AFFORDABLE CARE ACT CHANGES IN THE MEDICARE PROGRAM: MORE OF THE SAME BUT BETTER

Eleaonr D. Kinney
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By

Eleanor D Kinney, JD, MPH*

ABSTRACT

The Patient Protection and Affordable Care Act (“ACA”), as amended by the Health Care and Education Reconciliation Act of 2010, has made many changes in the Medicare program as part of comprehensive health reform for the US health care sector. This article reviews the changes that ACA is making and will make in the Medicare program in the years to come. Described in detail are the changes to improve the quality and efficiency of Medicare services as well as to improve program integrity and transparency. The article evaluates the past and current efforts of the Medicare program to reduce Medicare expenditures. The article concludes with an assessment of the potential effectiveness of these reforms to bend the proverbial cost curve and make the Medicare program sustainable over the long term.

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*J.D., Duke University School of Law, 1973, MPH, University of North Carolina School of Public Health, 1979, Hall Render Professor of Law Emerita, Hall Center for Law and Health, Indiana University Robert H. McKinney School of Law.
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I. INTRODUCTION

The Patient Protection and Affordable Care Act (“ACA”), as amended by the Health Care and Education Reconciliation Act of 2010, has made many changes in the Medicare program as part of comprehensive health reform for the US health care sector. This article reviews the changes that ACA is making and will make in the Medicare program in the years to come. Described in detail are the changes to improve the quality and efficiency of Medicare

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services as well as to improve program integrity and transparency. The article evaluates the current efforts of the Medicare program to reduce Medicare expenditures. The article concludes with an assessment of the potential effectiveness of these reforms to bend the proverbial cost curve and make the Medicare program sustainable over the long term.

II. THE MEDICARE PROGRAM

Amending the Social Security Act (“SSA”), Congress established the Medicare program to provide health care coverage for the aged in 1965. Medicare, a federal social insurance program, administered by the Centers for Medicare and Medicaid Services (“CMS”) within the Department of Health and Human Services (“DHHS”), provides hospital insurance for hospital and extended care services and supplementary medical insurance for physician and associated services to the aged, disabled, and certain individuals with end stage renal disease.

A. The Design of the Medicare Program

The Medicare program is comprised of four parts. Parts A and B were contained in the original Medicare statute and are called “Fee-for-Service” or “original” Medicare. Part A, Hospital Insurance for the Aged covers hospital and extended-care services, and Part B, Supplementary Medical Insurance, provides physician and other outpatient services. Part C of the Medicare program, now called the Medicare Advantage program since substantial changes to the program in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (“MMA”), was established in the Balanced Budget Act of 1997. Established in MMA, Part D is a voluntary prescription drug benefit program.

The Medicare program is financed through two trust funds, the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund. The Hospital Insurance Trust Fund, which pays for items and services under Part A and Part A services provided in Medicare

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5 42 U.S.C. §§ 1395c to 1395i.


9 § 911 (codified at 42 U.S.C. § 1395kk-1).

10 42 U.S.C. §§ 1395i, 1395t.
Advantage plans under Part C, is funded primarily by a payroll tax.\textsuperscript{11} The Supplementary Medical Insurance Trust Fund, which pays for Part B items and services, is funded from premiums under Parts B and D and, to a minimal extent, from general revenues.\textsuperscript{12} This trust fund also pays for Part B services provided through Part C Medicare Advantage plans and Part D prescription drug plans.\textsuperscript{13}

At Figure 1 are presented the major institutional as well as professional providers that serve Medicare beneficiaries. The Medicare program also contracts with Medicare Administrative Contractors to manage claims and payment of Medicare Part A and B providers. Under Part C, Medicare Advantage plans handle payments to Medicare providers.

<table>
<thead>
<tr>
<th>Figure 1</th>
<th>Health Care Providers that Serve Fee-for-Service Medicare Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Paid under Medicare Part A</td>
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<tr>
<td></td>
<td>Institutional Providers</td>
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<tr>
<td></td>
<td>Hospitals</td>
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<tr>
<td></td>
<td>Acute Care Hospitals</td>
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<td></td>
<td>Psychiatric Hospitals</td>
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<td>Long Term Care Hospitals</td>
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<td></td>
<td>Rehabilitation Hospitals</td>
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<td></td>
<td>“Swing Bed” Units in Acute Care Hospitals</td>
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<tr>
<td></td>
<td>Skilled Nursing Facilities</td>
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<tr>
<td></td>
<td>Long Term Care Hospitals</td>
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<tr>
<td></td>
<td>Rehabilitation Hospitals</td>
</tr>
<tr>
<td></td>
<td>“Swing Bed” Units in Acute Care Hospitals</td>
</tr>
<tr>
<td></td>
<td>Home Health Agencies</td>
</tr>
</tbody>
</table>

B. Processes for the Reform of the Medicare Program

Each year, since the program’s inception, Congress has made changes in the Medicare program. Generally these changes are made in amendments to the Social Security Act or in legislation to reconcile the federal budget. Occasionally, Congress will enact legislation specifically designed to change the Medicare program directly as was done in 2003 with the MMA.\textsuperscript{14} At Figure 2 are listed the annual legislation making major changes to the Medicare program. Titles III and IV of ACA are provisions that would likely have been enacted as part of

\textsuperscript{11} 42 U.S.C. § 1395i.

\textsuperscript{12} 42 U.S.C. § 1395t.


budget legislation or amendments the Social Security Act in order to continue expansion and improvement of existing Medicare reform initiatives.

In the early years of the program, Congress and the Medicare program would generally focus on Parts A, B and C independently and also on each provider and supplier group independently. Thus, specific reforms were confined to one part of the Medicare program and generally involved one type of provider. Further, most major reforms focused on inpatient hospitals under Part A and physicians services under Part B. Since the inception of the Medicare program, the largest proportion of expenditures went to hospitals and secondarily to physicians and other Part B providers.\(^{15}\)

Since 2000, Congress and policy makers have approached reform in a more integrated fashion. They preceded from an understanding that, because physicians and hospitals were inextricably intertwined in their decision-making and Medicare needed to incentivize all providers to work together in coordinating care in an efficient and cost effective manner. In the MMA, reforms promoted managed care organizations on the theory that they, as private entities, could best deliver the efficiencies needed in the delivery of health care. The models of reform were medical practices that were closely and, indeed, seamlessly integrated with institutional providers. These models were well established specialty clinics, such as the Mayo Clinic in Minnesota or the Cleveland Clinic in Ohio.

In making reforms, the Medicare program follows a distinct pattern. First, Congress and policy makers recognize a problem in the program or the health care sector that needs attention. Congress will often assign CMS in statute to prepare a report describing the problem and proposing solutions. Then, if the change is major and would require a statutory change, Congress often directs CMS to conduct a demonstration to test the contemplated changes.\(^{16}\) After the evaluation of the demonstration, which takes several years, Congress implements the change in stages with different providers or suppliers.

Title III of ACA and pertain to improving the efficiency and quality of health care. Title VI calls for greater program integrity for all federally funded health insurance programs. Collectively the changes in Medicare in these two titles address the three major problems facing the Medicare program since its inception – cost inflation, quality assurance and fraud and abuse. For the most part, the changes are additions to initiatives and programs that have been in the works for many years and would probably have been enacted in annual budget legislation if there had been no health reform bill.

\(^{15}\) Marian Gornick et al., Twenty years of Medicare and Medicaid: Covered Populations, Use of Benefits, and Program Expenditures, 7 Health Care Financing Rev. 13 (Supplement 1985).

**Figure 2**  
**Legislation Enacting Major Changes in the Medicare Program**

<table>
<thead>
<tr>
<th>Legislation</th>
<th>P.L. 89-97, Social Security Amendments of 1965</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Established the Medicare and Medicaid programs</td>
<td>Establishes Part A. Hospital Insurance</td>
</tr>
<tr>
<td>• Established Part A. Supplementary Medical Insurance</td>
<td>Established Part B. Supplementary Medical Insurance</td>
</tr>
<tr>
<td>P.L. 90-248, Social Security Amendments of 1967</td>
<td></td>
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<tr>
<td>• Professional Standards Review Organization Program</td>
<td></td>
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<tr>
<td>• Added Severely Disabled as Medicare Beneficiaries</td>
<td></td>
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<tr>
<td>P.L. 92-603, Social Security Amendments of 1972</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare Anti-Kickback Authority</td>
<td></td>
</tr>
<tr>
<td>P.L. 93-248, Social Security Amendments of 1977</td>
<td></td>
</tr>
<tr>
<td>• Professional Standards Review Organization Program</td>
<td></td>
</tr>
<tr>
<td>• Added Severely Disabled as Medicare Beneficiaries</td>
<td></td>
</tr>
<tr>
<td>P.L. 95-142, Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>• Established Part A. Hospital Insurance</td>
<td></td>
</tr>
<tr>
<td>P.L. 95-216, Social Security Amendments of 1977</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare Secondary Payer Act</td>
<td></td>
</tr>
<tr>
<td>P.L. 96-499, Omnibus Reconciliation Act of 1980</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>• Established Part A. Hospital Insurance</td>
<td></td>
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<tr>
<td>• Repealed the PSRO Program</td>
<td></td>
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<tr>
<td>• Enacted Civil Monetary Penalties Law</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare Secondary Payer Act</td>
<td></td>
</tr>
<tr>
<td>• Authorized Medicare HMOs</td>
<td></td>
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<tr>
<td>P.L. 98-21, Social Security Amendments of 1983</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>P.L. 98-369, Deficit Reduction Act of 1984</td>
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<tr>
<td>• Established Prospective Payment for Inpatient Hospital Care</td>
<td></td>
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<tr>
<td>• Repealed the PSRO Program</td>
<td></td>
</tr>
<tr>
<td>P.L. 99-272, Consolidated Omnibus Budget Reconciliation Act of 1985</td>
<td></td>
</tr>
<tr>
<td>• Emergency Medical Treatment and Active Labor Act</td>
<td></td>
</tr>
<tr>
<td>P.L. 99-509, Omnibus Budget Reconciliation Act of 1986</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>P.L. 99-562, False Claims Amendments of 1986</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>P.L. 100-93, Medicare and Medicaid Patient and Program Protection Act of 1987</td>
<td></td>
</tr>
<tr>
<td>• Established Medicare and Medicaid programs</td>
<td></td>
</tr>
<tr>
<td>P.L. 100-203, Omnibus Budget Reconciliation Act of 1987</td>
<td></td>
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<tr>
<td>• Established National Standards for Nursing Homes</td>
<td></td>
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<tr>
<td>P.L. 100-360, Medicare Catastrophic Coverage Act of 1988</td>
<td></td>
</tr>
<tr>
<td>• Established a Catastrophic Coverage benefit under Medicare</td>
<td></td>
</tr>
<tr>
<td>P.L. 101-234, Medicare Catastrophic Coverage Repeal Act of 1989</td>
<td></td>
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<tr>
<td>• Established Physician Self-Referral Restrictions (So-called “Stark I”)</td>
<td></td>
</tr>
<tr>
<td>P.L. 101-239, Omnibus Budget Reconciliation Act of 1989</td>
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<tr>
<td>• Established Physician Self-Referral Restrictions (So-called “Stark II”)</td>
<td></td>
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<tr>
<td>P.L. 101-508, Omnibus Budget Reconciliation Act of 1990</td>
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<tr>
<td>• Expanded Physician Self-Referral Restrictions (So-called “Stark II”)</td>
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<tr>
<td>P.L. 102-59, Omnibus Budget Reconciliation Act of 1993</td>
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<tr>
<td>• Established Physician Self-Referral Restrictions (So-called “Stark III”)</td>
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<tr>
<td>P.L. 103-342, Social Security Act Amendments of 1994</td>
<td></td>
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<tr>
<td>P.L. 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996</td>
<td></td>
</tr>
<tr>
<td>• Established the Medicare Advantage Program in place of the Medicare+Choice Program (Part C)</td>
<td></td>
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<tr>
<td>P.L. 104-33, Balanced Budget Act of 1997</td>
<td></td>
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<tr>
<td>• Established the State Childrens Health Insurance Program</td>
<td></td>
</tr>
<tr>
<td>P.L. 106-554, Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000</td>
<td></td>
</tr>
<tr>
<td>• Reformed Medicare Coverage Policy and Decision-making</td>
<td></td>
</tr>
<tr>
<td>P.L. 108-173, Medicare Prescription Drug, Improvement, and Modernization Act</td>
<td></td>
</tr>
<tr>
<td>• Established the Medicare Advantage Program in place of the Medicare+Choice Program (Part C)</td>
<td></td>
</tr>
<tr>
<td>P.L. 109-171, Deficit Reduction Act of 2005</td>
<td></td>
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<tr>
<td>• Limited Payment for “never events” including “hospital-acquired conditions.”</td>
<td></td>
</tr>
<tr>
<td>P.L. 109-432, Tax Relief and Health Care Act of 2006</td>
<td></td>
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<tr>
<td>• Established Physician Quality Reporting Initiative</td>
<td></td>
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<tr>
<td>• Established the Physician Quality Feedback Program</td>
<td></td>
</tr>
<tr>
<td>• Funded Comparative Effectiveness Research</td>
<td></td>
</tr>
<tr>
<td>P.L. 111-48, Patient Protection and Affordable Care Act</td>
<td></td>
</tr>
<tr>
<td>P.L. 111-152, Health Care and Education Reconciliation Act of 2010</td>
<td></td>
</tr>
</tbody>
</table>
III. TAMING THE GROWTH IN MEDICARE EXPENDITURES

Individual and aggregate health care expenditures are a function of the cost of an item or service times the volume of items or services. Mathematically, the function is expressed as follows: HCE = C x V. In the early years of the Medicare program, Congress and policy makers focused on reducing the two variables – cost and volume – as both had grown beyond expectations in the early years of the Medicare program. Most reforms of Medicare payment methods focused on controlling these two variables and the particular phenomenon of providers’ predilection to increase the volume of services to make up for cuts in prices.

The seriousness of the cost problem, displayed in Figure 3, surfaced shortly after the inauguration of the Medicare program and has dominated health policy making ever since. Congress and HEW almost immediately recognized that the costs of the Medicare program would greatly exceed the initial Medicare cost projections. These predictions proved correct, and total Medicare expenditures rose from $4.6 billion in 1967 to $62.9 billion in 1985. During this period, Part A expenditures rose from $3.4 billion to $43.3 billion, and Part B expenditures rose from $1.2 billion to $19.7 billion.

From the early days of the Medicare program, Congress and the administrations of presidents from both parties sought to reduce the growth in Medicare expenditures. The underlying premise of the Social Security Amendments of 1965 was that the provider community would provide only reasonable and necessary care and would not respond to financial incentives in the program to provide excess and unnecessary care or engaged in fraud and abuse. However, according to Wilber Cohen, the Secretary of the Department of Health, Education and Welfare (“DHEW”) when the Medicare programs was enacted, at the time “[t]he ideological and political issues were so dominating that they precluded consideration of issues such as reimbursement alternatives and efficiency options.”

At Figure 4 is a schematic to illustrate the focus of the Medicare program’s regulation of Medicare expenditures. The goal of this regulation is to achieve only reasonable and necessary care for Medicare beneficiary. Over the years, the Medicare program had to adopt a continuum of regulation to achieve this goal. Specifically, the Medicare program has had to develop strategies to eliminate wasteful and unnecessary care as well as outright fraudulent care that was never provided.

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### Figure 4
**Regulatory Strategies and Goals to Regulate the Volume Component of Medicare Expenditures**

<table>
<thead>
<tr>
<th>Regulatory Goals</th>
<th>Regulatory Strategies to Achieve Goals</th>
<th>Efficiency Level in the Delivery of Items and Services</th>
<th>Impact on HCE = CV Equation</th>
<th>Resulting Character of Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Achieve Reasonable and Necessary Items and Services</td>
<td>Medicare Coverage Policy, Medicare Payment Policies, Medicare Quality Measures</td>
<td>Efficient</td>
<td>No Adverse Impact</td>
<td>High Quality, Cost Effective Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inefficient</td>
<td>Impact on Cost Variable</td>
<td>High Quality, High Cost Care</td>
</tr>
<tr>
<td>Reduce Arguably Reasonable but Unnecessary Items and services</td>
<td>Medicare Coverage Policy, Medicare Payment Policies, Medicare Quality Measures</td>
<td>Efficient</td>
<td>Impact on Cost and Volume Variables</td>
<td>Poor Quality, Wasteful Higher Cost Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inefficient</td>
<td>Impact on Cost and Volume Variables</td>
<td>Poorer Quality, Wasteful Higher Cost Care</td>
</tr>
<tr>
<td>Eliminate Unreasonable and Unnecessary Items and Services Care</td>
<td>Medicare Coverage Policy, Medicare Payment Policies, Medicare Fraud and Abuse Authorities</td>
<td>Efficient</td>
<td>Greater Impact on Cost and Volume Variables</td>
<td>Wasteful and Abusive Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inefficient</td>
<td>Lesser Impact on Cost and Volume Variables</td>
<td>Wasteful and Abusive Care</td>
</tr>
<tr>
<td>Prevent Claims for Items and Services which were not Provided</td>
<td>Medicare Criminal Fraud and Abuse Authorities</td>
<td>Efficient</td>
<td>Greater Impact on Cost and Volume Variables</td>
<td>Fraudulent Care</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inefficient</td>
<td>Lesser Impact on Cost and Volume Variables</td>
<td>Fraudulent Care</td>
</tr>
</tbody>
</table>

### A. The Challenge of Cost Inflation

Initially, the Medicare program paid hospitals the costs, as calculated by hospitals, of providing services to beneficiaries with the only prescription that the costs be “reasonable.” The Medicare program paid physicians a reasonable charge based on usual and customary charges in the market place. Both of these reimbursement methodologies located control over the cost of care in the hands of the providers. Providers were able to effectively set the price of items or services. Not surprisingly, these methods proved very costly and Medicare expenditures grew at alarming rates immediately upon implementation of the program.

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1. Inpatient Hospital Payment

Congress focused initially on hospital costs as these represented the greatest proportion of Medicare expenditures and were the greatest problem. In the Social Security Amendments of 1972, Congress adopted several regulatory strategies to address the problem of cost inflation in the Medicare program. Congress authorized the HEW, the predecessor of HHS, to impose a limit on the routine costs that Medicare paid hospitals. These amendments also supported state capital expenditure review programs by authorizing the Medicare program to withhold reimbursement for capital costs for any projects disapproved under a state certificate-of-need program. In addition, Congress authorized DHEW to conduct demonstrations of different ways Medicare could pay for inpatient hospital and skilled nursing care services. The Medicare prospective payment system (“IPPS”) for acute-care, inpatient hospitals followed a demonstration of the use of diagnosis related groups (“DRGs”) in New Jersey.

The most important payment reform for hospitals was the prospective payment system for the Medicare program. In the Tax Equity and Fiscal Responsibility Act of 1982, Congress laid the groundwork for prospective payment by establishing limits on the costs that Medicare would pay hospitals for each patient case and calling on HHS to develop a legislative proposal for a prospective payment system by December 1982. Following the Administration's proposal for a prospective payment system based on DRG's, Congress adopted a prospective payment system the following spring in the Social Security Amendments of 1983.

Under the prospective payment system, the Medicare program pays acute care hospitals a fixed price, adjusted for geographic and wage cost differences, for each Medicare case based on the DRG in which the patient's particular condition falls. As HHS said in its mandatory report to Congress on the new payment system:

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22 Id. at § 222. (codified at 42 U.S.C. 1395b-1 note).


The ultimate objective of PPS is to set a reasonable price for a known product. This provides incentives for hospitals to produce the product more efficiently. When PPS is in place, health care providers will be confronted with strong lasting incentives to restrain costs for the first time in Medicare's history.\textsuperscript{28}

The Medicare prospective payment system for hospitals has been in place for twenty-seven years. Neither Congress nor has fundamentally changed IPPS since its inception in 1983. Congress and CMS (and also its predecessor agency the Health Care Financing Administration (“HCFA”)) have extended prospective payment methodologies to nursing homes and other institutional providers.\textsuperscript{29}

\section{Physician Payment}

In the Social Security Amendments of 1983, Congress directed the Secretary to study possible methods of paying physicians according to a methodology similar to the prospective payment system for hospitals.\textsuperscript{30} The major reforms of physician payment methods before 1983 included limiting the permissible rate of increase in the prevailing charge to an index that reflects inflation,\textsuperscript{31} reforming the payment methods for physicians in teaching hospitals,\textsuperscript{32} and tightening up the payment methods for hospital-based physicians, such as anesthesiologists, pathologists, and radiologists.\textsuperscript{33}

In 1989, Congress enacted a revised payment system for physician services that paid physicians based on the time and resources involved in treating specific conditions rather than on a charge basis.\textsuperscript{34} Congress enhanced the system in the Omnibus Budget Reconciliation Act of 1990.\textsuperscript{35} In these two pieces of legislation, Congress replaced the disaggregated fee schedule with the Resource Based Relative Value Scale (“RBRVS”).

\begin{footnotesize}
\begin{footnote}{\textsuperscript{28}DHHS Hospital Prospective Payment for Medicare, \textsuperscript{supra} note 26, at 101.}
\end{footnote}
\end{footnote}
\begin{footnote}{\textsuperscript{30}Social Security Amendments of 1983, § 603(a)(2)(B).}
\end{footnote}
\begin{footnote}{\textsuperscript{31}Social Security Amendments of 1972, § 223 (codified as amended at 42 U.S.C. § 1395u(b)(3)(F)).}
\end{footnote}
\begin{footnote}{\textsuperscript{32}Social Security Amendments of 1972, § 227(b)(2) (codified as amended at 42 U.S.C. § 1395f(g)).}
\end{footnote}
\end{footnote}
\begin{footnote}{\textsuperscript{34}Omnibus Budget Reconciliation Act of 1989, P.L. 101-239, §5202 (codified as amended at 42 U.S.C. 1395u(b)).}
\end{footnote}
\begin{footnote}{\textsuperscript{35}Omnibus Budget Reconciliation Act of 1990, P.L. 101-508, §§ 4101-4112 (codified as amended at 42 U.S.C. 1395u(b)).}
\end{footnote}
\end{footnotesize}
Dr. William Hsiao of Harvard University and his multidisciplinary team developed the RVUs for physicians’ work over many years. Dr. William Hsiao of Harvard University and his multidisciplinary team developed the RVUs for physicians’ work over many years.6 Annualy CMS updates the physician work RVUs for new and revised codes based, in part, on of recommendations of the American Medical Association’s Specialty Society Relative Value Update Committee (“RUC”).7

The RBRVS is based on relative value units (“RVUs”) for three cost components of medical care -- physicians' work effort, physicians' practice expenses, and malpractice liability insurance expenses—that are adjusted for geographic differences. These RVUs are then adjusted for geographic differences, and a conversion factor designed to curtail the increase in Part B expenditures.9

B. The Challenge of the Burgeoning Volume of Medicare Services

The second challenge of concern to policymakers has been controlling the volume of care for Medicare beneficiaries. The issue of volume is complicated. At a minimum increases in volume might represent new beneficiaries receiving services, any beneficiaries receiving marginally necessary services or beneficiaries receiving initially necessary services more frequently. At some point, increased volume becomes poor quality care and/or program abuse. The problem historically for the Medicare program is that, by locating the definition of the content and quality of medical care with the Medical profession, stewards of the Medicare program were unable to determine when care was excessive, poor quality and/or abuse. Only with the advances in health services research, discussed in Section II.D, and the empirical demonstration of poor quality and excessive care in terms understandable to non-physician policy-makers, was the dominance of physicians in defining the content and quality of medical care reduced.

1. Retrospective Utilization Review

The Social Security Amendments of 1965 required hospitals to have utilization review committees as a condition of participation in Medicare. Thus began Medicare's express

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39 See notes 50-55 infra and accompanying text.

responsibilities regarding the volume and quality of care of Medicare beneficiaries. However, the statute did not specify detailed requirements for these programs. In March 4, 1969, DHEW promulgated a regulation requiring that hospitals engage in utilization review of hospital services for the Medicare and Medicaid programs. Congress required hospitals to establish more aggressive internal utilization review programs.

In 1972, Congress established the Professional Standards Review Organization (“PSRO”) program. This program required the Medicare program to contract with independent physician-dominated organizations to review the utilization of health care services for Medicare beneficiaries. In 1981, the Reagan Administration and Congress repealed the program apparently in response to concerns from the medical profession about the program's intrusiveness into medical practice.

In 1982, in preparation for enactment of the new hospital prospective payment system, Congress, in preliminary legislation to support the move to prospective payment for hospitals, established the Medical Utilization and Quality Control program. This program established Peer Review Organizations (“PROs”) to review the utilization of services provided to Medicare beneficiaries.

By the late 1990s, CMS had concluded that retrospective review of PROs and PSROs before had not been particularly successful in addressing unnecessary volume in Medicare services or improving quality of care. At that point, CMS determined to refocus the work of PROs to quality improvement.

2. Volume Controls in Physician Payment Methodologies


48 Id.
Since 1972, Congress and the Medicare program have sought to control the overall spending for physician service with the imposition of limits on overall spending. Congress enacted several factors to adjust for increasing volume in Part B items and services.\textsuperscript{49}

In the Balanced Budget Amendments of 1996, Congress replaced existing volume controls\textsuperscript{50} with the “sustainable growth rate” factor that uses the real GDP to adjust for volume and intensity of services.\textsuperscript{51} This variable has proven to be very controversial and in recent years, if applied, would have resulted in markedly lower physician payments.\textsuperscript{52} Congress has delayed these rate cuts since 2008,\textsuperscript{53} and finally readjusted the conversion factor in 2011.\textsuperscript{54} The sustainable growth rate factor is the so-called conversion factor that is adjusts the final physician payment amount.

Like retrospective review of utilization, volume controls in Part B payment methodologies have proven problematic and not particularly effective in controlling Medicare expenditures. Certainly, the continued controversy over the sustainable growth rate exemplifies this inadequacy.

C. The Problem of Fraud and Abuse

A major problem for the Medicare program since its inception has been fraud and abuse by providers and other opportunists. Health care “fraud” has been described as an intentional attempt to wrongfully collect money relating to medical services, while “abuse” has been described as actions which are inconsistent with acceptable business and medical practices.\textsuperscript{55}


\textsuperscript{50} Balanced Budget Act of 1997, §§ 4202(b) & (c) (codified as amended at SSA §§1848(d) & (f), 42 U.S.C. §1395w-4(d) & (f).


1. **False Claims and Anti-Kickback Prohibitions**

Early on in the Medicare program, it was clear that some providers and suppliers were defrauding and abusing the Medicare program through a variety of business and criminal practices. In the Social Security Amendments of 1972, Congress enacted the first anti-fraud provision for the Medicare and Medicaid programs.\(^{56}\) This provision essentially prohibited kick-backs and other payments among providers for referrals of patients. As indicated in the House Ways and Means Committee report, Congress sought only to prohibit practices that had “long been regarded by professional organizations as unethical, as well as unlawful in some jurisdictions, and which contribute appreciably to the cost of the medicare and medicaid programs.”\(^{57}\)

Congress expanded these fraud and abuse provisions in the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977.\(^{58}\) These amendments accorded the newly-established Office of the Inspector General (“OIG”) within DHHS expanded authority to identify and eliminate waste, fraud and abuse in the department.

The anti-kickback prohibitions have created an extensive regulatory regime over the way in which health care providers do business with one another. While kickbacks are illegal or unethical in many other businesses,\(^{59}\) the Medicare statute and its interpretations have been much stricter in defining kickbacks and have even proscribed splitting fees which is common in other professions. The Medicare anti-kickback prohibitions seem to seek to limit entrepreneurial behavior on the part of providers to generate business.

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59 The Legal Information Institute at Cornell University Law School defines kickback generally as:

>A "kickback" is a term used to refer to a misappropriation of funds that enriches a person of power or influence who uses the power or influence to make a different individual, organization, or company richer. Often, kickbacks result from a corrupt bidding scheme. Through corrupt bidding, the official can award the contract to a company, even though the company did not place the lowest bid. The company profits by having been awarded the bid and getting to perform the contract. In exchange for this corrupt practice, the company pays the official a portion of the profits. This portion is the “kickback.” Such a practice falls within a sphere of practices often referred to as “anti-competitive practices.” Organized crime has been traced using kickbacks for many years. Some also consider kickbacks to be a type of bribery.

Cornell University School of Law, Legal Information Institute, Kickbacks, at http://www.law.cornell.edu/wex/kickback
In 1981, Congress enacted the Civil Monetary Penalties Law (“CMPL”) as part of the Omnibus Budget Reconciliation Act of 1981. This law authorized the OIG to impose penalties on violators without having to refer cases to the US Department of Justice. This authority greatly facilitated the Medicare program’s ability to go after false claims because the enhanced role of the OIG and the simpler penalty sanctions.

In the False Claims Act Amendments of 1986, Congress strengthened the False Claims Act (“FCA”) to make clear that the FCA applied to claims against the Medicare and Medicaid programs. These amendments opened a new front on Medicare defrauders and abusers. The amendments facilitated the ability of private parties, who were often internal whistle blowers that witnessed the fraud and abuse to bring suit as “relaters” on the government’s behalf under the False Claims. As a result, the federal government has been able to recover millions of dollars from health care providers under the False Claims Act since the late 1980s.

The Medicare and Medicaid Patient and Program Protection Act of 1987 provided new authority to the OIG to exclude persons or entities from participation in the Medicare if the party engaged in a prohibited remuneration scheme. This Act also established alternative civil remedies that would facilitate regulating abusive business practices.

In the mid-1990s, Congress added significant provisions to the Medicare fraud and abuse armamentarium. In the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), Congress greatly strengthen and coordinated Medicare fraud and abuse authorities. Specifically, HIPAA created a new crime of health care fraud, which includes theft, embezzlement, false statements, obstruction of a criminal investigation, and money laundering, among others. HIPAA also enhanced administrative enforcement mechanisms, and strengthened provisions for exclusion from Medicare participation for offenders.

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68 HIPAA §§ 241-250 (codified at scattered sections of 18 U.S.C.)

addition, HIPAA greatly increased penalties under the Civil Monetary Penalties Act. HIPAA established the national health care fraud and abuse data collection program for the reporting of final adverse actions (not including settlements in which no findings of liability are made) against health care providers, suppliers, or practitioners.

HIPAA also created three distinct new programs -- the Fraud and Abuse Control Program, the Medicare Integrity Program, and the Beneficiary Incentive Program -- with designated funding streams. The Fraud and Abuse Control Program is jointly administered by the Attorney General and the Secretary of HHS and coordinates fraud control work throughout the government. Pursuant to the Medicare Integrity Program, HHS contracts with private companies to perform fraud control functions in which fiscal intermediaries and carriers had historically shown little interest. Finally, the Beneficiary Incentives Program offers incentive payments to beneficiaries who provide information that lead to monetary recoveries.

2. Physician Self-Referral Prohibitions

In 1989, Congress enacted fraud and abuse legislation targeted at addressing physician referrals to clinical laboratories that the physicians owned. There had been much controversy and commentary about the growing practice of physicians of referring patients to their own service providers. The Omnibus Budget Reconciliation Act of 1993 expanded the restriction to a range of additional health services and applied it to both Medicare and Medicaid. This legislation, known as “Stark II,” also contained clarifications and modifications to the exceptions in the original law.

The Medicare statute includes the so-called whole hospital exception to the physician self-referral prohibitions. This exception has become controversial in recent years with the

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70 HIPAA §§ 231-232 (codified at SSA § 1128A (42 U.S.C. § 1320a–7a)).
71 HIPAA § 221 (codified at SSA § 1128E, 42 U.S.C. § 1320a-7e).
72 HIPAA § 201 (codified at SSA § 1128C, 42 U.S.C. § 1320a–7c)
emergence of physician-owned specialty hospitals in many states. In the late 1990s, physicians began building and investing in medical specialty hospitals that that were independent of community hospitals in highly lucrative specialties such as cardiology and orthopedics. Physicians, which had been tussling with community hospitals and managed care companies throughout the 1990s to get their perceived fair share of patient revenue, moved toward specialty hospitals to gain greater corporate and financial control over care.\textsuperscript{79} Their advent was very controversial especially for community hospitals which lost lucrative services and procedures to specialty hospitals especially.\textsuperscript{80}

The rise of physician-owned specialty hospitals raised concerns among policy makers. In 2003, the US General Accounting Office (now the US Government Accountability Office) conducted two studies of these emerging developments and raised concerns about their profitability vis-à-vis not-for-profit hospitals and other matters.\textsuperscript{81} In the Medicare Prescription Drug, Improvement, and Modernization Act of 2003,\textsuperscript{82} Congress imposed an 18 month moratorium on the whole hospital exception for new specialty hospitals in the physician self-referral prohibitions and directed the Medicare Payment Advisory Panel to study and report on physician-owned medical specialty hospitals.

The MEDPAC conducted a study and gave some remarkable recommendations about the future treatment of physician-owned specialty hospitals.\textsuperscript{83} The conclusions of MEDPAC were mixed, reflecting external studies of specialty hospitals.\textsuperscript{84} MEDPAC concluded:

We found that physicians may establish physician-owned specialty hospitals to gain greater control over how the hospital is run, to increase their productivity, and to provide greater satisfaction for them and their patients. They may also be


\textsuperscript{79} Ron Winslow, Fed-Up Cardiologists Invest in own Hospital: They'll Regain Autonomy but Critics See a Grab for More Profitable Care, Wall Street Journal (June 22, 1999), at A1.

\textsuperscript{80} Rau Voelker, Specialty Hospitals Generate Revenue and Controversy. 289(4) JAMA 409 (2003).


motivated by the financial rewards, some of which derive from inaccuracies in the Medicare payment system.\textsuperscript{85}

MEDPAC recommended addressing “inaccuracies, which result in the system paying too much for some DRGs relative to others and too much for patients with relatively less severe conditions.”\textsuperscript{86} Such reforms would make competition between community hospitals and specialty hospitals more equitable. MEDPAC also recommended promoting gainsharing to align physician and hospital incentives to allow physicians and hospitals “to share savings from more efficient practices and might serve as an alternative to direct physician ownership.”\textsuperscript{87}

In 2006, MEDPAC revisited physician-owned specialty hospitals and reported on its empirical study of physician-owned specialty hospitals.\textsuperscript{88} In general, the study found that in communities with physician-owned specialty hospitals, rates of cardiac and other procedures were a little higher but that community hospitals seemed able to maintain financial stability.\textsuperscript{89} MEDPAC offered no recommendations on further policy action regarding these hospitals.

D. Medicare and Healthcare Quality

The initial approach of the Medicare program toward assuring quality of care for Medicare beneficiaries were focused mainly on required licensure and/or accreditation of health care providers.\textsuperscript{90} Physicians, hospitals and other providers were responsible for quality assurance and improvements. Indeed, Title II of the Social Security Amendments of 1965 which pertain to the Medicare program mention the word “quality” only once in connection with the responsibilities of state agencies in managing survey and certification responsibility for facilities participating in Medicare.\textsuperscript{91}

In the 1980s, spurred on by health services research indicating that little was known about whether expensive medical procedures were more efficacious than less expensive treatment approaches, medical researchers and third party payers promoted outcome measures as the appropriate indicators of quality in quality assurance and improvement activities.\textsuperscript{92} Health

\textsuperscript{85} MEDPAC, Report to Congress, \textit{supra} note 83, at vii.

\textsuperscript{86} \textit{Id.}

\textsuperscript{87} \textit{Id.} at viii.


\textsuperscript{89} \textit{Id.}

\textsuperscript{90} Some of the material in this section on value-based purchasing has been taken from Eleanor D. Kinney, The Affordable Care Act and the Medicare Program: Linking Medicare Payment to Quality Performance, 67 New York University Annual Survey of American Law (forthcoming 2012).


services researchers demonstrated that not all costly medical procedures are more effective than less costly care.\textsuperscript{93}

Extensive health services research shaped the future of quality science in medicine and paved the way for reforms that reduced volume and improved quality. For health services research produced empirical evidence in a form comprehensible to non-physicians on where high quality and appropriate healthcare services. First is the work of Dr. John Wennberg and colleagues which demonstrated sharp variation in services provided Medicare beneficiaries among different geographic areas for the same conditions.\textsuperscript{94} The finding dramatically documented provider induced demand for services and the resulting inefficiencies and provision of health care.

The second important development was the application of the theories of Total Quality Management (“TQM”) and Continuous Quality Improvement (“CQI”), developed by William E. Deming and Joseph Juran,\textsuperscript{95} to health care institutions.\textsuperscript{96} According to TQM/CQI theory, quality management should strive to reduce statistical variation in products and production to a level that is uniform and predictable, and also meets the expectations of the customer. Since the 1990s, data-driven TQM/CQI theory and practice has become an integral part of quality assurance and improvement concepts in the health care field.\textsuperscript{97}

The third critical development was the patient safety movement inspired by the Institute of Medicine’s (“IoM”) report, \textit{To Err Is Human}.\textsuperscript{98} This report made two important factual findings that have literally precipitated a revolution in US health care. These observations were: (1) an estimated 44,000 to 98,000 people die each year in hospitals from medical injury; and (2) systems failures, rather than poor performance by individual practitioners, cause at least half of patient injuries.\textsuperscript{99} The IoM report recommended that providers create a culture of safety in

\begin{itemize}
\item \textsuperscript{93} See, e.g., David M. Eddy, Variation in Physician Practice: The Role of Uncertainty, 3 Health Aff. 74 (1984); Robert H. Brook & Kathleen N. Lohr, Efficacy, Effectiveness, Variations, and Quality: Boundary-Crossing Research, 23 Med. Care 710 (1985); David M. Eddy & John Billings, The Quality of Medical Evidence: Implications for Quality of Care, 7 Health Aff. 19 (1988).
\item \textsuperscript{94} John E. Wennberg & John Gittelsohn, Small Area Variation in Health Care Delivery 182 Science 1102 (1973); John E. Wennberg & John Gittelsohn, Variations in Medical Care Among Small Areas, 246 Scientific American 120 (1982); John E. Wennberg et al., Professional Uncertainty and the Problem of Supplier-Induced Demand, 16 Social Science and Medicine 811 (1982).
\item \textsuperscript{96} Donald M. Berwick et al., Curing Health Care: New Strategies For Quality Improvement (1990); Donald M. Berwick, Continuous Improvement as an Ideal in Health Care, 320 New England Journal of Medicine 53 (1989); Glenn Laffel & David Blumenthal, The Case for Using Industrial Quality Control Management Science in Health Care Organizations, 262 JAMA 2869 (1989).
\item \textsuperscript{98} Institute of Medicine, \textit{To Err is Human, Building a Safer Health Care System}, (Linda T. Kohn et al. eds., 2000).
\item \textsuperscript{99} Id.
\end{itemize}
institutions by borrowing from quality science in the engineering industries. Providers were largely persuaded by these findings and instituted data driven strategies to reduce risks to patient safety.

In 2001, CMS (the successor of HCFA) began launching quality initiatives “to assure quality health care for all Americans through accountability and public disclosure.” CMS established the Health Care Quality Improvement Initiative (“HCQII”) to move from addressing individual clinical errors to helping providers to improve care generally. In 2002, hospital associations, employers, payers, consumer organizations, the Joint Commission and also CMS established the Hospital Quality Alliance (“HQA”) to make “meaningful, relevant, and easily understood information about hospital performance accessible to the public and to informing and encouraging efforts to improve quality.”

In July 2003, CMS launched the National Voluntary Hospital Reporting Initiative. This initiative is now known as the “Hospital Quality Alliance: Improving Care through Information,” which is a public-private collaboration to improve the quality of care provided by the nation's hospitals by measuring and publicly reporting on that care. In CMS' Hospital Quality Initiative, CMS works with the HQA and other key stakeholders with the support of Agency for Healthcare Research and Quality (“AHRQ”), the National Quality Forum (“NQF”), and the Joint Commission, among other organizations. Through this initiative, CMS developed a standardized set of hospital quality measures for use in voluntary public reporting. As part of this initiative, CMS has launched the website Hospital Compare to provide information on the comparative performance of hospitals on health care quality.

The MMA of 2003 established the authority for the Hospital Inpatient Quality Reporting program and revised the methodology for updating the so-called standardized amount that reflects routine operating under the Medicare inpatient prospective payment system. Since

100 Id.
104 Hospital Quality Alliance, at http://www.hospitalqualityalliance.org/.
2003, CMS has been moving forward with value-based purchasing first for inpatient, acute care hospitals and then for other institutional providers.109

A very important step in the development of value-based purchasing was the Premier Hospital Incentive Demonstration initiated in 2003.110 This demonstration conducted in partnership with Premier Healthcare Alliance, a national health care performance improvement organization, involved hospitals in 38 states and tested whether paying hospitals for performance on various quality metrics would shift the performance upward across the whole group of hospitals.111 In evaluation results, announced in 2010,112 participating hospitals improved performance across the board.113 Some research findings have suggested that the actual impact of the value-based purchasing initiative will not have a great effect on Medicare payment even of high and low performing hospitals.114

The Deficit Reduction Act of 2005 (“DRA”) authorized the launch the value-based purchasing program.115 DRA required a reduction by two percent of the applicable percentage increase in payment for covered hospitals that not submit quality data in a form and manner and at a time specified by the Secretary.116 DRA called for the Secretary to develop a plan for the hospital value-based purchasing program which would begin in FY 2009.117 In 2007, CMS submitted this plan to Congress.118 In the FY 2007 final rule for the inpatient prospective

109 Centers for Medicare & Medicaid Services, Roadmap for Implementing Value Driven Healthcare, supra note 105.
111 CMS, Premier Hospital Quality Incentive Demonstration Rewarding Superior Quality Care: Fact Sheet (Dec. 2010), at https://www.cms.gov/HospitalQualityInits/35_HospitalPremier.asp.
118 CMS, Report to Congress: Plan to Implement a Medicare Hospital Value-Based Purchasing Program (Nov. 21, 2007).


A very important development in quality reporting and payment reform was the establishment of a formal role for the NQF. NQF is a nonprofit organization with a mission to improve quality of American health care by:

- “Building consensus on national priorities and goals for performance improvement and working in partnership to achieve them;
- Endorsing national consensus standards for measuring and publicly reporting on performance; and
- Promoting the attainment of national goals through education and outreach programs.”\footnote{National Quality Forum, About NQF (2012), at http://www.qualityforum.org/About_NQF/About_NQF.aspx.}

The membership of NQF is diverse and includes a wide variety of healthcare stakeholders, including consumer organizations, public and private purchasers, physicians, nurses, hospitals, accrediting and certifying bodies, supporting industries, and healthcare research and quality improvement organizations.\footnote{Id.} As NQF asserts, “NQF’s unique structure enables private- and public-sector stakeholders to work together to craft and implement cross-cutting solutions to drive continuous quality improvement in the American healthcare system.”\footnote{Id.}

The Medicare Improvements for Patients and Providers Act of 2008 required the Secretary to contract with a consensus-based entity, “like the National Quality Forum,” regarding
performance measurement. The central duty of this consensus-based entity is to “synthesize evidence and convene key stakeholders to make recommendations on an integrated national strategy and priorities for health care performance measurement in all applicable settings.”

The entity also has to be a private nonprofit organization with a board with designated representatives of stakeholders such as insurers, providers and consumers. The entity’s membership must include people with experience with urban health care issues, safety net health care issues, rural and frontier health care issues, and health care quality and safety issues. The entity must conduct its business in an open and transparent manner and provides the opportunity for public comment on its activities. The entity must operate “as a voluntary consensus standards setting organization,” as defined in section 12(d) of the National Technology Transfer and Advancement Act of 1995, and Office of Management and Budget Revised Circular A-119. Finally, the entity has to have at least four years of experience in establishing national consensus standards.

CMS awarded the contract to NQF to serve as the “consensus-based entity.” NQF has specific responsibility regarding the endorsement of measures. Regarding endorsements of measures, the entity must consider whether a measure meets the following criteria:

- The measure is “evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level.”
- The measure is “consistent across types of health care providers, including hospitals and physicians.”

In addition, the entity is required to maintain, including update, measures to promote the development of electronic health records, and make reports to Congress.

Finally, in more recent years, there has been great interest in comparative effectiveness research as a tool to reduce health care expenditures. In 2009, the American Recovery and

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Reinvestment Act ("ARRA") launched a major research initiative on comparative effectiveness research.\textsuperscript{134} ARRA also called on the Institute of Medicine to develop national priorities for comparative effectiveness research for this initiative.\textsuperscript{135} In 2009, the Institute of Medicine published developed national priorities for research that have been the basis of the comparative effectiveness research initiative in ACA.\textsuperscript{136} As to whether comparative effectiveness research will have the impact warranted by the federal investment in it remains unclear.\textsuperscript{137}

IV. IMPROVING THE QUALITY AND EFFICIENCY (Title III)

The reforms in Title III of ACA are intended to improve the quality and efficiency of health care. In reality, the reforms are targeted at the Medicare program. At Figure 5 is a list of all the subtitles in Title III that address the Medicare program.

A. Transforming the Health Care Delivery System (Subtitle A)

The reforms in Subtitle A have two common themes. The first is to link Medicare payment to measurable clinical performance. The second theme is to integrate Part A and Part B services to facilitate the innovative delivery of health care services and bundled payments methodologies.

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\textsuperscript{136} Institute of Medicine, Initial National Priorities for Comparative Effectiveness Research (2009).

\textsuperscript{137} Symposium, Current Challenges In Comparative Effectiveness Research, 31 (10) Health Affairs 2160 (2012).
1. Linking Payment to Quality Outcomes under the Medicare Program (Subtitle A, Part 1)

Subtitle A, Part 1 essentially advances the Medicare value-based purchasing program for hospitals, physicians and other providers.  

At Figure 6 are listed the section in Title III, Subtitle A, Part 1.

a. Hospital Value-Based Purchasing Program (Section 3001)

Section 3001 of ACA establishes the value-based purchasing program for IPPS hospitals. This program covers 3,500 US hospitals. In spring 2011, CMS issued the final rule establishing the Hospital Value-Based Purchasing Program under the Medicare IPPS. The ACA Value-Based Purchasing Program marks a definite departure from how the Medicare program has paid hospitals in the past. As CMS asserts:

Starting in October 2012, Medicare will reward hospitals that provide high quality care for their patients through the new Hospital Value-Based Purchasing Program. This program marks the beginning of an historic change in how Medicare pays health care providers and facilities—for the first time, hospitals across the country

Figure 6
Subtitle A—Transforming The Health Care Delivery System
Part 1—Linking Payment To Quality Outcomes Under The Medicare Program

| Sec. 3001. Hospital Value-Based purchasing program |
| Sec. 3002. Improvements to the physician quality reporting system |
| Sec. 3003. Improvements to the physician feedback program |
| Sec. 3004. Quality reporting for long-term care hospitals, inpatient rehabilitation hospitals, and hospice programs |
| Sec. 3005. Quality reporting for PPS-exempt cancer hospitals |
| Sec. 3006. Plans for a Value-Based purchasing program for skilled nursing facilities and home health agencies |
| Sec. 3007. Value-based payment modifier under the physician fee schedule |
| Sec. 3008. Payment adjustment for conditions acquired in hospitals |


will be paid for inpatient acute care services based on care quality, not just the
quantity of the services they provide.\textsuperscript{142}

The program applies to all Medicare inpatient hospitals discharges on or after October 1, 2012.\textsuperscript{143} ACA establishes measures for ascertaining hospitals’ achievement of high quality.\textsuperscript{144} ACA charges the Secretary of DHHS with selecting measures but mandates that, at least, the measures pertain to the five conditions, including acute myocardial infarction, heart failure, pneumonia, certain surgeries and hospital acquired infections.\textsuperscript{145} Quality measures must also be related to the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), which collects data on patients’ perspectives on hospital care in a standardized fashion.\textsuperscript{146}

The Secretary must also establish “performance standards” for each quality measure, which include “levels of achievement and improvement.”\textsuperscript{147} The standards also reflect “practical experience” with the measures involved such as “whether a significant proportion of hospitals failed to meet the performance standard during previous performance periods.”\textsuperscript{148} In the case of hospitals that CMS determines meet (or exceed) the performance standards for the performance period, CMS must increase the hospital’s base operating DRG payment amount, with some adjustments,\textsuperscript{149} for each discharge occurring in such fiscal year by the value-based incentive payment amount.\textsuperscript{150} The value-based incentive payment amount for each discharge of a hospital in a fiscal year is equal to the product of:

\begin{itemize}

\item \textsuperscript{143} ACA § 3001(a) (codified as amended at § 1886(o)(a)(1)(C) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(1)(B)).

\item \textsuperscript{144} ACA § 3001(a) (codified as amended at Section 1886(o)(a)(1)(C) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(1)(C)).

\item \textsuperscript{145} ACA § 3001(a) (codified as amended at § 1886(o)(a)(2) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(2)).

\item \textsuperscript{146} ACA § 3001(a) (codified as amended at § 1886(o)(a)(2) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(2). See HCAHPS: Hospital Care Quality Information from the Consumer Perspective, CAHPS® Hospital Survey, at http://www.hcahpsonline.org/home.aspx (for detailed information about the survey).

\item \textsuperscript{147} ACA § 3001(a) (codified as amended at § 1886(o)(a)(3) (A) & (B) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(3)(A) & (B).

\item \textsuperscript{148} ACA § 3001(a) (codified as amended at § 1886(o)(a)(3) (D) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(3)(D).


\item \textsuperscript{150} ACA § 3001(a) (codified as amended at § 1886(o)(a)(6)(A) of the Social Security Act, 42 U.S.C. § 1395ww(o)(a)(6)(A).
• The value-based incentive payment percentage for the hospital for such fiscal year.

• The base operating DRG payment amount for the discharge for the hospital for such fiscal year.

Funding for value-based incentive payments will come from assigned payment to hospitals under the Medicare prospective payment system. The amount of reduction in FY 2013 is 1.0 percent and moves to 2.0 percent by 2017.

b. Improvements to the Physician Quality Reporting System (Section 3002)

Under ACA, CMS has created the Physician Feedback/Value-Based Modifier Program which provides comparative performance information to physicians as part of the Medicare program’s efforts to improve the quality and efficiency of medical care. These goals are achieved, in the words of CMS, “by providing meaningful and actionable information to physicians so they can improve the care they furnish, and by moving toward physician reimbursement that rewards value rather than volume.” The Program contains two primary components: (1) the preparation of the Physician Quality and Resource Use Reports (“QRURs”), and (2) the development and implementation of a Value-based Payment Modifier (“VBPM”).

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155 ACA § 3008(b) (codified at Social Security Act § 1886, 42 U.S.C. § 1395ww, as amended by ACA § 3001).


157 Centers for Medicare & Medicaid Services, Roadmap for Implementing Value Driven Healthcare, supra note 105.

27
Section 3002 of ACA enhances the quality reporting initiative for physicians, which Congress established in the Tax Relief and Health Care Act of 2006. The Physician Quality Reporting Initiative now is a voluntary program for eligible practitioners and provides an incentive payment to physicians and/or practices that satisfactorily report data on specified quality measures.

ACA extends this voluntary program until 2014. ACA also renamed the initiative to the Physician Quality Reporting System ("PQRS") and established the Physician Compare website. By 2015, eligible professionals must submit data on quality measures for covered professional services or incur a percent reduction in the fee schedule amount for service provided for that pay period. The percentage reductions will be 1.5 percent in 2015 and 2.0 percent thereafter. CMS promulgated a proposed rule to implement these and other changes in physicians in July 2012.

ACA requires the Secretary to provide timely feedback to eligible professionals on their performance on submitting data on selected quality measures. ACA also requires establishment of an informal appeals process by January 1, 2011, for eligible professionals to seek a review of the determination that an eligible professional did not satisfactorily submit data on selected quality measures.

ACA also contains incentives for physicians to participate in the Maintenance of Certification ("MOC") Program operated by the American Board of Medical Specialties. This program requires physicians with medical specialty certifications to participate in continuing medical education and other activities to maintain current in their specialty. ACA provides that physicians who are eligible for the PQRS can receive an additional 0.5 percent incentive payment if they meet the MOC requirements as well. These include an initial assessment that demonstrates the physician's use of evidence-based medicine, a survey of patient

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160 ACA § 3002(a) (codified as amended at SSA § 1848(a), 42 U.S.C. §. 1395w–4(a)).

161 Id. (CHECK).

162 ACA § 3002(b) (codified as amended at SSA § 1848(a)(8)(A), 42 U.S.C. §. 1395w–4(a)(8)(A)).

163 ACA § 3002(b) (codified as amended at SSA § 1848(a)(8)(A)(ii), 42 U.S.C. §. 1395w–4(a)(8)(A)(ii)).


165 ACA § 3002(e) (codified as amended at SSA § 1848(m)(5)(H), 42 U.S.C. §. 1395w–4(m)(5)(H)).

166 ACA § 3002(f) (codified as amended at SSA § 1848(m)(5)(I), 42 U.S.C. §. 1395w–4(m)(5)(I)).


168 Id.
experience with care, and implementation of a quality improvement intervention to address a practice weakness identified in the initial assessment.\textsuperscript{169} ACA also seeks to integrate physician quality reporting with the electronic medical record.\textsuperscript{170}

c. Improvements to the Physician Feedback Program (Section 3003)

ACA expands the current Physician Feedback Reporting initiative.\textsuperscript{171} Specifically, the feedback reporting program, using claims data, provides reports to physicians and physician groups, called Physician Quality and Resource Use Reports (“QRURs”).\textsuperscript{172} These QRURs contain information on the resource use, costs and quality of care provided to Medicare patients, including quantification and comparisons of patterns of resource use and costs among physicians and medical practice groups.\textsuperscript{173}

For reports on utilization, the Secretary must develop an “episode grouper” by January 2012 that combines separate but clinically related items and services into an episode of care for an individual patient.\textsuperscript{174} The grouper will enable production of individualized reports that compare the per capita utilization of physicians to other physicians who see similar patients. The details of the grouper must be made available to the public and endorsed by NQR.\textsuperscript{175} The methodologies used must meet statutory standards and be available to the public as well.\textsuperscript{176} Further, there is no administrative or judicial review of the grouper’s design, methods or determinations.\textsuperscript{177} Finally, the feedback program must be coordinated with other value-based

\textsuperscript{169} ACA § 3002(c), as amended by ACA§ 10327(b) (codified as amended at SSA § 1848(k)(4), 42 U.S.C. §1395w–4(k)(4)).


\textsuperscript{172} CMS, Medicare FFS Physician Feedback Program/Value-Based Payment Modifier (2012), at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/index.html?redirect=/physicianfeedbackprogram

\textsuperscript{173} Id.

\textsuperscript{174} ACA § 3003(a)(4) (codified as amended SSA § 1848(n)(A)(9) (i) & (ii), 42 U.S.C. § 1395w–4(n)(A)(9) (i) & (ii)).

\textsuperscript{175} ACA § 3003(a)(4) (codified as amended SSA § 1848(n)(A)(9)(ii), 42 U.S.C. § 1395w–4(n)(A)(9) (ii)).

\textsuperscript{176} ACA § 3003(a)(4) (codified as amended SSA § 1848(n)(A)(9)(C) ↔(F), 42 U.S.C. § 1395w–4(n)(A)(9) (C) & (F)).

\textsuperscript{177} ACA § 3003(a)(4) (codified as amended SSA § 1848(n)(A)(9)(G) ↔(F), 42 U.S.C. § 1395w–4(n)(A)(9) (G)).
purchasing programs. CMS promulgated a proposed rule to implement these and other changes in physicians in July 2012.

d. Quality Reporting for Long-Term Care Hospitals, Inpatient Rehabilitation Hospitals, and Hospice Programs (Section 3004).

Effective the rate year 2014, section 3005 of ACA extends the quality reporting requirement to long-term care hospitals, inpatient rehabilitation hospitals and hospice programs. The Secretary must develop and publish the quality measures for these institutions by 2012 and make quality data from these institutions available to the public through a website.

e. Quality Reporting for PPS-Exempt Cancer Hospital (Section 3005)

Section 3005 of ACA establishes a quality reporting program for PPS-Exempt cancer hospitals. Historically, the Medicare program has exempted major cancer hospitals that are designated as comprehensive or clinical cancer centers by the National Institutes of Health from the prospective payment system. Beginning in 2014, cancer hospitals will have to submit data on quality measures to the Secretary in a manner the Secretary specifies. By October 1, 2012, the Secretary must publish quality measures for cancer hospitals that will be effective in fiscal years 2014. The quality measure must be endorsed by the NQF although the may

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178 ACA § 3003(a)(4) (codified as amended SSA § 1848(n)(A)(10)), 42 U.S.C. § 1395w–4(n)(A)(10)).
179 Proposed Rule, Medicare Program; Medicare Physician Fee Schedule: . . ., supra note 171.
180 ACA § 3004(a) (codified as amended at SSA § 1886(m), 42 U.S.C. § 1395ww(m)).
181 ACA § 3004 (codified as amended at SSA § 1886(j), 42 U.S.C. § 1395ww(j)).
182 ACA § 3004(c) (codified as amended at SSA § 1814(i), 42 U.S.C. § 1395f(i)).
186 ACA § 3005(2) (codified as amended at SSA § 1866(k), 42 U.S.C. § 1395cc(k)).
specify measures not so endorsed as long as consideration has been given the NQF’s endorsed measures. The data on which these measures are based must be made available to the public and the measures must be published on a CMS website.

f. Plans for a Value-Based Purchasing Program for Skilled Nursing Facilities and Home Health Agencies (Section 3006)

Section 3006 of ACA requires the Secretary develop a plan to implement a value-based purchasing program for skilled nursing facilities, home health agencies, and ambulatory surgery centers. For all three types of providers, the Secretary must develop a plan for reporting quality measures in a collaborative and transparent process and report to Congress on plans for skilled nursing facilities and home health agencies by October 1, 2011, and plans for ambulatory surgery centers by January 1, 2011.

g. Value-Based Payment Modifier under the Physician Fee Schedule (Section 3007)

ACA section 3007 mandates that, by 2015, the Secretary must establish the Value-based Payment Modifier (“VBPM”) that provides for differential payment to physicians or physician groups based on quality performance. To establish the VBPM, the Secretary must develop appropriate risk adjusted measures of quality of care which also reflect outcomes of care. ACA requires that implementation begin with rulemaking for Fiscal Year 2013.

CMS promulgated a proposed rule to implement these changes in physician payment in July 2012. Beginning January 1, 2015, CMS must apply the VBPM to specific physicians

188 ACA § 3005(3) (codified as amended at SSA § 1866(k)(W)(3), 42 U.S.C. § 1395cc(k)(W)(3)).

189 ACA § 3005(3) (codified as amended at SSA § 1866(k)(W)(3), 42 U.S.C. § 1395cc(k)(W)(3)).

190 ACA § 3006(a).

191 ACA § 3006(b).

192 ACA § 3006(f).

193 DHHS, Report to Congress: Plan to Implement a Medicare Home Health Agency Value-Based Purchasing Program (No Date), at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/Downloads/Stage-2-NPRM.pdf.

194 ACA §§ 3006(a), (b) & (f).

195 ACA § 3007 (codified as amended at SSA § 1848(p)(2), 42 U.S.C. § 1395w–4(p)(2)).

196 ACA § 3007 (codified as amended at SSA § 1848(p)(4), 42 U.S.C. § 1395w–4(p)(4)).

197 Proposed Rule, Medicare Program; Medicare Physician Fee Schedule . . . , supra note 171.
and physician groups that CMS determines appropriate. No later than January 1, 2017, the VBPM must be applied to all physicians and physician groups.\(^{198}\) In applying the payment modifier, the Secretary must take into account the special circumstances of physicians or groups of physicians in rural areas and other underserved communities.\(^{199}\) The Secretary must also coordinate the value-based payment modifier with the Physician Feedback Program.\(^{200}\) Finally, ACA prohibits administrative or judicial review of the issues in the design, implementation and application of the payment modifier.\(^{201}\)

**h. Payment Adjustment for Hospital-Acquired Conditions (Section 3008)**

An important step toward linking Medicare payment to quality performance was the Medicare program’s identification of so-called “never events” and not paying for associated hospital care needed because of the never event.\(^{202}\) In 2002, NQF published a report, Serious Reportable Events (“SREs”) in Healthcare, identifying 27 adverse events occurring in hospitals that are “serious, largely preventable and of concern to both the public and healthcare providers.”\(^{203}\) According to NQF, the report’s objective is establishment of “a consensus among consumers, providers, purchasers, researchers, and other healthcare stakeholders about those preventable adverse events that should never occur and to define them in a way that, should they occur, it would be clear what had to be reported.”\(^{204}\)

In the DRA of 2005, Congress required the Secretary to identify conditions that are: (1) high cost or high volume or both, (2) result in the assignment of a case to a DRG that has a higher payment when present as a secondary diagnosis, and (3) could reasonably have been prevented through the application of evidence based guidelines.\(^{205}\) In August 2007, CMS adopted a final rule identifying eight “never events” for which, beginning Oct. 1, 2008, Medicare

\(^{198}\) ACA § 3007 (codified as amended at SSA § 1848(p)(6), 42 U.S.C. § 1395w–4(p)(6)).

\(^{199}\) ACA § 3007 (codified as amended at SSA § 1848(p)(6), 42 U.S.C. § 1395w–4(p)(6)).

\(^{200}\) ACA § 3007 (codified as amended at SSA § 1848(p)(9), 42 U.S.C. § 1395w–4(p)(9)).

\(^{201}\) ACA § 3007 (codified as amended at SSA § 1848(p)(10), 42 U.S.C. § 1395w–4(p)(10)).


would not provide additional payment to hospitals unless the events were present on admission. Adverse payment adjustments mark a great change in Medicare’s relationship with providers. Formerly, the Medicare program paid providers regardless if they generated expenses associated with their errors without question. Now hospitals are punished when they provide highly substandard care. Presumably hospitals will have greater incentives to improve the experience of safety for their patients.

2. Developing a National Strategy to Improve Health Care Quality (Subtitle A, Part 2)

Subtitle A, Part 2, calls for the development of a National Strategy to Improve Health Care Quality. To develop this strategy, the Secretary of HHS is to convene an interagency working group on health care quality that will focus primarily on developing quality measures and methods for measuring quality. DHHS has developed a national strategy as directed. CMS has submitted the requisite reports to Congress reporting on its progress with this initiative.

3. Developing New Patient Care Models (Subtitle A, Part 3)

Subtitle A, Part 3, Encouraging Development of New Patient Care Models, includes other strategies to control Medicare expenditures. These are some of the most important Medicare reforms in ACA. They are designed to make the delivery of and payment for health care services to Medicare fee-for-service beneficiaries more integrated and efficient and therefore less costly. At Figure 7 are presented the sections included in Part 3.

a. Center for Medicare and Medicaid Innovation (CMI) (Section 3021)

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207 ACA § 3011.

208 ACA § 3012-3014.


211 ACA § 3021-3027.
ACA section 3021 calls for the creation of the Center for Medicare and Medicaid Innovation ("CMI"). The purpose of CMI is “to test innovative payment and service delivery models to reduce program expenditures” and “improve the coordination, quality, and efficiency of health care services.” CMI has been quite active in launching new and continuing old initiatives. Currently, it is engaged in research and analysis on the following Medicare issues: Accountable care organization demonstrations, bundled payment demonstrations, the independence at home demonstration among other projects.

b. Medicare Shared Savings Program (Section 3022)

A very important strategy that compliments value-based purchasing is the Medicare shared savings program in Section 3022 of ACA. This shared savings program is intended to facilitate coordination and cooperation among providers to improve the quality of care for fee-for-service Medicare beneficiaries. Eligible providers, hospitals, and suppliers may participate in the Shared Savings Program by creating or participating in an Accountable Care Organization ("ACO").

Under the program, groups of providers of services and suppliers can work together to manage and coordinate care and, if they meet quality performance standards, they may receive payments for shared savings. The organizations they create are called ACOs. CMS defines ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients.”

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213 ACA § 3021(a) (codified at SSA § 1115A(1), 42 U.S.C. § 1315a(1)).


coordinated care is “to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.”

CMS has initiated a demonstration to test two models of ACOs: the Pioneer ACO Model and the Advance Payment ACO Model. The Pioneer ACO Model was designed specifically for organizations with “experience offering coordinated, patient-centered care, and operating in ACO-like arrangements.” There are 32 organizations participating in the Pioneer ACO Model. The Advanced Payment ACO Model provides additional support to physician-owned and rural providers who would benefit from additional start-up resources to build the necessary infrastructure, such as new staff or information technology systems.

c.  **Pilot Program on Payment Bundling (Section 3023)**

ACA section 3023 also calls for a national pilot program on payment bundling. The pilot program explores ways to pay groups of providers for services associated with an episode of care and move from the practice of essentially paying the bills of lots of individual providers. The basic idea is that such bundling would encourage providers to work together in efficient ways to care for the patient is a cost effective manner and not seek to maximize their individual reimbursements. In this program, CMS will pay a subset of Medicare providers will receive a single payment for an episode of acute care in a hospital, followed by postacute care in a skilled nursing or rehabilitation facility, the patient’s home, or other appropriate setting.

d.  **Independence at Home Demonstration Program (Section 3024)**

Section 3024 establishes the “Independence at Home Demonstration program.” This program will test payment incentives and service delivery model for the care of chronically ill patients that utilizes physician and nurse practitioner directed home-based primary care teams. Specifically, the demonstration is testing a service delivery and payment incentive model that uses home-based primary care teams, directed by physicians and nurse practitioners, designed to

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220 Id.


222 Id.

223 Id.

224 ACA § 3024 (codified at SSA §866E, 42 § U.S.C. § 1395cc–5). See Neeraj Sood1 et al., Medicare’s Bundled Payment Pilot For Acute And Postacute Care: Analysis And Recommendations on Where To Begin, 30(9) Health Affairs 1708 (2011).


improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions.227

e. Hospital Readmissions Reduction Program (Section 3025)

ACA Section 3025 finally establishes authority for reducing payment for readmissions to hospitals.228 Readmissions to hospitals have been a difficult and costly problem for the Medicare program since the implementation of the Medicare prospective payment system in the early 1980s.229 In 2005, MedPAC reported that in 2005, 17.6 percent of hospital admissions resulted in readmissions within 30 days of discharge, 11.3 percent within 15 days, and 6.2 percent within seven days.230 Other research reported similar findings.231 Through demonstrations and other analysis, CMS has been working on how to tailor Medicare payment rates for hospital readmissions.232 ACA established the Hospital Readmissions Reduction Program effective October 1, 2012.233 Under this program, payments for certain readmissions of eligible hospitals are reduced in order to account for excess readmissions.234 CMS has issued regulations for the Hospitals Readmissions Reduction Program.235


234 ACA § 3025 (codified at Social Security Act § 1886(q)(1), 42 U.S.C. § 1395ww(q)(q), as amended by ACA § 3001 & § 3008).
f. Community-Based Care Transitions Program (Section 3026)

Pursuant to ACA § 3026, the Secretary will establish a Community-Based Care Transitions Program under which CMS will fund entities that furnish improved care transition services to high-risk Medicare beneficiaries without reducing quality.\(^{236}\) The idea is that various entities, typically hospitals and a community-based organization would formally collaborate and provide transition services for a high risk Medicare beneficiary that would ensure timely post-discharge follow-up services.\(^ {237}\)

The partnership would submit a proposal on how it would deliver these transition services.\(^ {238}\) The intervention should provide high-risk Medicare beneficiaries and/or their caregivers with information regarding responding to symptoms that may indicate additional health problems or a deteriorating condition as well as assistance to ensure productive and timely interaction between patients and post-acute and outpatient providers. The intervention must also include comprehensive medication review.

g. Extension of Gainsharing Demonstration (Section 2027)

ACA § 2027 extends the “gainsharing demonstration” established under the DRA of 2005.\(^ {239}\) The basic theory of this demonstration is that providing payments to physicians that “represent solely a share of the savings incurred as a result of collaborative efforts” will “improve overall quality and efficiency.”\(^ {240}\) This demonstration is examining whether the practice of “gainsharing” is an effective means of aligning financial incentives to enhance quality and efficiency of care.\(^ {241}\)

B. Improving Medicare for Patients and Providers (Title III, Subtitle B)

\(^{235}\) CMS.gov, Hospital Readmissions Reduction Program (2012), at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.


\(^{238}\) ACA § 3026(a)(2)(B).

\(^{239}\) ACA § 3027 (codified at DFA, § 5007 (d)(3)).


Subtitle B contains a hodgepodge of provisions directed at improving various Medicare program policies. The changes are contained in three parts: (1) Ensuring Beneficiary Access to Physician Care and Other services, (2) Rural Protections, and (3) Improving Payment Accuracy. At Figure 8 is displayed the statutory sections in Subtitle B, Part I.

1. Ensuring Beneficiary Access to Physician Care and Other Services (Subtitle B, Part I).

This part contains fourteen sections with provisions modifying physician payment methodologies under Part B of the Medicare Program.242 Perhaps the most important change is the extension of the work geographic index floor243 and revisions to the practice expense geographic adjustment under the Medicare physician fee schedule.244 A geographic practice cost index (“GPCI”) has been established for every Medicare payment locality for each of the three components of a procedure's relative value unit (i.e., the RVUs for work, practice expense, and malpractice).245 The GPCIs are applied in the calculation of a fee schedule payment amount by multiplying the RVU for each component times the GPCI for that component. ACA requires the Secretary to “evaluate data that fairly and reliably establishes distinctions in the cost of operating a medical practice in different fee schedule areas” for the purpose of the practice expense GPCI.246

242 Section 3101, entitled “Increase in the Physician Payment Update” was included in the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-48 and was intended to accomplish the so-called “doc fix” and adjust the sustainable growth rate factor in the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 10310. See notes 53-57 supra and accompanying text.

243 ACA §§ 3102(a) (codified as amended at SSA § 1848(e)(1)(E), 42 U.S.C. § 1395w–4(e)(1)(E)).

244 ACA §§ 3102(b) (codified as amended at SSA § 1848(e)(1), 42 U.S.C. § 1395w4(e)(1)).


246 ACA §§ 3102(b)(1) (codified as amended at SSA § 1848(e)(1), 42 U.S.C. § 1395w4(e)(1)).
2. Rural Protections (Subtitle B, Part II).

Part II, displayed in Figure 9, contains seven sections that address problems of rural providers, particularly hospitals. Rural hospitals today and historically have experienced unique problems with respect to Medicare payment. Specifically, as described by the American Hospital Association, rural hospitals provide essential health care services to nearly 54 million people, including 9 million Medicare beneficiaries. Rural hospitals experience “Medicare payment challenges” due to workforce shortages, rising health care liability premiums and poor access to capital. Further, rural hospitals face with cost containment measures due to their small size, modest assets and financial reserves, and higher percentage of Medicare patients.

Part II contains a host of different payment policies to assist rural hospitals in maintaining financial sustainability. ACA extends and expands the Rural Community Hospital Demonstration Program. ACA also extends the Medicare-Dependent Hospital program for rural hospitals. ACA also mandates that the MedPAC conduct a study on adequacy of Medicare payments for health care providers serving in rural areas.

3. Improving Payment Accuracy (Subtitle B, Part III).

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247 ACA §§ 3121 – 3129.


249 Id.

250 Id.


253 ACA § 3127.
Part III, as displayed in figure 10, contains provisions for improving payment accuracy. ACA reforms payment methods for home health care, hospice services, medical imaging, electronic wheelchairs, among many other items and services.

ACA also updates Disproportionate Share (DSH) payments to hospitals that serve large numbers of Medicare, Medicaid and uninsured patients. Specifically, section 3133 modifies Medicare DSH payments to reflect lower uncompensated care costs associated with decreases in the number of uninsured.

This modification of Medicare DSH payments may have to be changed in light of the Supreme Court’s decision in National Federation of Independent Business v. Sebelius. In that decision, the Supreme Court ruled that the federal government could not terminate all federal matching funds for state Medicaid programs if states declined to implement the Medicaid expansion in Title II of ACA. The ACA provisions reducing Medicare DSH payments are predicated on the expectation that states would have to adopt the ACA Medicaid expansions.

C. Provisions Relating to Part C (Title III, Subtitle C)

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254 ACA § 3131.
255 ACA §3132.
256 ACA §3135.
257 ACA §3136.
259 ACA §3133, as amended by HCERA §1104 (codified at SSA §1886(r), 2 U.S.C. § 1395ww(r))
260 No. 11–393 (June 28, 2012).
261 ACA, Title II.
ACA also makes substantial changes to Medicare Part C, the Medicare Advantage program. These changes are presented at Figure 11. ACA will reduce payments to Medicare Advantage plans over time to bring Part C expenditures in line with fee-for-service Medicare.\(^{262}\) ACA also limits on variation of cost sharing for certain benefits such as chemotherapy administration services, renal dialysis services and skilled nursing care.\(^{263}\)

Plans under the predecessor of the Medicare Advantage program, the Medicare+Choice program established in the Balanced Budget Act of 1997,\(^{264}\) were unable to provide services for the same or less money than fee-for-service Medicare.\(^{265}\) Consequently, many Medicare+Choice plans discontinued serving Medicare beneficiaries. In the MMA, a republican dominated Congress reconceived the Medicare+Choice program in the Medicare Advantage program and paid Medicare Advantage plans at levels above fee-for-service Medicare.\(^{266}\) The Medicare Payment Advisory Committee reported in 2010 that the Medicare program spent roughly $14 billion more for beneficiaries enrolled in MA plans than for beneficiaries in the Medicare Fee-for-Service program.\(^{267}\)

Under ACA, Medicare payments to plans will be predicated on the average of the bids submitted by plans in each market.\(^{268}\) New payments will be implemented over a four-year transition period.\(^{269}\)

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\(^{262}\) ACA § 3201 as amended by HCERA § 1102(b) (codified as amended at SSA §1853, 42 U.S.C. §1395w–23).

\(^{263}\) ACA § 3201(codifie\(\text{d at SSA §1853, 42 U.S.C. §1395w–23).}


\(^{265}\) Bruce E. Landon et al., Comparison of Performance of Traditional Medicare vs Medicare Managed Care, 91(14) JAMA 1744 (2004)


\(^{268}\) ACA § 3201(a) as amended by HCERA § 1102(b) (codified as amended at SSA §1853, 42 U.S.C. §1395w–23).

\(^{269}\) ACA § 3201(b) as amended by HCERA § 1102(b) (codified as amended at SSA §1853, 42 U.S.C. §1395w–23).
ACA required that, effective January 1, 2012, CMS must provide quality bonus payments to MA plans under a 5-star quality rating system it developed.\(^{270}\) Instead, in November 2010, CMS announced that would waive the ACA 5-star quality rating system provisions and that would determine quality bonus payments for 2012 through 2014 under the massive Medicare Advantage Quality Bonus Payment Demonstration.\(^{271}\) There is considerable political debate over the advisability of CMS’ decision given the cost and scope of the demonstration.\(^{272}\) The US Government Accountability Office took the position that DHHS exceeded its authority in launching this demonstration rather than implement ACA.\(^{273}\)

**Figure 12**

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**D. Medicare Part D Improvements for Prescription Drug Plans and MA-PD Plans (Title III, Subtitle D)**

Perhaps the largest Medicare expansion in ACA is closing the so-called “donut hole” in the Medicare prescription drug benefit. ACA also started the process of closing the “donut hole” or coverage gap by providing a rebate for beneficiaries who had reached the gap in coverage in 2010.\(^{274}\) Also as a condition of having their drugs included in the Part D program,  

\(^{270}\) ACA § 3201(c) as amended by HCERA § 1102(b) (codified as amended at SSA §1853, 42 U.S.C. §1395w–23).


pharmaceutical manufacturers must provide a fifty percent discount to Part D beneficiaries for brand name pharmaceuticals during the coverage gap. As is evident from Figure 12, many provisions in Subtitle D are intended to reduce the cost of coverage to lower income Medicare beneficiaries and reduce subsidies for higher income beneficiaries. Other important changes include improvements in the appeal procedures associated with Part D benefits.

E. Ensuring Medicare Sustainability (Title III, Subtitle E)

Subtitle E, Ensuring Medicare Sustainability, is one of the more controversial provisions of ACA. The first two provisions of Subtitle E are relatively straightforward. Section 3401 adds a productivity adjustment to the market basket update for inpatient hospitals, home health providers, nursing homes, hospice providers, inpatient psychiatric facilities, long-term care hospitals and inpatient rehabilitation facilities. Section 3402 provides a temporary adjustment to the calculation of Part B premiums.

The controversial provision is the establishment of the Independent Payment Advisory Board (IPAB) which is intended to reduce the per capita rate of growth in Medicare spending. The IPAB is a 15-member panel charged with recommending a set of Medicare program changes if program spending growth exceeds specified targets in 2015. Section 3403 establishes a complicated procedure by which the Chief Actuary of CMS to determine annually the projected per capita growth rate in the under Medicare program for the year for the next year. If the projection for the second year exceeds the target growth rate for that year, the board is required to develop and submit a proposal containing recommendations to reduce the Medicare per capita growth rate as directed by statute. The Secretary must implement such proposals unless Congress enacts legislation pursuant to this section.


277 ACA § 3401 (codified as amended at scattered sections of SSA, Title 18, 42 U.S.C. §1395 et seq.).

278 ACA § 3402 (codified at SSA § 1839(i). 42 U.S.C. 1395r(i))

279 ACA § 3403(a) (codified at SSA § 1899A(b), 42 U.S.C. §1395kkk(b)).


281 ACA § 3202(a) (codified at SSA § 1899A(b)(1), 42 U.S.C. §1395kkk(v)(b)(1)).

282 ACA § 3202(a) (codified at SSA § 1899A(b)(2), 42 U.S.C. §1395kkk(b)(2)).
F. Health Care Quality Improvements (Title III, Subtitle F)

Subtitle F contains 11 sections establishing various research initiatives on health care quality improvement. Section 3501 establishes an extensive health services research agenda for the Agency for Healthcare Research and Quality ("AHRQ") in the Public Health Service. The Director of AHRQ is directed to:

identify, develop, evaluate, disseminate, and provide training in innovative methodologies and strategies for quality improvement practices in the delivery of health care services that represent best practices in health care quality, safety, and value.

The Director of AHRQ must also furnish technical assistance to providers in implementing models and practices identified in its research. The remainder of Subtitle F contains a variety of initiatives. An exemplary initiative is establishing community health teams to support patient-centered medical homes.

G. Protecting and Improving Guaranteed Medicare Benefits (Title III, Subtitle G)

Subtitle G contains two provisions that establish the principle that nothing in the ACA will compromise the guaranteed benefits in the Medicare program. Section 3601 states:

(a) PROTECTING GUARANTEED MEDICARE BENEFITS.—Nothing in the provisions of, or amendments made by, this Act shall result in a reduction of guaranteed benefits under title XVIII of the Social Security Act.
(b) ENSURING THAT MEDICARE SAVINGS BENEFIT THE MEDICARE PROGRAM AND MEDICARE BENEFICIARIES.—Savings generated for the Medicare program under title XVIII of the Social Security Act under the provisions of, and amendments made by, this Act shall extend the solvency of the

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283 ACA §§ 3501 – 3512.
287 ACA §3502 (codified at 42 U.S.C. § 256a–1).
Medicare trust funds, reduce Medicare premiums and other cost-sharing for beneficiaries, and improve or expand guaranteed Medicare benefits and protect access to Medicare providers.  

Section 3602 affirms that ACA will not cut guaranteed benefits in Medicare Advantage plans:

Nothing in this Act shall result in the reduction or elimination of any benefits guaranteed by law to participants in Medicare Advantage plans.

V. IMPROVING TRANSPARENCY AND PROGRAM INTEGRITY (Title VI)

Title VI contains measures to improve transparency and program integrity in the Medicare and Medicaid programs. These provisions are displayed in Figure 15. Title VI is somewhat of a hodgepodge of provisions. Only Subtitles A, B, D and E actually pertain to the Medicare program.

The transparency provisions in Subtitle A concern physician financial activities with respect to investments in health care enterprises. Subtitle B addresses transparency and fraud and abuse enforcement in nursing homes. Subtitle D establishes an agency and program to conduct patient-centered outcomes research which is essentially research on the comparative effectiveness of medical treatment modalities and products. Subtitle E contains improvement in existing Medicare, Medicaid and CHIP program integrity programs, and includes Subtitle E includes extensive provisions on new procedures screening health care providers.

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288 ACA § 3601.

289 ACA § 3602.
A. Physician Ownership and Other Transparency (Title VI, Subtitle A)

ACA specifically addresses physician ownership of specialty hospitals and as well as other physician investments in health care. These provisions are displayed in figure 16. ACA section 6001 provides that physician-owned hospitals that do not have a provider agreement prior to February 2010 will not be able to participate in Medicare. 290

The remaining sections of Subtitle A establish a transparency reporting program for pharmaceutical and medical device manufacturers with respect to transactions with physicians and teaching hospitals as well as reporting requirements for physicians regarding various ownership and investment interests. 291 This transparency and reporting program responds to concerns that physicians and teaching hospitals receive various remuneration from industry that create conflicts of interest for the physician and teaching hospitals in selecting items and services for patient care. 292

Although directly related to Medicare but relevant for all health care payers, ACA section 6002 imposes new transparency and reporting requirements on suppliers of medical devices and other items about financial transactions with physicians, teaching hospitals and other covered recipients. 293 Specifically, suppliers must report to the Secretary electronically the following information regarding each transaction: the name and contact information of the recipient, the date and amount of payment or transfers of value, a description of the form and nature of payment, and whether the payment was related to marketing, education, or research specific to a covered drug, device, biological, or medical supply. 294 ACA section 6002 also requires manufacturers and suppliers to report any investment and ownership interests of physicians in their organizations. 295 By September 2013, CMS must publish “transparency reports” that

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disclose industry payments on a public website in a search manner. Pursuant to section 6004, pharmaceutical and medical device manufacturers and suppliers must report any gifts to physicians, physicians groups or teaching hospitals. ACA 6004 imposes comparable reporting and transparency requirements on pharmaceutical and medical device manufacturers and suppliers regarding the provision of drug samples.

Of more relevance to Medicare specifically, ACA section 6003 imposes disclosure requirements for physicians with respect to specified medical imaging services excluded for the in-office ancillary services exception to Stark physician self-referral prohibitions. Physicians referring patients to imaging services in which they or members of their practice have investments must notify patients of this interest in writing.

Also section 6005 requires that pharmacy benefit managers (PBM) (or health benefits plans that provide PMB services) which contract with health plans under Medicare or state health insurance exchanges must report information regarding payment reductions negotiated by the PBM.

B. Nursing Home Reforms

Subtitle B of Title VI pertains to program integrity measures for nursing homes. Part A of Subtitle B addresses nursing home transparency and improvement. Specifically, section 6101 requires that skilled nursing facilities under Medicare and nursing facilities under Medicaid (to make available information on their ownership. They must also implement a compliance and ethics program to promote greater accountability. CMS will also publish information on staffing data, number of complaints and criminal violations along with data on the Nursing Home Compare Medicare Website. The Secretary is charged with making other changes to achieve greater nursing home accountability, including the development of a standardized complaint form for beneficiaries. Part 2 of Subtitle B contains provisions to strengthen

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296 ACA § 6002 (codified at SSA § 1128G, 42 U.S.C. § 1320a-7h).
299 ACA § 6003 (codified at SSA § 1877(b)(2), 42 U.S.C. § 1395nn(b)(2)).
300 ACA § 6004 (codified at SSA § 1128G, 42 U.S.C. § 1320a-7h).
301 ACA § 6005 (codified at SSA § 1877(b)(2), 42 U.S.C. § 1395nn(b)(2)).
302 ACA § 6101 (codified at SSA § 1124, 42 U.S.C. § 1320a–3).
303 ACA § 6102 (codified at SSA § 1128I, 42 U.S.C. § 1302a-7k)
enforcement. Part C contains measures to improve staff training on dementia and abuse prevention. The Secretary must establish a nationwide program for national and state background checks of direct patient access employees of certain long-term supports and services facilities or providers.

C. Subtitle D—Patient-Centered Outcomes Research

Of several initiatives to improve the quality and control the cost of health care services in the ACA, the most important is support for comparative effectiveness research through the establishment of the Patient-Centered Outcomes Research Institute (“PCORI”). The ACA defines “comparative clinical effectiveness research” and “research” as follows:

The terms ‘comparative clinical effectiveness research’ and ‘research’ mean research evaluating and comparing health outcomes and the clinical effectiveness, risks, and benefits of 2 or more medical treatments, services, and items described in subparagraph (B).

Subparagraph (B) describes the medical products, procedures and services subject to comparative effectiveness research under the act as follows:

The medical treatments, services, and items described in this subparagraph are health care interventions, protocols for treatment, care management, and delivery, procedures, medical devices, diagnostic tools, pharmaceuticals (including drugs and biologicals), integrative health practices, and any other strategies or items being used in the treatment, management, and diagnosis of, or prevention of illness or injury in, individuals.

The ACA establishes a new organization, PCORI, to conduct and supervise federally-funded comparative effectiveness research. The ACA defines the purpose of the PCORI as follows:

The purpose of the Institute is to assist patients, clinicians, purchasers, and policy-makers in making informed health decisions by advancing the quality and relevance of evidence concerning the manner in which diseases, disorders, and other health conditions can effectively and appropriately be prevented, diagnosed, treated, monitored, and managed.

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307 ACA §§ 6111 – 6114.
308 ACA § 6121.
309 ACA § 6201.
310 ACA § 6301(a).
311 Id.
through research and evidence synthesis that considers variations in patient subpopulations, and the dissemination of research findings with respect to the relative health outcomes, clinical effectiveness, and appropriateness of the medical treatments, services, and items described in subsection (a)(2)(B).  

The PCORI has a unique structure. It is a private, nonprofit entity organized under the District of Columbia Nonprofit Corporation Act and governed by a public-private sector board of directors appointed by the Comptroller General. It is independently funded through a federal trust fund and contributions from the Medicare program trust funds and from private health plans and insurers.  

The specific duties of the PCORI are straightforward and described in the statute in great detail. The duties all concern developing and executing a research project agenda. Several “duties” pertain to establishing processes to ensure the quality of the research, the proper dissemination of research results, and the transparency and integrity of the research process. The statute is unusually detailed in the degree to which it specifies processes for developing methodologies for comparative effectiveness research and other aspects of PCORI’s supervision of research.  

The ACA imposed several important limits on the use of PCORI comparative effectiveness research. Specifically, the statute provides: “Nothing in this section shall be construed . . . to permit the Institute to mandate coverage, reimbursement, or other policies for any public or private payer . . ..” Nor can the PCORI develop or employ a “dollars per-quality adjusted life year” or similar measures that discount the value of a life because of disability as a “threshold” to establish what type of health care is cost effective or recommended. Further, the ACA prohibits CMS, except with complete transparency and with extensive procedural safeguards, from using such measures as a threshold to determine Medicare coverage or reimbursement or in other incentive programs. These limits were imposed to address concerns among patients, consumers and providers as well as more conservative politicians that the federal

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312 Id.


314 ACA § 6303(b)(1)-(2).

315 ACA § 6301(d)-(e).

316 ACA § 6301(c).

317 ACA § 6301(c).

318 ACA § 6301.

319 ACA § 6301(c).

320 ACA § 6301(c).
government would use the results of comparative effectiveness research to ration health care based on such bloodless criteria.

D. Medicare, Medicaid, and CHIP Program Integrity Provisions (Subtitle E)

Subtitle E, which includes extensive provisions on new procedures screening health care providers, requires the Secretary to establish new and stricter procedures and criteria to screen providers and suppliers who are enrolling or re-enrolling in the Medicare, including criminal background checks and even fingerprinting. These provisions are presented in figure 17. Other matters to be screened are licensure checks, which may include such checks across states, unscheduled and unannounced site visits, database checks and such other screening as the Secretary determines appropriate. They are required to disclose all affiliations with any provider or supplier that has uncollected debt, has had their payments suspended, has been excluded from participating in a federal health care program, or has had their billing privileges revoked. They are also required to establish a compliance program that contains the core elements developed by the Secretary in consultation with the Inspector General of DHHS.

ACA section 6402 includes several so-called enhanced Medicare and Medicaid program integrity provisions. These include the integrated data repository (“IDR”) claims and payment data from all parts of Medicare, Medicaid, CHIP, health-related programs administered by the Departments of Veterans Affairs and Defense, the Social Security Administration, and the Indian Health Service which will allow Medicare to access information about the activities of


322 ACA § 6401 (codified at SSA §1866(j)(3), 42 U.S.C. §1395cc(j)(3)).

323 ACA § 6401 (codified at SSA §1866(j)(3), 42 U.S.C. §1395cc(j)(3)).

324 ACA § 6401 (codified at SSA §1866(j)(3), 42 U.S.C. §1395cc(j)(3)).

providers in other federal programs.\textsuperscript{326} Section 6402 also imposes new penalties on providers or suppliers who make false statements in connection with seeking Medicare payment.\textsuperscript{327}

ACA section 6403 eliminates duplication between the Healthcare Integrity and Protection Data Bank and the National Practitioner Data Bank, and consolidates the two databanks.\textsuperscript{328} The Secretary will enhance national health care fraud and abuse data collection program for reporting adverse actions taken against health care providers, suppliers, and practitioners, and submit information on the actions to the National Practitioner Data Bank.

Subtitle E closes with various sections to improve the integrity of the Medicare program. ACA section 6404 establishes a maximum period for submission of Medicare claims of not more than 12 months.\textsuperscript{329} Section 6405 requires physicians who order items or services required to be Medicare enrolled physicians or eligible professionals.\textsuperscript{330} Section 6406 enhances documentation requirements for physicians on referrals to programs at high risk of waste and abuse.\textsuperscript{331} Section 6407 requires a face-to-face encounter with patient required before physicians may certify eligibility for home health services or durable medical equipment.\textsuperscript{332} Section 6408 enhances penalties for violations of the Civil Monetary Penalties Act.\textsuperscript{333}

ACA section 6409 requires the Secretary, in cooperation with the Inspector General, to establish a protocol to enable health care providers of services and suppliers to disclose an actual or potential violation of section 1877 of the Social Security Act pursuant to a self-referral disclosure protocol.\textsuperscript{335}

The final provisions of Subtitle E pertain to durable medical equipment (DME). ACA section 6410 expands the competitive acquisition program for DME and addresses other issues.\textsuperscript{336}

\textsuperscript{326} ACA § 6402 (codified at SSA §1128J(a) , 42 U.S.C. §1320a–7k(a)).

\textsuperscript{327} ACA § 6402 (codified at SSA §1128J , 42 U.S.C. §1320a–7k).

\textsuperscript{328} ACA § 6403 (codified at SSA § 1128E, 42 U.S.C. § 1320a–7k).

\textsuperscript{329} ACA § 6404 (codified at SSA § 1814(a), 42 U.S.C. § 1395f(a)(1)).

\textsuperscript{330} ACA § 6405 (codified at SSA § 1834(a)(11)(B), 42 U.S.C. § 1395m(a)(11)(B)).

\textsuperscript{331} ACA § 6406 (codified at SSA § 1842(h) 42 U.S.C. § 1395u(h)).

\textsuperscript{332} ACA § 6407(a) (codified at SSA § 1834(a)(11)(B), 42 U.S.C. § 1395m(a)(11)(B)).

\textsuperscript{333} ACA § 6408 (codified at SSA § 1128A(a), 42 U.S.C. § 1320a–7a(a)).

\textsuperscript{334} 42 U.S.C. 1395nn.

\textsuperscript{335} ACA § 6409.

\textsuperscript{336} ACA § 6410 (codified at SSA §1847(a)(1), 42 U.S.C. § 1395w–3(a)(1)).
VI. PROSPECTS FOR SUCCESS IN CURBING MEDICARE EXPENDITURES

In 2011, Medicare 40.4 million aged 65 and over and 8.3 million disabled for a total of covered 48.7 million people.\textsuperscript{337} This is almost one-sixth of the US population depending on this important program. Total Medicare expenditures in 2011 were $549.1 billion.\textsuperscript{338} Medicare expenditures constituted 15 percent of total federal outlays in 2010 and over three percent of the gross domestic product.\textsuperscript{339} By size alone, Medicare is a tremendously important program to millions of people and the providers, manufacturers and suppliers who serve them.

In understanding Medicare and crafting its reforms, it is important to appreciate what the Medicare program has accomplished since its inception in 1965.\textsuperscript{340} Medicare has assured elders and the severely disabled access to affordable health insurance and health care. For the last forty-five years, Americans have not had to worry about paying for illnesses of elderly members of their families. Consequently, families are able to invest in the education and futures of upcoming generations. Medicare has also contributed to a vibrant health care sector including highly profitable pharmaceutical and medical device industries. Indeed, the medical device industry leads the world with over half of the medical device manufacturers located in the United States.\textsuperscript{341} It is hard to imagine what the United States would be like if there were no Medicare program.

A. Reducing Medicare Expenditures

The history of Medicare payment methodologies has been one of the federal government’s struggles to get control of the cost and volume variables in the fundamental equation for Medicare expenditures: \( H \times V = ME \). By necessity, the original architects of the Medicare program placed the levers controlling the cost of care in the hands of providers. As described in Section II above, in the 1980s and 1990s, the federal government was able to wrest control of the price of care with IPPS for hospitals and the Medicare Physician Fee Schedule. Both of these programs established a prospective price for a unit of service and basically transfer the risk of inefficient services from the Medicare program to providers for inefficient services. These actions were a tremendous first step for the Medicare program especially in an environment in which physicians and hospitals in which they practiced had tight control over the content of medical care and the definition of its quality.


\textsuperscript{338} Id.

\textsuperscript{339} Id.


\textsuperscript{341} Yair Holtzman, The U.S. Medical Device Industry in 2012: Challenges at Home and Abroad (Medical Device and Diagnostic Industry, Jul. 2012), at http://www.mddionline.com/article/medtech-2012-SWOT.
Nevertheless, rising Medicare expenditures do pose a real threat to the solvency of the United States. The trustees of the Medicare trust funds estimate that the trust funds will remain solvent until 2029, in part because of the reforms in ACA. The Medicare Trust Fund Trustees report the impact of ACA changes in Medicare:

Projected Medicare costs over 75 years are about 25 percent lower because of provisions in the . . . ACA. Most of the ACA-related cost saving is attributable to a reduction in the annual payment updates for most Medicare services (other than physicians’ services and drugs) by total economy multifactor productivity growth, which is projected to average 1.1 percent per year . . . . In addition, an almost 30-percent reduction in Medicare payment rates for physician services is assumed to be implemented in 2012, notwithstanding experience to the contrary.

There are other reports of slowing growth in Medicare and other health care expenditures. Analysts at CMS published an article in leading health policy journal Health Affairs describing very encouraging trends in the control of Medicare expenditures the trend and attributing it to the economic conditions since 2008. Specifically, CMS reported that Medicare spending in 2020 is now estimated to be $150 billion lower than the $1.07 trillion projected by CMS if reforms had not been enacted. Dr. Karen Davis, the former President of the Commonwealth Fund, has asserted that “Projected Medicare spending is even further below original estimates, and provisions in the Affordable Care Act play a major role in the new, lower numbers.”

However, these payment reforms for hospitals and physicians have not gotten a handle on controlling the volume of services nor have they addressed the increasingly complex and costly content of healthcare services. Nor have they addressed the role of entrepreneurialism in medicine. Specifically, entrepreneurial physicians and providers have had great incentives to provide more and arguably unnecessary services even under current Medicare payment methods. CMS’ efforts to control volume and expense of physician services proved difficult if not impossible as seen with the experience with the Medicare sustainable growth rate.

In the 1980s and 1990s, as discussed above, the federal government turned to health services research to determine how to assess the quality of care empirically and determine if

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346 Id.

Medicare expenditures were going for care of good value in terms of outcomes and efficiency. The focus on quality outcomes, variations in practice, TQM/CQI and patient safety were all fundamentally data-driven and created a new environment of accountability for physicians, hospitals and the entire health care sector. The definition of quality had become empirically based and was no longer the sole province of physicians. The stage was set for the quality reporting and value-based purchasing programs of the next century. Also, it became inherently easier for the stewards of the Medicare program to identify unnecessary and unsafe care as data could identify these types of care and the medical profession did not have complete control anymore over the definition of quality care.

B. ACA’s Approach to Reducing Medical Expenditures

ACA continues to pursue the major policy goals of the Medicare program since its inception. Medicare seeks to pay only for items and services which are medically necessary. Medicare does not want to pay for any unnecessary services even if they are not harmful to the beneficiaries or even marginally helpful. The quality and payment initiatives in Title III of ACA are designed to achieve these policy goals. Also, the entrepreneurial impulses of physicians and other providers which seek to increase the price and volume of services are curtailed.

The schematic at Figure 4 illustrates the focus of the Medicare program’s regulation of payment for health care. Medicare payment regulation seeks to prevent fraud and abuse that provides unreasonable and/or unnecessary care as well as non-existent care. Medicare payment regulation also seeks to reduce care that is inefficient and unnecessary. The ultimate goal of the payment regulation linked to quality measures to promote care that is only reasonable, necessary and efficient as determined by established measures of high quality care. With making this connection between payment and quality performance, Medicare is able to recognize redundant and excess care that is not necessarily abusive but useless. This is a very important step in Medicare’s effort to control the volume of Medicare services and thereby Medicare expenditures.

The Medicare fraud and abuse prohibitions are first and foremost about preventing outright fraud in obtaining money from for the Medicare program. Many also engage in abusive practices or even fraud to maximize reimbursement from the Medicare program. Just recently, there were reports that the Hospital Corporation of America, the largest for-profit hospital chain in the country, had engaged in the provision of unnecessary procedures to maximize profits. In 2009, DHHS estimated that of the $2 trillion the federal government spent on health care, three percent went to fraud. But the prohibitions do much more and this larger mission is the prevention of inappropriate profiteering from the Medicare program through program abuse. Over-prescription of items and services that are not necessary or marginally necessary for the diagnosis and treatment of illnes or injury are an abuse of the Medicare program. This principle is contrary to the theory of capitalistic markets in which the desired amount of items and services that an individual may need or buy depends on individual preferences and actions and there is no normative assessment of the necessity of the items or services. Indeed, in a


capitalistic market, providers and suppliers would be rewarded for “creating demand” among consumers for their items and services. Increased sales of these items and services would be applauded as, from a public benefit prospective, as a contribution to increased economic activity.

What is fundamentally important to understand about CMS’ approaches to controlling Medicare expenditures is that public funds, generated from regressive wage taxes for Part A of the Medicare program, general revenues and beneficiary payments for Part B premiums, will be spent on the health care needed to care Medicare beneficiaries. While the government of the United States has endorsed capitalism at its economic system and promotes entrepreneurialism among economic actors in the market place, these policies are not consistent with funding of activities under public programs. Too often, health care institutional providers, physicians and insurers, which operate Medicare Advantage plans, and Medicare manufacturers and suppliers of medical devices and other items, operate as capitalistic entrepreneurs. They seek to maximize profits, as is laudable in a conventional free market. Such entrepreneurs who seek to provide unnecessary and unduly expenses services are more easily exposed than in the old days when physicians and providers had sole authority to define quality and the content of medical care.

However, because Medicare is a taxpayer-supported public program that exists because of colossal market failure in the markets for health care items or services or insurance to cover the cost of items of services, these capitalistic principles do not apply. Excess demand that does not represent the need for reasonable or necessary items or services is not desirable. For such demand and meeting that demand translate into unnecessary government expenditures at taxpayers’ expense. However, there is room for entrepreneurialism in the health care sector and the Medicare program. Entrepreneurs who imagine more efficient and effective delivery of health care services for Medicare are welcome.

VII. CONCLUSION

Reforming Medicare will have tremendous benefits for American Society. The first potential benefit may be to ensure the availability of the Medicare program for supporting the health care expenses of the elderly and seriously disabled. However, a strong Medicare program can also serve as a safety net in the event of the failure of ACA. Medicare can easily be transformed into a single payer program if private health insurance were to become inaccessible or unaffordable and/or state Medicaid programs for the poor were to not expand. Some evidence suggests that private insurance companies are leaving the health insurance market already. And as the Supreme Court of the United States has recently ruled in National Federation of Independent Business v. Sebelius, that the federal government cannot eliminate funding for a state’s Medicaid program if the state elects not to adopt the ACA Medicaid expansions. If states are not required to proceed with federally-mandated expansions under ACA, there may be greater pressure for the expansion of the Medicare program to cover persons otherwise covered under the ACA Medicaid expansions. A strong Medicare program, made stronger with the ACA reforms to improve quality and efficiency as well as promote integrity and transparency, stands ready to be the health insurer of all Americans.


351 No. 11–393 (June 28, 2012).