Medicare Governance

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Health Industry Forum

November 24, 2008

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While I can explain the meaning of life, I don't dare try to explain how the Medicare system works.

Major Actors In Current Medicare Governance

- Career staff
- Political leadership
- Congress
- Administrative contractors: MACs, DMACs, RACs, QIOs, etc.
- Stakeholders
  - beneficiaries
  - providers, practitioners and suppliers
  - manufacturers
  - plans
- Recommendations from MedPAC, GAO and OIG, among others; news stories

Organization Has Evolved

- 1990 reorganization created Medicaid Bureau
  - to be more responsive to states and less focused on Medicare/Medicaid consistency
- 1997 reorganization
  - major reorganizations can be disruptive for a sustained period of time, and this one was
  - but it also broke up long-standing silos/fiefdoms and created focus for coverage decisions
- Gradual culture change
  - from divining congressional intent to being more proactive
  - greater willingness to engage outside stakeholders
- Contractor reform: 2005-ongoing
- Greater in-house capacity for coverage analysis, private plans and prescription drugs

State of CMS

- Understaffed, and…
  - high percentage of senior career staff eligible to retire in near future
  - very limited flexibility on salaries and bonuses and hiring
- Pulled in multiple directions
  - required annual regulations
  - new initiatives of political leadership
  - congressionally mandated demonstrations
  - implementing new legislation
- Many cooks in the kitchen
  - HHS, OMB, White House
  - authorizing and appropriation committees plus others
- Recently
  - Loss of focus on beneficiaries
  - Medicaid eclipsed in terms of resources and leadership

Career Staff

- Generally very competent and “get it done”
- Many are overworked
- Many are paid less than would earn outside government
- Focus is on establishing and maintaining principles
  - generally good, but also can block needed exception
- Sometimes insular
  - can be out of touch or out of date with what’s happening in real world
  - factors: resource constraints; fear of revealing too much and fueling a lobby campaign
- Limited to no dialogue with external stakeholders
  - varied interpretations of rulemaking requirements of Administrative Procedures Act

Political Leadership

- Opportunity for fresh evaluation and new ideas
- New leaders want to have new initiatives
- Time is short
- Learning curve
- Pull of a priori ideas and views
- Previous initiatives may lose focus

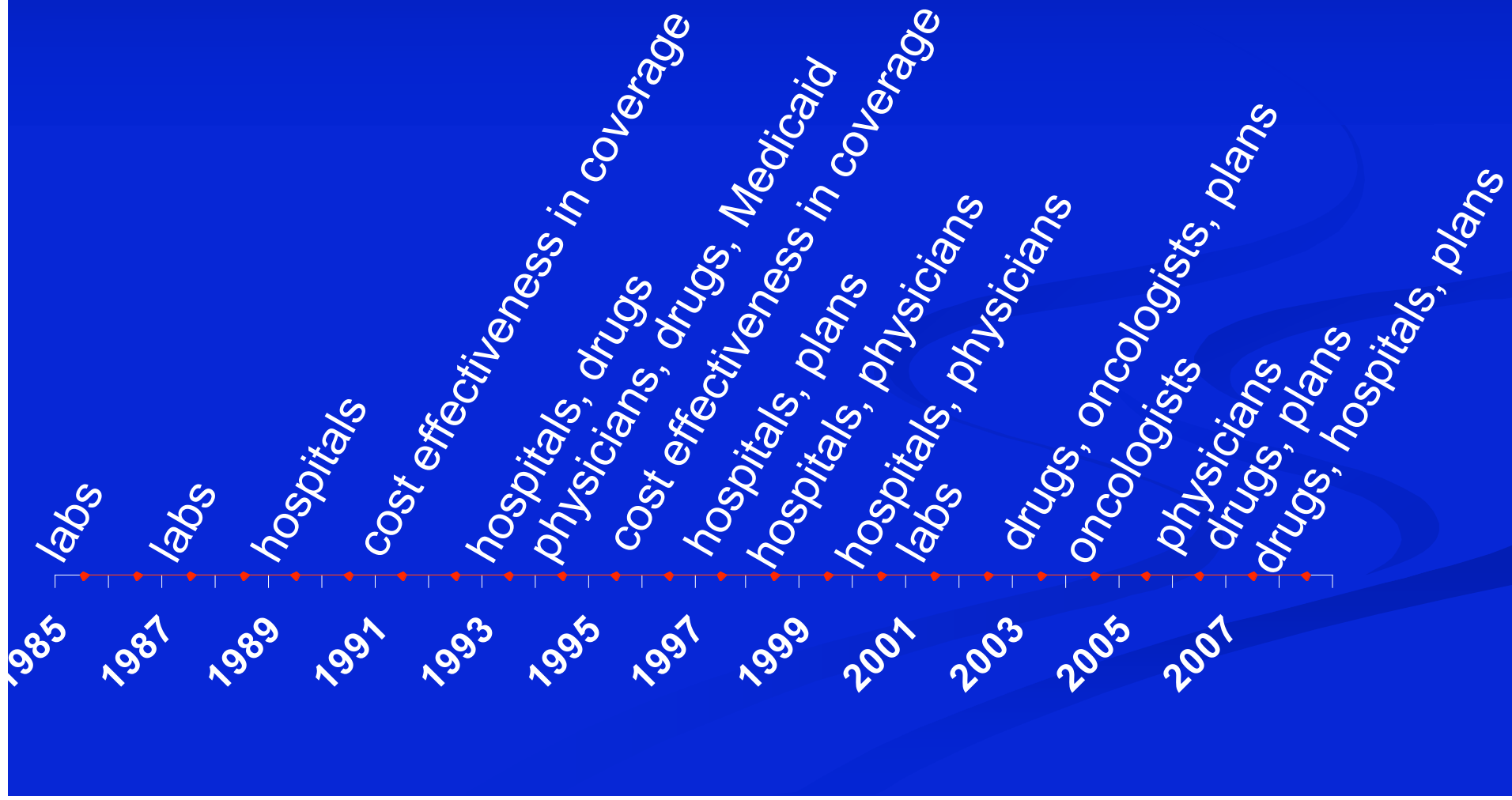
Political Leadership Defines Focus and Influences Program Direction

- Current administration
  - prescription drug coverage
  - private plans
  - quality initiatives
  - price transparency
  - payment accuracy of DRGs
  - Medicaid waivers
  - restrictive Medicaid regulations
- Previous administrations:
  - opening up coverage process
  - beneficiary access and coinsurance
  - nursing home quality
  - reducing fraud and abuse
  - release of hospital mortality data
  - home and community based waivers and emphasis on moving people out of nursing homes and back into the community
  - reducing expenditures

Missed Opportunities for Cost Containment or Quality Improvement

- 1985: labs
- 1987: labs
- 1989: hospitals
- 1991: cost effectiveness in coverage
- 1993: drugs; hospitals
- 1995: physicians; drugs; states (Medicaid)
- 1996: cost effectiveness in coverage
- 1997: hospitals; plans
- 1998: hospitals; physicians
- 2000: hospitals; physicians
- 2001: labs
- 2003: drugs; oncologists; plans
- 2004: oncologists
- 2005: physicians
- 2006: drugs; plans
- 2007: hospitals; drugs; plans
- 2008: durable medical equipment; labs

Missed Opportunities for Cost Containment or Quality Improvement



One Typical Scenario

- Stakeholder concern
- Robert Pear or other press story
- Congressional and/or White House reaction
- HCFA/CMS change in policy, or
- Legislation

"I have heard there are troubles of more than one kind. Some come from ahead and some come from behind. But I've bought a big bat. I'm all ready you see. Now my troubles are going to have troubles with me!" – **Dr. Seuss**

Medicare administrators need a very big bat.

But "Bold" Administrative Actions Occasionally Succeed

1988:	1.22 percent reduction in DRG payments implemented by regulation
1993:	inpatient hospital capital PPS implemented by regulation
1995:	national non-coverage decision for lung volume reduction surgery
1996:	required presence of attending physician in order to bill for residents' services
1998:	moratorium on certifying new home health agencies to address fraud
2003:	applied "functional equivalence" to limit payment rate for Aranesp
2006-2008:	DRG refinement implemented by regulation
2007:	national coverage decision limiting use of ESAs; broader implementation of payment limits for hospital-acquired conditions

Some Keys to Success

- Policy is …
  - supported by strong rationale/ recognized need
  - technically sound
  - has champions outside of CMS
- Coordinated strategy to overcome opposition
  - some congressional supporters
  - outreach to stakeholders
  - at least some support among stakeholders
  - support from opinion leaders
  - some positive news accounts
- Why this isn't the usual scenario
  - requires enormous agency resources
  - reserved for the one or two pressing initiatives at a time

Successful Implementation of Major Initiatives

- Part D (2006)
- Prospective payment systems for outpatient hospital, SNF, HHA, IRF, IPPF, LTAC and ASCs (2000-2008)
- SCHIP (1998)
- Physician fee schedule (1993)
- Hospital capital PPS (1993)
- Inpatient hospital PPS (1983)

Is Medicare Governance An Issue Needing Attention?

- Cost and quality issues demand action
- Too many current and future problems to address one at a time
- Persistent pattern over three decades suggests that systemic change is needed
- Hospital DRGs, physician payment reform and private plans:
  - major initiatives that offered an opportunity for lasting reform
  - but full potential was unmet or success diminished over time
  - each offers an interesting case study

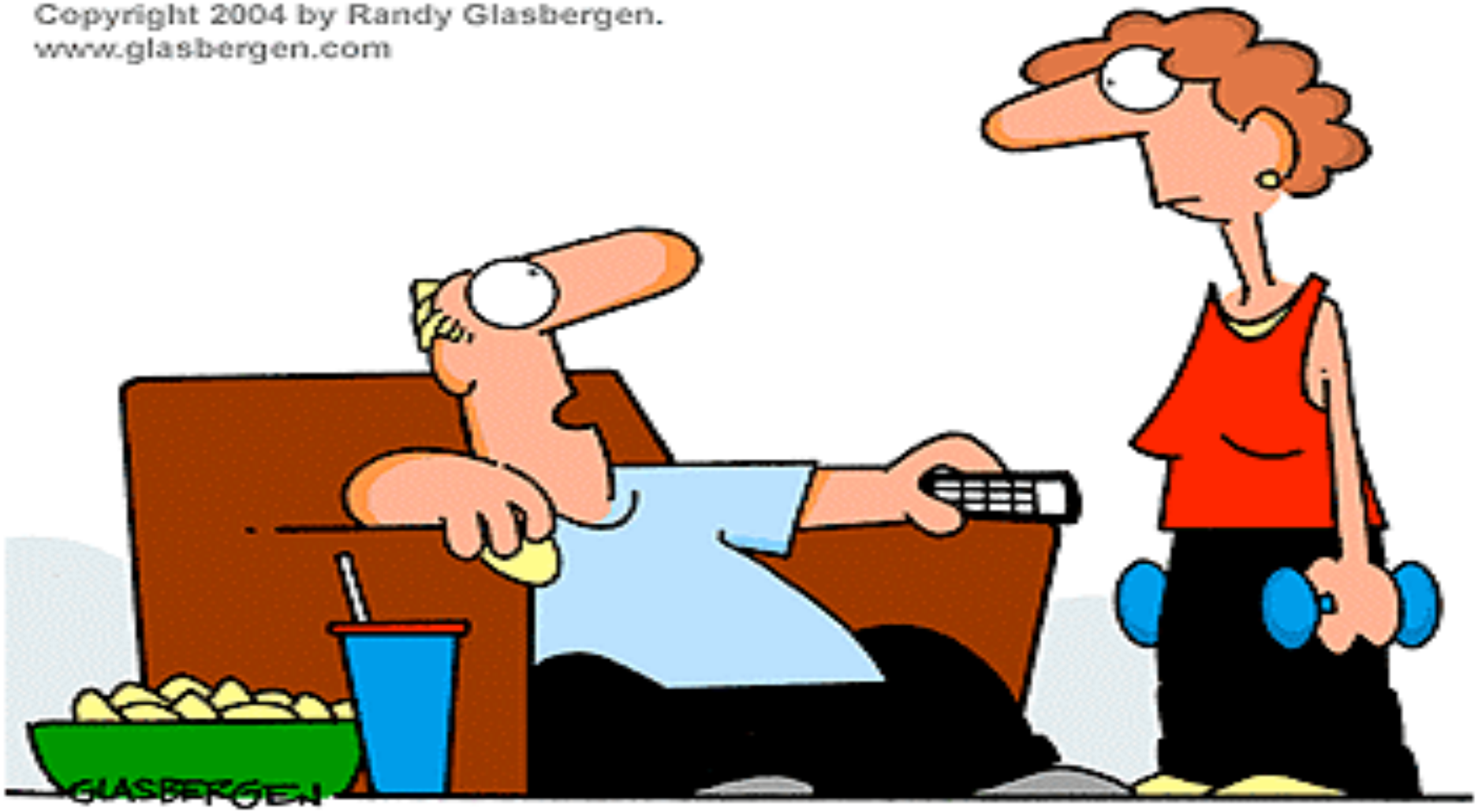
Medicare Administration: What Problems Need to be Addressed?

- Size, scope and complexity of Medicare make it nearly impossible to manage
- Lack of resources and other capacity issues at CMS
- Congressional micromanagement and political influence generally
- Organizational inefficiencies and episodic focus

Medicare Governance: No Lack of Good Studies

- Bipartisan Medicare Commission (1998)
- National Association of Social Insurance (NASI) Study Panel (2000)
- Studies and reports of the Congressional Research Service, Government Accountability Office (GAO) and Office of the Inspector General (OIG)
- Congressional hearings

Change is Hard: In Lifestyles or Healthcare Policies



**"My doctor told me to keep in shape.
Well, this is my shape and I'm keeping it!"**

NASI Study of Medicare Governance (2000)

- I am struck by how much things have changed
  - CMS was under siege in 2000; report called for “a greater sense of trust and comity” between Congress and CMS
  - CMS was viewed as struggling to implement all of the new laws in a timely and effective way – and frequently viewed as not up to the challenge
- Well, the laws were implemented successfully – and today there is greater trust and confidence in CMS

NASI Study of Medicare Governance (2000)

- And I am struck by how much two primary factors noted by the NASI study remain true today
  - CMS continues to face “a pervasive and persistent shortage of resources”
  - Congressional involvement in the management of Medicare remains large
- And, of course, the size, scope and complexity of Medicare is even greater 8 years later.

NASI Study of Medicare Governance (2000)

- Considered four models:
  - independent agency, like Social Security Administration
  - independent board, like Federal Reserve Board
  - performance-based organization
  - government corporation
- Panel did not reach a consensus
  - some panel members preferred current structure, some independent agency, some independent board
  - many believed that a variant of the independent agency or board models merited further consideration

Option: Independent Agency

- Social Security Administration (SSA)
  - Commissioner appointed for 6-year term; removal only for cause
  - Commissioner's budget submitted to Congress without change along with President's budget
  - Legislative recommendations, regulations and testimony submitted directly to the Office of Management and Budget (OMB)
- Goals and results
  - Promotes a degree of autonomy, reduces bureaucratic layers and promotes heightened visibility
  - No formal evaluation of impact of independent agency for SSA
- Concerns
  - Loss of advocacy and protection by the Secretary
  - Independent agency may be more at the mercy of special interests
  - Medicare is substantially more complex, raises more policy issues and directly affects 42 million beneficiaries and a significant sector of the economy

Option: National Health Board

- Some insulation from financial stakeholders
- But public program should be accountable to President, Congress and public
- How to establish some independence while maintaining transparency and accountability
- Administrator accountable to board and public, then President and Congress
- Administrator position likely to be less policy-oriented; might be filled by a manager

Option: National Health Board

- Administrative and regulatory authority over all public and private health care (e.g., Sen. Daschle)
  - minimum benefit standards
  - standard setting organization, including coverage, but not the executing entity
  - if an independent administering agency were created, the board could provide oversight
- Many important questions:
  - should Medicare have a separate board in addition to the national health board?
  - what is the link between the administrative bureaucracy and the board?
  - should statutory specificity be replaced with more general requirements?
  - how are openness, transparency, oversight and due process maintained?
  - what are the roles of Congress and the President?

How Can National Program Have Regional/Local Flexibility?

- For example, to work with a state, like Massachusetts (health reform); or Maryland (all-payer hospital rates); or Minnesota (all-payer nursing home rates)
- Is regional/local flexibility a good idea?
  - must resolve local flexibility with principle of treating Medicare beneficiaries equitably regardless of where they live
- How much flexibility? In what areas?
  - coverage?
  - prior authorization, step therapy, least costly alternative, etc.?
  - payment rates?
  - could this be accomplished through MACs?
- Need for a focus on persons dually eligible for Medicare and Medicare

Points of Greatest Agreement

- Resources, resources, resources!!!
  - should be “as needed” up to a percentage of benefit payments
  - should be removed from competition of discretionary budget decisions
- Medicare needs an Administrator focused only on Medicare
  - responsibility for Medicaid, medical education, survey and certification, CLIA, HIPAA and other programs should be lodged elsewhere
- Medicare would benefit from Administrators with longer tenures

Most Challenging Issues

- Degree of statutory specificity
- National uniformity vs. local/regional flexibility
- Achieving a degree of political insulation while maintaining openness, transparency and accountability