MAC contracts in 2006; however, bid protests and consolidation of some of the MAC jurisdictions delayed some of the MACs from being fully operational. By 2009, most of the legacy contracts had been transitioned to MACs and by December 2013, CMS completed that transition.

CMS is moving toward further consolidation of MAC contracts in hopes that consolidation will further improve CMS's procurement and

administration processes. Since the original implementation, CMS chose to consolidate the 15 A/B MACs into 10 jurisdictions and is in the process of that consolidation. Currently, there are 5 consolidated A/B MACs that are fully operational, 7 A/B MACs that will eventually be consolidated into 5 jurisdictions, and 4 DME MACs that are fully operational (p. 3-4.)"

GAO notes new program integrity and audit and recovery authorities, functions and modes of payment in Medicare contracting:

"Under the FAR [federal acquisition regulations], agencies may generally select from two broad categories of contract types: fixed-price and cost-reimbursement. When implementing contractor reform, CMS chose to structure the MAC contracts as cost-plus-award-fee contracts, a type of cost-reimbursement contract. This type of contract allows CMS to provide a financial incentive—known as an award fee—to contractors if they achieve certain performance goals. In addition to reimbursement for allowable costs and a contract base fee (which is fixed at the inception of the contract), a MAC can earn the award fee, which is intended to incentivize superior performance. In 2010, we reviewed three MACs that had undergone award fee plan reviews and found that all three received a portion of the award fee for which they were eligible, but none of the three received the full award fee (p. 4.)"

"The Health Insurance Portability and Accountability Act of 1996 established the Medicare Integrity Program, authorizing CMS to award separate contracts for program integrity activities such as investigating suspected fraud. These contracts are now handled by Zone Program Integrity Contractors and are generally aligned with the same jurisdictions as the MACs. In 2003, the MMA directed CMS to develop a demonstration project testing the use of contractors to conduct recovery audits in Medicare. These contractors, known as recovery auditors, conduct data analysis and

review claims that have been paid to identify improper payments. While other contractors that review claims are given a set amount of funding to conduct reviews, recovery auditors are paid contingency fees on claims they have identified as improper. To increase efforts to identify and recoup improper payments, Congress passed the Tax Relief and Health Care Act of 2006, which, among other things, required CMS to implement a permanent and national recovery audit contractor program (p. 5 – 6.)”

Conclusion—The GAO’s March 2014 report provides a particularly timely and useful underpinning for understanding the critical role contracting plays in Medicare operations. This same report also addresses the very different purposes contracting serves under the Medicare Advantage and Part D drug benefit programs. We draw further on this and other materials in highlighting Medicare benefit modernization and competition issues in Chapter IV. In particular, we discuss crucial differences in CMS’s role in centralization of policy development and execution via contractors in the traditional program, and how CMS’s role and relationship to contractors differs in Parts C and D of Medicare.

Part IV: Medicare Today – A Data Primer

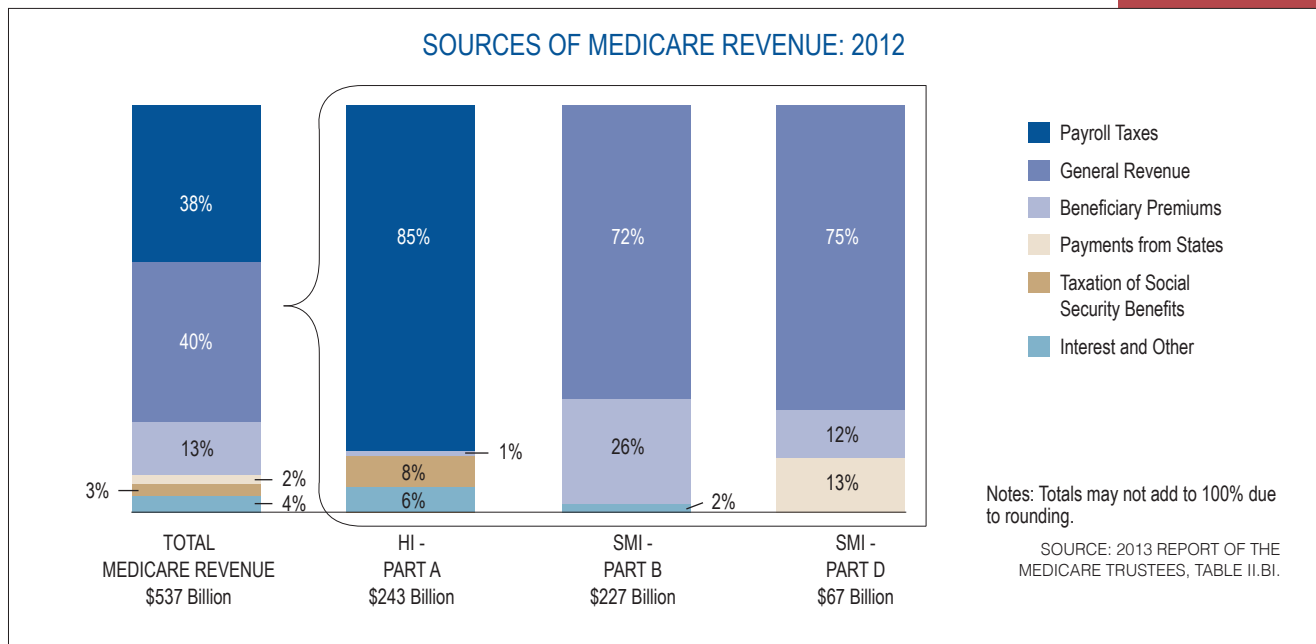
Purpose—In this section, we examine briefly the

key characteristics of the Medicare program in the most recent periods for which data are publicly available. This is the foundation upon which over 50 million older, and in many cases, impoverished, and disabled Americans rely upon for their essential health benefits. It is also the foundation upon which any realistic reforms to Medicare in the future must rest.

Unless otherwise noted, for the following material, we draw primarily upon major reports from the Congressional Research Service (CRS), the Congressional Budget Office, the Medicare Board of Trustees and MedPAC. As with previous reports in this series, we seek factual information released into the public domain from highly professional and credible sources. These sources and any additional materials reviewed in preparation of this report appear in the Bibliography.

As described by CRS in “A Medicare Primer”— Medicare consists of four distinct parts:

- **PART A (HOSPITAL INSURANCE, OR HI)** covers inpatient hospital services, skilled nursing care, hospice care, and some home health services. The HI trust fund is mainly funded by a dedicated payroll tax of 2.9% of earnings, shared equally between employers and workers.
- **PART B (SUPPLEMENTARY MEDICAL INSURANCE, OR SMI)** covers physician services, outpatient



services, and some home health and preventive services. The SMI trust fund is funded through beneficiary premiums (set at 25% of estimated program costs for the aged) and general revenues (the remaining amount, approximately 75%).

➤ **PART C (MEDICARE ADVANTAGE, OR MA)** is a private plan option for beneficiaries that covers all Parts A and B services, except hospice. Individuals choosing to enroll in Part C must also enroll in Part B. Part C is funded through the HI and SMI trust funds.

➤ **PART D** covers outpatient prescription drug benefits. Funding is included in the SMI trust fund and is financed through beneficiary premiums, general revenues, and state transfer payments.

Medicare is required to pay for all covered services provided to eligible persons, so long as specific criteria are met. Spending under the

program (except for a portion of administrative costs) is considered mandatory spending and is not subject to the appropriations process.

Medicare Program Overview and Spending—

According to CRS, in 2014, Medicare will cover an estimated 54 million persons (45 million aged and 9 million disabled). This represents about one in six Americans and nearly all individuals over the age of 65. Under the Congressional Budget Office’s April 2014 Medicare Baseline, it was estimated that total Medicare spending in 2014 will be about \$618 billion, of which about \$609 billion will represent benefit payments. About \$3 billion will be spent on program administration in 2014.

On page 23 is a graphic depicting the major sources of Medicare program revenues.

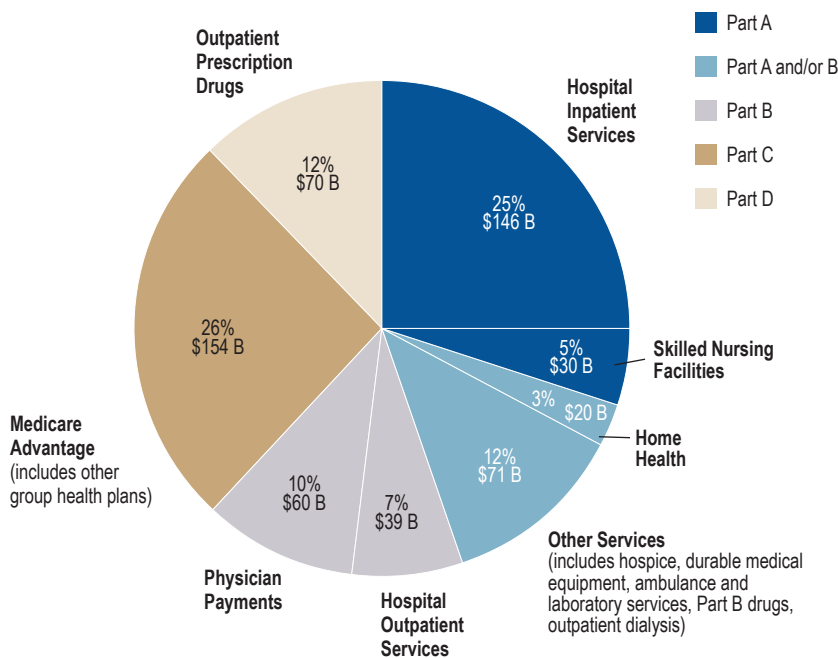
Separately, it is also useful to understand the distribution of spending across the four distinct parts of Medicare. Following is a graphic displaying projected spending by category for 2014.

Medicare Spending and Beneficiary Characteristics—

The Medicare patient population has different health characteristics, utilization patterns and health care spending profiles than is customary in private health plans (PHPs) in their private lines of business. In general, in their private lines of business, PHPs generally insure younger individuals and families (including children) who are healthier, and many adults actively in the labor force. Compared to the older and/or disabled and ESRD population covered by Medicare, such populations’ per capita levels of and distribution of health care utilization and spending patterns are different.

Separately, Medicare data are extensive and dense. We opted for a carefully selected set of visual data that convey more than words. Following are certain key characteristics of the Medicare program today, starting

PROJECTED MEDICARE BENEFIT SPENDING, BY CATEGORY, FY 2014
(\$591 BILLION*)



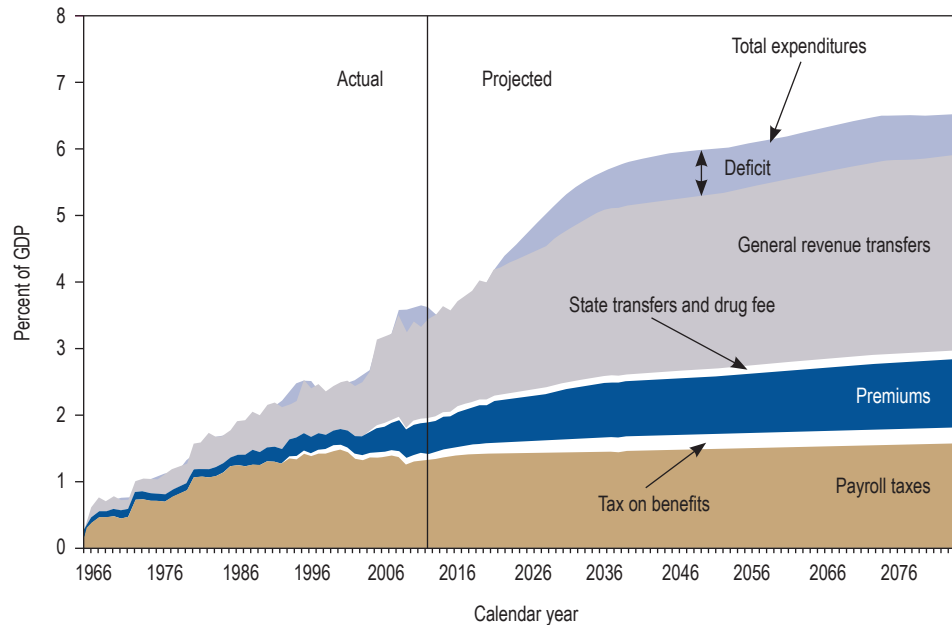
Notes: *Numbers may not add due to rounding. The \$591 billion in benefit payments does not include CBO’s estimated reductions under sequestration, administration costs or recoveries.

SOURCE: FIGURE BY CRS BASED ON DATA FROM THE CONGRESSIONAL BUDGET OFFICE, MAY 2013 MEDICARE BASELINE.

with long-term financing challenges, followed by select information on beneficiaries and spending. These are essential facts that will shape the federal budgetary debate, tempered by the realities of the demographic characteristics and health care needs of the aged, disabled and end-stage renal disease population, including those that are dually eligible for Medicare and Medicaid.

These are drawn from MedPAC's compendium titled "Health Care Spending and the Medicare Program—Data Book. March 2013. We refer interested readers to that Compendium for an array of data that are outside the scope of this report, including extensive program statistics by major provider categories. MedPAC has provided additional perspectives and data at the provider category level in its March 2014 Report to Congress, as well. All reports are available in digital form at Medpac.gov.

1. MEDICARE FACES SERIOUS CHALLENGES WITH LONG-TERM FINANCING.

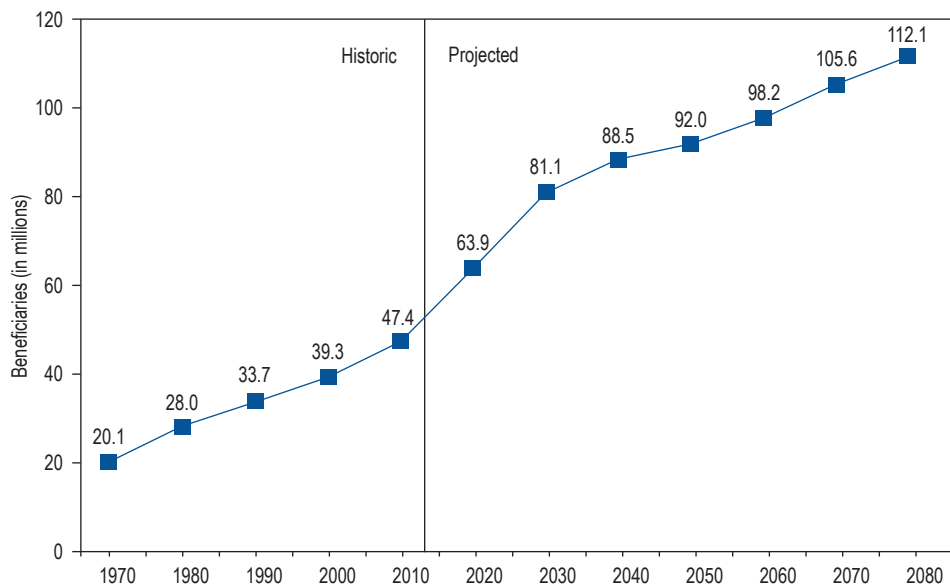


Note: GDP (gross domestic product). These projections are based on the trustees' intermediate set of assumptions. Tax on benefits refers to the portion of income taxes that higher income individuals pay on Social Security benefits that is designated for Medicare. State transfers (often called the Part D "clawback") refer to payments called for within the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 from the states to Medicare for assuming primary responsibility for prescription drug spending. The drug fee refers to the fee imposed in the Patient Protection and Affordable Care Act of 2010 on manufacturers and importers of brand-name prescription drugs. These fees are deposited in the Part B account of the Supplementary Medical Insurance trust fund.

SOURCE: 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE MEDICARE TRUST FUNDS.

- In 2012, Medicare expenditures exceeded Medicare revenues due to decreased Hospital Insurance payroll tax income caused by the weak economy. The Medicare trustees project that expenditures will continue to exceed revenues in 2013 and 2014.
- From 2015 to 2022, Medicare revenues are expected to exceed Medicare expenditures in part because expenditures are reduced as a result of provisions of the Budget Control Act of 2011 that require a 2 percent sequester of Medicare payments during this period.
- After 2022, the Medicare trustees project that Medicare expenditures will exceed Medicare revenues, and general revenues will grow as a share of total Medicare financing, adding significantly to federal budget pressures.

2. ENROLLMENT IN THE MEDICARE PROGRAM IS PROJECTED TO GROW RAPIDLY IN THE NEXT 20 YEARS.



Note: Enrollment numbers are based on Part A enrollment only. Beneficiaries enrolled only in Part B are not included.

SOURCE: CMS OFFICE OF THE ACTUARY, 2013.

- The total number of people enrolled in the Medicare program is expected to increase from about 50 million in 2012 to about 81 million in 2030.
- The rate of increase in Medicare enrollment will accelerate until 2030 as more members of the baby-boom generation become eligible, at which point it will increase more slowly after the entire baby-boom generation has become eligible.

3. MEDICARE HI AND SMI BENEFITS AND COST SHARING PER FFS BENEFICIARY IN 2011.

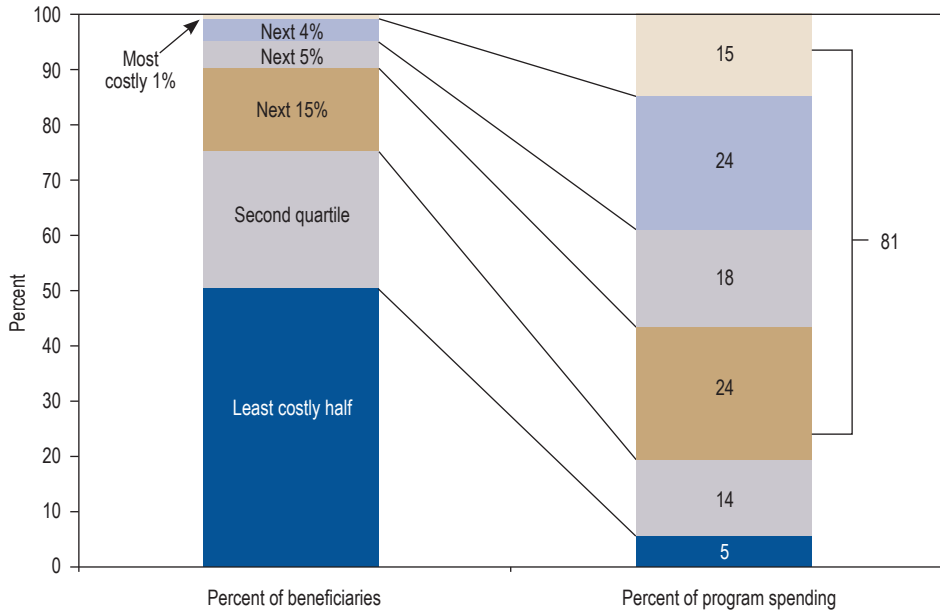
	Average benefit (in dollars)	Average cost sharing (in dollars)
HI	\$5,172	\$435
SMI	4,992	1,272

Note: HI (Hospital Insurance), SMI (Supplementary Medical Insurance), FFS (fee-for-service). Dollars are for calendar year 2011 for FFS Medicare only and do not include Part D. Average benefits represent amounts paid for covered services per FFS beneficiary and exclude administrative expenses. Average cost sharing represents the sum of deductibles, coinsurance, and balance billing paid for covered services per FFS beneficiary.

SOURCE: CMS OFFICE OF THE ACTUARY; THE 2013 ANNUAL REPORT OF THE BOARDS OF TRUSTEES OF THE MEDICARE TRUST FUNDS; AND THE MEDICARE AND MEDICAID STATISTICAL SUPPLEMENT 2012, CMS OFFICE OF INFORMATION SERVICES.

- In calendar year 2011, the Medicare program made \$5,172 in HI benefit payments and \$4,992 in SMI benefit payments on average per beneficiary.
- In the same year, beneficiaries owed an average of \$435 in cost sharing for HI; \$1,272 in cost sharing for SMI; and a total of \$1,567 in cost sharing for both.
- Most Medicare beneficiaries have supplemental coverage through former employers, medigap policies, Medicaid, or other sources that fill in much of Medicare's cost-sharing requirements.

4. FEE-FOR-SERVICE PROGRAM SPENDING IS HIGHLY CONCENTRATED IN A SMALL GROUP OF BENEFICIARIES, 2009.

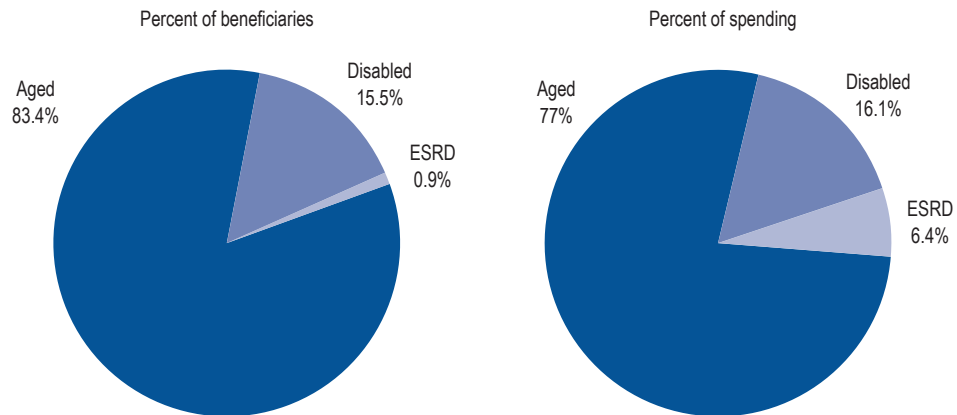


Note: FFS (fee-for-service). All data are for calendar year 2009. Analysis excludes beneficiaries with any group health enrollment during the year.

SOURCE: MEDPAC ANALYSIS OF 2009 MEDICARE CURRENT BENEFICIARY SURVEY, COST AND USE FILES.

- Medicare FFS spending is concentrated among a small number of beneficiaries. In 2009, the costliest 5 percent of beneficiaries accounted for 39 percent of annual Medicare FFS spending and the costliest quartile accounted for 81 percent. By contrast, the least costly half of beneficiaries accounted for only 5 percent of FFS spending.
- Costly beneficiaries tend to include those who have multiple chronic conditions, are using inpatient hospital services, are dually eligible for Medicare and Medicaid, and are in the last year of life.

5. AGED BENEFICIARIES ACCOUNT FOR THE GREATEST SHARE OF THE MEDICARE POPULATION AND PROGRAM SPENDING, 2009.

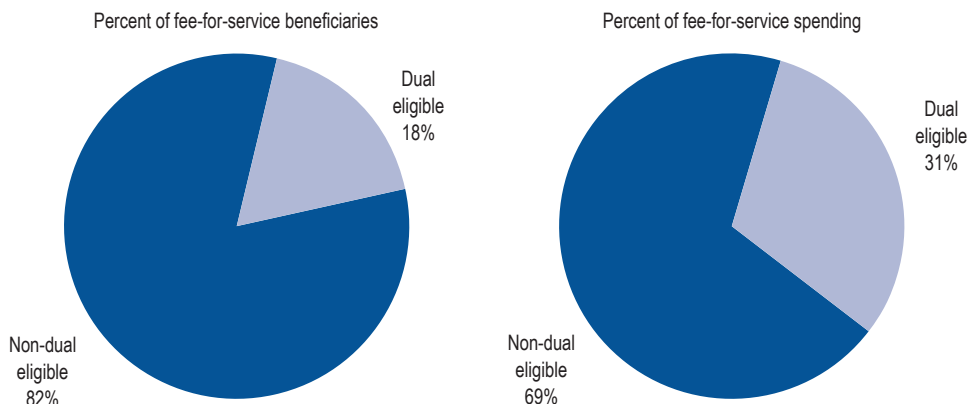


Note: ESRD (end-stage renal disease). The aged category refers to beneficiaries age 65 or older without ESRD. The disabled category refers to beneficiaries under age 65 without ESRD. The ESRD category refers to beneficiaries with ESRD, regardless of age. Results include fee-for-service, Medicare Advantage, community dwelling, and institutionalized beneficiaries. Totals may not sum to 100 percent due to missing data or to rounding.

SOURCE: MEDPAC ANALYSIS OF THE MEDICARE CURRENT BENEFICIARY SURVEY, COST AND USE FILE, 2009.

- In 2009, Medicare beneficiaries age 65 or older without ESRD composed 83.4 percent of the beneficiary population and accounted for 77 percent of Medicare spending. Beneficiaries under 65 with a disability and beneficiaries with ESRD accounted for the remaining population and spending.
- In 2009, average Medicare spending per beneficiary was \$10,499.
- A disproportionate share of Medicare expenditures is devoted to Medicare beneficiaries with ESRD. On average, these beneficiaries incur spending that is more than six times greater than spending for aged beneficiaries (65 years or older without ESRD) and for beneficiaries under age 65 with disability (non-ESRD). In 2009, \$69,770 was spent per ESRD beneficiary versus \$9,690 per aged beneficiary and \$10,896 per beneficiary under age 65 enrolled due to disability.

6. DUAL-ELIGIBLE BENEFICIARIES ACCOUNT FOR A DISPROPORTIONATE SHARE OF MEDICARE SPENDING, 2009.



Note: Dual-eligible beneficiaries are designated as such if the months they qualify for Medicaid exceed the months they qualify for supplemental insurance. Spending data reflect 2009 Medicare Current Beneficiary Survey Cost and Use file from CMS.

SOURCE: MEDPAC ANALYSIS OF THE MEDICARE CURRENT BENEFICIARY SURVEY, COST AND USE FILE, 2009.

- Dual-eligible beneficiaries are those who qualify for both Medicare and Medicaid. Medicaid is a joint federal and state program designed to help low-income persons obtain needed health care.
- Dual-eligible beneficiaries account for a disproportionate share of Medicare expenditures. As 18 percent of the Medicare fee-for-service population, they represented 31 percent of aggregate Medicare fee-for-service spending in 2009.
- On average, dual-eligible beneficiaries incur twice as much annual fee-for-service Medicare spending as non-dual-eligible beneficiaries: In 2009, \$17,888 was spent per dual-eligible beneficiary, and \$8,336 was spent per non-dual-eligible beneficiary.
- In 2009, average total spending which includes Medicare, Medicaid, supplemental insurance, and out-of-pocket spending across all payers for dual-eligible beneficiaries was about \$29,100 per beneficiary, nearly twice the amount for other Medicare beneficiaries.

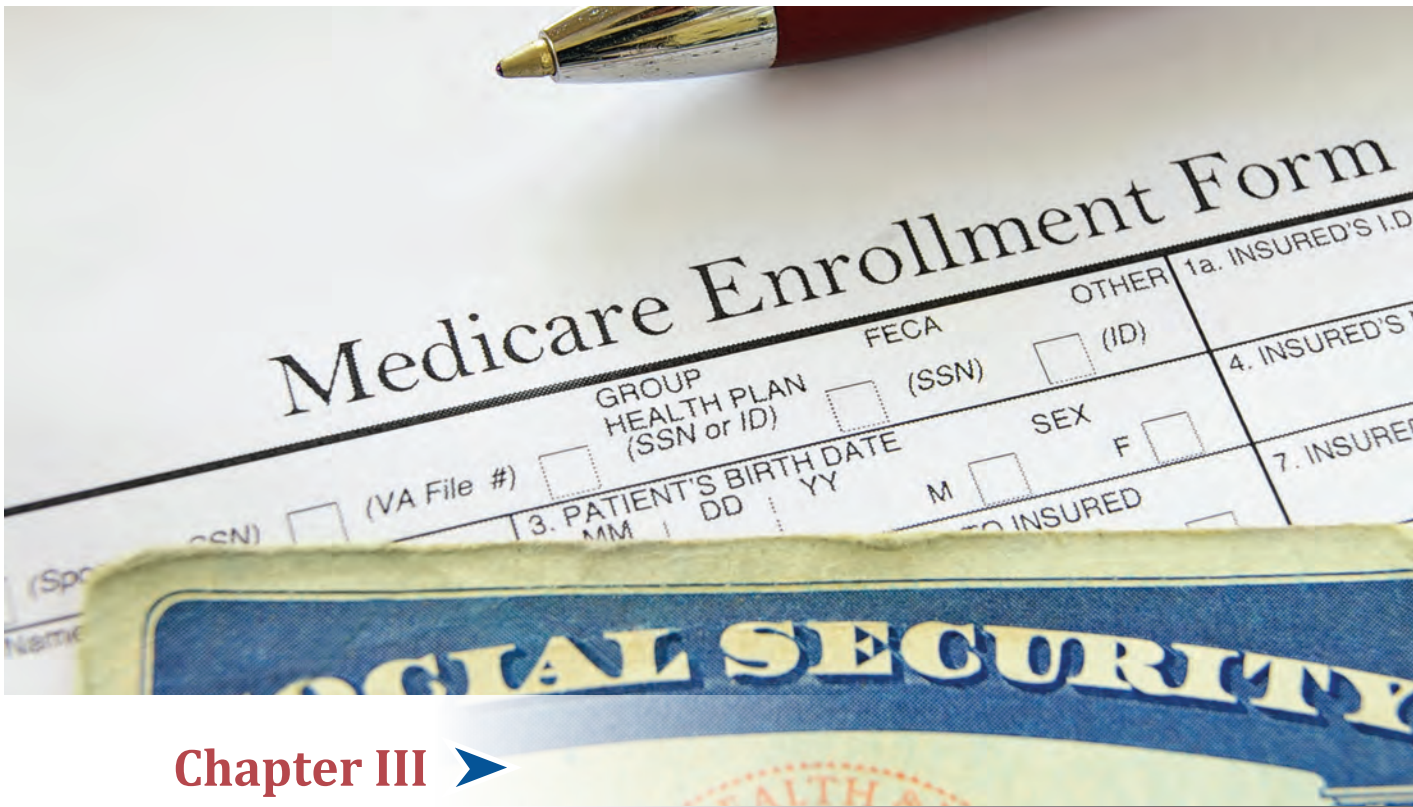
7. CHARACTERISTICS OF THE MEDICARE POPULATION, 2009.

Characteristic	Percent of the Medicare population	Characteristic	Percent of the Medicare population
Total (47,176,547)	100%		
Sex		Living arrangement	
Male	45	Institution	5
Female	55	Alone	29
Race/ethnicity		Spouse	49
White, non-Hispanic	77	Other	18
African American, non-Hispanic	10	Education	
Hispanic	8	No high school diploma	24
Other	5	High school diploma only	30
Age		Some college or more	45
<65	16	Income status	
65–74	44	Below poverty	16
75–84	27	100–125% of poverty	9
85+	13	125–200% of poverty	19
Health status		200–400% of poverty	31
Excellent or very good	42	Over 400% of poverty	24
Good or fair	50	Supplemental insurance status	
Poor	8	Medicare only	9
Residence		Managed care	24
Urban	76	Employer	34
Rural	24	Medigap	15
		Medigap/employer	3
		Medicaid	14
		Other	1

Note: Urban indicates beneficiaries living in metropolitan statistical areas (MSAs). Rural indicates beneficiaries living outside MSAs. In 2009, poverty was defined as income of \$10,289 for people living alone and \$12,982 for married couples. Totals may not sum to 100 percent due to missing data or to rounding. Some beneficiaries may have more than one type of supplemental insurance.

SOURCE: MEDPAC ANALYSIS OF THE MEDICARE CURRENT BENEFICIARY SURVEY, COST AND USE FILE, 2009.

- Most Medicare beneficiaries are female and White.
- Close to one-quarter of beneficiaries live in rural areas.
- Twenty-nine percent of the Medicare population lives alone.
- One-quarter of beneficiaries have no high school diploma.
- Most Medicare beneficiaries have some source of supplemental insurance. Employer-sponsored plans are the most common source of supplemental coverage.



Chapter III

Perspectives on Medicare as an Instrument of Health Care Reform

The “Complexification” of Medicare—Medicare, from its inception, has had a major impact on the American system of health care. The federal government, meaning the American taxpayer and all that implies, was now financing the health care of millions of Americans principally through a combination of general revenues and premium receipts. Along with that new responsibility followed development over time of an ever more extensive system of federal policies and regulations to manage benefits and costs. These policies introduced conditions of participation for providers, benefit and coverage policies, provider reimbursement policies and systems to pay for health services in an array of care settings, and program integrity safeguards. The early implementation approaches were rapidly deemed inadequate to the growing demands of the program and underwent rapid change.

As Medicare enrollment expanded and program costs grew at higher average rates than did the U.S. economy, Congress repeatedly revisited the legislative contours of the Medicare program (see Chapter I, Appendix A). Every round of legislation has led to new or revised

federal regulations and policies, numerous new directives to providers, change orders to contractors, new educational materials and outreach to beneficiaries, and more.

The DRG and RBRVS Examples—Cost control efforts have often focused on alterations and reforms to Medicare’s payment methods for provider services, in order to modify incentives. The original intent was to replace provider cost and charge data, as applicable, as the bases for Medicare payments, and to substitute more methodologically sophisticated and federally pre-determined (prospective) rates for services. Notable examples include:

- 1983** ➤ Enactment of the Medicare Part A diagnosis-related group (DRG) methodology for reimbursement of inpatient hospital services.
- 1989** ➤ Enactment of the Medicare Part B Resource-Based, Relative Value Scale (RB-RVS) methodology for reimbursement of medical services under the physician fee schedule.

These methodological provider payment

approaches have been exhaustively developed, adapted to other care settings, debated, and critiqued. We cite them here simply as examples of traditional Medicare program interventions that have grown beyond the imaginings of their early developers. The original methodologies cited above have changed deeply, but their underlying conceptualization remains. Each has arguably better defined the “products” of, in these examples, medical care and inpatient hospital services. This has been accomplished through ever more complex algorithms that introduce more factors regarding patient and health services characteristics, continually modifying payment values.

Such payment system(s) algorithms may have material value in examining care and identifying factors for improvement, as well as for setting payment levels. But it comes at a cost to the practice of medicine. The impact of the RB-RVS system upon physicians’ non-medical educational requirements and practice management has been significant (as have been other design features of the Medicare program as they affect physicians). As a hint of the complexity of *just this one thing* in Medicare, we note that the American Medical Association’s most recent guide entitled *Medicare RBRVS 2014: The Physician’s Guide* is a mere 624 pages long!

Medicare laws are frequently modified by the Congress, which in turn requires promulgation of new or modified implementing regulations. Understanding and working with these complex systems has changed the level and composition of employment in government and in the health care sector due to the proliferating need for legal and technical advice, requiring trained researchers, clinical support personnel, software and hardware engineers and technicians, medical coders, etc., to provide support for design, management and evaluation of these intricate policies and systems.

The Slowly Shifting Paradigm in Medicare Policy Approaches—For the past 49 years, the Medicare program has largely followed a *direct federal benefit administration model*, where federal employees craft most of the policies and arrangements required to shape and support the delivery of the health insurance benefits written into the law. Over time, each

major new policy paradigm became codified into law, as did many subsequent changes sought by the bureaucracy or by Members of Congress. In some cases, the law was changed in ways that career officials objected to or felt were unworkable. Some provisions would be subsequently repealed due to poor conceptualization, excessive costs or operational challenges.

To a certain extent, the Congress and the Executive Branch have slowly acknowledged the deep shortcomings of these long-term approaches in promoting effective, quality care in Medicare while also “bending the cost curve” downward. (Nonetheless, it is important to grasp how very deeply the government is invested in their continued maintenance and application.) We would cite two major examples of this recognition, while acknowledging there are others that could have been chosen.

One major example is the passage of the Medicare Part D drug benefit in 2003. The competition model chosen by the Congress to add outpatient drug coverage to the Medicare program was an explicit decision to not follow the traditional, directly administered benefit approach that has defined the Medicare program since the beginning. We discuss this in our next and final chapter where we explore ideas about Medicare’s future.

The second is an array of ideas that have been incorporated into more recent laws, especially the ACA. Physicians are actively engaged in the implementation of these provisions, e.g. accountable care organizations (ACOs), bundled payments, conversion to sophisticated electronic health records and health information technologies (HIT), reporting of quality measures and Physician Compare.

Covered in depth by the Physicians Foundation upon enactment, and updated regularly in a series of reports available on our website, the ACA added over 122 discrete and significant policy provisions *just* to the Medicare program. And Medicare was ostensibly not the primary purpose of the ACA reforms; those were private insurance market changes and coverage expansions. Still, it took the estimable Congressional Research Service (CRS) ninety-two pages in small type just to enumerate the

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main elements of these 122-plus Medicare provisions (Congressional Research Service. “An Overview of Medicare Provisions in the Patient Protection and Affordable Care Act.” April 2010.)

As a reminder, the issues highlighted in the ACA Select Topics box have received attention in prior reports, along with unfolding ACA legal, coverage expansion, Healthcare.gov, and physician network issues. Our goal throughout has been to select the most significant issues for physicians for closer discussion.

Leveraging Medicare to Achieve Health Care System Goals—If one is an advocate of the *public direct administration model* for Medicare, many of the ACA policy provisions represent important shifts in focus intended to leverage Medicare to promote deeper systemic improvements in patient care, while constraining costs. The strongest supporters of the Medicare Advantage and Part D *private, at-risk benefit management models*, however, are less likely to support the expanding reach

of Medicare into health system dynamics represented by many ACA provisions. We join this issue in Chapter IV.

Today, the most immediate emerging issues in Medicare for physicians may have more to do with the objectives and increasingly sophisticated data tools of the federal executives administering the program, as with the law. We investigate this question and focus on illustrative issues in the balance of this chapter.

It is first important to understand the goals and objectives federal officials hold regarding improvements needed to the American health care system. In this case, we are referring primarily to the goals and activities of the Centers for Medicare and Medicaid Services (CMS), as the Agency advances proposals to the Congress, and implements changes in or develops interpretations of federal law.

In particular, we are interested in considering CMS perspectives regarding Medicare as an instrument of health care reform. That is, what key set of changes is CMS seeking to accomplish through the leverage of the Medicare program? In particular, what changes do its leaders most seek in medical practice organization and care delivery? We examine select issues below and consider in Chapter IV what broader Medicare modernization and competition models reform might mean relative to the federal micromanagement of health care seen in Medicare today.

CMS Strategic Plan 2013 – 2017—Any examination of how the Medicare program has been deployed by government as an instrument of systemic reform benefits from insight into the views, objectives and “policy footprint” of the federal agency responsible for administering it, namely CMS. There are few better places to start than with the Agency’s own strategic plan, updated in 2013 (see Appendix B in Chapter III for a copy of the plan in its entirety.)

CMS’s strategic plan reflects the devolution from its parent organization, the Department of Health and Human Services (DHHS), of key responsibilities over the ACA, adding to the Agency’s existing Medicare, Medicaid and other responsibilities. This was accomplished in part by integration of the Center for Consumer

Previous ACA Select Topics

- 1 > CMS Center for Medicare and Medicaid Innovation
- 2 > Independent Payment Advisory Board
- 3 > Patient-Centered Outcomes Research Institute, Comparative Effectiveness, Quality Reporting, Feedback Programs and Physician Compare
- 4 > Value-based Purchasing (Hospitals)
- 5 > Payment Pilots and Reform Initiatives
 - Accountable Care Organizations
 - Medical Home
 - Bundled Payments and Global Capitation
 - Value-Based Modifier on the Physician Fee Schedule
 - Gainsharing Demonstrations
- 6 > Physician Fee Schedule Adjustments; Market Basket Update and Productivity Adjustment; Geographic Adjustment; Other Payment Adjustments
- 7 > Workforce Initiatives
- 8 > Rural Initiatives
- 9 > Health Plans and Medical Loss Ratios
- 10 > Health Insurance Exchanges

SOURCE: PHYSICIANS FOUNDATION, A ROADMAP FOR PHYSICIANS TO HEALTH CARE REFORM, MAY 2011

Information and Insurance Oversight (CCIIO) into the CMS “Centers” structure. As CMS notes, this action extended its responsibilities to national private health insurance market reforms and consumer protections that intersect and in some areas pre-empt state insurance regulation. More broadly, the strategic plan states:

“The ACA greatly expanded the Agency’s role and responsibilities by effectively tasking CMS to lead the charge to provide high quality care and better health at lower costs through improvement in health care for all Americans. This expansion not only involves growth in CMS’s traditional base but also includes a greater emphasis on its continuing efforts in program integrity, health care innovation and health disparities reduction, as well as the establishment of Affordable Insurance Marketplaces (p. 1.)”

CMS’s vision statement includes the following:

“We are focused on measurably improving care and population health by transforming the U.S. health care system into an integrated and accountable delivery system that continuously improves care, reduces unnecessary costs, prevents illness and disease progression, and promotes health (p.2.)”

“Policies such as establishing Accountable Care Organizations, increasing value-based purchasing, coordinating care for individuals enrolled in both Medicare and Medicaid, and reducing hospital readmissions will improve the value of care (p. 1.)”

Perspectives—The CMS strategic plan is a highly activist-oriented plan, with broad, societal health care improvement goals within the Agency’s sphere of influence, which is considerable. It also represents a genuine transformation in perspective from an agency that was viewed for many years as insular, primarily dominated by the minutiae of Medicare provider coverage and payment policies and claims administration, and a place where Medicaid, SCHIP and even Medicare’s private plan options were “stepchildren” to

traditional Medicare. One thing is clear, the ACA arrived with important new resources for CMS, but also with exceptional new responsibilities, accelerating institutional changes in this established Agency, and broadening its perspectives on the health care system, as well as its roles.

CMS’s words in its strategic plan and in policy documents speak for themselves. In turn, readers may judge for themselves whether they agree that the Agency’s stated objectives are appropriate and whether the Agency executes well on these objectives.

A full reading of the CMS Strategic Plan makes crystal clear that the Agency takes a very broad view of its roles and abilities to influence improvements in the American health care system, as it cross-pollinates ideas and policies across its major spheres of influence, especially the ACA’s private health insurance market standards and coverage expansions, and the policies and operations of the Medicare and Medicaid programs.

The right goals are central, but once defined, execution is key—how CMS pursues its objectives in exercising its regulatory authorities and powers, is very important to program beneficiaries, but also to physicians, hospitals and others engaged in delivering health care under diverse and taxing standards. A note: Considering the “How” of Medicare is also one simple way to distinguish the “direct federal” vs. “supervised private” administration models. At present, we are considering activities only under the “direct federal” administration model.

An Author’s Note on CMS Culture—Along with its self-definition as an Agency that is implicit in the strategic plan, it’s also important to have some insight into the Agency’s origins, culture and the larger “policy matrix” in which it operates. Speaking as a native of Baltimore and from prior professional experience in the Agency and DHHS through the Agency’s BHI, HCFA and CMS incarnations, the changes in CMS over time have been remarkable, yet some elements endure. Recall from the Agency history snapshot in Chapter II that CMS’s earliest origins were as the Bureau of

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Health Insurance headquartered as part of SSA in Woodlawn, Maryland, a near-western suburb of Baltimore City. In the first few Medicare start-up years, due to lack of office space in Woodlawn, small groups of employees were initially housed in downtown Baltimore warehouses, rode in freight elevators, and even came in on one memorable weekend (physicians and file clerks), with their own supplies to build badly needed bookshelves for beneficiary case files.

Today, CMS resides in a fully modern office headquarters of its own only three miles from BHI's original location, but at an unrecognizable remove from its bootstrap beginnings. Aside from a handful of early leaders recruited nationally, the overwhelming majority of initial employees were drawn locally from the greater Baltimore metropolitan and suburban areas. Most of the headquarters employees reside today in the same catchment area, despite a national (and international) reach over time in recruiting talent, and the location in Washington, D.C. of a relatively small number of employees. There has been a concerted effort in recent years to recruit physicians and other medical personnel, and individuals with private insurance industry expertise, in certain areas. The majority of employees are career civil servants, led by a relatively small cadre of career Senior Executive Service employees and an even smaller number of political leaders, which includes the Administrator of CMS.

Finally, while CMS's history and non-Washington centric location has led to certain insularity at times, it also has created a cadre of experienced people who have worked together for a long time, through daunting law changes and implementation challenges. However, a growing wave of retirements is changing the composition and depth of experience in the workforce. [KM.]

CMS Reach in the U.S. and International Health Policy Apparatus—CMS does not work in a vacuum; quite the contrary. Operationally, CMS has a deep reach across the United States through policy, research or operational interactions with university-based and other health services research organizations, hospital, medical and other health care associations, think-tanks, accreditation and quality standard

setting organizations, its regional consortia and contractors, and interactions with other federal agencies, including but not limited to the following:

FDA—Food and Drug Administration (drug and medical device approvals and related clinical information; Medicare coverage policy interactions with CMS),

DOL—Department of Labor (employer health benefits),

NIH—National Institutes of Health (research),

HRSA—Health Resources and Services Administration (health care resources and policy studies),

PCORI—Patient-Centered Outcomes Research Institute (patient care services, models and research),

ONC—Office of the National Coordinator for Health Care Information Technology (electronic health information and interoperability nationwide),

OIG—Office of the Inspector General for the Department of Health and Human Services (program integrity and operations oversight), and

DOJ—Department of Justice (investigation and prosecution of program fraud).

Separately, CMS interacts frequently with Congressional advisory bodies on broader health care organization and financing issues, and on specific regulatory responsibilities. These organizations, all established to directly assist the Congress in its oversight responsibilities, include:

MEDPAC—Medicare Payment Advisory Commission,

MACPAC—Medicaid and CHIP Payment and Access Commission

GAO—General Accountability Office

CBO—Congressional Budget Office, and

CRS—Congressional Research Service

CMS also assists Members of Congress and their staffs directly regarding multiple program matters and inquiries. Extensive technical assistance can occur between CMS staff and House and Senate Committees with jurisdiction over CMS programs, especially when major legislation is being considered or is in House

or Senate Legislative Counsel undergoing legal drafting. One important CMS objective in the latter situation is to ensure new law is crafted in a manner the Agency can administer effectively.

Pre-ACA, CMS already had extensive professional interactions across states through its state-oriented work, primarily under its CLIA responsibilities, state survey and certification agencies, Medicare local contractor administration, and Medicaid state agencies. Many of these relationships are now intensified under the ACA coverage expansion, insurance standards and exchange functions. These include interactions with Governors, state legislators, health officials and state insurance regulators.

Finally, CMS officials have also traveled to other countries to share data and perspectives with foreign health officials and to examine international health systems. In turn, they have hosted foreign officials who are interested in particular ideas and tools. In this regard, the DRG and RB-RVS systems have been of particular interest over the years. So have differences in the U.S.'s approaches to drug and medical device approvals, and the intersection of these policies with CMS's approaches to establishing coverage policy for Medicare, including evaluation of medical interventions.

Working within an extensive matrix of private industry and public policy venues, CMS:

- sponsors and consumes health services research,
- formulates coverage, payment, program integrity and contracting policies under Medicare, and
- seeks to operationalize policies and methods to achieve continual improvements in value (cost, quality, effectiveness and efficiency) in how benefits are delivered.

The Medicare Policy Cycle—There are patterns in the evolution of policy ideas and their translation to action in Medicare. Virtually every important change in Medicare developed first, and usually slowly, in the matrix of ideas and private and public organization interactions described in the preceding section. This includes interactions in the legislative environment, where CMS both proposes and

seeks to inform legislation development in the U.S. Congress.

The most recent generation of ideas, such as medical home models, accountable care organizations, bundled payments and others, share a commonality with the DRG and RB-RVS systems of 20-30 years ago. Prior to enactment into law, each major new concept adopted into Medicare usually involved a pre-history of research, public commentary and consensus

The most recent generation of ideas, such as medical home models, accountable care organizations, bundled payments and others, share a commonality with the DRG and RB-RVS systems of 20-30 years ago. Prior to enactment into law, each major new concept adopted into Medicare usually involved a pre-history of research, public commentary and consensus building before it made its way into legislation and official public policy.

building before it made its way into legislation and official public policy. That does not mean every detail was thought through or that every ramification was understood. Rather, it means that enough individuals in the decision-making process were persuaded of the merits of adopting a particular concept into the Medicare program for the concept to be enacted into law.

Finally, statutory language varies in its degree of prescriptiveness, but is generally intended to provide authorization for and general shaping of policy or operational requirements. It then becomes the Administration's responsibility to develop and promulgate the regulatory policies and operational details to implement the legislative language. This process can lead to conflict with political leaders and other stakeholders due to disagreements over interpretation, operational realities, and impact. In closing, it is a continuous cycle of policy development, application, modification, and infrequently, legislative repeal. Despite this complex cycle, summarized below, the Medicare program has been a major, durable and strongly supported benefits program in the U.S. for nearly 50 years.

A Snapshot of the Medicare Policy Cycle

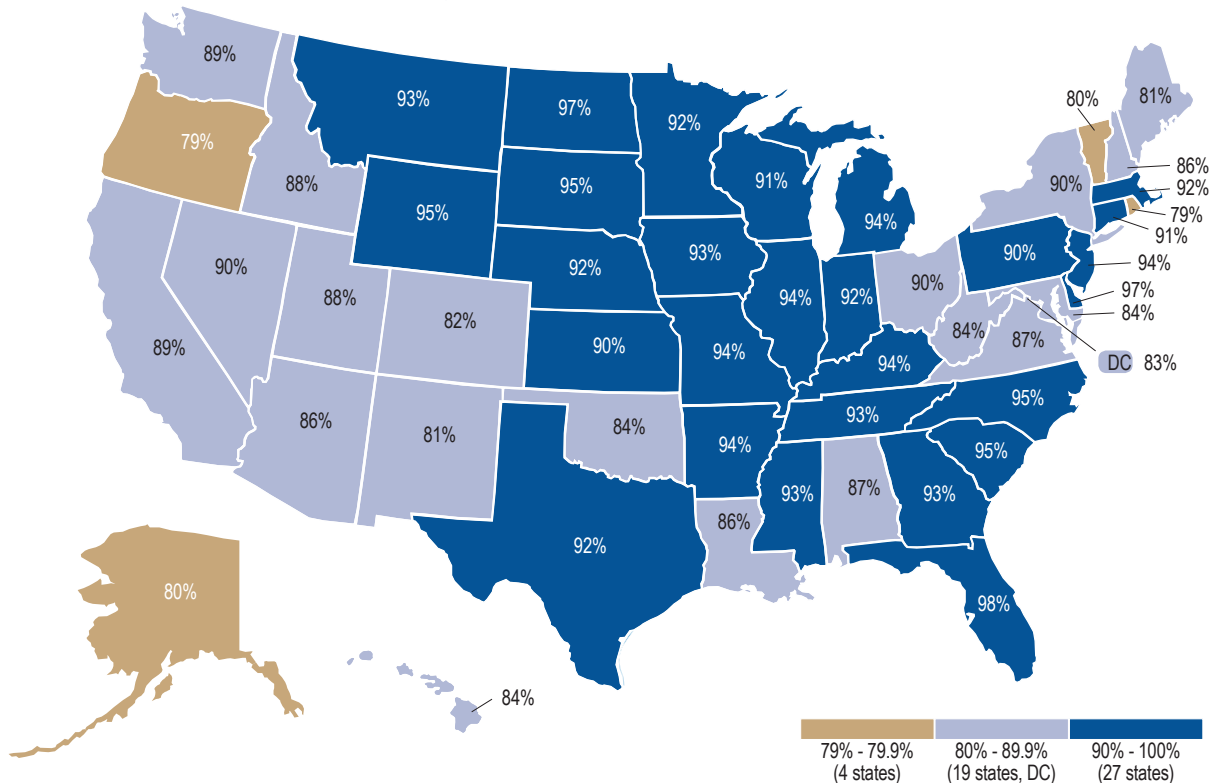
- 1) Issues or objectives are identified
- 2) Research is undertaken,
- 3) Solutions are suggested and vetted,
- 4) Goals firm-up,
- 5) Consensus builds (or, in some quarters, resignation),
- 6) Legislation is passed,
- 7) Regulations are written and promulgated,
- 8) Implementation begins,
- 9) Change occurs,
- 10) Issues are identified, and the cycle repeats.

Emerging Initiatives in Medicare—As noted earlier, important emerging issues in traditional Medicare for physicians, and other providers, may have as much to do with the objectives of, and increasingly sophisticated data tools available to, federal administrators, as with

current law. As we reviewed an array of recent CMS and other federal statements and actions relating to Medicare, three consistent objectives echo throughout. These were pursuit of 1) transparency, 2) accountability and 3) value in the health care provided to Medicare beneficiaries.

We selected two current issue areas to serve as “case-studies” that illustrate how a specific policy concern may build to legislative and regulatory interventions of some import systemically. The choices are: 1) Site-neutral payments for medical services, and 2) Public data releases of physicians’ Medicare billing information. We chose these because of their direct significance to physician payments or to the manner in which physicians are organized to practice medicine. Before reviewing the case studies, we’d like to note that physician participation in Medicare remains high despite program challenges.

ACROSS ALL STATES, MOST PHYSICIANS ACCEPT NEW MEDICARE PATIENTS



Notes: Pediatricians are excluded from this analysis. Physicians were not asked to distinguish between patients in traditional Medicare and Medicare Advantage plans.

SOURCE: NATIONAL AMBULATORY MEDICAL CARE SURVEY – NATIONAL ELECTRONIC HEALTH RECORDS SURVEY, 2012.



1 Case-Study: Site-Neutral Payment Policy for Ambulatory Care Services

Description: CMS and the Medicare Payment Advisory Commission (MedPAC) both have long-standing concerns over the higher amounts the Medicare program pays for medical services performed on an outpatient basis, where patients are receiving ambulatory care in multiple settings without being admitted to a facility or hospital.

Although such “ambulatory care” is generally covered and reimbursed through Part B of Medicare, payments are made using site-specific payment methodologies. Consequently, payment rates can vary considerably for comparable medical services due to the artifact of site-specific payment methodologies authorized and developed over time in Medicare. One example is the greater cost associated with an ambulatory procedure in a hospital outpatient department compared to the same service provided in a physician’s office. This has led to perceived inequities in payment across sites of care and also has a negative impact upon beneficiaries’ out-of-pocket costs in higher payment settings due to their liability being based on a percentage of the reimbursable amount.

MedPAC Testimony: MedPAC has examined this growing issue multiple times in recent annual Reports to Congress. Recently, the Executive Director of MedPAC, Mark Miller, PhD, testified on this issue before the Subcommittee on Health of the Committee on Energy and Commerce, of the U.S. House of Representatives (MedPAC. “Medicare Fee-For Service Payment Policy Across Sites of Care.” May 21, 2014.)

Following are certain key points abstracted from that testimony, including concern over the impact of the phenomenon of rapid growth in hospitals purchasing physician practices:

“Payment rates often vary for the same ambulatory services provided to similar patients in different settings. Medicare sets payment rates for physician and other practitioner services in the fee schedule for physicians and other health professionals, also known as the physician

fee schedule (PFS); payment rates for most hospital outpatient department services in the outpatient prospective payment system (OPPS); and payment rates for ASC services in the ASC payment system.

When a service is provided in a practitioner’s office, there is a single payment for the service. However, when a service is provided in a facility, such as an OPD or ASC, Medicare makes a payment to the facility in addition to the payment to the practitioner. For example, if a 15-minute evaluation and management (E&M) office visit for an established patient is provided in a freestanding practitioner’s office, the program pays the practitioner 80 percent of the PFS (non-facility) payment rate and the patient is responsible for the remaining 20 percent. If the same service is provided in an OPD, the program pays 80 percent of the PFS (facility) rate and 80 percent of the rate from the OPPS and the patient is responsible for 20 percent of both rates. As a result, Medicare typically pays much more when services are performed in an OPD, and the beneficiary has higher cost sharing. For example, in 2014 both the program and the beneficiary paid 116-percent more in an OPD than in a freestanding office for a level II echocardiogram.

Payment variations across settings need immediate attention because the billing of many ambulatory services has been migrating from freestanding offices to the usually higher paid OPD setting [emphasis supplied]. Among E&M office visits, echocardiograms, and nuclear cardiology services, for example, the volume of services decreased in freestanding offices and increased in OPDs from 2010 to 2012 (Table 3). For example, the volume of echocardiograms in freestanding offices dropped by 9.9 percent from 2010 to 2012, but grew by 33.3 percent in OPDs.

One of the factors driving this phenomenon is the rapid growth in hospital purchases of physician practices. According to data from the American Hospital Association Annual Survey of hospitals, the number of physicians and dentists employed by

E&M OFFICE VISITS AND CARDIAC IMAGING SERVICES ARE MIGRATING FROM FREESTANDING OFFICES TO OPDS, WHERE PAYMENT RATES ARE HIGHER

Type of service	Share of ambulatory services performed in OPDs, 2011	Per beneficiary volume growth, 2010-2012	
		Freestanding office	OPD
E&M office visits (CPTs 99201 through 99215)	10.7%	-2.3%	17.9%
Echocardiograms without contrast (APCs 269, 270, 697)	34.6	-9.9	33.3
Nuclear cardiology (APCs 377, 398)	39.0	-16.8	24.3

Note: E&M (evaluation and management), OPD (outpatient department), CPT (current procedural terminology), APC (ambulatory payment classification).

SOURCE: MEDPAC ANALYSIS OF STANDARD ANALYTIC CLAIMS FILES FROM 2010 AND 2012

hospitals grew by 55 percent from 2003 to 2011. As billing of services shifts from freestanding offices to OPDs, **program spending and beneficiary cost sharing increase without significant changes in patient care.** *To limit the incentive to shift cases to higher cost settings, there is a need to align OPD rates with freestanding office rates*” [emphasis supplied.](p. 14-15.)

After examining beneficiary cost-sharing and site variation issues, MedPAC reiterates five considerations for action on selective site-neutral payment policy (evaluation and management (E&M) office visits):

“In order to account for legitimate differences between freestanding offices and OPDs, the Commission developed five criteria to identify services that are good candidates for setting OPD payment rates equal to freestanding office rates:

- Services are frequently performed in freestanding offices (more than 50 percent of the time). This indicates that these services are likely safe and appropriate to provide in a freestanding office. Also, the PFS payment rates for these services are sufficient to assure access to care.
- Services entail minimal packaging differences across payment systems (i.e., the payment rate includes a similar set of services).
- The services are infrequently provided with an emergency department (ED) visit

when furnished in an OPD (such services are unlikely to have costs that are directly associated with operating an ED).

- Patient severity is no greater in OPDs than freestanding offices.
- The services do not have a 90-day global surgical code (CMS assumes that physicians’ costs for these codes are higher when performed in a hospital than a freestanding office.)”

Within this framework, **MedPAC recommends** the following changes:

- 1) Total payment rates for an E&M visit provided in an OPD should be reduced to the amount paid when the same visit is provided in a freestanding office, which is the lower cost setting (March 2012 *Report to Congress.*)
- 2) The differences in payment rates between OPDs and freestanding offices should be reduced or eliminated for 66 service categories that generally satisfy the criteria above. (June 2013 and March 2014 *Reports to Congress.*)
- 3) Equalizing payment rates between OPDs and ASCs for certain ambulatory surgical procedures (12 groups of services.) (Same reports as #2 above.)
- 4) Limiting Medicare revenue losses for hospitals that serve a large share of low-income patients, e.g. a stop-loss policy.

Perspectives—The development of MedPAC’s

site-neutral payment policy recommendations to the Congress follows the classic Medicare policy development path described earlier. Issues of questionable payment disparities and beneficiary out-of-pocket cost burdens arise. Evidence is developed and analyzed and solutions are proposed, and then refined into final recommendations.

MedPAC's process is to consult closely with CMS and other experts on such matters, hold regular public meetings at which such emerging issues are discussed in front of industry and other stakeholders, and report on details in their regularly scheduled Reports to Congress. Often, affected stakeholders are granted meetings and may always submit written concerns and information throughout, and also share their concerns, support or opposition with other stakeholders, the Administration and the Congress. This is a typically slow, lengthy, labor-intensive process at every stage, involving many individuals and entities. Albeit unwieldy, the traditional Medicare program policy process is essentially a public and somewhat democratic one.

One important aspect is that the area of concern is larger than the recommended solution. The fact that the latest recommendations are carefully scaled makes them harder for industry to refute and makes it easier for Congress to act. The second aspect is that the policies, if adopted, would reduce costs to beneficiaries, a reliably important goal. The third is that these policies would score federal budget savings, if enacted. If we had to predict, we would expect the next time a Medicare package is acted upon by the Congress, it will contain some, if not all, of the proposed policy changes leading to site-neutral payments for select medical services.

What are some systemic implications? Adoption of site-neutral payments will likely reduce aggregate payments to hospitals and ambulatory surgery centers for the affected services. This could affect employment and payment arrangements hospitals and ASCs have with their physicians. If profitability is reduced enough, it might affect the growth in hospitals' acquisition of physician practices. Interestingly, it could lead to higher beneficiary traffic to such sites and away from physician offices. To the extent that significantly higher

co-pays in the HOPD or ASC setting may have deterred some patients from relying on such locations for the selected medical services, out-of-pocket cost "equalization" could encourage some patients to seek care at such locations rather than the physician office setting.

Conclusion—For nearly every policy change enacted in Medicare, there are real effects upon beneficiaries and providers, not all of which are foreseen, or even foreseeable. Second, it is highly unlikely once such a policy is codified into law *that it will remain unchanged*. The more typical path would be for the principle of site-neutrality to be expanded to more services, and possibly more settings, in the future.

Case in Point: On June 13, 2014, MedPAC released its annual mid-year Report to Congress on Medicare issues. (Due to its brevity and for convenience, we provide the Executive Summary as an appendix to this chapter. The entire report is available on MedPAC.gov.) In addition to what we have discussed above, MedPAC has examined site-neutral payments for select conditions across acute care hospital and long-term care hospital settings. In the new report, MedPAC devotes an entire chapter on site-neutral payment for select conditions for patients treated in inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). Using several criteria, they selected major joint replacement, other hip and femur procedures (such as hip fractures), and stroke cases to examine the feasibility of paying IRFs and SNFs the same rates. Stroke data were more variable upon examination, but MedPAC concluded that the other two procedures are a good starting point for a site-neutral policy, especially if certain regulatory conditions for IRFs could be waived to create a more level playing field.

Conclusion—In closing, site-neutral payments for selected services is an issue ripening for Congressional action, including debate over how broadly or narrowly crafted legislative language should be governing the scope of such policies, and how broadly defined CMS's authority should be.

If we had to predict, we would expect the next time a Medicare package is acted upon by the Congress, it will contain some, if not all, of the proposed policy changes leading to site-neutral payments for select medical services.

2 Case-Study: Public data releases of physicians' identifiable Medicare billing information.

CMS Strategic Views on Display in a Letter—

On April 2, 2014, CMS Deputy Administrator Jonathan Blum wrote a letter to Dr. James Madara, Executive Vice President and CEO of the American Medical Association. The purpose of the letter was to prominently describe CMS's purposes, rationale and procedures for a comprehensive data release about the types of Medicare services provided by physicians, the charges billed and the actual Medicare payment made. In brief, the letter conveyed:

- CMS's interpretation of the Freedom of Information Act required CMS to release these extensive data;
- CMS was taking steps to safeguard beneficiaries' privacy and avoid sharing of any personally-identifiable information about beneficiaries;
- CMS weighed the privacy interests of physicians against the public's interest in government operations and determined the public's interest outweighed the privacy interests of physicians;
- CMS's view that the health care system is changing from a system dominated by "a dearth of usable, actionable information to one where care coordination and dramatically enhanced data availability and

data exchange will power greater innovation, higher quality, increased productivity and lower costs," and

- CMS's assessment that multiple provisions in the ACA especially support the release of meaningful data, such as Physician Compare, the Physician Quality Reporting System and provisions allowing certain qualified entities to receive Medicare claims data for purposes of "creating, reviewing and publishing performance reports about individual provider performance."

Magnitude of Physician Billing and Payment Data Release—

On the CMS.gov website, under the Research, Statistics, Data & Systems tab, CMS posted extensive Microsoft Excel spreadsheet files, methodological protocols, and summary tables. CMS also provided a Medicare physician and other supplier "Look-up Tool" and a frequently asked question resource. The actual datasets are of a magnitude that many physicians' or practices' systems may lack the storage or programming capacity to successfully extract useful data from the datasets without specialized technical assistance.

There are two major datasets that summarize data on the services provided to over 33 million beneficiaries in Medicare Part B in 2012. (These data do not include services provided to the over 13 million beneficiaries who were enrolled in Medicare Advantage plans.) The first dataset provides Medicare billing and payment data for over 880,000 providers, and includes details by name, address, specialty, national provider number, and total Medicare payment, as well as other statistics.

The second dataset is what CMS commonly refers to as an "analytical file," which in this case, breaks-down common Medicare procedures and services, the number of providers administering them, the number of times each was performed, the total number of patients that received each service, and the total amount Medicare paid for the service.

Perspectives—The Medicare physician billing and payment public data release, and more to follow, are game-changing events in the history of Medicare, and of the health care system. It has received a storm of media attention, much of it poorly reported due to

Views on CMS Release of Physician Data

- The Medicare physician billing and payment public data release, and more to follow, are game-changing events in the history of Medicare, and of the health care system.
- CMS's provider data release actions, and carefully constructed legal and policy rationales, serve notice that it intends to permanently alter the environment in which all health care providers practice, in the name of transparency and the public interest.
- CMS intends to use its clout to alter the health care environment in ways it believes will lead to improved quality and affordability.

the lack of understanding of Medicare billing and payment complexities. Much has focused on multi-million dollar payments to identified physicians without context over what the payments encompassed, such as inclusion of therapeutic drugs administered in oncology or ophthalmology in conjunction with the professional service.

CMS is justly criticized for failing to live up to its own statement that it intended for such data releases to be done in a way that makes the data “meaningful” to the public. In fact, the data were released with very little information about how to read and interpret the data; nor were clear explanations offered about the array of situations in which drug payments or other factors, such as practice organization, billing protocols, geographic location, etc., can meaningfully affect the evaluation of the raw data.

However, in our view, this remains a game-changing event for at least the following reasons:

1 > CMS SERVES NOTICE—CMS’s provider data release actions, and carefully constructed legal and policy rationales, serve notice that it intends to permanently alter the environment in which all health care providers practice, in the name of transparency and the public interest. In our view, there will be no turning back from this action and it will only expand. This is consistent with the statements we highlighted earlier regarding CMS’s strategic plan. CMS intends to use its clout to alter the health care environment in ways it believes will lead to improved quality and affordability.

2 > RESEARCH DATA AGREEMENTS EXPANSION—Second, the April 2014 data release is only CMS’s “initial shot across the bow.” In its April 2 letter to Dr. Madara, CMS served warning that it “plans to offer modifications to its current data use agreements to allow researchers to use our data as we are permitted to do under the applicable routine uses in our Privacy Act systems of record uses...this would include the removal of the prohibition on researchers redisclosing physician-identifiable information.”

There will be substantial opportunities for health services researchers to “mine” these and other provider data to come, for an array of

research and policy objectives. Note the “policy matrix” we described that CMS works in with the private sector and with federal and state organizations.

3 > DATA LINKAGES ACROSS CARE SETTINGS: We expect CMS to accelerate, expand-on and refine its provider data releases across multiple provider categories, and also connect and analyze cross-cutting data, such as linking physicians’ services to other payments in sites of care not captured in the initial data release. Such data can be used to judge provider service patterns and payments more broadly to inform judgments about care and payment appropriateness.

4 > PHYSICIAN PERFORMANCE ASSESSMENTS IN PRACTICES—We expect physicians will use these and similar data over time to judge their own performance and that of their colleagues in certain circumstances, such as in forming a practice group, or in organizing or operating an accountable care organization. As CMS well knows, facts are not only “stubborn things,” they can be surprising and powerful.

5 > PROGRAM INTEGRITY AND OIG STUDY: Over time, these and other more targeted algorithms will be used for program integrity purposes to better detect instances of possible billing fraud or abuse.

6 > UNEXPECTED DATA RESULTS AND CMS RESPONSE—Despite expectations about the potential risks and misinterpretation of data that can occur, other findings can emerge. As we noted, facts can be surprising. Physicians should be aware that in May 2014, the DHHS Office of the Inspector General released a physician billing study with this title: “Improper Payments for Evaluation and Management Services Cost Medicare Billions in 2010” (OEI-04-10-00181).

The OIG conducted a medical review of Part B claims for E&M services from 2010, stratifying so-called “high-coders” and claims from other physicians. The OIG stated that Medicare inappropriately paid \$6.7 billion for claims for E&M services in 2010 that were incorrectly coded and/or lacked documentation, representing 21 percent of Medicare payments for E&M services in 2010.

As CMS well knows, facts are not only “stubborn things,” they can be surprising and powerful.

However, the OIG also determined that fifteen percent of the E&M claims were *downcoded*, i.e., a higher code would have been appropriate for the documented service. This led to a recommendation that CMS take steps to better educate physicians on correct coding and documentation due to problems in both directions. Alternatively, CMS was reluctant to pursue additional contractor reviews of high-coding physicians due to previous “negative returns on contractor investment” in a similar review effort. CMS stated it would assess such a strategy relative to using Comparative Billing Reports.

7 > CONGRESSIONAL IMPACT (FEE SCHEDULE REFORM)—CMS’s data releases will evolve into tools and information to be presented to and mined by the Congress (or its assisting agencies, such as CBO, GAO and MedPAC) as it considers Medicare legislation. It is unclear what the longer-term impact of factual and meaningful

data might be on such major issues as the reform of the Medicare fee schedule and sustainable growth rate formula (see chart).

It has also been noted in some quarters that these data begin to raise deeper questions about the building blocks and ongoing management of the RB-RVS system, and possible anomalies in Medicare payment results.

Conclusion—We opened this chapter with a discussion of the growing “complexification” of Medicare since its enactment in 1965. We are witnesses to that phenomenon in the current time to a degree barely imagined even ten or fifteen years ago. We proceeded to highlight ways in which select provisions in the ACA and CMS’s strategic goals as an agency are complementary with respect to leveraging the power of the Medicare program to address larger health system goals.

THE SUSTAINABLE GROWTH RATE (SGR)—MEDICARE’S PAYMENT FORMULA FOR PHYSICIAN SERVICES



24%

Scheduled SGR cut in Medicare payments to physicians starting April 1, 2014



\$115 Billion

10-year cost of repealing the SGR and preventing fee cuts; higher cost if fees are increased



16 times

Number of times Congress has overridden scheduled SGR fee cuts since 2003

SOURCE: CONGRESSIONAL BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024*, P. 58, FEBRUARY 4, 2014.

Note: CBO estimate of \$115 billion reflects the change in estimated Medicare outlays if Medicare payment rates for physician services remained at current levels through 2024. Any payment increases to fees for physician services during this 10-year period would incur higher Medicare spending (all else equal). Subsequent to publication of the related *JAMA* infographic (Vol. 311, No. 8, February 26), CBO released a cost estimate for the *SGR Repeal and Medicare Provider Payment Modernization Act of 2014* (H.R. 4015/S. 2000). This cost estimate—\$138 billion over 10 years—includes changes in Medicare outlays due to specified payment updates for physician services (i.e., no payment cut in 2014; 0.5% increases annually through 2018). Although this estimate encompasses other provisions in the Bill, CBO attributes most of the cost to the specified fee-schedule updates.

CBO cost estimate, released February 27, 2014:

H.R. 4015, SGR Repeal and Medicare Provider Payment Modernization Act of 2014: <http://www.cbo.gov/publication/45148>

S. 2000, SGR Repeal and Medicare Provider Payment Modernization Act of 2014: <http://www.cbo.gov/publication/45149>

Legislative actions to override SGR fee cuts:

- Consolidated Appropriations Resolution of 2003 (CAR, P.L. 108-7)
- Medicare Modernization Act of 2003 (MMA, P.L. 108-173)
- Deficit Reduction Act of 2005 (DRA, P.L. 109-171)
- Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109-432)
- Medicare, Medicaid, and SCHIP Extension Act of 2007 (MMSEA, P.L. 110-173)
- Medicare Improvement for Patients and Providers Act of 2008 (MIPPA, P.L. 110-275)
- Department of Defense Appropriations Act (P.L. 111-118)
- Temporary Extension Act (P.L. 111-144)
- Continuing Extension Act (P.L. 111-157)
- Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010 (P.L. 111-192)
- Physician Payment and Therapy Relief Act of 2010 (P.L. 111-286)
- Medicare and Medicaid Extenders Act (P.L. 111-309)
- Temporary Payroll Tax Cut Continuation Act of 2011 (P.L. 112-78)
- Middle Class Tax Relief and Job Creation Act of 2012 (P.L. 112-96)
- American Taxpayer Relief Act (P.L. 112-240)
- Pathway for SGR Reform Act of 2013 (P.L. 113-67)



Finally, we noted that if one is an advocate of the *traditional program model* for Medicare, many of the ACA policy provisions represent important new tools that enable federal agencies to pursue deeper systemic improvements in patient care, while constraining costs. The strongest supporters of the Medicare Advantage and Part D *private plan benefit management models*, however, are less supportive of the expanding reach of the federal government, especially through Medicare and the ACA, directly into health system dynamics. What would happen to the body of policies and regulations that define the traditional Medicare program if the entire program was converted over to a private plan competition model? We join this issue in Chapter IV: Medicare Modernization and Competition.

What would happen to the body of policies and regulations that define the traditional Medicare program if the entire program was converted over to a private plan competition model?

Appendix B: CMS Strategic Plan



CMS Strategy: The Road Forward 2013-2017



OUR JOURNEY BEGINS HERE

The United States is a global leader in health care. Our academic institutions, health care professionals and service providers are internationally known and admired. Yet, despite this, Americans die sooner than citizens of many other nations.¹ In most years, U.S. health care spending has grown faster than the economy.² By 2020, health care expenditures are projected to reach \$4.6 trillion and account for close to 20 percent of the nation's gross domestic product (GDP).³ By 2030, people over 65 will make up 20 percent of our population, with the fastest growing group over age 85.^{4,5} As greater numbers of Americans lead longer lives, the cost of care will continue to rise. Health disparities are a persistent challenge for the U.S. health care system, and high rates of preventable diseases among racial and ethnic minorities add to growing health care expenditures. The effectiveness of the health care system is also limited by those without health coverage. In addition, a significant number of Americans are underinsured – meaning that, if they were faced with a significant health or medical issue, their existing health insurance would not provide adequate coverage. This lack of coverage contributes to individuals' inability to access health care, which can lead to early death. Finally, health care costs directly reflect the underlying health of the population. When underlying health is poor, health care costs – both economic and non-economic (such as reduced quality of life) – are high. When a population is healthier, costs are lower, and societies can invest resources in other priorities such as education, infrastructure, and defense.

We know change is possible. The Affordable Care Act (ACA) takes significant steps towards expanding coverage and improving access to health care while also improving the quality and affordability of health care for all Americans. It strengthens the workings of the private health insurance market and extends help to moderate- and low-income Americans to make health insurance coverage more affordable. It also takes important steps toward changing how services are paid for in Medicare and Medicaid, by increasingly rewarding better outcomes instead of volume. Reducing spending and improving quality and care coordination are strategic objectives for CMS and are also a major focus of the ACA. Policies such as establishing Accountable Care Organizations, increasing value-based purchasing, coordinating care for individuals enrolled in both Medicare and Medicaid, and reducing hospital readmissions will improve the value of care. The Affordable Care Act also created incentives and other initiatives to better coordinate patient care across settings and over time.

CMS' role in the larger health care arena has been further expanded beyond our traditional role of administering the Medicare, Medicaid and CHIP Programs. Designed to expand access to affordable health care and make the U.S. health care system more outcome-driven and cost-effective, the ACA requires that CMS coordinate with States to set up Health Insurance Marketplaces, expand Medicaid, and regulate private health insurance plans. The ACA greatly expanded the Agency's role and responsibilities by effectively tasking CMS to lead the charge to provide high quality care and better health at lower costs through improvement to health care for all Americans. This expansion not only involves growth in CMS' traditional base but also includes a greater emphasis on its continuing efforts in program integrity, health care innovation and health disparities reduction, as well as the establishment of Affordable Insurance Marketplaces. The

1 Muennig, PA, & Glied, SA. What changes in survival rates tell us about US health care. *Health Affairs*, 29(11), 2105-2113, 2010.

2 CMS Office of the Actuary, National Health Expenditures Tables.

3 CMS Office of the Actuary, National Health Expenditure Projections 2010 – 2020.

4 Vincent, GK & Velkoff, VA, The Next Four Decades: The Older Population in the United States: 2010 to 2050, Census Bureau, May, 2010.

5 http://www.aoa.gov/agingstatsdotnet/Main_Site/Data/2010_Documents/Population.aspx.

integration of the Center for Consumer Information and Insurance Oversight into the Agency extended its responsibilities to market reforms and consumer protections in the private health insurance market. Through other legislation, CMS also now shares major responsibility for promoting the adoption and use of health information technology in the nation's health care system.

The standup of the Center for Medicare and Medicaid Innovation (CMMI) will help to coordinate these Agency-wide efforts to promote experimentation and innovation in payment and delivery models, reduce disparities in health care outcomes, promote primary care, and improve patient protections. CMMI will also, coordinate and drive many Agency-wide efforts to address continued growth in the cost of care, the aging of the population, the increased prevalence of costly chronic conditions, and budgetary pressures.

OUR DESTINATION

CMS will continue to leverage our internal resources and external partnerships to fulfill our mission – *as an effective steward of public funds, CMS is committed to strengthening and modernizing the nation's health care system to provide access to high quality care and improved health at lower cost.*

In our effort to fulfill this charge, our vision of future success is **a high quality health care system that ensures better care, access to coverage and improved health.** We are focused on measurably improving care and population health by transforming the U.S. health care system into an integrated and accountable delivery system that continuously improves care, reduces unnecessary costs, prevents illness and disease progression, and promotes health. We will find better ways to ensure that the right care is accessible and delivered to the right person at the right time, every time.

To fulfill our mission and achieve our vision of a high quality health care system, CMS has chosen four Strategic Goals that we must achieve. These strategic goals cut across programs and support functions throughout CMS. In addition, each Strategic Goal is described in “end state” language that describes the goal's intent.

While pursuing our strategic goals, CMS will continually reference our core values that serve as the basis of decision-making and should influence our everyday actions.

WE WILL LIVE BY OUR CORE VALUES:

People First – CMS puts first the best interest of the people it serves and the employees who faithfully serve them.

Public Service – CMS takes pride in its unique and privileged role in the health care of the nation.

Integrity – CMS holds itself to the highest standards of honesty and ethical behavior.

Accountability – CMS earns trust by being responsible for the outcomes of its actions.

Teamwork – CMS fosters unconditional teamwork and regards every employee in CMS as valuable and willing to help each other. CMS strives to fully cooperate with our partners in the private sector.

Innovation – CMS encourages finding and testing new ideas.

Excellence – CMS is committed to strengthening its organizational culture of striving for excellence with regard to its products and services, as well as how CMS conducts business.

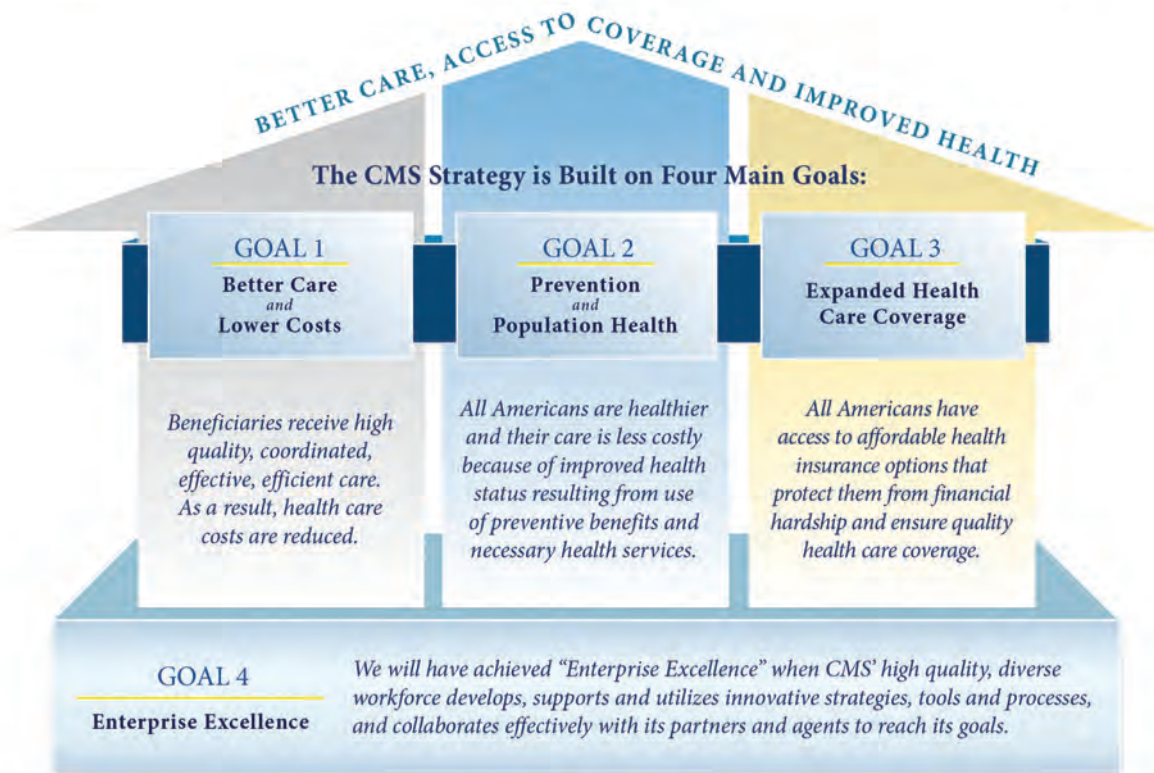
Respect – CMS treats all stakeholders and one another with the utmost respect and professionalism.

Continuous Improvement – CMS strives to continually refine its processes, systems and services in the pursuit of excellence.



OUR STRATEGIC GOALS

Every four years, the Department of Health and Human Services (HHS) updates its strategic plan as required by the Government Performance and Results Act (GPRA) of 1993 (Public Law 103–62) and the GPRA Modernization Act (GPRA-MA) of 2010 (PL 111-352). HHS’ plan defines its mission, goals, and the means by which it will measure its progress in addressing mission-related challenges. This CMS Strategy directly aligns with the HHS plan (Appendix #1). As we refine our Strategy over time, we will align to and draw upon the various planning efforts at work throughout the federal government. This alignment helps ensure that the CMS Strategy reflects the most current priorities and best available thinking, while also providing a coordinated implementation approach that ensures the Strategy is put into action.



THE ROAD WE WILL TRAVEL

A “Strategic Plan” is only good if it is implemented and managed – and only effective if it drives the decisions we make. Missing from many high level strategic plans is a comprehensive picture of *how* an organization will accomplish its goals and fulfill its vision. As CMS builds a capacity for strategic thinking and performance management that will enrich the policy and operational decisions we make in administering the programs and ultimately improve care and supports provided to individuals, CMS must also articulate how it will reach these lofty aspirations. The CMS Strategic Roadmap describes the mission, vision, values, and goals of the Agency in administering its programs and implementing its new responsibilities under the Affordable Care Act, but it is not a fully implementable strategic plan – it is only the beginning.

Our Agency’s plan, we refer to as the CMS Strategy, goes one step further. It describes a unified Agency approach to managing our Strategy based on common goals and outcomes. We are aligning our internal operations to meet the demands of new challenges, leverage our resources to reduce waste and redundancy, improve the management and use of data, and promote a culture of multi-component collaboration.

Beginning with our vision, mission and goals, we will investigate our strategic objectives and desired outcomes – or “what continuous improvements are needed to get results”, establish performance measures which tell us how we will know if we are achieving desired results, and then move on to identifying specific strategic initiatives and initiative-aligned projects that will contribute to our desired outcomes.

The figure below describes the “logic” of the CMS Strategy. Beginning at the top of the pyramid, our mission describes “what we intend to do” in order to achieve our “vision” for what the future will look like if we are successful. Our “goals” are further described by “objectives” that are measured to help us understand if we are making progress. This logical approach leads us to identify specific “initiatives” and those projects that will directly contribute to achieving our goals.



Over the last year, with the leadership and support of the Strategic Planning and Management Council (SPMC), comprised of component leadership, CMS identified seven Strategic Objectives (see figure #2). Our strategic objectives span four organizational perspectives, or lenses. In the figure below, the organizational perspectives are arrayed on the left with organizational capacity and internal processes forming the foundation, culminating in the value delivered to our stakeholders at the top. This graphic, or “Strategy Map”, displays the cause-and-effect relationships among the Strategic Objectives that make up our Strategy. It tells the story of “how” CMS creates value — improvements in

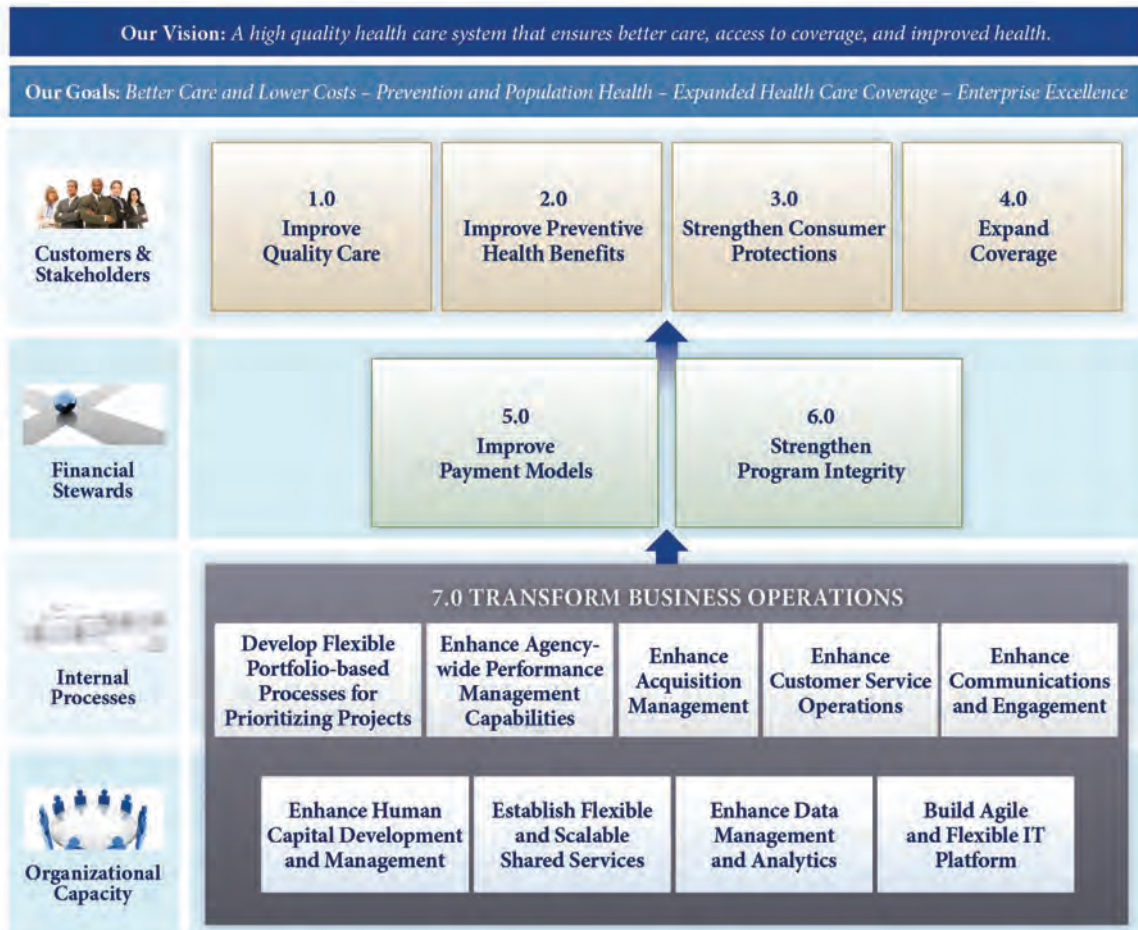
organizational capacity lead to better processes and better processes enable us to improve our financial stewardship and achieve better outcomes for CMS' stakeholders overall.

The CMS Strategy illustrated in the map below depicts how investments relate to our organization's objectives in the following areas:

- **Organizational Capacity:** How can we improve the internal processes through improved competencies, tools and technology, leadership and other capacities and/or capabilities?
- **Internal Processes:** How well can we improve internal processes so we can deliver products and services better, faster, and cheaper?

Allow us to achieve outcomes in the top two perspectives:

- **Financial Stewardship:** How well do we maximize mission value and effectiveness with the resources we are given?
- **Customers & Stakeholders:** How well are we meeting the needs of our customers and stakeholders?



Note: Objective 7.0, Transform Business Operations, includes nine operational objectives that span the organizational capacity and internal process perspectives. In addition to being the foundation of the CMS Strategy, these objectives are the key to achieving transformed business operations and will help CMS achieve its enterprise excellence goal.



OUR STRATEGIC OBJECTIVES AND DESIRED OUTCOMES

Improve Quality Care

- Care is made safer by reducing harm caused in the delivery of care.
- Patients and families are engaged as informed, empowered partners in their care.
- Communication and care coordination across providers and health care facilities improves, leading to better health care quality at lower costs.
- Leading causes of mortality are reduced and prevented.
- A population-based approach to health care and preventive services improves health outcomes for all populations and helps individuals achieve their highest health-related quality of life.
- Best practices are promoted and disseminated in communities.
- The meaningful use of electronic health records results in better care, better coordination, and lower costs.
- Quality care is affordable for individuals, families, employers and governments.
- Patient outcomes are improved and reporting burden is reduced through strengthened alignment of quality measures and associated payment and public reporting programs with the National Quality Strategy.
- Integrated care models allow physicians and other providers to come together in new ways to better coordinate care.
- Accessibility to quality long term supports for individuals with disabilities and older adults achieve greater community integration.
- Informal caregivers can effectively provide valuable support to their family.
- Value-based payment ensures providers are incentivized to provide high-quality, efficient care.
- Adequate provider supply in needed areas is supported.



Improve Preventive Health Benefits

- Use of evidence-based preventive services and primary care keeps individuals healthy, improves population health, and avoids adverse outcomes. CMS uses the latest scientific evidence to determine coverage.
- Use of lifesaving/cost-saving preventive benefits increases; including screenings and tests (e.g., blood pressure, diabetes, immunizations) and home- and community-based services.
- Disparities in the use of preventive benefits, community-based services, outreach, and education are identified and reduced.



Strengthen Consumer Protections

- Partnerships among issuers, consumers, the community, and state-based insurance oversight activities strengthen consumer protections against private insurance abuses.
- Consumer protections in the private marketplace promote transparency into issuers' business operations and increases their accountability that result in cost savings for enrollees.



Expand Coverage

- Support to States as they create affordable insurance marketplaces reduce the number of uninsured and help ensure eligible individuals receive needed assistance.
- Guidance, resources and flexibility for States enable them to construct competitive insurance marketplaces that best meet the needs of their citizens.



Strengthen Program Integrity

- Federal and state oversight of Medicaid expenditures improves financial accountability.
- Coordination and collaboration with law enforcement in order to achieve law enforcement buy-in and support for CMS' new approach away from "pay and chase" and towards prevention and detection.
- Enrollment processes are refined, inappropriate payments are identified, and detection of bad actors is enhanced.
- Policy levers and all available mechanisms to combat fraud, waste, and abuse are considered early in regulation development and policy changes.
- Risk management improves proactive stance with consistent and effective program oversight across the range of CMS' programs.



- Compliance and oversight activities strengthen enforcement.
- A more targeted screening process improves prevention of fraud, waste and abuse.
- Risk is managed and strategic investments provide high impact and rate of return.
- Audit processes are improved resulting in reduced audit frequency inconsistencies.
- Program data is integrated, better aligned, and used for decision-making.
- Partnerships with States on implementing health care delivery reform and increasing access to health care coverage are enhanced.
- Decision makers and other key staff have necessary access to financial information related to Agency resources creating a more accountable, reliable, and transparent CMS.
- CMS takes a proactive and integrated approach to Agency program integrity activities.

Improve Payment Models

- Patient/provider incentives for better outcomes and more efficient care align payment with performance and provide new incentives that encourage care coordination, high quality, and efficient care delivery. Value-based payment ensures providers are incentivized to provide high-quality, efficient care.
- Claims processing accuracy and timeliness of payments to providers and States, through the use of electronic reporting tools and transparency; assure appropriate provision of care and services, and reduce the administrative burden for providers and States, while decreasing Agency administrative costs.



Transform Business Operations

- Application of the conditions of participation and conditions for coverage and the survey and certification process promotes high quality care and safety, and reduces provider burden and operational costs. By routinely reviewing all regulatory requirements and survey guidance to incorporate changes in practice, we reduce unnecessary burden that does not contribute to improved health for beneficiaries.
- Processes for reviewing and approving state proposals accelerate and simplify to expand access to Medicaid and establish health care marketplaces. This results in the timely negotiation, approval, and implementation of state plan amendments, state health care delivery reform initiatives, and other state-federal administrative activities. Modern technology and business process redesign ensures that timeliness goals are met, and that structured data on program design is available to CMS and our state partners.
- Culture of lean production and the continuous improvement of our operations and operating processes decrease the cost of production.
- Enterprise operations, performance reliability, resilience and accountability minimize waste, mitigate risk, optimize resources, assure continuity, and deliver timely response.



- Agency acquisition planning allows CMS to prioritize investments, and better define requirements, to identify opportunities for strategic sourcing that leverages the Agency's buying power, and ensures delivery of better and more cost effective programmatic results and outcomes for our beneficiaries and for taxpayers.
- Regulatory burden decreases by reducing unnecessary, obsolete, or burdensome regulations, simplifying requirements of the public and private sectors, and enhancing net benefits of the regulations.
- Administrative simplification activities align with other e-health and business initiatives in order to streamline interactions among health plans, providers, and other entities through standardized, real-time transactional automation; resulting in the integration of clinical and claims information and reductions in provider burden.
- Efficiency and agility of "shared" and common support services promote timely access, transparency and communication, and improve service quality. The development of enterprise shared services, reduces costly redundancies and increases our effectiveness.
- Accountable, reliable, accessible, and transparent financial information aids decision makers in the day-to-day management of CMS programs.
- The understanding of new delivery system and payment models support choice and person-centered care and services and allow CMS to quickly integrate new programs.
- Health care information available to consumers is understandable, culturally and linguistically-appropriate and comprehensive. Health information assists consumers in making informed decisions about finding health care coverage that best meets their needs.
- Stakeholders can obtain insight on the Medicare, Medicaid, CHIP, and Health Insurance Marketplace programs through modernized monitoring and reporting.
- Engagement with other public and private sector entities promote collaborative partnerships that enhance policy, operations, and other enterprise interests and initiatives. Partnerships extend the reach and impact of many programs aimed to improve the health and wellness of Americans.
- Internal CMS employees benefit from enhanced communication and opportunities for collaboration.
- Recruitment, staff support, and skill development provide the resources, competencies and opportunities for a diverse staff to work to their fullest potential in a supportive work environment that achieves the overall mission.
- An environment which supports employee wellness improves staff morale and productivity. Retention and productivity are improved by addressing opportunities for improvement such as those identified in the Employee Viewpoint Survey.
- Investments in information systems expands the CMS knowledge base.
- New innovative technologies are adopted that enhance the availability, quality and delivery of information.
- Infrastructure and technology improvements enhance interoperability and promote evidence-based decisions made by public stakeholders, researchers, state officials and others using enterprise data, analytics, and information products.
- Data standardization and integration effectively improves care coordination, performance, transparency, and knowledge discovery.
- The CMS Workforce has systems, tools and data to perform at the highest levels.

SIGNS OF PROGRESS

We will know that we are making progress in effectively managing our Strategy when we see several things occurring:

1. We are able to manage our performance by effectively using data to gauge our progress.

As part of the movement toward a performance-based and results-oriented environment, the Government Performance and Results Act (GPRA) requires Federal agencies to set strategic goals and objectives, measure performance, and report their accomplishments. CMS must excel at thinking strategically and taking appropriate action to effectively manage its many mission-critical activities. As an Agency, we must use performance metrics that are measurable, usable and actionable to ensure that resources are directed towards priorities, operational risks are identified, and employees are held accountable for meeting strategic goals.

The Administration, Congress, public, and health care industry expect CMS to be accountable for the efficient and effective administration and oversight of its programs. As such, we are planning a comprehensive Agency-wide process to define, capture and report on performance outcomes and project milestones associated with the Strategy's activities. For example, an executive-level dashboard will be developed to report at-a-glance information on the status of CMS' key performance accomplishments and challenges, provide timely and relevant information to decision makers, reduce reporting burden on program staff, and enable them to make mid-course adjustments to the Strategy.

CMS understands that managers and employees must be engaged to foster a culture of accountability. Our new performance management framework will align the Agency's progress on its strategic goals and objectives to the performance commitments of senior executives responsible for moving particular priorities forward. These expectations will cascade to the performance plans of managers and employees. This new framework will help support CMS as it evolves into a more nimble, performance-focused organization that can effectively and efficiently respond to the changing demands and expectations of its stakeholders.

2. Various Agency strategic plans are coordinated and integrated; staff at all levels of the organization align their work to the CMS Strategy.

Progress will be realized when independent strategic and action plans across all levels of the organization are consistently aligned with the CMS Strategy. In most cases, strategic plans for the Centers, Offices, Consortia and other components will "cascade" from the CMS Strategy. This means that each component's vision, mission and strategy supports the Agency's Strategy and day-to-day work provides individuals with a clear understanding of how their efforts fit into the CMS Strategy. A clear understanding of the Agency goals and objectives will meaningfully guide staff's decisions on a day-to-day basis. By aligning to strategic objectives, the organization can better focus efforts on long-term results and accomplishments, instead of short-term milestones and task completion.

3. We are "open" – transparent, participatory and collaborative – with internal and external partners and stakeholders.

Having a defined Strategy will enable us to be open with our internal and external partners in meaningful ways. By inviting and using meaningful input across the Agency and with our partners and stakeholders our Strategy will be enhanced and we will have greater opportunities for success. We will continually strive to create mechanisms for the public to contribute their ideas, and harness the energy and expertise both inside and outside the government to achieve our goals.



THE ROAD FORWARD

We are not simply “implementing the plan” but rather “managing our Strategy”. We will work together, across component lines, to devise better ways of doing business and understand how our current initiatives contribute to attaining our goals, as well as what new things we can do to make measureable progress. We will hold ourselves accountable for our Strategy’s success and will make refinements over time.

Over the next several months, with the leadership and support of the Strategic Planning and Management Council (SPMC), Implementation Teams will be convened. These cross-Agency implementation teams will identify more specific objectives, outcome-based performance measures, and initiatives. The SPMC will provide a forum for on-going collaboration between teams and overall management of the CMS Strategy.

Each of the Implementation Teams will have a champion and will be comprised of a cross-cutting team of those who understand the policy considerations, as well as staff who are involved in Project Planning, Performance Measurement, Strategy Management, Process Management, Enterprise Excellence, and other disciplines, to foster a comprehensive view of how to achieve the strategic objectives.

While this plan will include specific strategic initiatives that will reposition us to meet the current challenges of the health care system, we all have a part to play. Our success depends on the involvement and support of every CMS employee. Each of us will be called to contribute — either to a specific strategic initiative, or to maintain our progress in ongoing program operations that are critical to fulfilling our Agency’s mission.

CMS Strategy 2013-2018	HHS STRATEGIC PLAN				
Better Care and Lower Costs Prevention and Population Health Expanded Health Care Coverage Enterprise Excellence	Strengthen Health Care	Advance Scientific Knowledge and Innovation	Advance the Health, Safety, and Well-Being of the American People	Increase Efficiency, Transparency, and Accountability of HHS Programs	Strengthen the Nation's Health and Human Services Infrastructure and Workforce
Improve Quality Care	★		★		
Improve Preventive Health Benefits	★		★		
Strengthen Consumer Protections	★	★	★	★	
Expand Coverage	★		★	★	
Improve Payment Models	★	★	★	★	
Strengthen Program Integrity	★		★	★	
Transform Business Operations				★	★



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Appendix C: Executive Summary – Medicare and the Health Care Delivery System

Medicare Payment Advisory Commission

Executive Summary—As part of its mandate from the Congress, each June the Commission reports on refinements to Medicare payment systems and on issues affecting the Medicare program, including broader changes in health care delivery and the market for health care services. In the seven chapters of this report we consider:

- **Synchronizing Medicare policy across payment models**—In 2012, a third payment model, the accountable care organization (ACO), became available in addition to the traditional fee-for-service (FFS) and Medicare Advantage (MA) payment models. A major issue is that Medicare’s payment rules and incentives are different and inconsistent across the three payment models. To address that issue and start to synchronize Medicare policy across payment models, we examine setting a common spending benchmark—tied to local FFS spending—for MA plans and ACOs.
- **Improving risk adjustment in the Medicare program**—Risk adjustment is currently used to ensure that Medicare’s payments track the expected costs of beneficiaries. We examine three models for improving how well risk adjustment predicts cost for the highest cost and lowest cost beneficiaries and suggest that, given the limitations of those models, administrative measures may be needed to better calibrate payments to expected costs.
- **Measuring quality of care in Medicare**—Current quality measures are overly process oriented, too numerous, may not track well to health outcomes, and are a burden on providers; they may not be appropriate for each of the payment models discussed in Chapter 1. We examine which approaches to quality measures would be appropriate to each payment model and consider using population-based outcome measures (e.g., potentially avoidable admissions for the FFS population in an area) to evaluate and compare quality within a local area across Medicare’s three payment models. Provider-specific quality measures may still be needed for FFS payment adjustments.
- **Financial assistance for low-income beneficiaries**—We discuss how changing income eligibility for the Medicare Savings Programs could help low-income Medicare beneficiaries afford out-of-pocket (OOP) costs under a redesigned Medicare FFS benefit package.
- **Paying for primary care using a per beneficiary payment**—The current FFS-based primary care bonus program expires in 2015. We consider an option to continue additional payments to primary care practitioners, but in the form of a per beneficiary payment. The current FFS approach encourages volume. A per beneficiary approach could help encourage care coordination.
- **Medicare payment differences across post-acute settings**—Medicare’s payment rates often vary for treating similar patients in different settings, such as inpatient rehabilitation facilities (IRFs) and skilled nursing facilities (SNFs). We examine three conditions and assess the feasibility of paying IRFs the same rates as SNFs for those conditions.
- **Measuring the effects of medication adherence on medical spending for the Medicare population**—We examine the effects of medication adherence for patients with congestive heart failure (CHF) and find that greater medication adherence is associated with lower medical costs, but that effect is dependent on the beneficiaries’ previous health status, decays over time, and is sensitive to the specifications of the model. In an online appendix (available at <http://www.medpac.gov>), as required by law, we review CMS’s preliminary estimate of the update to payments under the physician fee schedule for 2015.

Synchronizing Medicare policy across payment models

Historically, Medicare has had two payment models:

traditional FFS and MA. Traditional FFS pays for individual services, according to the payment rates established by the program. By contrast, under MA, Medicare pays private plans capitated payment rates to provide the Part A and Part B benefit package except hospice. Starting in 2012, Medicare introduced a new payment model: the ACO. Under the ACO model, a group of providers is accountable for the spending and quality of care of a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives given to private plans under the MA program.

A major issue is that Medicare’s payment rules and quality improvement incentives are different and inconsistent

across the three payment models. There are various approaches to making those rules more consistent. From the program perspective, the Commission is examining synchronizing policy across payment models with respect to spending benchmarks, quality measurement, and risk adjustment and will be examining synchronizing regulatory oversight. The Commission is also interested in the beneficiary perspective on synchronizing policy across payment models, including how beneficiaries learn about the Medicare program, choose plans, and respond to financial incentives.

Chapter 1 represents the Commission's initial exploration of synchronizing Medicare policy across payment models and is not intended to be a definitive or comprehensive discussion. In this initial analysis, we focus on setting a common spending benchmark—based on local FFS spending—for MA plans and ACOs as a key element of synchronizing Medicare policy across payment models. Using an analysis of early results from the Pioneer ACOs, we illustrate that no single payment model is uniformly less costly than another model in all markets across the country. Which model is less costly and which ACOs and MA plans may want to enter the program would be sensitive to how benchmarks are set.

Improving risk adjustment in the Medicare program

Health plans that participate in the MA program receive monthly capitated payments for each Medicare enrollee. Each capitated payment has two parts: 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. The purpose of the risk scores is to adjust MA payments so that they accurately reflect how much each MA enrollee is expected to cost.

Currently, Medicare uses the CMS–hierarchical condition category (CMS–HCC) model to risk adjust MA payments. This model uses beneficiaries' demographic characteristics and medical conditions collected into hierarchical condition categories to predict their costliness. But, although it is an improvement over past models, the CMS–HCC model predicts costs that are higher than actual costs (overpredicts) for beneficiaries who have very low costs and lower than actual costs (underpredicts) for beneficiaries who have very high costs. These prediction errors can result in Medicare paying too much for low-cost beneficiaries and not enough for high-cost beneficiaries. These underpayments and overpayments raise an issue of equity among MA plans. Plans that have a disproportionately high share of high-cost enrollees may be at a competitive disadvantage relative to those whose enrollees have low costs.

A related issue is how risk-adjustment inaccuracies affect equity among MA plans, FFS Medicare, and ACOs. If payment equity among these three payment models is a goal, risk adjustment that results in more accurate payments for high-cost and low-cost beneficiaries is vital. For example, if the MA sector can attract low-cost beneficiaries (for which Medicare overpays) and avoid high-cost beneficiaries (for which Medicare underpays), the risk-adjusted payments in the MA sector would exceed what their enrollees would cost in ACOs or FFS Medicare.

In Chapter 2, we investigate alternative methods discussed in the literature for improving how well risk adjustment predicts costs for the highest cost and lowest cost beneficiaries. We examine three models and find that all three would introduce some degree of cost-based payment into the MA program, which could reduce incentives for plans to manage their enrollees' conditions to hold down costs. The Commission concludes that because of the limitations of these models, administrative measures may be needed to better calibrate payments to expected costs.

Measuring quality of care in Medicare

The Commission is considering alternatives to Medicare's current system for measuring the quality of care provided to the program's beneficiaries. A fundamental problem with Medicare's current quality measurement programs, particularly in FFS Medicare, is that they rely primarily on clinical process measures for assessing the quality of care provided by hospitals, physicians, and other types of providers, measures that may exacerbate the incentives in FFS to overuse services and fragment care. As well, some of the process measures are often not well correlated to better health outcomes, there are too many measures, and reporting places a heavy burden on providers. In Chapter 3, we examine which approaches to quality measurement are appropriate for each of the three payment models in Medicare: FFS Medicare, MA, and ACOs. We discuss an alternative to the current measurement system: using population-based outcome measures (e.g., potentially avoidable admissions for the FFS population in an area) to evaluate and compare quality within a local area across Medicare's three payment models. We consider a small set of measures that would be less burdensome to providers and directly related to health outcomes. A population-based approach could be useful for public reporting of quality for all three models and for making payment adjustments within the MA and ACO models.

A population-based outcomes approach may not be appropriate for adjusting FFS Medicare payments in an area because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries. Therefore, at least for the foreseeable future, FFS Medicare will need

to continue to rely on provider-based quality measures to make payment adjustments. We find current provider-level quality measurement technology may not be sufficiently developed to support payment adjustments for all providers in all settings; for example, it may not address the full range of physician services. We discuss steps that Medicare could take in the short term to improve its provider-based quality measurement programs.

Financial assistance for low-income Medicare beneficiaries

In Chapter 4, we discuss how changing income eligibility for the Medicare Savings Programs (MSPs) could help low-income Medicare beneficiaries afford OOP costs under a redesigned Medicare FFS benefit package. The Commission has made two previous recommendations on this issue:

- The first recommendation, from 2008, was for the Congress to align the MSP income eligibility criteria with the Part D low-income drug subsidy (LIS) criteria, effectively increasing the full Part B premium subsidy to beneficiaries with incomes up to 150 percent of the federal poverty level. MSPs provide financial assistance with the Medicare Part B premium for beneficiaries with incomes up to 135 percent of the poverty level. Medicare's Part D prescription drug benefit incorporates a subsidy structure that provides assistance to beneficiaries with incomes up to 150 percent of the poverty level.
- The second recommendation, from 2012, was to redesign the FFS benefit package to balance two main goals: first, give beneficiaries better protection against high OOP spending, and second, create financial incentives for them to make better decisions about their use of discretionary care.

Because reducing beneficiaries' OOP costs (deductibles, copayments, or coinsurance) at the "point of sale" could undermine their incentives to make cost-conscious decisions about the health care they use, the redesigned FFS benefit package does not eliminate those costs. Without additional help, Medicare beneficiaries with limited incomes could have difficulty paying those OOP costs. Increasing the MSP income eligibility criteria to 150 percent of the poverty level would provide additional financial assistance to lower income beneficiaries by fully subsidizing their Part B premium, thus giving them resources to pay their OOP costs at the point of service. It therefore represents a targeted and efficient approach to help low-income beneficiaries. Chapter 4 also provides examples of variation in MSP eligibility across states.

Per beneficiary payment for primary care The Commission has a long-standing concern that primary care services are undervalued by the Medicare fee schedule for

physicians and other health professionals compared with procedurally based services. That undervaluation has contributed to compensation disparities: Average compensation for specialist practitioners can be more than double the average compensation for primary care practitioners. Such disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided. While Medicare beneficiaries generally have good access to care, in both patient and physician surveys, access for beneficiaries seeking new primary care practitioners raises more concern than access for beneficiaries seeking new specialists.

With the goal of directing more resources to primary care and rebalancing the fee schedule, the Commission made a recommendation in 2008 for a budget-neutral primary care bonus payment, funded by a reduction in payments for non-primary care services. The Patient Protection and Affordable Care Act of 2010 created a bonus program, but it was not budget neutral and thus required additional funding. The program provides a 10 percent bonus payment for primary care services provided by primary care practitioners, from 2011 through 2015.

The primary care bonus program expires at the end of 2015. The Commission believes that the additional payments to primary care practitioners should continue.

While the amount of the primary care bonus payment is not large and will probably not drastically change the supply of primary care practitioners, it is a step in the right direction. However, the Commission has become increasingly concerned that FFS is ill suited as a payment mechanism for primary care. FFS payment is oriented toward discrete services and procedures that have a definite beginning and end. In contrast, ideally, primary care services are oriented toward ongoing, non-face-to-face care coordination for a panel of patients.

In Chapter 5, we consider an option to continue the additional payments to primary care practitioners, but in the form of a per beneficiary payment. Replacing the primary care bonus payment with a per beneficiary payment could help move Medicare away from an FFS volume-oriented approach and toward a beneficiary-centered approach that encourages care coordination, including the non-face-to-face activities that are a critical component of care coordination. In establishing a per beneficiary payment for primary care, the Commission has considered several design issues: practice requirements for receipt of the payment, attribution of beneficiaries to primary care practitioners, and funding.

Site-neutral payments for select conditions treated in inpatient rehabilitation facilities and skilled nursing facilities

Site-neutral payments reflect the Commission’s position that the program should not pay more for care in one setting than another if the care can safely and effectively be provided in the lower cost setting. In previous reports, the Commission has recommended site-neutral payments for certain services across the physician fee schedule and the hospital outpatient department payment system, as well as for select patients across long-term care hospitals and acute care hospitals.

In Chapter 6, the Commission focuses on site-neutral payment to two post-acute care facilities—IRFs and SNFs—that are paid under separate payment systems. Currently, payments for similar patients with the same condition can differ considerably between the two payment systems. Using several criteria, we selected three conditions frequently treated in IRFs and SNFs—major joint replacement, other hip and femur procedures (such as hip fractures), and stroke—and assessed the feasibility of paying IRFs the same rates as SNFs for these conditions. We found that the patients with the two orthopedic conditions were very similar across the two settings. Differences in outcomes between IRFs and SNFs were mixed, with unadjusted measures showing larger differences between the settings and risk-adjusted measures generally indicating small or no differences between the settings. Thus, we find the two conditions represent a good starting point for a site-neutral policy. If IRFs were paid under current SNF policy for the two conditions, net IRF payments would decrease. However, the combined industry-wide effects on total payments to IRFs would be mitigated because under the design we explored IRFs would continue to receive add-on payments for the select conditions and current IRF payments for the majority of their cases. Patients recovering from strokes were more variable, and we conclude that more work needs to be done to more narrowly define the cases that could be subject to a siteneutral policy and those that could be excluded from it.

If payments for select conditions were the same for IRFs and SNFs, CMS should evaluate waiving certain regulations for IRFs, such as the requirements for intensive therapy and the frequency of physician supervision. Waiving certain IRF regulations would allow IRFs the flexibility to function more like SNFs when treating those cases. This flexibility would help level the playing field between IRFs and SNFs when treating patients with the site-neutral conditions.

Measuring the effects of medication adherence for the Medicare population

Medication adherence is viewed as an important component in the treatment of many medical conditions. Adherence to appropriate medication therapy can

improve health outcomes and has the potential to reduce the use of other health care services. At the same time, improved adherence increases spending on medications. This issue has led to a proliferation of research on policies that encourage better adherence to medication therapy (e.g., reduced patient cost sharing) and the impact of improved medication adherence on health outcomes, typically measured by the use of other health care services.

In Chapter 7, we examine the effects of medication adherence on medical spending for the Medicare population. We examine how changes in cohort definitions and model specifications affect estimated effects on medical spending of Medicare beneficiaries with CHF adhering to a medication therapy.

The results of our analysis show that:

- Better adherence to an evidence-based CHF medication regimen is associated with lower medical spending among Medicare beneficiaries with CHF, but the effects likely vary by beneficiary characteristics (e.g., age).
- Beneficiaries who follow the recommended CHF therapies tend to be healthier before being diagnosed with CHF than nonadherent beneficiaries, with fewer medical conditions and lower medical spending.
- The effects of medication adherence diminish over time.
- The estimated effects of medication adherence on medical spending are highly sensitive to how they are modeled. For example, including whether beneficiaries died in the model reduced the effect on health care spending by half. The magnitude of the effect is also sensitive to how adherence is defined and the criteria used to select the study cohort.

Although our analysis examined only one condition (CHF) and is therefore not generalizable to other conditions or populations, our findings highlight the difficulty of estimating the effects of medication adherence. This difficulty may be exacerbated by the more complex health profiles of the Medicare population compared with the general population often used in studies of medication adherence.

Chapter IV

Medicare Modernization and Competition

Some Reflections on the “State of the State”



Introduction—As we indicated at the beginning of the report, Medicare has not only been an instrument for health care system reforms, but is also a target of reform ideas due to growing criticism of the program’s costliness and deeply centralized federal oversight structure.

In general, the most persistently argued reform idea for Medicare is to replace the traditional program with a competing, private health plan (PHP) model where beneficiaries would have a choice of plans to enroll in to obtain program benefits. It is argued that PHPs will have the incentives and tools to compete for enrollment by lowering costs and improving benefits and service in ways that the government cannot accomplish. Two variations on these ideas are at work in Medicare today under Part C, the Medicare Advantage program, and Part D, the outpatient drug benefit program.

Our purpose in our closing chapter is to invite fresh consideration of the changing context of the Medicare competition discussion, which is where the battleground over the reform of Medicare itself has been conducted. Our interest is prompted by the public investment in and potential enrollment success of the ACA exchanges, and by the growing enrollment of Medicare beneficiaries into the Part C Medicare Advantage and Part D drug benefit plans.

All three of these approaches are voluntary private health plan competition and individual enrollment models, although their legal frameworks, targeted populations, and operational contexts are different. Each is framed within federal law, and each is both operationalized and supervised, to varying degrees, by the same federal agency, the Centers for Medicare and Medicaid Services (CMS).

Each of the three models, the ACA exchanges, and Medicare Parts C and D, have differing features on important dimensions: target population(s); benefit(s) definitions; reference packages for valuation and premium-setting purposes; plan bidding rules; government subsidies for enrollees; financial performance, risk-adjustment and payment features for plans; market conduct rules for plans, and so forth. An examination of these comparative features is outside the scope of this report. However, all three models share one distinguishing feature: private health plan competition is the central feature, but all three competition models are heavily regulated through varying degrees of federal and state insurance market oversight, and/or Medicare-specific legislative and regulatory requirements.

To the extent these models grow in public acceptance and participation, it suggests growing public comfort with the concepts of structured, private health plan shopping and enrollment (and disenrollment) programs. We should note this is a familiar model to federal employees, whose employer health benefits, provided by a broad roster of competing PHPs, have been offered for many years in a structured, annual enrollment period, with both paper or secure, government website shopping and enrollment options.

From a health care provider perspective, the interactions and arrangements with private health plans, including with those plans competing in Medicare for enrollees, could be fundamentally different from

the requirements of participating in and receiving payment for services in the traditional Medicare program. Yet, as we investigate the topic of introducing stronger competition models into Medicare than Parts C and D represent today, we find minimal consideration of the deeper programmatic changes such models might entail, beyond the highest theoretical level. We don't have answers, but we have a lot of questions.

CMS Operational Imperatives—As we noted in the opening to this report, Medicare is nothing if it's not the “nuts and bolts” undergirding the vast operations required to almost seamlessly ensure that Medicare's aged and disabled beneficiaries receive the benefits they are entitled to with minimal disruptions in service. This is a “nuts and bolts” policy framework and operational process that more or less successfully links over 50 million beneficiaries with the services of thousands of hospitals, over 880,000 physicians, and thousands more care professionals and entities, such as ambulatory surgery centers, skilled nursing facilities, and home health agencies, nationwide.

Medicare is costly – over \$600 billion in spending for 2014, and deeply complex in its regulatory apparatus. For many health care professionals, traditional Medicare regulatory policies, including many added by the ACA, have become perplexingly intricate and intrusive interventions into the health care system as CMS seeks to drive improvements in value.

Many policy leaders think there are ways to improve Medicare's benefits, and reduce federal costs and complexity, by substituting private plan coverage for Medicare's directly, federally administered traditional program. The private plan models of Medicare Part C and D, with modifications, might provide a pathway for replacement of the traditional program. The ACA private health insurance exchange model differs in key particulars

from the current Medicare plan options, but still provides another pathway.

Before we turn to consideration of the current political environment, it is helpful to understand the basic Part C and Part D relationships with the federal government. In short, competition models do not imply abdication of federal oversight. Nor, in the case of the Medicare Advantage program, in particular, does the existing traditional fee-for-service program “go away.” Since the MA plans are offering plans designed to cover all the traditional Parts A and B benefits, the existing program stands as a bulwark reference plan shaping many of the MA program’s requirements and plans’ payment levels. The Part D program has a more flexible design, but there are still important rules for Part D plans to follow.

Indeed, some might argue that the law and regulations governing both programs are microcosms of the traditional program regarding the depth of federal oversight and regulation of plan participation, bidding and payment methodologies. And, in fact, plans in both programs are contractors to the government. Are the same regulatory dynamics inherent in the traditional Medicare program operating in the competition models, just through different channels? If so, is it a

good thing, or not? Would new proposals, such as the House Republicans’ recently endorsed Medicare reform plan genuinely change these regulatory superstructures in the Medicare program?

Are there alternatives that are less regulatory to consider that would also offer appropriate Medicare beneficiary protections? Would less regulatory models actually succeed in attracting plans? Critics of government regulation in this context may fail to consider that plan participation is voluntary; some *may not participate* absent rules that protect them from assuming undue financial risk. Regulatory safeguards cut in interesting directions.

We simply invite readers to keep these questions in mind as we turn to brief overviews of the Medicare Advantage and drug benefit programs. Our goals are simply to highlight certain key elements and data regarding both programs. We then close our report with a brief discussion on the politics of Medicare competition going forward, asking “Who Owns Competition Theory?”--Republicans or Democrats?

Medicare Advantage Basics

“Unlike Medicare FFS, in which contractors process and pay claims, in Medicare Part C, CMS contracts with private organizations, known as Medicare Advantage organizations (MAOs), to offer MA health plans and provide covered health care services to enrolled beneficiaries. CMS pays MAOs a pre-determined, fixed monthly payment for each Medicare beneficiary enrolled in one of the MAO’s health plans. MA plans must provide coverage for all services covered under Medicare FFS, except hospice care, and may also provide additional coverage not available under Medicare FFS. MA plans, with some exceptions, must generally allow all Medicare beneficiaries who reside within the service area in which the plan is offered to enroll in the plan. In addition, MA plans must meet all federal requirements for participation, including maintaining and monitoring a network of appropriate providers under contract; having benefit cost-sharing amounts that are actuarially equivalent to or lower than Medicare FFS cost-sharing amounts; and developing marketing materials that are consistent with federal guidelines.

Exceptions include special needs plans (SNP) and employer group plans. SNPs offer benefit packages tailored to beneficiaries who are dually eligible for Medicare and Medicaid, are institutionalized, or have certain chronic conditions. Employer group plans can be offered to employers’ or unions’ Medicare-eligible retirees and Medicare-eligible active employees, as well as to Medicare-eligible spouses and dependants of participants in such plans.

Medicare beneficiaries with end-stage renal disease (ESRD) may only enroll in an MA plan if they meet certain criteria. For example, beneficiaries with ESRD may enroll in an MA plan if (1) they were already enrolled in the MA plan when they developed ESRD; and (2) they are eligible for a plan offered by their current or former employer or union that has opted to enroll beneficiaries with ESRD; or (3) they had a successful kidney transplant. *(Source: GAO. Contractors and Private Plans Play a Major Role in Administering Benefits. Testimony. March 4, 2014.)*”

Medicare Advantage Contracting and Enrollment—

As we discussed in earlier chapters, the traditional Medicare program is an operating health insurance plan and its benefits are delivered through private contractors to the government, carrying out CMS-established policies and protocols. It may surprise some to understand that PHPs, participating in Medicare Advantage (MA) and competing *against* the traditional program for enrollment, are also contractors to CMS in their MA capacity. Please refer to the GAO description of the contracting arrangements between CMS and MA plans.

The MA program had early structural and plan payment problems, but successive legislative and policy adjustments in the MMA (2003) and the ACA (2010) have made the program more attractive to plans. Enrollment is steadily growing, showing increased acceptance and popularity with Medicare beneficiaries.

Separately, as GAO notes later in the same report, CMS has significant oversight and administrative responsibilities under the MA program:

“While contract requirements for MA plans and parameters of the program are largely derived from statute, CMS has responsibility to implement the program and ensure compliance with these requirements. The agency’s responsibilities include, among other things, making monthly payments to MA plans, implementing health status adjustments to the payments, establishing processes for enrolling and dis-enrolling beneficiaries, reviewing marketing materials, providing for independent review of coverage appeals, conducting audits, and enforcing compliance. The audits typically involve a combination of desk reviews of documents submitted by MA plans, and at CMS’s discretion, site visits. To ensure compliance, CMS may take a variety of enforcement actions, ranging from informal contacts offering technical assistance to civil money penalties or plan suspension for egregious or sustained noncompliance.” (p. 9)

Interestingly, though, GAO does not characterize the MA program as a “competition model” in the ordinary or purest sense. Rather, it states that “Whereas MA offers beneficiaries an alternative

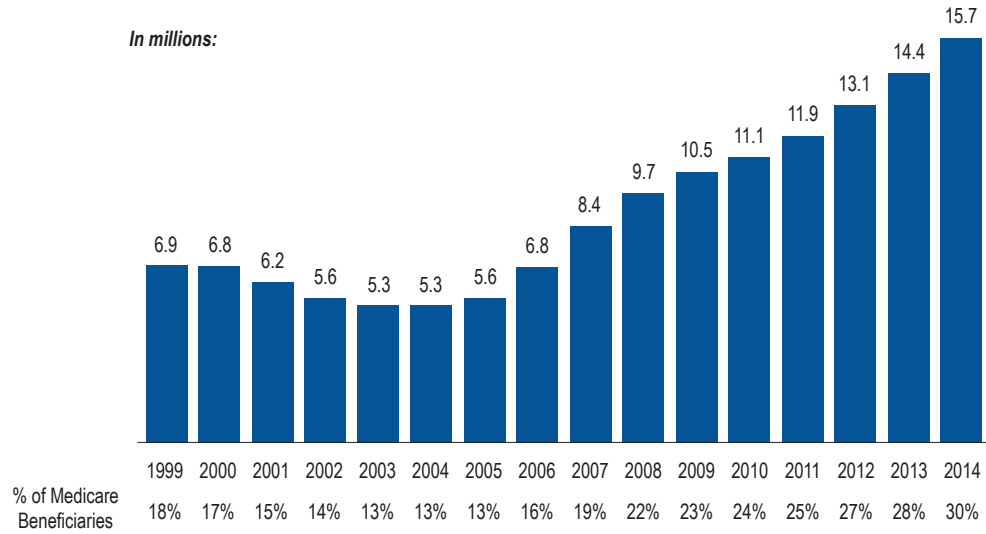
way to access their Part A and B benefits, Part D is structured to provide benefits only through private organizations under contract to Medicare.”(p. 9.) For GAO, the ongoing presence of the traditional program, and the fact that many of the contracting parameters under MA are related to the underlying experience in the traditional plan, appears to make that model something less than a genuine competition design, although the plans compete against CMS and each other for enrollment, and bear a degree of financial risk.

“What-If?”—The MA program raises longer-term “What If” questions. What if MA enrollment levels reached 60, 70, 80-percent penetration levels? Could the MA program be converted from a voluntary enrollment program to a system where beneficiaries were required to choose a private plan? What are the implications for the panoply of policies and operations currently driving the traditional program, for the MA model, and for the health care system? Is it correct to think of today’s MA program as closer to an “administered price” PHP contract with risk parameters, than as a competition model for the future? One might argue that the MA program shifts operational responsibilities away from CMS to MA plans, reducing the support responsibilities CMS would otherwise have incurred for those enrollees.

Separately, can plans achieve or surpass the program spending performance achievable under regulation? Under a mandatory plan choice model, would all providers contract with plans under negotiated terms? Would the government abandon its multiple provider participation, payment systems and models, and quality standards programs and substitute “network adequacy” requirements instead?

TOTAL MEDICARE PRIVATE HEALTH PLAN ENROLLMENT, 1999-2014

In millions:

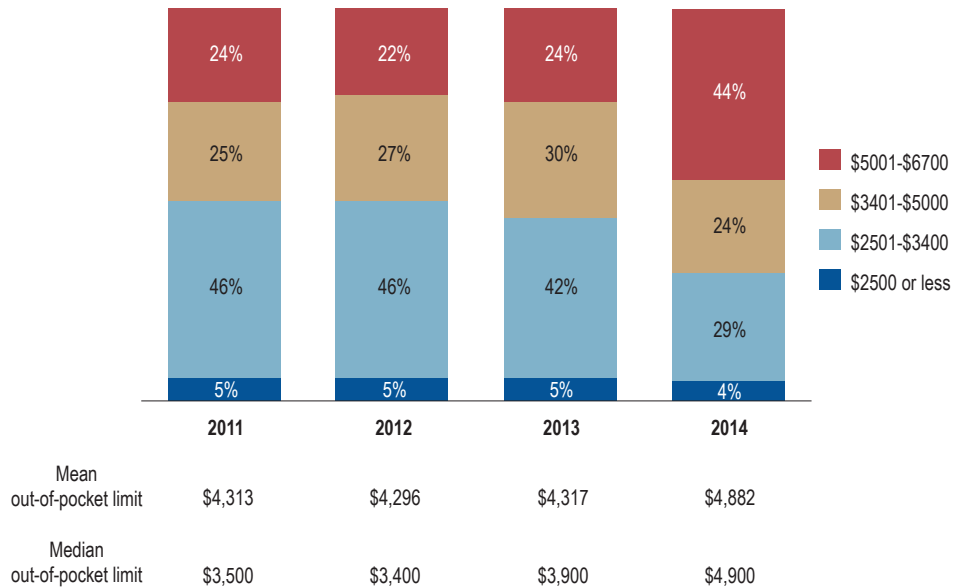


Note: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

SOURCE: MPR/KAISER FAMILY FOUNDATION ANALYSIS OF CMS MEDICARE ADVANTAGE ENROLLMENT FILES, 2008-2014, AND MPR, "TRACKING MEDICARE HEALTH AND PRESCRIPTION DRUG PLANS MONTHLY REPORT," 1999-2007; ENROLLMENT NUMBERS FROM MARCH OF THE RESPECTIVE YEAR, WITH THE EXCEPTION OF 2006, WHICH IS FROM APRIL.



MEDICARE ADVANTAGE ENROLLEES' OUT OF POCKET LIMITS, 2011-2014

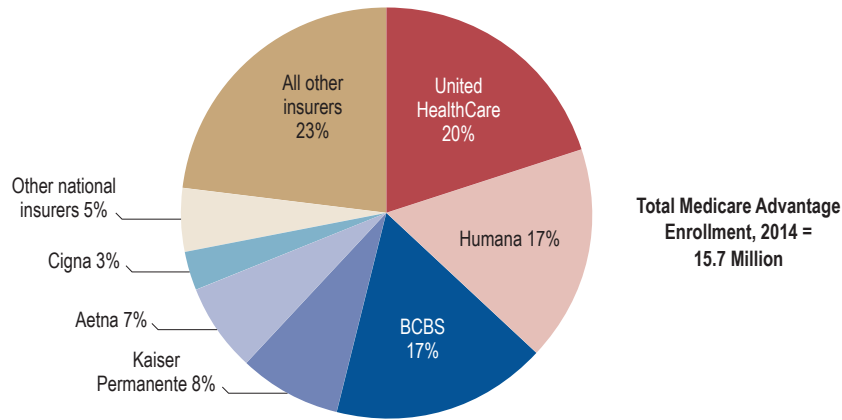


Notes: Excludes Medicare Advantage plans that do not offer prescription drug coverage, special needs plans (SNPs), employer group health plans, demonstrations, and cost plans. Percentages may not sum to 100% due to rounding. Plans with 4% of enrollees were missing information out-of-pocket limits, including 99% of PFFS plan enrollees, and less than 1% of enrollees in HMOs, local PPOs, and regional PPOs.

SOURCE: MPR/KAISER FAMILY FOUNDATION ANALYSIS OF CMS ENROLLMENT FILES, 2014.



MEDICARE ADVANTAGE ENROLLMENT, BY FIRM OR AFFILIATE, 2014

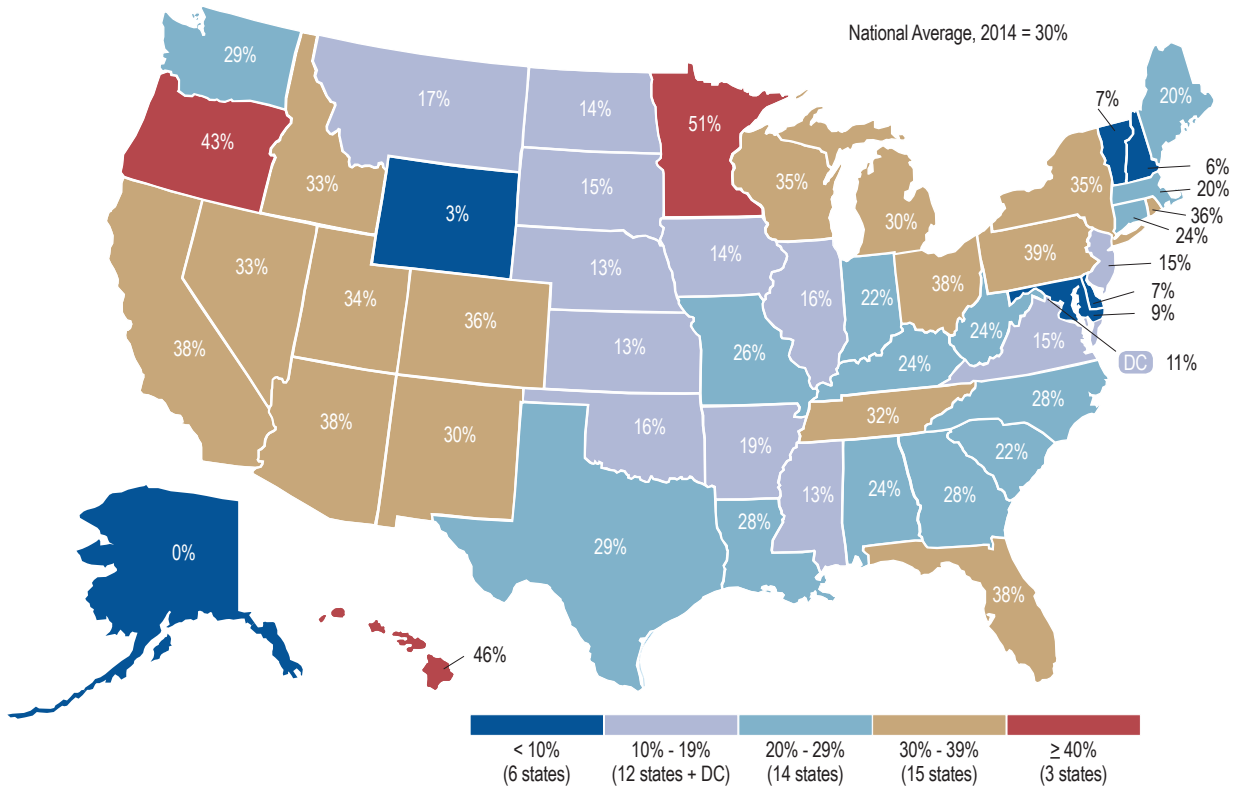


Note: Other includes firms with less than 3% of total enrollment. BCBS are BlueCross BlueShield affiliates and includes Wellpoint BCBS plans that comprise 4% of all enrollment (approximately 600,000 enrollees) in Medicare Advantage plans. Other national insurers includes approximately 428,000 enrollees across the following firms: Wellcare, HealthNet, Universal American, Munich American Holding Corporation, and Wellpoint non-BCBS plans. Accounts for merger between Coventry and Aetna in 2013; Medicare Advantage plans offered by Coventry covered 306,000 beneficiaries and Aetna plans covered 615,000 in 2013. Percentages may not sum to 100% due to rounding.

SOURCE: MPR/KAISER FAMILY FOUNDATION ANALYSIS OF CMS ENROLLMENT FILES, 2014.



SHARE OF MEDICARE BENEFICIARIES ENROLLED IN MEDICARE ADVANTAGE PLANS, BY STATE, 2014

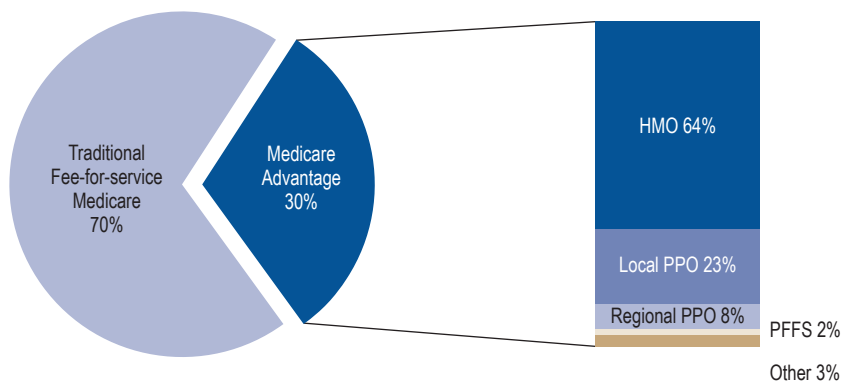


Notes: Includes MSAs, cost plans and demonstrations. Includes Special Needs Plans as well as other Medicare Advantage plans.

SOURCE: MPR/KAISER FAMILY FOUNDATION ANALYSIS OF CMS STATE/COUNTY MARKET PENETRATION FILES, 2014.



DISTRIBUTION OF ENROLLMENT IN MEDICARE ADVANTAGE PLANS, BY PLAN TYPE, 2014



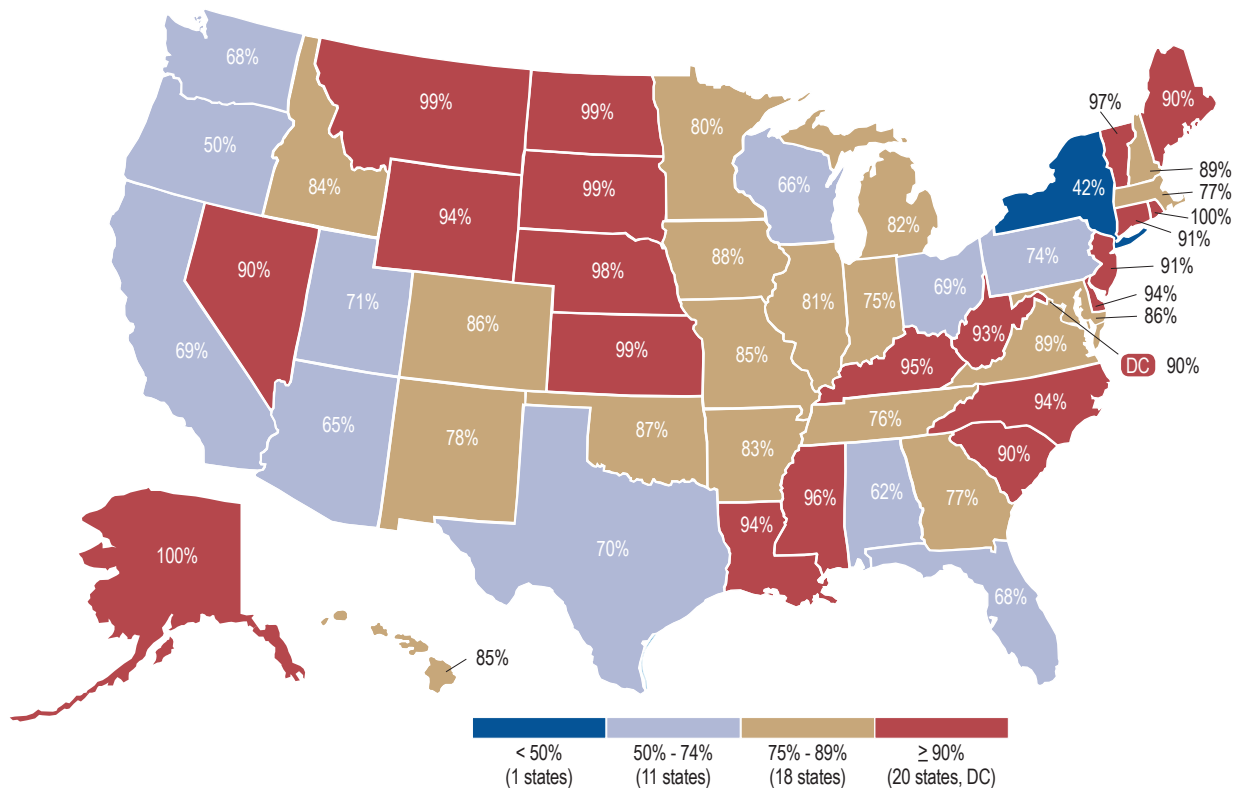
Total Medicare Advantage Enrollment, 2014 = 15.7 Million

Note: PFFS is Private Fee-for-Service plans, PPOs are preferred provider organizations, and HMOs are Health Maintenance Organizations. Other includes MSAs, cost plans, and demonstration plans. Includes enrollees in Special Needs Plans as well as other Medicare Advantage plans.

SOURCE: MPR / KFF ANALYSIS OF THE CENTERS FOR MEDICARE AND MEDICAID SERVICES (CMS) MEDICARE ADVANTAGE ENROLLMENT FILES, 2014.



COMBINED MARKET SHARE OF THE THREE FIRMS OR AFFILIATES WITH THE LARGEST NUMBER OF MEDICARE ADVANTAGE ENROLLEES IN EACH STATE, 2014



SOURCE: MPR/KAISER FAMILY FOUNDATION ANALYSIS OF CMS STATE/COUNTY MARKET PENETRATION FILES, 2014.



Medicare Part D Basics

“Whereas MA offers beneficiaries an alternative way to access their Part A and B benefits, Part D is structured to provide benefits only through private organizations under contract to Medicare. Under the Part D program, which began providing benefits on January 1, 2006, CMS contracts with private organizations called plan sponsors. Part D plan sponsors offer outpatient prescription drug coverage either through stand-alone prescription drug plans for those in original FFS Medicare, or through MA prescription drug plans for beneficiaries enrolled in MA. Through the Part D contracts, plan sponsors offer prescription drug plans which may have different beneficiary cost-sharing arrangements (such as copayments and deductibles) and charge different monthly premiums. Plan sponsors include health insurance companies and pharmacy benefit managers. Although pharmacy benefit managers typically manage prescription drug benefits for third-party payers, some pharmacy benefit managers have contracted directly with Medicare to offer Part D plans.

Medicare pays plan sponsors a monthly amount per enrollee independent of each enrollee’s drug use, therefore creating an incentive for the plan sponsor to manage spending. Payments to prescription drug plan sponsors are adjusted according to the risk factors—including diagnoses and demographic factors—of beneficiaries enrolled in a sponsor’s plans. However, sponsors still have an incentive to control spending to ensure it remains below the adjusted monthly payments received from CMS and payments received from enrolled beneficiaries. Sponsors can lower drug spending by applying various utilization management restrictions to drugs on their formularies. The Part D program also relies on sponsors to generate prescription drug savings, in part, through their ability to negotiate price concessions, such as rebates and discounts, with entities such as drug manufacturers, pharmacy benefit managers, and pharmacies. Medicare spending on the Part D program has been lower than originally anticipated. Medicare’s actuaries have attributed lower-than-projected expenditures to a combination of factors, including lower-than-projected Part D enrollment, slower growth of drug prices in recent years, greater use of generic drugs, and higher-than-expected rebates from pharmaceutical manufacturers to the prescription drug plans.

The MMA required that plan sponsors offer beneficiaries a standard benefit plan, with specified deductible and coinsurance amounts, or a plan with benefits that are actuarially equivalent to the standard plan. Actuarially equivalent plans have the same average benefit value as the standard benefit plan but a different benefit structure. If a sponsor offers the standard benefit or an actuarially equivalent plan, it may also offer an enhanced plan with a higher average benefit level in the same area. For instance, an enhanced plan may offer lower cost sharing, an expanded formulary, or coverage in the coverage gap. *(Source: GAO. Contractors and Private Plans Play a Major Role in Administering Benefits. Testimony. March 4, 2014.)*”

Medicare Part D Contracting and Enrollment—

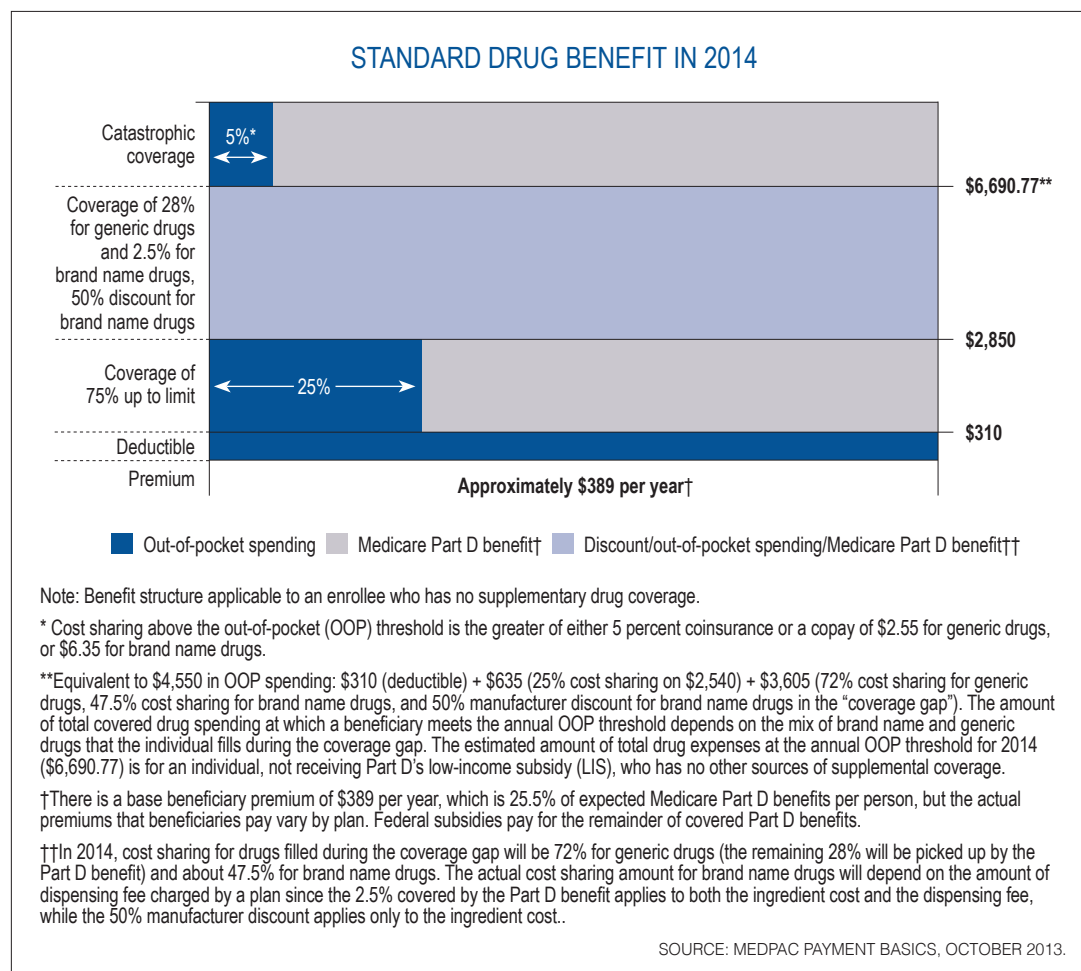
The Medicare Part D structure is viewed as a more purely competitive model. The outpatient drug benefit did not exist in the Medicare program until it was enacted in 2003 as a stand-alone program. By definition, there was no underlying or residual Medicare program that had previously set benefit parameters that created spending and utilization experience for the covered population. Please refer to GAO’s description of the contracting arrangements.

The Part D program’s fiscal success has exceeded expectations, despite a very complex statutory benefit structure relative to coverage and cost-sharing elements.

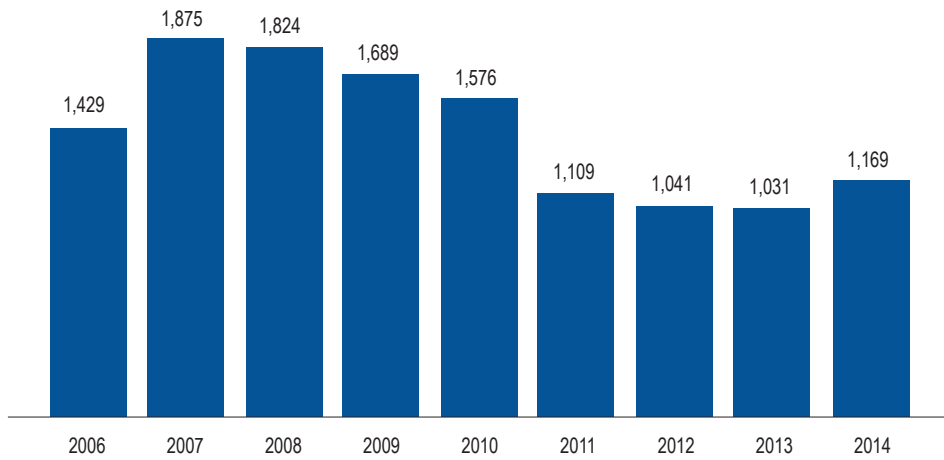
In closing, once again, it is important to understand that Part D plans are also contractors to CMS. As GAO states:

“While CMS contracts with plan sponsors to offer the Part D benefit, the agency has an

oversight role. As with MA, CMS is responsible for ensuring that the payments it makes to plans sponsors are accurate. Given that final payments to plan sponsors are based, in part, on the price concessions that plan sponsors have negotiated, CMS is responsible for ensuring that data plan sponsors submit on price concessions are accurate. CMS also ensures that plan sponsors submit accurate information to the Medicare Plan Finder interactive website, which helps beneficiaries compare different plans and identify the plan that best meets their needs. CMS oversees the complaints and grievances processes and may rely on complaints and grievances data to undertake compliance actions against specific plan sponsors. CMS also oversees Part D sponsors’ fraud and abuse programs, which include compliance plans that must include measures to detect, correct, and prevent fraud, waste, and abuse.” (p. 11).



NUMBER OF MEDICARE PART D STAND-ALONE PRESCRIPTION DRUG PLANS, 2006-2014

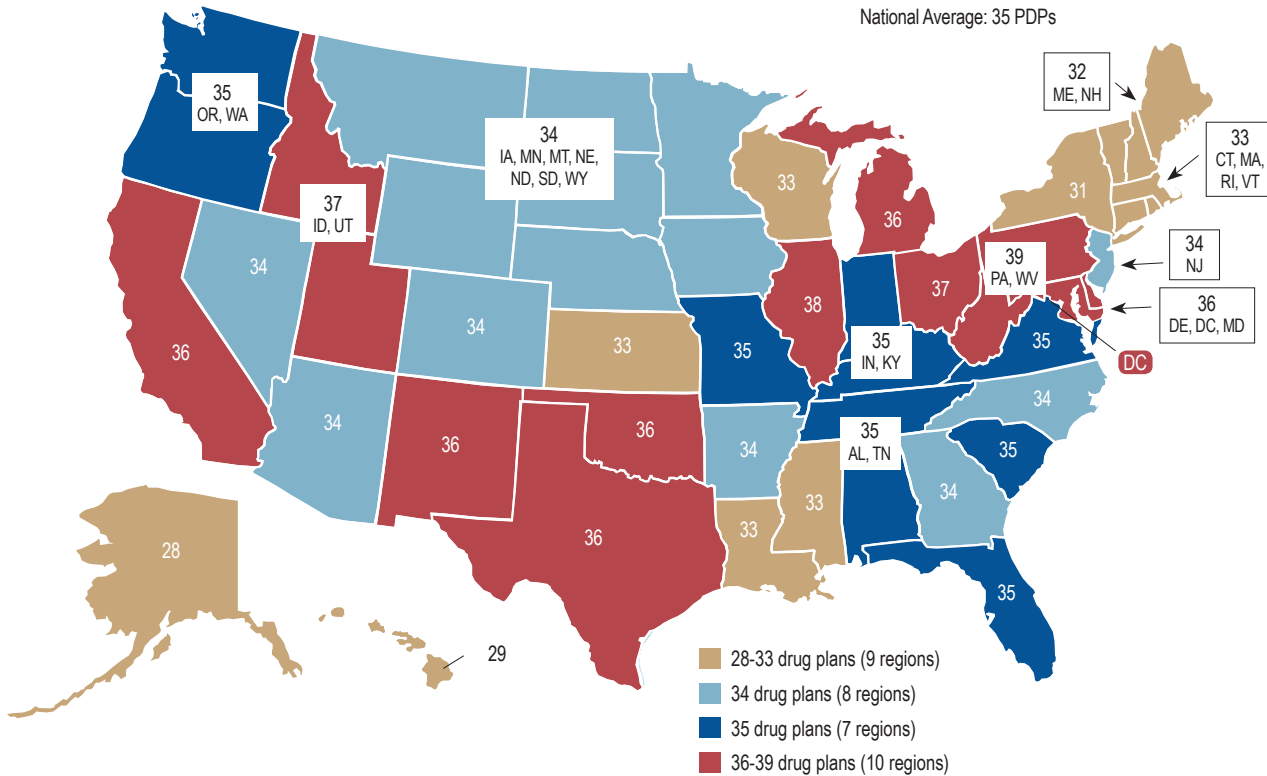


Note: Excludes plans in the territories. Total for 2014 includes 168 plans under CMS sanction and closed to new enrollees as of October 2013.

SOURCE: GEORGETOWN/NORC/KAISER FAMILY FOUNDATION ANALYSIS OF CMS PDP LANDSCAPE SOURCE FILES, 2006-2014.

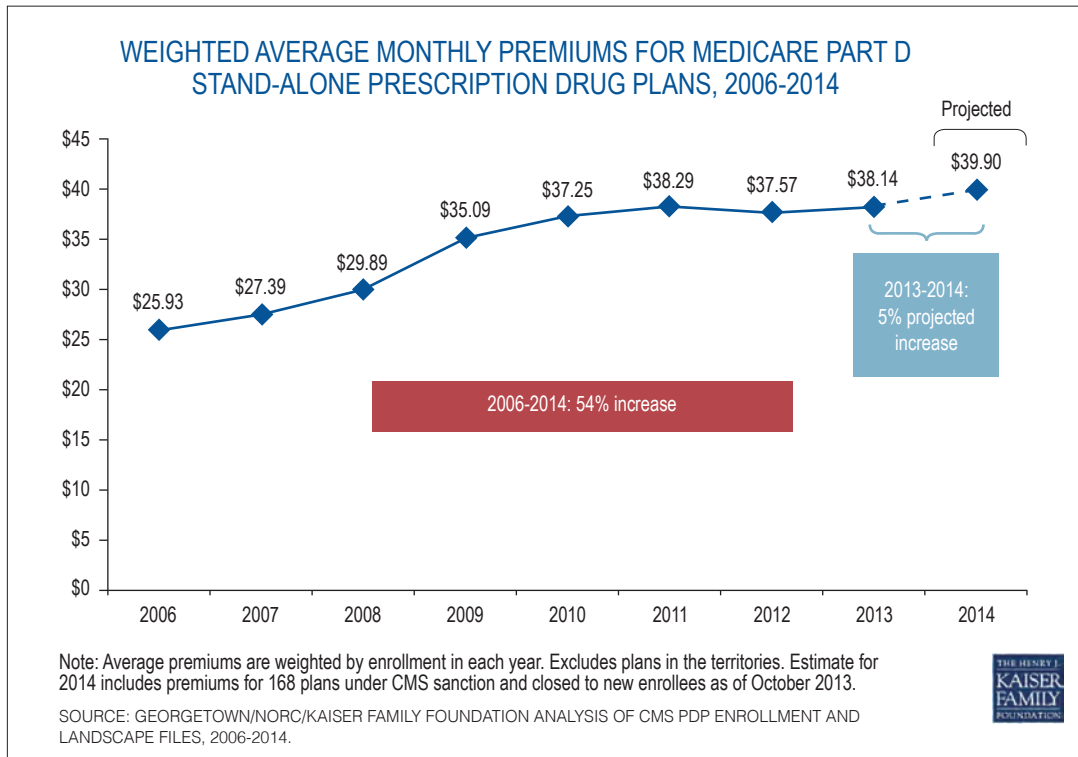


NUMBER OF MEDICARE PART D STAND-ALONE PRESCRIPTION DRUG PLANS, BY REGION, 2014



Notes: PDP is prescription drug plan. Excludes plans in the territories. Includes 168 plans under CMS sanction and closed to new enrollees as of October 2013.





“What-If?”—Our “What If” question is a little different under the Part D model. What if the Part D competition model effectively replaced the Medicare Advantage model, and plans had a much different responsibility for valuing, providing and managing comprehensive Medicare benefits without regard to the traditional program, but only with regard to benefit, bidding, and contracting requirements, and the competitive success of other plans? What would be the implications for program beneficiaries, for the future of the program, and for the health care system? Would plans

participate and what transitional steps would be required? What would happen to Part D plans—in other words, what reason would there be to allow any single benefit like drugs to be handled outside the comprehensive package?

These are interesting and important questions that could be hotly contested in the future. That leads us to the current political environment and the deteriorated state of the Medicare competition model discussion.

Political Cross Currents Over Health Care Competition Models

—It is important to first acknowledge the enactment of the ACA in 2010, and the 2013-14 initial open enrollment period for individuals purchasing PHPs through federal or state insurance exchanges. We raise the ACA in this context simply to highlight it as a government-directed “competition model-in-progress” for delivering health insurance benefits to a targeted population.

The ACA’s initial enrollment period closed with approximately 9 million individuals choosing private health plans through the federal and state insurance exchanges. This may have swollen to about 15 million considering many individuals chose to enroll in ACA-compliant plans outside of the exchange framework. The ACA’s marketplace/plan competition model is less than one full year into “boots on the ground” implementation. It is too soon to judge how fully successful the ACA’s competition model shall be over time regarding enrollment, costs, benefits, administration and public acceptance. Nonetheless, it represents an actively proceeding competition model that could influence future thinking about new models for injecting competition into the Medicare program’s benefits and delivery systems. Early indications are that more PHPs will be competing in the 2014-15 open enrollment period than did in the first year.

Final “What-ifs?”—If the ACA model succeeds over time, is it conceivable that Medicare beneficiaries could also choose private plans through the ACA-based exchanges, or through a new Medicare-specific exchange? There are enormous implications, but theoretically, no shifts that could not be thought through and accomplished over time, perhaps in stages.

Separately, all these alternatives treat the Medicare population as individual enrollees, i.e. as an “individual market” as defined by health insurers with all the selection factors, premium setting, financial uncertainty and other issues that implies. What if Medicare beneficiaries were pooled into groups by sub-state, state-level, or regional levels and plans competed to provide group coverage for all beneficiaries at the chosen pooled group levels? This is an idea that received some attention in the Congress in the past. It has very different implications for

premium levels and other elements affecting beneficiaries and plans. For one thing, it would likely end uniform national premium structures in Medicare. Today, because health care costs vary widely around the country, Medicare beneficiaries in rural and other lower-cost areas deeply cross-subsidize the costs of beneficiaries residing in high-cost areas. This is a complicated issue...just one of many.

In closing, there are challenging policy and political cross currents around the ACA’s federal and state government supervised exchanges, and other models, such as the Medicare “premium support” model supported by House Republicans. However, for the following reasons, it’s hard in the current environment to clearly categorize major political parties’ positions on competition models, or to predict what environmental changes will provide clarity. It is also not clear in many instances of what either protagonists or antagonists of “competition in Medicare” consider the key ingredients to be.

Who “Owns” Competition Theory?—Most would answer this question by saying the Republican party. However, despite prior support for competitive private plan models in health care and in Medicare, the Republican Party has objected to many features of the ACA. In particular, it has objected to the federal government’s heightened authority over health insurance exchange functions, and over private insurers’ benefit offerings and market conduct. The Democratic Party in the past was often reluctant to embrace competitive plan models, yet became the Party to drive that model to enactment in the ACA, albeit by granting much stronger federal regulatory oversight over insurers (in partnership with states). Yet there has been notable reluctance to go further into a competition model in the Medicare setting.

Most Republican Governor-led states chose to not take control of ACA operations in their states and defaulted to the national exchange instead of creating a state-based exchange. This has likely enhanced federal power over the ACA’s competition model. Now, more states are considering, or are actively in the process of, abandoning their state-based exchanges in favor of defaulting to the (initially troubled, but increasingly functioning) federal exchange.

This may be a structurally and politically important development under the ACA. What might the reversion to an increasingly federal, centrally-directed competition model imply for the future of the ACA, and for Medicare competition models?

Federal Learning on the ACA's Dime—Regardless of one's perspective on the merits of the ACA, the federal government is rapidly gaining experience and lessons in implementing the ACA. Growing private insurance market oversight responsibilities and expertise, deepened relationships with State insurance regulators and laws, and major investments in exchange technologies theoretically pave the way for also administering Medicare under a more truly competitive private health plan model than exists today in Parts C and D.

The ACA's initially steep learning curve and operational challenges, now being addressed by federal civil servants, could be viewed as an essential "boot-camp" in developing their future ability to execute successfully on a more robust Medicare competition model. Is the ACA health plan competition model effectively paving the way for a federal "Medicare Exchange" system? If yes, political ironies abound.

House of Representatives 2015 Budget Resolution—On April 1, 2014, House Budget Committee Chairman Paul Ryan (R-WI) released a report entitled *The Path to Prosperity: Fiscal Year 2015 Budget Resolution*, which outlined his budgetary and accompanying policy objectives. This report accompanied the Chairman's Mark, a budget resolution that, with modifications, passed the House of Representatives as H.Con. Res. 96 on April 10, 2014. There are a number of significant, but not very detailed, proposals relating to the ACA and Medicaid. Importantly, beginning in 2024, the 2015 House of Representatives' budget resolution assumes the conversion of Medicare to a fixed federal contribution ("premium support") program, i.e., a competing private plan system.

House Budget Committee Chairman Ryan's private plan competition model for Medicare, by definition, might require a federal oversight structure under which, at a minimum:

➤ Medicare benefits are defined (a standard "reference" plan),

➤ Terms for private plan participation, benefit offerings, and market conduct and consumer protections are defined,

➤ Beneficiaries' plan selection and enrollment processes are facilitated (a de facto exchange or marketplace),

➤ Income-related premium subsidies for lower-income beneficiaries, and premium surcharges or other adjustments for higher-income beneficiaries are calculated and administered,

➤ Supplemental insurance plans and dually eligible individuals (Medicare and Medicaid) are addressed, and

➤ Mechanisms are considered for moderating excess risks (or profits) for PHPs, such as government reinsurance for exceptionally high-cost cases or other policies.

First, all of the above elements are addressed in some fashion under the Medicare Part C and Part D plan competition models. They also exist as part of the private insurance competition framework under the ACA. The Republican Majority in the Congress in 2003 was largely responsible for changes to the Medicare Advantage model, and the creation of the Part D drug benefit competition model (with some bipartisan support). The Democrat Majority in 2010 was responsible for the ACA's private insurance plan competition model, the exchange rules and requirements, the reference benefit packages and plans' market conduct obligations, borrowing heavily from these earlier ideas and programs. Can the political parties really be so far apart on these ideas and how they might be adapted to extend competition in Medicare?

When one considers the likely federal underpinnings for a premium support model, the optics of the House of Representatives' 2024 Medicare proposal could look remarkably like the key elements of the ACA competition model now being employed to offer private health plans to non-Medicare individuals. Yet the same House budget resolution provides for full repeal of the ACA's health insurance exchanges.

Conclusion—Having noted these confusing political cross-currents and messages, it is less

clear how much further either major political party is *actually* willing to go in the near future to advance the role of serious competition and private plan coverage in Medicare. It is also unclear what would unite the currently highly polarized political parties in such a major, bipartisan effort.

Finally, it is unclear what Medicare reform parameters will be in the future. Especially, what would be the deeper implications of any proposal for a continued role for the federal policy and operational apparatus that has taken nearly 50 years to build, and that undergirds the traditional Medicare program? It is often stated that government doesn't lead; it follows. That would suggest a relatively cautious path to a deeply changed Medicare program.

Meanwhile, as we write this report, the Congress continues to rewrite those existing policies and laws, many of deep concern to practicing physicians. Would a restructured, reformed Medicare program under a competition model render those rules obsolete? These are all important questions, both for millions of Americans who will be relying upon Medicare in the future, and for the entire American health care system. ■

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