CMS Demonstrations: Background Briefing

Health Policy Forum

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DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Why do a demo, when we need solutions to problems now?

- Litany of problems in the health care system:
  - Ala carte fee-for-service medicine is expensive and wasteful
  - Paper based medical practices don't foster quality and efficiency
  - Need to improve quality, well documented problems

- CMS programs are large: they affect millions of beneficiaries and providers, they don't turn on a dime.
  - More than 92 million beneficiaries (nearly 1 in 3 Americans)
  - $702 billion in FY2009 outlays (nearly 1 in 3 of the nation's health dollars)
  - Medicare is 13% of the federal budget, Medicaid is an additional 7%
  - More than 1.5 million providers and suppliers, hundreds of health plans.

- "Do no harm" applies to demos as well.
  - If the proposed solution is ineffective or causes problems, let's find that out on a small scale first.

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Demonstration authority: What kinds of demos can we do?

- Section 402 demonstration authority established in 1967 and 1972:
  - to test whether methods of payment will increase efficiency and economy of programs without adversely affecting quality
  - there is no general authority to waive Title XI (e.g., quality and Civil Monetary Penalties (CMPs)); Medicare eligibility; or conditions of participation (waiver of CMPs was an issue for gainsharing demo)
  - successful demos cannot be adopted into Medicare without additional legislation

- Congress has authorized many Medicare demos in specific pieces of legislation

- Medicaid demonstrations are generally through State initiatives/instigation

- OMB generally requires budget neutrality for section 402, and always for 1115 demonstrations

Why does CMS do demonstrations?

- CMS conducts demonstration projects to test and measure the effect of potential program changes before they are launched nationwide.
- Implementing a demonstration teaches valuable lessons about policy choices and practical operational issues
- Evaluations measure the demonstration against a comparison group to determine if the demo achieved its goals or was no different than the comparison group.

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What are Medicare's current demonstrations?

Health IT:

- Electronic health record demonstration
- Medicare care management and performance demonstration

Value-based purchasing:

- Premier hospital quality incentive demonstration
- Physician group practice demonstration
- Nursing home value based purchasing demonstration
- Home health pay for performance demonstration
- Medicare health care quality demonstration
- Physician/hospital gainsharing demonstrations

Medicare medical home demonstration

Disease management/care coordination:

- Disease management for dual eligibles demonstration
- Care management for high cost beneficiaries demonstration
- ESRD disease management demonstration
- Medicare coordinated care demonstration

Prevention:

- Senior risk reduction demonstration
- Disparities cancer prevention and treatment demonstration

Bundled payments:

- Acute care episode demonstration

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What are Medicaid's current demonstrations?

- More than half of the States operate demonstration projects
  - More than ¼ of Medicaid Expenditures
  - About 20% of Program Enrollment
- Comprehensive Medicaid Programs in 24 States
  - $38 billion in 2006
  - More than 11 million participants
- Additional Targeted Programs
  - SCHIP
  - Family Planning
  - Disabled and Elderly
  - Disease or Service Specific

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Why do Medicaid demonstrations?

- Medicaid demonstrations provide CMS and States with important information on programmatic changes other States may want to consider.

- Pilot Increasing Program Efficiencies and Reduction of the Number of Uninsured Individuals: Doing more for the Same Dollars
  - Redirect from Fee For Service to Managed Care
  - Redirect Uncompensated Care to Coverage of Care

- Medicaid Program Changes with Prior Demonstration Experience
  - The Balanced Budget Act enables States to implement Managed Care, PACE, and children expansions (Title XXI) as State Plan Options
  - The Balanced Budget Act and Deficit Reduction Act of 2005 enables States to benchmark benefits for targeted populations as part of Title XXI and XIX State Plans

How much has Medicare saved from R and D?
Examples of return on investment

- Hospital PPS- R&D Investment ~ $13 million

  Return: Decrease in average rate of increase from 8.2% to 6.8% from 1983 to 1992 for a 10 year savings of $25 billion (OACT estimate).

- SNF PPS – R&D Investment ~$10 million

  Return: CBO estimated at enactment provision would save $32.4 billion over 10 years.

- DME Competitive Bidding – R&D Investment ~$4.7 million

  Return: CBO estimated at enactment that provision would save $6.8 billion over 10 years. Implementation was planned for July 1, 2008, but delayed by Congress for 18 months. First round bids showed 26% savings.

- Risk Adjustment --R & D Investment ~ $ 3 million

  Return: Allows competitive model to work by adjusting for beneficiary risk. Decision was made to implement risk adjustment without garnering billions of dollars in savings.

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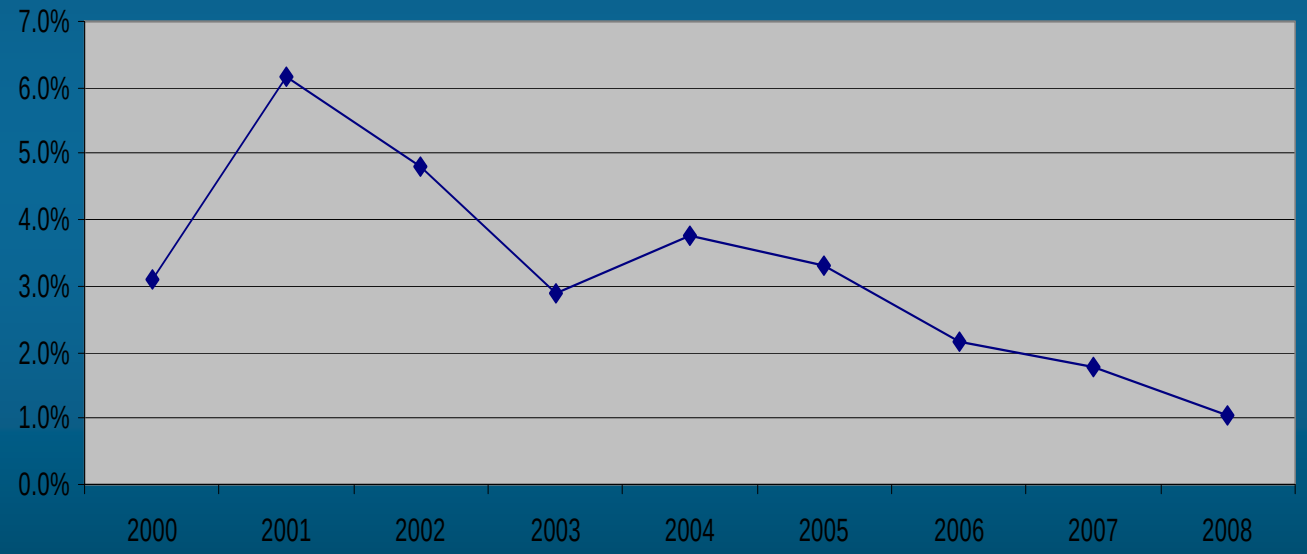
CMS research budget as a percent of program management budget, FY 2000 - FY 2008



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How has Medicare changed as a result of R and D?

- Capitated payment with risk adjustors for private health plans in Medicare
- Prospective payment systems for: inpatient and outpatient hospital; SNF; HHA; inpatient rehab, psych and LTC hospitals
- Hospice benefit
- Dual eligible demos and special needs plans
- Physician fee schedule RB-RVS
- Medicare HMOs and PPOs
- PACE and Social HMOs
- Smoking cessation

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What are the challenges in doing demonstrations?

- Demonstration is launching a “programmette”
- Long time period required for design, stakeholder consultations, site solicitation, clearances, payment system computer changes, implementation, and evaluation
- Operational complexities for CMS and the sites
- Getting the right control groups and timely data for evaluations
- Budget neutrality issues
- Inadequate resources for implementation and evaluation
- External Pressures:
  - Opposition to mandatory demonstrations (e.g., competitive pricing for health plans, competitive bidding for DME and clinical lab)
  - Extending demos where evaluation results are not favorable

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Conclusion: research and demonstrations are an investment in the future

- Research and demonstration investments have developed new payment methods
- Preventing costly mistakes: evaluations can alert us to program changes that would be extremely costly if implemented nationwide.
- Payment reforms take years to develop.
- To preserve the Medicare program for future generations, we need new tools to control spending.

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For more information:

Details about Medicare demonstration projects:

http://www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage

Details about Medicaid and SCHIP demonstration projects and evaluations:

http://www.cms.hhs.gov/MedicaidStWaivProgDemoPGI/08_WavMap.asp

http://www.cms.hhs.gov/DemonstrProjectsEvalRepts/EMD/list.asp#TopOfPage

http://www.cms.hhs.gov/NationalSCHIPPolicy/07_EvaluationsAndReports.asp

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