

GAO REPORT: THE OBAMA ADMINISTRATION'S \$8 BILLION EXTRALEGAL HEALTHCARE SPENDING PROJECT

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT
AND GOVERNMENT REFORM

HOUSE OF REPRESENTATIVES

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CONTENTS

Hearing held on July 25, 2012	Page 1
WITNESSES	
Mr. James C. Cosgrove, Director, Health Care, U.S. Government Accountability Office	
Oral Statement	4
Written Statement	7
Ms. Edda Emmanuelli-Perez, Managing Associate General Counsel, U.S. Gov- ernment Accountability Office	
Oral Statement	14
Mr. Jonathan Blum, Acting Principal Deputy Administrator and Director, Centers for Medicare and Medicaid Services	
Oral Statement	15
Written Statement	17
APPENDIX	
The Honorable Chairman Darrell Issa, a Member of Congress from the State of California, Preview Statement	60
Professor Jeffrey S. Lubbers, Professor of Practice in Administrative Law, Washington College of Law, American University, Written Statement	61
The Honorable Elijah E. Cummings, a Member of Congress from the State of Maryland, Opening Statement	64
Medicare Waiver Demonstration Application	66
The Honorable Gerald E. Connolly, a Member of Congress from the State of Virginia, Opening Statement	71

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Wednesday, July 25, 2012

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The committee met, pursuant to call, at 9:30 a.m., in Room 2154, Rayburn House Office Building, Hon. Darrell Issa [chairman of the committee] presiding.

Present: Representatives Issa, Platts, Jordan, Chaffetz, Walberg, Lankford, Gosar, Labrador, DesJarlais, Gowdy, Ross, Guinta, Kelly, Cummings, Norton, Kucinich, Tierney, Clay, Connolly, Davis, Murphy and Speier.

Staff Present: Brian Blase, Majority Professional Staff Member; Molly Boyl, Majority Parliamentarian; Lawrence J. Brady, Majority Staff Director; Sharon Casey, Majority Senior Assistant Clerk; John Cuaderes, Majority Deputy Staff Director, Linda Good, Majority Chief Clerk; Christopher Hixon, Majority Deputy Chief Counsel, Oversight; Mark D. Marin, Majority Director of Oversight; Mary Pritchau, Majority Professional Staff Member; Jeff Solsby, Majority Senior Communications Advisor; Beverly Britton Fraser, Minority Counsel; Kevin Corbin, Minority Deputy Clerk; Ashley Etienne, Minority Director of Communications; Susanne Sachsman Grooms, Minority Chief Counsel; Carla Hultberg, Minority Chief Clerk; Una Lee, Minority Counsel; Suzanne Owen, Minority Health Policy Advisor; Dave Rapallo, Minority Staff Director; Safiya Simmons, Minority Press Secretary.

Chairman ISSA. The Committee will come to order.

The Oversight Committee's mission statement is that we exist to secure two fundamental principles. First, Americans have a right to know the money Washington takes from them is well spent. And second, Americans deserve an efficient, effective government that works for them. Our duty on the Oversight and Government Reform Committee is to protect these rights.

Our solemn responsibility is to hold government accountable to taxpayers. Because taxpayers have a right to know what they get from their government. Our job is to work tirelessly in partnership with citizen watchdogs to deliver the facts to the American people and bring genuine reform to the Federal bureaucracy.

I now recognize myself for an opening statement.

The Affordable Care Act, often called Obamacare, was brought through this Congress in a rushed fashion on a purely partisan

basis. That doesn't make everything in it bad, but certainly it causes many questions to have been unanswered. The Speaker herself, at the time, Nancy Pelosi, famously said, we have to pass it to find out what is in it.

Many conceded they had not even read the entire contents, choosing instead to learn about the bill's consequences after the fact. Sloppy work process produces dire consequences.

In the case of the Affordable Care Act, or Obamacare, we are close to seeing one of those consequences, an \$8.3 billion consequence. Today's hearing will examine how the Administration may have politicized the implementation of Obamacare. The Obama Administration promised Americans who like their coverage they would be allowed to keep it. We now know that nothing could be further from the truth. Whether it is the one out of ten employers who plan to drop coverage, and have stated so in numerous non-partisan polls, or in fact, the Obamacare's forced major cuts in a popular program known as Medicare Advantage, which serves exclusively seniors.

Obamacare's cuts to Medicare mean many seniors will lose their coverage they enjoyed under the prior law. These cuts are particularly painful to senior citizens enrolled in Medicare Advantage. Medicare Advantage relies on private sector competition to deliver greater coverage and planned choices to seniors when compared to traditional fee for service under Medicare.

The program is widely liked by seniors around the Country and actually disproportionately well-liked in California. Acknowledging the political nature of these cuts, it is very clear that when implementation would have led to massive increases in costs and often seniors leaving that program, this demonstration project, which is clearly not a demonstration project, one that does not follow the rules or the path standards for a demonstration project, one that is in fact larger than all 85 so-called demonstration projects before, in fact was a thinly veiled attempt to call a demonstration program in order to shore up votes that surely would be lost when October brought higher costs to a program that in fact was always intended to be effectively defunded.

The \$8.3 billion is not being taken by appropriated funds. In fact, the system that allows for this demonstration project, never intended to be this high, allows for the funds to be taken around Congress' appropriation process. The funds will essentially be taken out of Medicare.

These funds will have to be backfilled to higher costs in the future. But in an election year, very clearly, this will shore up President Obama's position on re-election. No ifs, no ands, no buts.

I have not had to make a statement questioning the sincerity of a program like this before. Clearly and simply put, an imperial president is using the power of his administration to play politics with seniors' health care. We will hear from the Government Accountability Office, a non-partisan policy expert, who will testify about concerns their watchdog agency has on this program.

Let's understand, a non-partisan agency has clearly said, this may not be legally allowed. This Chairman will say, this should not be legally allowed. This clearly does not pass the Washington sniff test for legitimate use of funds for demonstration purpose.

I claim not to be a scientist. But it is pretty clear that when you put 90 percent of a group into a subsidized funding system, you are not comparing 90 to 10. More importantly, CMS has not demonstrated any control group of any normal size or normal way of doing. If someone wanted to do a demonstration project, you could do a demonstration project, but it would not shore up the President's re-election the way this \$8.3 billion, unappropriated bailout of the President's flawed Obamacare will do. No question about it, this is pure politics, pure politics being played with the taxpayer's money that Congress did not appropriate.

With that, I recognize the Ranking Member for his opening statement.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

I would like to thank the witnesses for coming here today to testify before the Committee. This is an important topic, and I am grateful for the opportunity to hear your views.

I think we can all agree that we need to continue reforming our health care system, so that we are paying for value rather than volume, and encourage prevention as well as treatment.

The Affordable Care Act works toward these goals in a number of ways. For example, it provides seniors with free preventive care, including wellness visits and cholesterol checks. Last year, more than 32 million seniors used at least one preventive service under Medicare without paying deductibles or co-pays. This saves lives and lower cost to the program.

The Affordable Care Act also makes reforms to the Medicare payment system to align payments with better performance and outcome. One innovation is the quality bonus payment program that provides incentives for Medicare Advantage plans to improve the quality of care by establishing bonus payments to plans that achieve certain quality standards.

The Center for Medicare and Medicaid Services, CMS, initiated a demonstration program to test an alternative method for these bonus payments in order to examine ways to generate quicker and more significant quality improvement in the plans. The Government Accountability Office has raised a number of concerns about this demonstration program. GAO disagrees with how CMS structured the program, and it has methodological concerns about the way CMS will measure the results.

CMS responded that it believes the program will incentivize plans to improve the quality of care and increase efficiency. CMS also believes that GAO's methodological concerns can be addressed. As this back and forth demonstrates, there is no scandal here. This is legitimate and substantive disagreement about how best to structure bonuses to incentivize quality care and how to design a demonstration program to achieve its intended results in an effective and efficient manner. In our efforts to research this issue, we contacted a legal expert, Professor Jeffrey Lubbers, Professor of Administrative Law at American University. I request unanimous consent to enter his statement into the record, Mr. Chair.

Chairman ISSA. Without objection, so ordered.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

Professor Lubbers reviewed GAO's concerns as well as the legislative history and case law relating to the Secretary's authority. He

concluded that the disagreement between GAO and CMS “amounts to a methodological disagreement, not a legal one.” He found that “the law gives HHS very broad authority to conduct demonstration programs in this area. And in my view, the proposed MA quality bonus payment demonstration fits comfortably within the authority.”

In my opinion, today’s hearing title is a little bit misleading. It suggests that GAO has accused the Secretary of Health and Human Services of doing something illegal. In fact, GAO questioned the authority of HHS to conduct this program based on GAO’s underlying policy and methodology concerns about the program design. This type of rhetoric affects the tone and tenor of this hearing and makes it more difficult to engage in a reasoned debate focused on the merits or flaws of a demonstration program.

We can do better than that. Let’s focus on the substantive discussion; let’s discuss GAO’s concerns with the program and CMS’ response to those concerns. This is the hearing I hope we will have today.

With that I yield back.

Chairman ISSA. I thank the gentleman.

All members will have seven days to submit opening statements for the record and extraneous information.

We now welcome our witnesses. Mr. James Cosgrove is the Director of Health Care at the General Accountability Office. Ms. Edda Emmanuelli-Perez is the Managing Associate General Counsel at the GAO. And Mr. Jonathan Blum is the Principal Deputy Administrator and Director at the Center for Medicare.

Pursuant to the Committee rules, would you please rise to take the oath, and raise your right hands. Do you solemnly swear or affirm that the testimony you are about to give will be the truth, the whole truth and nothing but the truth?

[Witnesses respond in the affirmative.]

Chairman ISSA. Let the record indicate all witnesses answered in the affirmative. Please be seated.

Your prepared statement will be placed in the record in their entirety. I welcome your summarizing those and including additional comments that you may have. It is not a sin to use less than five minutes. It is, however, an offense for which you can be locked in the House jail if you go far beyond five. So do everything you can to use the five minutes for something other than simply a written prepared statement, all of which will be placed in the record. And again, we haven’t yet jailed anybody.

So with that, Ms. Cosgrove, you are recognized for five minutes or so.

WITNESS STATEMENTS

STATEMENT OF JAMES C. COSGROVE

Mr. COSGROVE. Chairman Issa, Ranking Member Cummings, members of the Committee, I am pleased to be here today as you discuss the Medicare Advantage Quality Bonus Payment Demonstration. As you know, back in March of this year, GAO recommended that the Secretary of HHS cancel the demonstration

and allow the quality bonus payment system established by the ACA to take effect.

This morning, I would like to provide context for that recommendation and explain why we believe this demonstration is not a wise use of Medicare funds.

Seeking to improve the quality of health care for Medicare beneficiaries is a laudable goal. Currently, the quality of MA plans is indicated using a star rating system, five stars being the highest possible rating. It was established in 2008 to help beneficiaries identify high quality plans. The ACA would have added a financial incentive for plans to achieve the highest quality by awarding bonuses to plans that receive four or more stars beginning in 2012.

However, instead of implementing the ACA's quality bonuses, HHS established a three-year demonstration program intended to test the effectiveness of a different quality incentive system. This demonstration rewards not just the high quality plans, but also extends bonuses to plans of average quality, three and three and a half stars. And it dramatically increases the size of those bonus payments.

Thus, the vast majority of plans, which together account for more than 90 percent of all plan enrollees, will receive bonuses. And this is in sharp contrast to the ACA's bonus structure, which would have awarded bonuses only to the highest quality plans.

CMS' actuaries estimate that the demonstration will cost more than \$8.3 billion every 10 years. And most of the money is expected to go to plans of average quality. Bonus payments are expected to offset about one-third of the ACA's payment reductions that were designed to achieve savings from the MA program. The largest offset occurs this year, when the bonuses restore about 70 percent of the ACA's reductions.

The quality bonus payment demonstration dwarfs all other Medicare demonstrations in terms of its budgetary impact. It is larger than the combined budgetary impact of approximately 85 demonstrations that have taken place since 1995. In fact, it is seven times larger than the largest of those 85 demonstrations.

Although the cost of this demonstration is unprecedented, that is not why GAO recommended it be canceled. We made our recommendation because, at the end of the day, after spending \$8.35 billion, we are unlikely to learn much about the demonstration's impact on quality improvement.

Several design flaws that preclude a credible evaluation of the demonstration's effectiveness. One flaw is that in the first two years, the demonstration bonuses largely reward plans for their pre-demonstration performance. Bonuses in 2012 and 2013 are completely or mostly based on quality data that were measured before the demonstration's final specifications were announced. Only in the final year of the demonstration will the actions that plans have taken in response to the demonstration's incentives have an effect on their bonus payments.

A second flaw is that there is no natural comparison group against which to measure the effect of the demonstration. Because all plans are participating in the demonstration, HHS has suggested that Medicare cost contract plans, commercial plans or Medicaid plans may provide a suitable control group. However, none of

these are eligible for an ACA quality bonus. Thus, there is no opportunity to compare and contrast the quality improvements made by plans eligible for the demonstration with the quality improvements made by plans eligible for ACA bonuses.

Other confounding factors will also make it hard to gauge the demonstration's impact. For example, CMS has announced that plans receiving less than three stars for three consecutive years may be terminated from the program. Therefore, if we observe plans improving from two and a half, three stars, we cannot determine whether it was the demonstration's bonus payments or the threat of termination that was the driving factor.

And finally, the demonstration's bonus percentages do not offer all plans better incentives than they would receive under the ACA. Plans improving from three and a half to four stars, for example, would receive a larger bonus under the ACA. HHS has stated that one of the principles of the demonstration is to offer financial rewards for quality improvements throughout the ratings continuum. But in 2014, the only potentially meaningful year of the demonstration, the bonus is exactly the same, 5 percent for four star, four and a half, five star plans.

In conclusion, although CMS has said that the goal of the demonstration was to test whether a scaled payment structure leads to larger and faster quality improvements, the demonstration's design is inadequate to determine whether this is the case. For that reason, we recommended the demonstration be canceled.

I am happy to answer any questions that you or any of the members may have.

[Prepared statement of Mr. Cosgrove follows:]

United States Government Accountability Office

GAO

Testimony
Before the Committee on Oversight and
Government Reform, House of
Representatives

For Release on Delivery
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MEDICARE ADVANTAGE

Quality Bonus Payment Demonstration Has Design Flaws and Raises Legal Concerns

Statement of

James Cosgrove
Director, Health Care

Edda Emmanuelli-Perez
Managing Associate General Counsel



G A O

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Chairman Issa, Ranking Member Cummings, and Members of the Committee:

We appreciate the opportunity to participate in today's hearing on the Medicare Advantage (MA) Quality Bonus Payment Demonstration, which the Centers for Medicare & Medicaid Services (CMS) initiated rather than implementing the MA quality bonus payment program established in the Patient Protection and Affordable Care Act (PPACA).¹ Our testimony today discusses our March 2012 review of the 3-year demonstration's cost and design, as well as our July 2012 letter to the Secretary of Health and Human Services (HHS) regarding the agency's authority to conduct the demonstration.² Our March 2012 report concluded that the demonstration, with an estimated cost of over \$8 billion over 10 years, is unlikely to produce meaningful results. It recommended that the Secretary of HHS cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect. That review also gave rise to concerns about the agency's authority to conduct the demonstration under the Social Security Amendments of 1967.³ In our July 2012 letter, we noted that the statute provides broad authority, but found that the agency has not established that the demonstration meets the criteria set forth in that statute.

Background

The MA program, an alternative to the original Medicare fee-for-service (FFS) program, provides health care coverage to Medicare beneficiaries through private health plans offered by organizations under contract with CMS. About a quarter of all Medicare beneficiaries are enrolled in an MA

¹Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 3201-02, 124 Stat. 119, 442, 454 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1102, 124 Stat. 1029, 1040 (Mar. 30, 2010) (hereafter, "PPACA").

²See GAO, *Medicare Advantage: Quality Bonus Payment Demonstration Undermined by High Estimated Costs and Design Shortcomings*, GAO-12-409R (Washington, D.C.: Mar. 21, 2012) and *Medicare Advantage Quality Bonus Payment Demonstration*, B-323170, July 11, 2012.

³CMS conducted the MA Quality Bonus Payment Demonstration under section 402(a)(1)(A) of the Social Security Amendments of 1967, as amended, Pub. L. No. 90-248, § 402, 81 Stat. 821, 930-31 (Jan. 2, 1968), as amended by the Social Security Amendments of 1972, Pub. L. No. 92-603, § 222, 86 Stat. 1329, 1390-93 (Oct. 30, 1972) (both codified at 42 U.S.C. § 1395b-1) (hereafter, "section 402").

plan. MA plans may offer additional benefits not provided under Medicare FFS, such as reduced cost sharing or vision and dental coverage.

Effective January 1, 2012, PPACA requires CMS to provide quality bonus payments to MA plans that achieve 4, 4.5, or 5 stars on a 5-star quality rating system developed by CMS. In November 2010, CMS announced that it would waive the PPACA quality bonus provisions and instead determine quality bonus payments for 2012 through 2014 under a demonstration in which all MA plans would participate unless they affirmatively opt out. Compared with the quality bonus program established by PPACA, the demonstration provides larger bonuses earlier to more plans. Specifically, it extends quality bonuses to plans with 3 or more stars, accelerates the phase-in of the bonuses for plans with 4 or more stars, increases the size of the bonuses for plans with 4 or more stars in 2012 and 2013, and applies the quality bonus percentage to a plan's entire benchmark during the phase-in of PPACA's new MA plan payment methodology.⁴ In announcing the demonstration, CMS stated that the demonstration's research goal is to test whether a scaled bonus structure leads to larger and faster annual quality improvement for plans at various star rating levels compared with what would have occurred under PPACA. Under PPACA, about one-third of MA enrollees would be covered by MA contracts eligible for a bonus in 2012 and 2013. In contrast, under the demonstration, about 90 percent of enrollees will be covered by MA contracts eligible for a bonus in those 2 years. The demonstration ends on December 31, 2014, at which time CMS is expected to implement the quality bonus payment program that PPACA authorized.

⁴The "benchmark" is used to determine the maximum amount to pay an MA plan.

Table 1. Comparison of PPACA Quality Bonus Payment Percentages to Demonstration Quality Bonus Payment Percentages

Star Rating	MA Quality Bonus Payments					
	PPACA			Demonstration		
	2012	2013	2014	2012	2013	2014
5 stars	1.5	3	5	5	5	5
4 or 4.5 stars	1.5	3	5	4	4	5
3.5 stars	0	0	0	3.5	3.5	3.5
3 stars	0	0	0	3	3	3
Fewer than 3 stars	0	0	0	0	0	0

Source: GAO analysis.

Notes: Under PPACA, the bonus percentages generally would be applied only to a portion of the benchmark. Under the demonstration, the bonus percentages will be applied to the entire benchmark. Under both PPACA and the demonstration, MA plans in qualifying counties will be eligible for double bonuses.

Section 402 of the Social Security Amendments of 1967, as amended, provides the Secretary of HHS with broad authority to undertake demonstration projects to test new Medicare payment methodologies.⁵ Specifically, it authorizes the Secretary to conduct demonstration projects to determine whether changes in payment methods would increase the efficiency and economy of Medicare services through the creation of additional incentives, without adversely affecting quality. Accordingly, a demonstration under section 402 includes (1) changes in payment methods that create additional incentives toward increasing the efficiency and economy of Medicare services and (2) a determination of whether the changes in payment methods actually increase the efficiency and economy of such services. While a demonstration need not in fact result in increased efficiency and economy, it must meet these criteria.

⁵Section 402(a)(1)(A) authorizes the Secretary to develop and engage in experiments and demonstration projects "to determine whether, and if so which, changes in methods of payment or reimbursement for health care and services under health programs established by the Social Security Act ... would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services." 42 U.S.C. § 1395b-1(a)(1)(A). Relatedly, section 402(b) authorizes the Secretary to waive Medicare payment requirements to carry out such demonstrations. 42 U.S.C. § 1395b-1(b).

MA Demonstration Characterized by High Estimated Costs and Large Scope

Our March 2012 review found that the CMS Office of the Actuary's (OACT) estimated cost of the demonstration exceeds \$8 billion over 10 years. About \$5.34 billion of this estimate is attributed to quality bonus payments more generous than those prescribed in PPACA, specifically to (1) higher bonuses for 4-star and 5-star plans, (2) new bonuses for 3-star and 3.5-star plans, (3) applying bonuses to plans' entire benchmarks during the phase-in of PPACA's new payment methodology, and (4) allowing plans' benchmarks to exceed their pre-PPACA levels. Most of the remaining projected demonstration spending stems from higher MA enrollment because the bonuses enable MA plans to offer beneficiaries more benefits or lower premiums. Taken together, the expanded bonuses and higher enrollment mainly benefit average-performing plans—those receiving 3 and 3.5-star ratings. Also, while a reduction in MA payments was projected to occur as a result of PPACA's payment reforms, OACT estimated that the demonstration would offset more than one-third of these payment reductions projected for 2012 through 2014.

In addition, the demonstration dwarfs all other Medicare demonstrations—both mandatory and discretionary—conducted since 1995 in its estimated budgetary impact and is larger in size and scope than many of them.⁶ Specifically, our review of CMS and Office of Management and Budget data shows that the estimated budgetary impact of the demonstration, adjusted for inflation, is at least seven times larger than that of any other Medicare demonstration conducted since 1995 and is greater than the combined budgetary impact of all of these demonstrations. Moreover, while the demonstration is similar in size and scope to some Part D demonstrations, it is unlike many Medicare pay-for-performance demonstrations in that it is implemented nationwide and allows all eligible plans to participate.⁷

⁶The estimated budgetary impact refers to the difference between the total costs of the demonstration and the total costs that would occur in its absence.

⁷The Medicare Part D program provides voluntary, outpatient prescription drug coverage for eligible individuals.

MA Demonstration Is Unlikely to Achieve Its Research Goal as Designed and Raises Legal Concerns

Our March 2012 report identified several shortcomings of the demonstration's design that preclude a credible evaluation of its effectiveness in achieving CMS's stated research goal—to test whether a scaled bonus structure leads to larger and faster annual quality improvement compared with what would have occurred under PPACA. Subsequently, in our July 2012 letter, we raised concerns about whether the demonstration meets the requirements of section 402 and, therefore, falls within the agency's authority.

Notably, the bonus payments are based largely on plan performance that predates the demonstration. All of the performance data used to determine the 2012 bonus payments and nearly all of the data used to determine the 2013 bonus payments were collected before the demonstration's final specifications were published. The demonstration's incentives to improve quality can have a full impact only in 2014. Therefore, we are concerned about the demonstration's ability to provide additional incentives to increase the efficiency and economy of Medicare services. In response to our inquiries on this issue, CMS acknowledged that payments in 2012 and 2013 reward plans for their past performance, but asserted that these payment changes are consistent with the requirements of section 402.

In addition, our March 2012 report found that the demonstration's design is inconsistent with CMS's stated research goal. First, the demonstration's bonus percentages are not continuously scaled. For example, in 2014, plans with 4, 4.5, and 5 stars will all receive the same bonus percentage. Second, the demonstration's bonus percentages in 2014 do not offer all plans better incentives than PPACA to achieve higher star ratings. In 2014, most plans improving from 3.5 to 4 stars would receive a larger increase in their bonus payment under PPACA. These features also call into question whether the demonstration includes additional incentives to increase the efficiency and economy of Medicare services. Notably, for highly-rated plans, CMS chose to revise the payment methodology for years in which the changes are unlikely to have any impact on plan quality, while making no changes from PPACA for the year in which changes could induce improved quality.

Furthermore, characteristics of the demonstration raise concerns about the agency's ability to determine whether the payment changes result in increased efficiency and economy, one of the criterion specified in the law. A determination of whether a change in payment methodology results in an increase in efficiency and economy involves a comparison of the effect of the payment methodology adopted under the demonstration

to the effect of the payment methods in place under current law. CMS will evaluate the impact of the demonstration using MA plans' 2012 and 2013 star ratings and what would have occurred under PPACA using their 2014 star ratings. However, because of the timing of data collection for plan star ratings, this evaluation approach appears far more likely to enable CMS to compare plan performance under the demonstration to plan performance under the law in effect prior to PPACA—not under current law. Moreover, because the demonstration lacks a direct comparison group, it may not be possible to isolate its effects, and any changes in quality observed could be attributable, at least in part, to other MA payment and policy modifications.

In closing, given the findings from our program review and legal analysis of the demonstration's characteristics, our recommendation to cancel the demonstration and allow the MA quality bonus payment system established by PPACA to take effect remains valid.

Chairman Issa, Ranking Member Cummings, and Members of the Committee, this completes our prepared statement. We would be happy to respond to any questions.

Chairman ISSA. Thank you.
Ms. Perez?

STATEMENT OF EDDA EMMANUELLI-PEREZ

Ms. EMMANUELLI-PEREZ. Good morning, Mr. Chairman, Ranking Member and members of the Committee. Thank you for the opportunity to discuss GAO's legal analysis of HHS's authority to undertake the Medicare Advantage Quality Bonus Payment Demonstration under Section 402 of the Social Security Act Amendments of 1967.

As GAO conducted the work described by my colleague, those facts also raised concerns about the legal authority to conduct the demonstration under Section 402. So we sought additional information and requested HHS's views on its legal authority.

GAO has concluded that HHS has not established that the Quality Bonus demonstration is authorized by law, because it has not shown how the demonstration satisfies two elements of Section 402. First, it should provide for the creation of additional incentives toward efficiency and economy of Medicare services. And second, provide for the agency to determine whether changes in payment methods increase the efficiency and economy of such services.

Under the first element, GAO has concerns about the demonstration's ability to provide additional incentives to increase efficiency and economy of Medicare services. For example, the majority of the demonstration relies on data that predates the demonstration. Instead, as CMS has acknowledged, in 2012 and 2013, the payment reward plans for their past performance, and thus do not provide incentives to increase efficiency or economy.

According to CMS the increase in payments in those years provide a transition period, during which plans can use additional bonus payments to improve quality of care. CMS assumes that plans will use these additional monies to increase quality, even though there is no requirement that plans use the demonstration's bonus payments to improve or attempt to improve quality.

In fact, current Medicare regulations preclude plans' ability to use additional bonus payments to improve the quality of care provided to beneficiaries, an issue CMS has not addressed.

With respect to the only year in which payment changes could induce improved quality, 2014, CMS did not revise the payment methodology⁷ for plans with four, four point five or five stars. And there are other plans in 2014 that would generally receive a larger increase in their bonus under PPACA than under the demonstration, which could actually reduce incentives to improve quality.

With respect to the second element of Section 402, the demonstration's shortcomings raise concerns about the agency's ability to determine whether the payment changes resulted in increased efficiency and economy. In order to make that determination, the agency must compare the effect of the payment methods adopted under the demonstration to the effective payment methods in place under current law, in this case PPACA.

Due to the significant time lag between the collection of data upon which the plan's star ratings are based, and the issuance of those ratings, the demonstration's violation appears far more likely to enable the agency to compare plan performance during the dem-

onstration to plan performance before PPACA, rather than comparing plan performance under the demonstration to plan performance under PPACA, as contemplated by Section 402.

In addition, CMS has not explained how the comparison groups it has identified would allow it to determine whether the demonstration's changes in payment increase efficiency and economy compared to current law. CMS identified comparison groups as described by Mr. Cosgrove that are outside the Medicare Advantage program, ones that may serve different populations, they may follow different regulations and policies, and importantly, they are not subject to PPACA quality bonus provisions, but did not explain how those groups would yield a useful comparison.

Nor has the agency accounted for other Medicare Advantage payment and policy changes that may lead to changes in quality. CMS did not explain how it would be able to effectively identify whether the demonstration payment changes are responsible, and if so, to what extent, for any improvements in plan quality, economy and efficiency.

After analyzing these details of the demonstration in light of Section 402, GAO concluded that CMS has not established that the Quality Bonus demonstration meets the essential elements of the law that require the creation of additional incentives toward efficiency and economy of Medicare services, and that the demonstration allow the agency to determine whether the changes in payment methods increase the efficiency and economy of such services.

This concludes my statement, and I would be pleased to answer any questions that you and the members may have.

Chairman ISSA. Thank you.

Mr. Blum?

STATEMENT OF JONATHAN BLUM

Mr. BLUM. Mr. Chairman, Mr. Cummings, members of the Committee, I want to thank you for the opportunity to talk about how CMS is working to improve the overall Medicare program.

Currently, 27 to 28 percent of beneficiaries choose to receive the Medicare services through a private plan. Over the last 10 years, I think it is fair to say the program has gone through dramatic changes during the last 10 years. Prior to 2010, and prior to the Affordable Care Act, I think there were a lot of questions regarding the value that plans provided for beneficiaries and for taxpayers.

On average, the plans were paid 14 percent more than the traditional fee for service program, without much confidence, without much data that taxpayer beneficiaries were getting more value for those extra subsidies. CMS had tremendous compliance failures with plans and I think it is fair to say that we had both a financial challenge for the program, but also a quality and performance challenge for the program.

In 2010, the program was reformed. The Affordable Care Act puts us on a track to phase down those subsidies over the next 10 years, down on average to the traditional fee for service Medicare program. The Affordable Care Act also authorized a quality bonus structure to provide higher payments to four star, five star plans consistent with the CMS five star system. And the law gives CMS

more tools to aggressively review plan bids to ensure that we had the best possible plans providing services to beneficiaries.

In our view, the ultimate goal of the program is to ensure that every Medicare beneficiary has the opportunity to enroll into a five star plan. Today we have very few five star plans. I think roughly 7 percent of beneficiaries now are in five star plans, and most parts of the Country do not have access to a five star plan.

I think it is important to talk about what a five star plan is. A five star plan focuses on prevention, focuses on wellness. A five star plan demonstrates that they can proactively manage chronic conditions, they can keep beneficiaries well. A five star plan demonstrates that it is best in class in customer service. A five star plan demonstrates that they provide more services to beneficiaries during their time of need, not less, when they need assistance. I think our greatest challenge is two-fold. Number one, to reduced dramatically the cost to the Medicare program to keep it sustainable for the long-term for current beneficiaries and for future beneficiaries.

But I also believe that we have a quality deficit for too long, both in the traditional fee for service program and in the private side in Medicare. We have paid for volume, not paid for value.

Our demonstration program is designed to determine the best ways both to reduce the overall cost of the program, but also to improve the overall quality, so all beneficiaries, as rapidly as possible, have access to the best possible plans, four star, five star plans. To date, we see very positive signs that this overall strategy is working. Today we are paying much lower subsidies to the health plans. That 14 percent overpayment that was in place prior to the Affordable Care Act being passed now is down to 7 percent. We are on track to bring that down over the next 10 years, down on average to 100 percent of fee for service rates.

We are seeing the program growing at double digit rates. The program continues to be popular, beneficiaries continue to find value, and from that perspective, we are pleased. And we are also seeing dramatic changes in how plans interact with the program. I think prior to the Affordable Care Act, we didn't see the commitment to performance, the commitment to quality that has changed. I think what the strategy is doing is changing the business model for how plans interact with the program from being a program where plans were simply paid to pay claims and pay more on average than the traditional fee for service program to a business model that works to keep beneficiaries healthier, that works to keep beneficiaries well, that works to better manage chronic conditions and provide the best possible value, both to taxpayers and to beneficiaries.

With that, I yield my time and would be happy to answer any questions that you may have.

[Prepared statement of Mr. Blum follows:]

**Testimony of Jonathan Blum, Acting Principal Deputy Administrator and
Director, Center for Medicare, Centers for Medicare & Medicaid Services
on the Medicare Advantage Quality Bonus Payment Demonstration**

House Committee on Oversight and Government Reform

July 25, 2012

Chairman Issa, Ranking Member Cummings, and the Members of the Committee, thank you for your interest regarding the Centers for Medicare & Medicaid Services' (CMS) efforts to strengthen quality for about 13 million Medicare Advantage (MA) enrollees through the Medicare Advantage Quality Bonus Payment (MA-QBP) demonstration.

Background

Under the MA program (also known as Medicare Part C), Medicare beneficiaries have the option of enrolling in a private health plan to receive medical care. Beneficiaries can also enroll in a Medicare Advantage Prescription Drug (MA-PD) plan to receive prescription drug benefits. CMS pays private organizations contracting under the program (MA organizations) a capitated monthly payment to provide all Part A and Part B services¹, and also Part D services² for the MA-PD plans. Today the MA program provides health insurance to about 13 million beneficiaries through private insurance health plans and enrollment continues to grow despite recent payment reductions mandated by the Affordable Care Act. Each per-person payment is based on a bid amount validated by CMS that reflects the plan's estimate of average costs to provide benefit coverage to enrollees, subject to an upper-payment limit (or benchmark). CMS risk-adjusts these payments to take into account the cost associated with treating individual beneficiaries based on health status.

Nearly 100 percent of Medicare beneficiaries enjoy access to a MA plan. Today, on average, there are 26 MA plans to choose from in each county. Since 2010 when the Affordable Care Act

¹ In general, Medicare Part A covers inpatient care in hospitals, inpatient care in a skilled nursing facility, hospice care services, home health care services, and inpatient care in a religious nonmedical health care institution. In general, Medicare Part B covers medically-necessary services such as doctors' services, outpatient care, durable medical equipment, home health services, and some preventive services.

² Medicare Part D is Medicare prescription drug coverage.

was passed, MA premiums on average have fallen 16 percent and enrollment has climbed by 17 percent to over 12.8 million beneficiaries in plan year 2012. We expect this enrollment growth to continue in 2013.

CMS is committed to making MA quality, performance, and other data widely available so beneficiaries can choose a plan that best meets their individual health care needs. Since 1997, organizations contracting under Part C have been required to collect and report the majority of the data that feed into the current Medicare Plan Rating system, and CMS has posted these data for beneficiaries and the public since 1999 as part of the earlier version of the Medicare Plan Finder Tool on www.medicare.gov.

CMS began to aggregate the measures into Plan Ratings for Part D and for MA in 2007 and 2008, respectively, with the majority of these measures remaining consistent over time³. CMS created the Medicare Plan Ratings to quantify the quality and performance of plans offering the MA and Medicare Prescription Drug (PDP) Benefits. The Plan Ratings are scored using a 5-star system, with 5 stars being the highest rating. In addition, thresholds for the majority of the measures were established in 2010 and have remained consistent since then⁴, which ensures that plans are aware of the level of performance they must achieve to be rewarded with a high rating. The Medicare Plan Finder tool is intended to increase public confidence in choosing a plan by combining cost and coverage information with quality and performance information.

In 2012, MA plans were rated on how well they performed in five specific domains:

- Staying Healthy: Screenings, Tests and Vaccines (12 measures);
- Managing Chronic (Long-term) Conditions (13 measures);
- Ratings of Plan Responsiveness and Care (5 measures);

³ For Part C, 30 of the 36 measures have been consistent or the same across the past three years (2010, 2011 and 2012 Plan Ratings). For 2010, there were 32 measures, 37 in 2011, and 36 in 2012. For Part D, 13 measures have been consistent across the past three years in the areas measured (2010-2012 Plan Ratings). For 2010 and 2011 Ratings, there were 19 Part D measures; for 2012, there were 17 measures.

⁴ Of the 36 Part C measures, 28 had a pre-determined 4 star threshold for the 2012 Plan Ratings with 96 percent of them being consistent from the prior year. Of the 17 Part D measures, 9 had a pre-determined 3 or 4 star threshold for the 2012 Plan Ratings with 44 percent of them being the same from the prior year.

- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan (3 measures); and
- Health Plan Customer Service (3 measures).

Star Ratings for MA plans that offer Part D benefits also include measures in four additional categories:

- Drug Plan Customer Service (5 measures);
- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan (3 measures);
- Member Experience with Drug Plan (3 measures); and
- Drug Pricing and Patient Safety (6 measures).

The current Star Rating system for MA represents the best snapshot CMS has of the current quality of these plans. All clinical quality and patient experience measures used in the ratings have been developed, tested, and endorsed by multi-stakeholder organizations such as the National Quality Forum (NQF), National Committee for Quality Assurance (NCQA) and Pharmacy Quality Alliance (PQA), which incorporate substantive input from relevant stakeholders in these processes, including MA plans.

As described earlier, while Star Ratings have been available and in use since 2007, the Affordable Care Act expanded the use of Star Ratings, linking the ratings with payment, and requiring CMS to award bonus payments to MA plans with at least 4 stars beginning in 2012. Additionally, under these new Affordable Care Act provisions, qualifying plans (those with 4 or more stars) in qualifying counties (generally counties with low fee-for-service costs and MA penetration rates exceeding 25 percent) are eligible for double bonus payments. It is important to note that these bonus payments allow plans to invest in quality improvement. Organizations receiving bonuses can take the availability of these new resources into account in submitting their bids for Medicare Part A and B benefits, while still having a margin available to provide additional benefits to enrollees based on the difference between their bid and the higher benchmark amount produced by the bonuses.

Star Ratings and their Correlation to Enrollment Levels

While CMS has been stressing the many benefits for beneficiaries in choosing higher-quality health care, there are also early indications that better MA plan quality has a relationship to increased beneficiary enrollment for participating plans. According to CMS calculations of 2011 enrollment data, the Medicare Advantage Star Ratings Program demonstrated a strong association between improved Star Ratings and increased beneficiary enrollment in MA plans with higher ratings.

After controlling for beneficiary sociodemographic, clinical, and MA plan characteristics, CMS' analysis of internal data from 2011 has found that every "one star" increase in a plan's rating was associated with a more than 9 percentage point increase in enrollment for beneficiaries first enrolling in a MA plan. In 2011, among beneficiaries switching from one MA plan to another, the impact of a plan that had a "one star" increase in their rating was associated with a more than 4 percentage point increase in enrollment. These changes in enrollment show the impact that increased transparency and more information about plan quality has on beneficiaries' decisions to enroll and choose an MA plan. These results build on previous research demonstrating that patients consider quality information when choosing health plans^{5,6}, including MA plans⁷. Clearly, incentivizing plans to improve their quality with public reporting is a key driver to increasing enrollment in high quality MA plans.

The MA Quality Bonus Payment Demonstration

Building on the quality bonus payment provisions in the Affordable Care Act, CMS developed a Quality Bonus Payment (QBP) demonstration to further test whether stronger financial incentives and investments in quality plans will lead to more rapid increases in quality among MA plans. While the Affordable Care Act methodology provided for a new bonus payment to be awarded if a MA plan rating improved from 3 stars to 4 stars in 2012 and thereafter, under the current nationwide demonstration, there are financial incentives for MA plans to improve from 2

⁵Kolstad JT, Chernew ME. Quality and consumer decision making in the market for health insurance and health care services. *Medical Care Research and Review*. 2009;66(1 suppl):28S-52S.

⁶Faber M, Bosch M, Wollersheim H, Leatherman S, Grol R. Public reporting in health care: How do consumers use quality-of-care information?: A systematic review. *Med Care*. 2009;47(1):1-8.

⁷Dafny L, Dranove D. Do report cards tell consumers anything they don't already know? The case of Medicare HMOs. *Rand J Econ*. 2008;39(3):790-821.

to 3 stars, from 3 to 4 stars, and from 4 to 5 stars. With respect to the early years of the demonstration, this approach provides investments in plans that have quality ratings across a broader spectrum, as they have proven their ability to use resources effectively, and could be expected to improve quality more effectively. These incentives encourage, and the investments enable, quality improvement for a larger number of plans, positively affecting a larger number of beneficiaries. This demonstration is based on the premise that improved quality results in improved health outcomes, and thus savings over time from more effective and efficient delivery of needed health care. CMS fully supports this initiative and is committed to seeing the demonstration through its three-year duration. Without the demonstration, more than 262 plans serving the majority of MA enrollees would not have an immediate investment to maintain or improve the quality of care delivered to MA enrollees. In addition to providing resources for improved quality, the expanded bonuses provide incentives for still further improvement for plans with Star Ratings below 5 stars.

The QBP demonstration was created through a transparent and open process, providing stakeholders the opportunity to submit comments:

- On November 10, 2010, CMS released a proposed rule (CMS-4144-P) announcing a three-year MA-QBP demonstration program that would determine how quality bonus payments were made to MA organizations. Supplemental materials specified that MA organizations would receive such bonus payments on a sliding scale based on their quality Star Ratings, with the magnitude of the reward provided increasing with plan quality. The public had the opportunity to submit comments on this proposed rule.
- On February 18, 2011, CMS solicited comments on how to enhance the MA-QBP demonstration by publishing the Advance Notice of Methodological Changes for Calendar Year 2012 for MA Capitation Rates. In that advanced notice, CMS described in detail the payment methodology under which health plans would be eligible for QBPs based on the quality of care they provide to beneficiaries.
- On April 4, 2011, after receiving, reviewing, and responding to comments from the public and many stakeholders, CMS finalized its payment policies, including the methodology for applying QBPs, in the Announcement of Calendar Year 2012 MA Capitation Rates and MA and Part D Payment Policies.

The MA-QBP demonstration went into effect on January 1, 2012 and will terminate on December 31, 2014. When the 3-year demonstration is over, bonuses will be calculated according to the Affordable Care Act quality bonus structure. If under the MA-QBP demonstration, 3-star plans improve their quality scores and in turn their star ratings, then movement from 3 to 4 stars will provide a natural transition from the demonstration's bonus structure to the Affordable Care Act quality bonus structure in 2015.

Given the significant enrollment growth of the MA program in recent years, it is critical that we test concepts that encourage improved quality of care for Medicare beneficiaries who choose to enroll in MA plans. The MA-QBP demonstration supports improving the delivery of health care services, patient health outcomes, and population health. The demonstration reflects three principles: 1) all MA organizations would benefit from an improvement to their star rating, and should therefore have incentives to improve quality, so that they can provide better care at lower costs to Medicare beneficiaries; 2) MA organizations should be rewarded in increasing amounts for higher-quality performance along the continuum of fully achieving high quality care; and 3) MA organizations that are already at the 3-star level and above should have additional investments and incentives to invest heavily in activities to improve their quality even further.

The MA-QBP demonstration uses alternative payment methodologies to incentivize and invest in MA plans to pursue quality improvement through the Medicare Advantage Star Ratings program. The demonstration is testing whether providing payment incentives for higher quality and front-end investments result in greater savings from high-quality care over time. At the conclusion of the demonstration, the evaluation will determine whether quality improved because of the demonstration, in which domains improvement occurred, how improvement was accomplished, and how demonstration results might be replicated in the future.

CMS is committed to a thorough evaluation of the demonstration to inform future policy decisions. CMS' evaluation contractor will estimate the impact of the demonstration over and above the Affordable Care Act methodology by assessing year-to-year progress in plan ratings

among plans with different baseline ratings, which will provide evidence of the impact of additional incentives attributable to the demonstration.

For example, under the Affordable Care Act's structure, 5 star plans will receive the same quality bonus incentive payments as 4 star plans, but under the temporary demonstration in effect for 2012, 2013, and 2014, higher performing plans will receive a higher bonus. A significant shift of plans from 4 to 5 stars would suggest high-quality plans are motivated to improve further under the demonstration, thereby providing higher quality outcomes to beneficiaries and greater value to the Medicare program.

As a national demonstration, the sliding scale of quality bonus payments is available to all qualifying MA plans. As a result, all MA beneficiaries stand to benefit as plans strive to increase the quality of care that they provide. In addition, as part of the evaluation and analysis of this demonstration, CMS intends to determine the demonstration's impact on quality improvement by comparing MA plans' performance with that of non-MA plans—specifically, managed care plans contracting with Medicare under section 1876 of the Social Security Act cost contracts, Medicaid plans, and commercial plans. Plans contracting with Medicare under section 1876 receive payments based on costs rather than risk-based capitation, and will not participate in the MA-QBP demonstration. However, the Healthcare Effectiveness and Data Information Set (HEDIS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Health Outcomes Survey (HOS) are reported under section 1876 cost contracts, and plan ratings are generated. In order to achieve a valid comparison, cost contract plans will be compared to a subset of MA plans matched on enrollment, geographic location, and profit status/ownership type. The second comparison group consists of plans participating in commercial and Medicaid CAHPS and HEDIS programs. Payments under commercial insurance and Medicaid contracts will not be affected by the demonstration and trends in quality derived from these data sources can be compared to trends in quality reported by MA plans.

The design of the demonstration is consistent with the overall goal of improving quality in the MA program and is expected to improve the delivery of health care services and patient health outcomes. The hypothesis of the demonstration is that it will result in increased efficiency and

economy of care in MA compared to the current law bonus structure, which will lead to increased savings over time.

Addressing Concerns about the Legal Authority of the MA-QBP Demonstration

Section 402 of the Social Security Amendments of 1967, 42 U.S.C. 1395b-1, is the authority for this Medicare payment demonstration. Subsection 1395b-1(a)(1)(A) authorizes HHS to develop and engage in “experiments and demonstration projects” to determine whether changes in methods of payment or reimbursement would increase the “efficiency and economy of (Medicare) health services...through the creation of additional incentives...without adversely affecting the quality of such services.”

CMS has a long history of using section 402 authority during the last 40 years. Section 402 demonstration programs at CMS are designed, implemented, and overseen by the Center for Medicare and Medicaid Innovation (and its predecessor the Office of Research, Demonstrations, and Information) and the Center for Medicare. Demonstrations initially conducted under authority in section 402 were the foundation for many significant payment reforms in the Medicare program, including the original Medicare HMO risk-contracting program enacted in 1982 that formed the basis for Medicare Part C, the Inpatient Hospital Prospective Payment System (PPS), Skilled Nursing Facility PPS, Home Health PPS, Durable Medical Equipment Competitive Bidding, Medicare HMOs, Social HMOs, Medicare Preferred Provider Organizations (PPOs), and the Program of All-Inclusive Care for the Elderly (PACE), as well as the hospice benefit.

Below are more detailed examples of recent demonstrations that were national in scope and not budget neutral, which were conducted under section 402 authority:

- In 2007, CMS implemented the two-year demonstration, “Demonstration to Limit Annual Change in Part D Premiums,” which affected the premiums for all Part D beneficiaries in all Part D plans. Under this demonstration, CMS delayed the implementation of a statutory calculation used to determine beneficiary premiums and Federal direct subsidy payments. Specifically, the demonstration allowed for a multi-year transition to a

weighting methodology required by the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) that otherwise would have significantly increased Part D beneficiary premiums in 2007. The total cost of this demonstration was \$830 million due to the increased Federal direct subsidy payments made in 2007 and 2008.

- Also in 2007, CMS implemented the "Demonstration to Transition Enrollment of Low-Income Subsidy (LIS) Beneficiaries." This nationwide demonstration delayed the implementation of a statutory calculation of regional premium subsidy amounts for low-income beneficiaries. The methodology required by the MMA would have significantly reduced the regional LIS premium benchmarks in 2007 and thus, the number of prescription drug plans with fully-subsidized beneficiary premiums. By increasing the regional LIS benchmarks in 2007 and 2008, this demonstration significantly reduced the number of LIS beneficiaries who were reassigned to a different Part D plan because their plan's premiums exceeded the low-income premium subsidy amount. The total cost of this demonstration was approximately \$540 million due to the increased low-income premium subsidy amounts provided by the federal government.

CMS believes that the MA-QBP demonstration is consistent with the precedent established by the above demonstration projects, and disagrees with the Government Accountability Office's (GAO) recent letter suggesting that there are questions regarding our legal authority for implementing the demonstration⁸. Specifically, CMS does not agree with GAO's conclusion that there are questions about whether this demonstration will allow the agency to determine whether changes in MA-QBP provide for more efficient and economical care without adversely affecting quality. While bonus payments in early years are providing resources for MA plans that have already proven to be of higher quality, as the Star Ratings are based on data collected before the demonstration was announced, the availability of these resources provide a new incentive for MA organizations offering such quality plans to take even further measures to improve quality, and in future years, potential new financial rewards for doing so.

⁸ GAO B-323170, *Medicare Advantage Quality Bonus Payment Demonstration*. July 11, 2012. <http://www.gao.gov/products/B-323170>

Chairman ISSA. Thank you. I recognize myself for a few questions.

Mr. Cosgrove, are you a career professional at GAO?

Mr. COSGROVE. Yes, I am. I have been at GAO since 1989.

Chairman ISSA. Twenty-three years. Congratulations.

Ms. Perez, are you also a career professional at GAO?

Ms. EMMANUELLI-PEREZ. Yes.

Chairman ISSA. How long have you been there?

Ms. EMMANUELLI-PEREZ. I have been there 25 years, Mr. Chairman.

Chairman ISSA. So I have nearly half a century of non-partisan work at the GAO.

Mr. Blum, how long have you been on the job?

Mr. BLUM. I started at CMS in March of 2009.

Chairman ISSA. Are you a political appointee?

Mr. BLUM. Yes, I am.

Chairman ISSA. So when you tell us that this is lowered costs, let me run through a couple of quick questions. First of all, put the chart up, if you would.

That is the ratio between the next biggest demonstration plans that have happened versus this one, as Mr. Cosgrove said, seven times larger than the next largest. What is your demonstration project limit? What is Secretary Sebelius' limit to how much she can write on the taxpayers' back without appropriations?

Mr. BLUM. From my understanding of the demonstration law, the law does not require any set limits to demonstration.

Chairman ISSA. Okay. So the Secretary has unlimited ability to take all the money in the world without appropriations around Congress. Is that correct?

Mr. BLUM. I think what really the demonstration authority is designed to do is to test ways to improve the overall economy and efficiency of the program. But there is no overall limit.

Chairman ISSA. Okay. So this unlimited authority around Congress must come at some price. In your demonstration application, Medicare Waiver Demonstration Application at CMS, budget neutrality, Medicare waiver only demonstrates must be budget-neutral. Budget neutrality means that the expected cost under the demonstration cannot be more than the expected cost were the demonstration not to occur.

In other words, by your own application, you have to save \$8.3 billion. Where are you going to save \$8.3 billion when in fact, the vast majority of the \$8.3 billion is given away for no performance change, but retroactively in order to not have, essentially, seniors feel the pain of the Not Affordable Care Act?

Mr. BLUM. I think a couple of points, Mr. Chairman, in response. We are reducing, according to CBO's estimates, over \$200 billion from the Medicare program.

Chairman ISSA. No, no, wait a second. CBO has already scored and rescored the fact that the Affordable Care Act costs a whole lot more than it was scored at before, and it continues to go up. You are adding \$8.3 billion of new costs, not in ACA, and you are changing dramatically the law that said four and five star, and you are including, essentially, the mediocre plans in this bonus plan. You are doing it to 70 percent subsidy in the first year, which as

Mr. Cosgrove said and Ms. Emmanuelli-Perez said, is essentially paying them for what has already occurred.

Where are you going to get \$8.3 billion to pay back for what you are taking? Because by your own application, you have to be able to show you get it back. Where is the demonstration that you are going to get \$8.3 billion back, by this demonstration?

Mr. BLUM. That really is our goal for the demonstration, to test.

Chairman ISSA. Okay, so you have no plan to get the money back, you have a goal that is the demonstration. But the demonstration, according to Ms. Perez, may not be legal. You may not have dotted the Is of the legality, including those first two years in which the demonstration proves nothing. The existing ACA would have caused you to only give a lesser amount and only to better performers.

And if I understand correctly, logically you would have given that money only in year three, or in a year in which the demonstration that you paid for, they had an opportunity to achieve.

Ms. Perez, I am going to go to you. Wouldn't that have essentially taken care of the legal questions, if they structured it with the numbers that would be a smaller portion and thus more appropriate, in which people that are three could become four, in order to achieve the bonus? If I understand correctly, the first two years, if you are a two, two and a half, you can't become a three in those two years. If you are already a four, a three, a four and a half, you are going to get this bonus. Is that all correct?

Ms. EMMANUELLI-PEREZ. Well, Mr. Chairman, it is true that in those first two years, 2012, 2013, the plans are being rewarded for past performance. So to that extent, we do not believe that creates additional incentive. So in terms of looking at the year in which changes could occur that would incentivize this quality improvement, it would be 2014.

What we found is that in that year, the demonstration actually doesn't change the payment for four, four point five and five point programs. And the only ones where there is a change would be the three star. So we find that the majority of the demonstration does not have this incentive.

Chairman ISSA. So it doesn't meet the smell test, as I said in the opening.

Mr. Cosgrove, Ms. Perez, in your nearly combined half a century, have you had to come before Congress with a large amount, saying it just shouldn't be done, either legally or functionally like this before? Anything that even becomes close to this amount prospectively.

Mr. COSGROVE. To my knowledge, no. We have certainly questioned aspects of certain demonstrations. We have never. I have never recommended, worked on a study to recommend canceling a demonstration. I have never encountered one of this size.

Chairman ISSA. Thank you. As I recognize the Ranking Member, let us understand, it is not the program. We would like Medicare Advantage to succeed. It is in fact the President using \$8.3 billion of unappropriated funds to buy an election.

The gentleman is recognized.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

There is no one here that wants to see government funds used effectively and efficiently more than the Chairman and myself. I just had a lady, about a month ago, I ran into in front of my house, ask me to save her life. She has colon cancer and has no way to get insurance. So I see it every day. I live in the inner city of Baltimore.

And I must say to you, Mr. Blum, it is extremely important that programs run effectively and efficiently and that they do what they are supposed to do. To you, Mr. Cosgrove and Ms. Emmanuelli-Perez, I want to thank you for your service. I thought your report was thorough and well done, and I thank you.

You wrote, Ms. Perez, on July 11th, a letter to GAO Secretary Sebelius, is that right?

Ms. EMMANUELLI-PEREZ. That is correct, Mr. Cummings.

Mr. CUMMINGS. And just to be clear, this letter was not in any way binding on the Secretary, was it?

Ms. EMMANUELLI-PEREZ. It constitutes our views regarding the legal elements of the demonstration, but it is not binding on the Secretary.

Mr. CUMMINGS. Did you or your letter conclude that Secretary Sebelius acted illegally by implementing the demonstration program?

Ms. EMMANUELLI-PEREZ. No. We didn't conclude that it was illegal. What we found was that as presented to us by CMS during the course of our work, the details of the demonstration did not meet the elements of the statute. Therefore, we wrote to the Secretary to better inform the judgment regarding the violation of this demonstration, as well as to inform Congress in its oversight.

Mr. CUMMINGS. And did you get a response to that?

Ms. EMMANUELLI-PEREZ. No, we did not receive a response.

Mr. CUMMINGS. And Mr. Cosgrove, is it fair to say that GAO's main concern is you believe that the demonstration program is unlikely to produce meaningful results because of the way it was designed, is that right?

Mr. COSGROVE. Well, I suspect that there will be quality improvements. What we are concerned about is that we won't be able to attribute it to the demonstration, we won't be able to determine the effectiveness of the demonstration. That is why our recommendation was not only to cancel the demonstration, but to implement the bonus structure that the ACA provided for, and then if that proved inadequate at a future time, design and implement a better design demonstration.

Mr. CUMMINGS. Mr. Blum, you heard the testimony, you also heard the Chairman accuse the President, I guess he said, and I don't want to put words in his mouth, but of buying an election.

Chairman ISSA. Good words.

Mr. CUMMINGS. Yes, of buying an election. Do you agree with that?

Mr. BLUM. I think this demonstration is designed to rapidly test ways to improve, to how we can improve the overall elements of plans participating in the program. We have reviewed very carefully the findings of the GAO. But we also believe very strongly that this demonstration can be evaluated.

I think to the concern regarding the cost contracts, whether or not they provide an adequate control test, they do not, they are not eligible for the bonus payments per the Affordable Care Act. But I think the point is, they have to report the same quality information, the same quality data, so we can see in a comparison group the rise in quality compared to the plans participating in the demonstration.

I think the ultimate goal is for us to really figure out a way quickly, given the fact that we are adding 10,000 new Medicare beneficiaries to the program every business day, how we can best both lower the cost of the program, and I think—

Mr. CUMMINGS. Mr. Blum, let me say this. This is a program that has been under fierce attack. It was fought every inch of the way. And it seems as if we would be extra careful to try to make sure that it is done properly and that we try to get the results that we need. I know in my district, whenever there is any kind of program, we usually go to Johns Hopkins, and there is a study of the program as it goes along to make sure it is accomplishing what it is supposed to accomplish.

What these folks are saying is that they don't believe that you had the type of study that was appropriate to even measure the kind of results, so that you could even determine whether it was effective, and second, questioning whether or not it was effective at all. They are saying it is kind of hard to tell.

So how do you answer that?

Mr. BLUM. I think we have to wait for the evaluation to make definitive statements whether or not the demonstration has worked. The demonstration is three years.

But what I can say is based upon every interaction the agency has had with the health plans participating in the program, that they have changed their business models. They have changed the way they interact with the program. They are investing in new infrastructure to measure up to the assessed quality. They have changed their business plans, in my judgment, from a program of simply paying for claims, for health claims, to a program that keeps beneficiaries well, that manages chronic conditions.

I think at the end of the day, what our ultimate success factor will be is every Medicare beneficiary that wishes to sign up in a private plan has access or has the opportunity to sign up in the four star, five star plan. To me, as the overseer of the program, having beneficiaries enroll in low-performing plans, average quality plans, should not be sufficient and should not honor the promise that we have for Medicare beneficiaries.

To our view, every Medicare beneficiary should have the opportunity to enroll in a five star plan. Our challenge is, how do we make it possible quickly, rapidly, given the demographic shift, given how much beneficiaries want to be in the program, to have that opportunity.

So I can say, based on anecdotes, we have seen a dramatic change to how plans participate in the program, and their overall commitment to beneficiaries. Obviously, we will have to wait until the demonstration is complete to make definitive statements, did it work. But so far we are seeing very positive signs.

Mr. CUMMINGS. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

I would now recognize the gentleman from Utah for his statement. Would you yield me 10 seconds?

Mr. CHAFFETZ. Yes, I yield to the Chairman.

Chairman ISSA. I think what I heard you say, Mr. Blum, I am sure what I heard you say is we have to spend \$8.3 billion to find out if it is going to work, after GAO said it is a bad plan that was unlikely to bear any positive fruit. I am positive I heard you say that.

I thank the gentleman.

Mr. CHAFFETZ. Following up on the Chairman's comments, I remember the Speaker of the House, Nancy Pelosi, saying, we are going to have to pass this bill in order to find out what is in it. Now you are saying, even though we have experts who say it can't demonstrate any tangible results, that we are actually going to have to spend \$8 billion in order to test it to see if it would actually work, even though we don't believe that there is any objective way to come to conclusions, based on the way that this is set up.

Mr. Blum, do you have any non-partisan third party group or person or whatever that has gone on the record to claim that this demonstration research project is designed to actually demonstrate something?

Mr. BLUM. When CMS developed this demonstration, we worked very closely with our program staff, who are all career civil servants. We worked with our—

Mr. CHAFFETZ. Do you have any outside, third party person that has gone on the record to say that this is set up properly?

Mr. BLUM. What I have heard from—

Mr. CHAFFETZ. Pretty much a yes or no question.

Mr. BLUM. I am not aware of any outside. But I think that CMS will go through that rigorous review.

Mr. CHAFFETZ. Go through that rigorous review. Well, part of that rigorous review is going through the GAO.

Mr. Cosgrove, you have been at the GAO for 23 years, but your academic background, could you review for me quickly what your academic background is?

Mr. COSGROVE. Certainly. My Ph.D. is in economics, micro-economics. Before I came to GAO, I was teaching economics at Marquette University in Wisconsin.

Mr. CHAFFETZ. And based on what you have seen, in your expertise here, have you seen anything as fundamentally flawed or set up like this? You mentioned earlier when Chairman Issa was asking you that you, in your 23 years, actually never recommended the cancellation, is that correct?

Mr. COSGROVE. That is correct.

Mr. CHAFFETZ. So if this was presented in an academic setting, how do you think people would react to how this is structured?

Mr. COSGROVE. I think the concerns would be the same ones that I raised. In addition, we don't think there is a good control group. And we may see increases in quality among health plans, but we may have seen them under the ACA's bonus provision, but we will never know, because that was set aside to implement this nationwide demonstration program.

Mr. CHAFFETZ. Aren't these normally set up on a county basis, and if so, why is that?

Mr. COSGROVE. It is specifically so you can see what difference a new payment system makes. So for the durable medical equipment, for example, there are demonstrations that test competitive bidding for that, a new way of purchasing that. So that was done first in one county, expanded to two counties, and then it rolled out more slowly.

That allows you to see what actually the difference in going to competitive bidding rather than a fee schedule makes. That is not what happened here.

Mr. CHAFFETZ. My understanding is that generally these demonstration projects are at budget neutrality or at least close to budget neutrality. Is that the history of what you have seen in the past?

Mr. COSGROVE. My understanding is that Section 402 does not require budget neutrality, but that has been OMB's policy. We didn't look at individual demonstrations to determine whether they were budget neutral or not.

Mr. CHAFFETZ. And is it your understanding that a demonstration project has to actually be able to demonstrate something in order to qualify under Section 402(a)?

Mr. COSGROVE. My understanding is a demonstration is supposed to test the economy and efficiency of a new payment system to achieve something. And that is where we think it falls short.

Mr. CHAFFETZ. All right, Mr. Chairman, I will yield back. Thank you.

Chairman ISSA. Would the gentleman yield?

Mr. CHAFFETZ. Yes, I yield.

Chairman ISSA. I understand that there is no requirement. Let me rephrase, let me ask it a different way. Mr. Blum, if you were to follow ACA's mandate of four, four and a half, five, wouldn't that by definition cost less, yes or no?

Mr. BLUM. There would be less overall program spending.

Chairman ISSA. There would be a lot less, because this would be less than half of the size of the group. Wouldn't you by definition then encourage in year three entities to become fours in order to qualify, assuming that you restructured it back to where being a four benefitted you versus being a three?

Mr. BLUM. My understanding of the Affordable Care Act, and I probably don't have every detail straight in my head, but my understanding is the bonus payments are phased in over a five-year period. I think again, going back to our—

Chairman ISSA. Okay, so let me go back through, final question. By definition, if you followed the Affordable Care Act, it would cost less. You are choosing something that costs more, even though Congress scored this as essentially budget neutral when it passed it. So you are essentially changing something that was scored one way into something that is going to cost \$8.3 billion more. Isn't that correct?

Mr. BLUM. I think the real goal of the demonstration is, I think an important point—

Chairman ISSA. No, no, I am only concerned with the money you are spending without appropriation. So isn't it true that what you

have done is add substantially \$8.3 billion to the Affordable Care Act years after it was passed?

Mr. BLUM. I think the key point is that plans are paid based up on their bids. So our hope, the demonstration's goal is—

Chairman ISSA. Mr. Blum, I did not vote for the man that talked about hope. And I am here asking you a question I would expect you to answer. Isn't it true you are adding \$8.3 billion to the Affordable Care Act with this demonstration project, outside of that, the program scoring, and you are doing so without coming back to Congress?

Mr. BLUM. According to our actuaries, the 10-year estimate is \$8 billion over the next 10 years. But I think we are on track to reduce the subsidies down to the fee for service level over that same period.

Chairman ISSA. Right. After the election.

With that, we recognize the gentleman from Virginia, Mr. Connolly, for five minutes.

Mr. CONNOLLY. Mr. Blum, I proudly did vote for the man who talked about hope, and I intend to do it again. And I am very glad to have voted for the Affordable Care Act, and I am very glad you are here helping us illuminate the intricacies of its implementation and the benefits of its implementation.

We were reminded just yesterday by a CBO report that the numbers actually are better even than we predicted when originally passing the bill.

Mr. Cosgrove, let me ask you, you are the GAO, the reckless charge has been made that this demonstration project is nothing more than an attempt to buy an election. You are the GAO. Did you find any evidence of that?

Mr. COSGROVE. We did not look at the motive behind what was driving the demonstration. We looked at the structure of the demonstration.

Mr. CONNOLLY. And in looking at anything, find anything suspicious we ought to be worried about politically? And the mis-use of these funds or this program for undue political influence?

Mr. COSGROVE. Again, I am sorry, we were just looking at the structure of the demonstration itself.

Mr. CONNOLLY. Mr. Blum, you guys engaged in nothing more than a political campaign on behalf of the President?

Mr. BLUM. Again, our goal is to make sure that we can find ways quickly, rapidly, given the demographic shift, to ensure that every Medicare beneficiary, as rapidly as possible, has access to the best quality of care. Our demonstration is designed to test that premise; how can we reduce plan subsidies on average down to the fee for service level, at the same time dramatically improve the overall quality performance of our health plans and also keep the program growing.

So far, we have seen that strategy working. We have cut the subsidies to the health plans in half. We are now paying 107 percent of fee for service with the demonstration, today. We are on track to bring those overpayments down to 100 percent of fee for service on average.

We have seen dramatic changes to how plans interact with the program. We have seen dramatic focuses on compliance, on quality

improvements. And so there has been a fundamental shift in the overall psychology to how plans interact with the program.

Mr. CONNOLLY. Mr. Blum, if I could just clarify. You said you brought it down to 107 percent of fee for service and you hope to get to 100 percent, versus what in normal Medicare?

Mr. BLUM. Prior to the Affordable Care Act, the program was paying plans 14 percent more than the traditional fee for service program on average, without any solid evidence or measures that plans were providing 14 percent more value than the traditional fee for service program.

That framework has now changed. We are bringing the payments down over time to 100 percent of fee for service. We are changing how plans interact with the program, focus on the program, to encourage every plan to be a five star plan.

Mr. CONNOLLY. And far from being something extraneous to the Affordable Care Act, it sounds to me like this demonstration project is perfectly consistent with the Affordable Care Act, one of whose goals, primary goals, was to bring down the cost of health care long term, is that not correct?

Mr. BLUM. I think the Affordable Care Act's premise throughout the Medicare program, both in the traditional fee for service program and in the private side of Medicare, the MA program, is to reduce costs dramatically through improvement. We are doing the same strategies on the fee for service side, for hospitals, physicians, all health care providers to reduce the cost through straight programmatic changes, but also to provide very strong incentives for hospitals, physicians to improve the quality of care, to improve the performance.

We are confident at the end of the day that we can prove the premise that we can lower Medicare costs dramatically while improving the overall quality of the services. That is our fundamental challenge.

Mr. CONNOLLY. Mr. Blum, how important is it, given the complexity of a program like Medicare, to in fact test an alternative reimbursement program such as the one you are describing?

Mr. BLUM. I think in my experience, my judgment, CMS over the past 10, 15 years has not innovated rapidly enough. While it is true that the program in the past had very smaller demonstrations, I think most people would conclude that the program has failed on many measures. There are solvency deficits, there are quality of care deficits. I think our goal is to lower the overall costs and to improve the overall quality, given the fact that we have 10,000 new Medicare beneficiaries coming onto the program now every business day the program is open.

I believe the strategy so far seems to be working, showing very positive signs. Overall Medicare costs have fallen dramatically since passage of the Affordable Care Act. Yet we have seen no compromises in the quality of care and very strong indications the quality is improving.

Mr. CONNOLLY. If the Chairman would allow me a simple question with a simple answer.

Chairman ISSA. Without objection, the gentleman is recognized for an additional minute.

Mr. CONNOLLY. I thank the Chair.

Did Medicare premiums go up or down this year?

Mr. BLUM. For the Part C plans, premiums have fallen.

Mr. CONNOLLY. Mr. Blum, I promised the Chairman a simple question with a simple answer. And Medicare Advantage premiums in the last two years, did they go up or down?

Mr. BLUM. Down, on average.

Mr. CONNOLLY. Is there any evidence that that might be related to the provisions of the Affordable Care Act?

Mr. BLUM. We see very strong commitments from the health plans that participate in the program. To our analysis, they are making long-term commitments to this program, and we have every confidence this program will remain strong today and well into the future.

Mr. CONNOLLY. Thank you, Mr. Blum.

Chairman ISSA. Would the gentleman yield for a question?

Mr. CONNOLLY. It is actually the Chairman's time, I am done. But thank you, Mr. Chairman.

Chairman ISSA. Is the gentleman concerned, you only asked Mr. Blum questions, are you concerned that the other two witnesses stated unequivocally that this \$8.3 billion will not yield any usable data?

Mr. CONNOLLY. Mr. Chairman, I actually began by asking Mr. Cosgrove a question.

Chairman ISSA. But are you concerned about that?

Mr. CONNOLLY. About his answer?

Chairman ISSA. About the fact that Mr. Blum says that everything is rosy, but the non-partisan witnesses make it clear that this \$8.3 billion will yield no usable data?

Mr. CONNOLLY. I would be certainly concerned about testimony that would say that. But I have heard charges thrown around here, Mr. Chairman, that this is nothing but a political utilization of a program. Mr. Blum is here to give us technical expertise and testimony that actually contradicts that assertion.

And when I asked Mr. Cosgrove, that was my first question, he indicated they didn't look at that issue. They found no evidence, but they didn't look for it. So I necessarily then turned to Mr. Blum as the expert witness to talk about the actual aspects of the program and whether they were efficacious. And the testimony I think we have just heard from Mr. Blum would suggest that the answer to those questions is yes.

Chairman ISSA. Mr. Cosgrove, the gentleman mentioned your name. Did you in fact say that there is no evidence that this won't yield good, usable information as a demonstration?

Mr. COSGROVE. That is—

Mr. CONNOLLY. Would the Chairman yield?

Chairman ISSA. I was just allowing the gentleman to characterize what you characterized.

Mr. CONNOLLY. But I think that the Chairman perhaps mischaracterized. I didn't assert that. What I asserted was that Mr. Cosgrove in answer to my question said, we didn't look at whether this program was somehow being used to buy an election, which is the charge some have apparently leveled, and therefore found no such evidence. When I realized that Mr. Cosgrove didn't look at it, I ceased asking him questions in that line.

Chairman ISSA. So you didn't ask him if in fact this was simply a waste of \$8.3 billion.

Mr. CONNOLLY. If the Chairman wants to give this member more time, I would be glad to ask him that question and pursue it.

Chairman ISSA. Oh, I don't think we would ever get to those questions.

With that, we now recognize the gentleman from Oklahoma, Mr. Lankford.

Mr. LANKFORD. Thank you, Mr. Chairman.

Ms. Perez, I do want to follow up on a letter that GAO did send to the Secretary, Kathleen Sebelius. It stated, the demonstration's reliance on pre-demonstration performance data, the absence of an appropriate comparison group of Medicare Advantage plans and the demonstration's design make it unlikely that the demonstration will produce meaningful results. In other words, we are going to spend \$8.3 billion on something we are calling a demonstration, but it is very unlikely it is going to produce any results that will help us as a demonstration at all.

The second thing I found very interesting which I want to ask you about are findings during the course of the evaluation of the demonstration also raised concerns about whether the demonstration falls within HHS' Section 402 authority. You mentioned this, you said there are two things: the demonstration must provide additional incentives to increase efficiency, and the second thing, the demonstration must enable the agency to determine whether the demonstration in fact demonstrates increased efficiency.

So let me ask you about this. How can a demonstration based on data collected before the finalized rule was issued create incentives for 2012 and 2013? We have 70 percent of the money being spent on this \$8.3 billion right now to prove the efficiency of the changes but the changes haven't happened yet. How can that occur?

Ms. EMMANUELLI-PEREZ. Well, sir, those are exactly the concerns and questions that we have with the demonstration as designed. Both for 2012 and 2013, it is based on pre-demonstration data, performance that has already occurred. So therefore, those plans would not be able to take any action.

Mr. LANKFORD. So we are doing a demonstration and pouring \$8.3 billion in to demonstrate effectiveness of something that it is not possible this year or next year. Do we have the criteria established for 2014?

Ms. EMMANUELLI-PEREZ. For 2014, what we found was that for the majority of the demonstration, there still would not be additional incentives.

Mr. LANKFORD. Has the quality rating, the star quality rating, has that been established for 2014?

Ms. EMMANUELLI-PEREZ. For 2014, the data being collected would be collected between January of 2011 and June of 2012.

Mr. LANKFORD. The Medicare Advantage plans, do they know what the star rating will be for 2014?

Ms. EMMANUELLI-PEREZ. No, they will be receiving the star ratings in the fall of 2012.

Mr. LANKFORD. Okay, so let me try to evaluate this. Currently we are evaluating, we have an \$8.3 billion demonstration program that we are pouring the majority of the money into this year. But

we are not evaluating criteria on change, because it is from previous data. And then there is another chunk of it for the next year, and then we are trying to evaluate their effectiveness of changing into data they don't even know what that is yet. So no one even knows what 2014 data is yet.

So how do we evaluate the effectiveness of this demonstration toward data they don't even know what they are directing toward?

Ms. EMMANUELLI-PEREZ. That is what our concern is, sir. The problem is that in this situation, the plans would not have the information at a time when they could make changes. So therefore, we believe that because of that, they are not actually creating additional incentives.

Furthermore, even in those plans, like three start plans for 2014 where there are some changes, CMS still has not shown how they would be able to compare whether those changes had an effect to increase efficiency and economy. So we see flaws in that design.

Mr. LANKFORD. Okay, so a demonstration program is to demonstrate increased effectiveness. But we are pouring the bulk of this money into the first year of it when it is impossible to demonstrate effectiveness because there is no comparison, another large chunk of it into next year. And in trying to evaluate the effectiveness on three years out from now when the criteria is not even set yet and how they are going to manipulate toward that and change toward that.

My quandary in this is, the law requires those two things to be fulfilled for it to be a legal use of funds, for it to be a demonstration process and be legal. You were asked the question earlier, and you made the statement, it is not illegal but it is outside of the statute. Can you help me understand the difference between spending \$8.3 billion and it is not an illegal use of funds but it is outside of the statute? What is the difference?

Ms. EMMANUELLI-PEREZ. Yes. The reason that we reached our conclusion where we looked at those elements and said that they do not appear to meet the criteria of the statute, is there are several factors we had to take into account. First, we do recognize that the Section 402 authority does give the Secretary broad authority to make changes in payments for the efficiency and economy of services. So we recognized it was broad.

We looked at the legislative history and case law. And those sources were very limited. There was very little there that we could use where we could apply then the law to facts as presented in this demonstration. So we had that limitation as well.

And finally, we of course recognize that the Secretary does have discretion and that we did need to give some deference to that discretion.

Mr. LANKFORD. So basically you are saying that the Secretary has broad authority, no one has done this ever before, to this size, to this scale, this type. So it is hard to say it is illegal because it has never been done.

Ms. EMMANUELLI-PEREZ. Well, it is hard for us to say it is illegal, because the usual sources that we would have to apply the law would be legislative history and case law. And that is virtually nonexistent in this case. There is very little on those points.

Therefore, what we were able to look at was, really compare the facts that CMS presented, the rationale they presented for their demonstration, and then compared that to the plain language of the statute, which does require the creation of additional incentives as well as for the agency to be able to determine whether those changes did increase the efficiency and economy of services.

Mr. LANKFORD. So HHS is spending \$8.3 billion with no prior pathway to this in the past, and not sure they are going to be able to accomplish it in the future, and drop a lot of dollars into this particular year in the Medicare Advantage. And we don't know why, we are just left to guess at that point.

Ms. EMMANUELLI-PEREZ. Well, for our purposes, and looking at the work that we did as a legal matter, as well as Mr. Cosgrove, in looking at the demonstration, we cannot find how this demonstration is going to either test what it says it is testing, and from the legal standpoint, we cannot find that it meets the criteria as based on the plain language of that statute.

Mr. LANKFORD. Thank you. With that, I yield back.

Chairman ISSA. I thank the gentleman. I guess that is the question of a compelling legal authority, we once popularly heard from Vice President Gore.

We now recognize the gentleman from Illinois, Mr. Davis, for five minutes.

Mr. DAVIS. Thank you very much, Mr. Chairman. I want to thank you for calling this hearing. Because understanding health care costs is a very difficult and complex item. I think it requires and needs as much discussion as we can possibly have.

Mr. Blum, let me ask you, the quality bonus program has drawn attention for both its size and for its cost. The CMS Office of the Actuary has estimated that the quality bonus program would have a ten-year cost of \$8 billion above and beyond the cost of the bonus program included in the Affordable Care Act. Can you help us understand how this \$8 billion will be distributed, and does the entire amount represent bonus payments to the qualifying plans?

Mr. BLUM. I think, Congressman, it is important to have some overall context. Over the next 10 years, our actuaries project that we will spend more than \$1.3 trillion on private plans participating in the program. So I think from my perspective, this demonstration represents a very small portion, a very small proportion than what the program will spend on health plans going forward.

These are bonus payments designed to provide progressive payment incentives for plans to move up the payment scale. I think there is a longstanding principle, when we structure these payments, structure within the Medicare program, that we want to both reward the attainment, those plans that get to the five star level, for example, but also the improvement.

I think one of the things that I think the General Accountability Office did not look at is how have plans changed their operations, how have plans changed how they structure their programs since CMS put forward this demonstration program. I am convinced that we have seen fundamental changes in behavior. I am convinced that we have plans that have recognized that their service to beneficiaries is not just to pay claims but to improve the overall quality and value of services being provided to those beneficiaries.

So I think at the end of the day, when the demonstration is complete, we will see dramatic improvement without compromising what we mean to be a five star plan in quality and overall performance. I do believe also that because payments to plans are based upon their bids. We are demonstrating that with a focus on quality, with a focus on improvement, will we get more efficiency and economy in the program. I think that our demonstration will meet those tests.

Mr. DAVIS. So \$3 billion of the cost attributed to the program is due to higher enrolment in the demonstration period and the years that will follow, is that accurate?

Mr. BLUM. Well, these are 10-year estimates. So when our actuaries look at the cost, they look at it over a 10-year window. I think when you break down the \$8 billion, part of that is the fact that plans are improving. I think our actuaries believe that we have created strong incentives for improvement and to pay our more bonus payments because we have more four and five star plans. I think despite predictions that the Affordable Care Act was going to decimate the MA program, the opposite has occurred. I think both the actuaries and the Congressional Budget Office have substantially changed their projections for the future of this program. I am very confident that it is going to be a strong program today, tomorrow and well into the future.

Mr. DAVIS. Does this estimate suggest that the bonus program could result in improvements to benefits and services that would attract more seniors to the Medicare Advantage program?

Mr. BLUM. I think that is a key point, Congressman. These bonus payments don't go to health plans, they go to beneficiaries. So as plans improve, they are able to provide more services, they are able to invest those monies and provide better quality care. I think also not only trying to change health plans' perspectives and operations, we are also changing how beneficiaries think about the program. We want beneficiaries to seek out the best possible plans. We are confident that plans that achieve four star, five star status, they represent best in class.

My mother that lives in Illinois, in the Chicago area, does not have access to a five star plan. From my perspective, as the senior policy official, every Medicare beneficiary in every part of the Country should have the opportunity to enroll as quickly as possible in a five-star plan. I want my mother to be in that five star plan. That should be our ultimate goal.

Mr. DAVIS. Thank you very much. Thank you, Mr. Chairman.

Chairman ISSA. Thank you.

Mr. Cosgrove, would you also try to answer on that question?

Mr. COSGROVE. Well, I guess what I would like to add is, I would hope that if we paid plans \$8.35 billion more that they would enrich their benefit packages, and if they did so, that it would increase enrollment. That is not my understanding, though, of what the purpose of the demonstration was for.

Chairman ISSA. Thank you.

With that, we recognize the distinguished gentleman from Tennessee, Dr. DesJarlais.

Mr. DESJARLAIS. Thank you, Mr. Chairman, and thank you all for being here today.

Let's just step back for a minute and look at why we are here today. We have an awful lot of seniors out there that are very concerned about their Medicare, and they want to make sure that we preserve and protect it. So we are here today to make sure that is what we are doing, that we are spending our tax dollars well.

Mr. Cosgrove, if Medicare were your company and this \$8 billion were yours and your child's future depended on it, would you invest this \$8 billion on this demonstration?

Mr. COSGROVE. If my child's life were at stake, I would invest anything that I had.

Mr. DESJARLAIS. I am just saying, if your children's future depended on your financial welfare, if this were your \$8 billion, would you invest it in this particular demonstration?

Mr. COSGROVE. I would not have undertaken this demonstration. I would have done the way traditional demonstrations are done, you roll them out slowly, you test to see if it works, you make modifications, you expand the demonstration.

Mr. DESJARLAIS. Ms. Perez, would you spend \$8 billion on this demonstration if it were your money, not the taxpayers'?

Ms. EMMANUELLI-PEREZ. Based on the legal criteria we looked at, I would not spend those funds, because we don't feel that it meets the criteria of Section 402.

Mr. DESJARLAIS. Mr. Blum, you would make that investment if it were your money, yes or no?

Mr. BLUM. I think our challenge is to reduce overall Medicare costs.

Mr. DESJARLAIS. Would you spend it if it was your money, not the taxpayers', coming out of your pocket, would you spend it on this demonstration?

Mr. BLUM. I think the point is that all of us pay—

Mr. DESJARLAIS. It was just a yes or no. If you can't answer it, that is fine.

Let's look at what would happen if this demonstration didn't occur. If this demonstration project were not implemented, what would happen, Mr. Cosgrove? What would happen to our seniors' Medicare Advantage plans?

Mr. COSGROVE. If this demonstration didn't occur, then the bonus incentive system under the ACA would have been put in place, which would have meant that plans that got four, four and a half, five stars, would have received bonuses.

Mr. DESJARLAIS. Okay. What would happen to their costs, to the costs of their plans if this demonstration didn't occur when it is set to occur? Is their cost going to go up or down?

Mr. COSGROVE. Because of the demonstration?

Mr. DESJARLAIS. Right. Does the demonstration delay a cost increase in their plans, in their Medicare Advantage plans?

Mr. COSGROVE. Well, the demonstration, I am not sure it affects their costs. But it does affect the revenue stream that comes to them. If this demonstration didn't exist, then more of the ACA's payment reductions would have gone into place.

Mr. DESJARLAIS. Okay, so the payment reductions would have gone into place, it would occur in October, is that correct? In October of this year, the payment reductions, the Medicare Advantage

plans would cost more in October if this demonstration were not implemented, is that correct?

Mr. COSGROVE. It would have started January 1st of 2012, this year.

Mr. DESJARLAIS. So at any rate, their costs, the seniors' cost for their health care plans are going to go up if this demonstration is not implemented?

Mr. COSGROVE. It is likely, yes.

Mr. DESJARLAIS. Okay.

Mr. Blum, what percentage did you say of our seniors participate in Medicare Advantage?

Mr. BLUM. Today about 27 to 28 percent.

Mr. DESJARLAIS. Okay, so 27, 28 percent. How many million voters is that?

Mr. BLUM. That translates to about 13 million beneficiaries.

Mr. DESJARLAIS. Thirteen million beneficiaries, I am sorry, I said voters, excuse me.

So now, this study, this study that is going in, it was initially designed as a demonstration, was to be for four and five star plans. But for some reason now, you are going to do three star plans. Can we put up that slide that shows the number, the percentage? Okay. You can look at that slide. What percentage there is three star plans, or mediocre plans?

Mr. BLUM. I can't do the math fast.

Mr. DESJARLAIS. It looks like at least two-thirds, right? Would you agree with that? About two-thirds. So all of a sudden, this \$8 billion is not going to go to four and five star plans any more, like it was supposed to. But prior to this election, we are going to go ahead and include a much larger group of seniors in this study. We are going to reward mediocre plans with this \$8 billion, is that what you are telling us?

Mr. BLUM. I think my argument before the Committee is that we are creating a much stronger payment structure, an incentive structure, for plans to rise up the quality scale.

Mr. DESJARLAIS. You think. That is what you are hoping, that is what you are gambling the taxpayers' money on. You are taking an \$8 billion gamble with taxpayers' money in hopes that it will do this.

Mr. BLUM. Well, I think this was a demonstration. So we were coming into this demonstration hoping to learn more about ways to improve the Medicare program. That is consistent with the authority. I think the key point here is that we are paying today substantially less to our health plans across the board—

Mr. DESJARLAIS. Do doctors get more payment out of this? Will physicians? Because right now seniors are telling me they are having a hard time finding doctors. When I was practicing just two short years ago, I know that for a fact, that it was hard to find a doctor if you were on Medicare. Does this in any way incentivize physicians? Will they get higher pay? Or does this go to these plans? Do the plans get the money?

Mr. BLUM. What this incentivizes is plans to build much stronger relationships with their physicians, to build much stronger linkages, to encourage physicians to improve the overall quality of care.

Plans negotiate their own payment rates separately from Medicare for physician payments. So I can't speak to the actual rates.

Mr. DESJARLAIS. Well, there is a problem with access to care right now. The SGR formula is broken. That is still an issue we have to deal with. Physicians right now have not received any kind of pay increase for over a decade. Is there anything in this that is going to improve physician incentive on care? Because right now, I can tell you, if a Medicare patient comes in, and they are going to have an hour-long physical exam, and I was there when the Medicare Advantage came in, there were a lot of new criteria that we were supposed to do, EKGs and more screening tests, and it takes a lot longer time. As a physician, I might get \$50 to \$60, whether that takes a half hour, or hour, or hour and a half. You are asking for more and more from physicians. Is there going to be any more incentive? Because I can tell you, the overhead, when I started 20 years ago, was 50 percent. Now it is about 75 percent in a solo practice. So what are you going to do to improve access to care? You are wanting quality of care, but you are not wanting to pay for it. You are wanting to give it to plans, but not providers, is that correct?

Chairman ISSA. The gentleman's time is expired, but the gentleman may answer.

Mr. BLUM. I think I agree that the SGR is a challenge that we all have to face together. That is true for the private plan side of Medicare but also the traditional fee for service side of Medicare. What I hear from health plans who are now participating within the Medicare program is they are changing their payment structure with physicians to reward that extra time that is being spent with beneficiaries to provide wellness, to provide preventive care.

I think what is most exciting about the reaction to this demonstration is that it helps to build much stronger relationship links with health plans and the physicians they contract. Physicians don't have to contract with the MA plans. That is a private negotiation that CMS never interferes with. At the same time, what I believe this payment demonstration has created is a focus on how well beneficiaries receive services from their physicians, how much time do they have, do they focus on managing chronic conditions much better? I think from a physician perspective, and I am not a physician, so I can't speak from first-hand knowledge, but I believe that this structure, and a long-term strategy for both the fee for service program and the MA program, is to build much stronger relationships with patients and their doctors. Because that is how it will demonstrate better quality care.

Mr. DESJARLAIS. Mr. Chairman, can I have a few seconds to respond?

Chairman ISSA. I ask unanimous consent the gentleman have an additional 30 seconds.

Mr. DESJARLAIS. I thought just a few minutes ago you were essentially bragging on how you were going to bring the payment cost down, you are going to lower that. So how are you going to incentivize physicians, if you are bringing that down from 114 to 100 percent?

Mr. BLUM. I believe that our best ways to reduce Medicare cost is better chronic care management, better care coordination to reduce re-hospitalizations.

Mr. DESJARLAIS. And you are going to learn this from a study that Mr. Cosgrove and Ms. Perez say will not demonstrate anything. I yield back.

Chairman ISSA. I thank the gentleman.

We now recognize the distinguished gentleman from Missouri for five minutes, Mr. Clay.

Mr. CLAY. Thank you, Mr. Chairman.

To Mr. Blum, on the legal question, we reached out to an outside attorney, a professor of administrative law at American University, Jeffrey Lubbers. Professor Lubbers described the Secretary's authority as very broad. And he said he believed this demonstration program fits comfortably within that authority. Mr. Blum, do you agree with Professor Lubbers?

Mr. BLUM. When designing and constructing the demonstration, we worked very closely with our general counsel colleagues. We believe that we are operating consistent with the 402(b) authority. I haven't read the analysis, but my answer is yes.

Mr. CLAY. And then Professor Lubbers also explained that he considered this disagreement between CMS and GAO to be a methodological disagreement, not a legal one. Mr. Blum, do you agree with Professor Lubbers in that analysis?

Mr. BLUM. We have responded to the General Accountability Office's concerns. We believe that we have a program that can be demonstrated and that we have a plan for evaluation to compare the demonstration plans with other plans not part of the demonstration. So we are confident that when this demonstration is complete we will have very valuable information to determine how we can both accomplish the dual goal of reducing overall Medicare costs while substantially improving the overall quality and performance.

I am confident that our demonstration, when complete, will provide this thorough evaluation that we are concerned about.

Mr. CLAY. Yes. Thank you for that.

Mr. Blum, I think we can all agree that we need to continue to improve Medicare to ensure that these plans are providing quality, value service to seniors and to encourage the use of preventive services.

Mr. Blum, can you tell us about the status of your efforts under the Affordable Care Act to encourage the use of preventive care services in the Medicare program?

Mr. BLUM. I think overall, both in the traditional fee for service program and the Medicare Advantage program, one of our key strategies to make the program work better for beneficiaries but also to reduce long-term costs is a greater emphasis and a greater focus on prevention and wellness. The Affordable Care Act has waived cost-sharing for certain preventive benefits, provided beneficiaries the opportunity for the first time for free wellness visits with their physician of choice. That is the same is true in the fee for service side, as in the private side of Medicare, the private plan side.

So beneficiaries have reacted very strongly to these new benefits. We have been monitoring on a month to month basis the take-up rates and doing everything we can to make sure beneficiaries know that while we are reducing the overall cost of the program to keep it affordable for current beneficiaries and also future generations, there are more benefits being added overall to the program so beneficiaries are getting more services than they got before the Affordable Care Act was passed. And premiums have stayed very affordable as well.

Mr. CLAY. And I guess that goes into my next question, which is, about your efforts to incentivize improvements in the quality of care amongst both providers and insurance plans, can you talk a little about that?

Mr. BLUM. I think these new strategies are just going into place, but across our payment systems, be it in the inpatient hospital or in the physician payment side or in our health plan payment systems, we are creating structures that changes fundamentally our payment systems from being one that pays on a service or pays on kind of monthly capitated to a payment structure that pays based upon the overall value and quality that providers provide to their beneficiaries. We assess quality in a whole range of measures, from the processes of care measures to the outcome measures to the overall patient satisfaction. So we have sophisticated ways, and I think ways like never before to assess and to measure quality. But I think from the Medicare program's perspective, we are very proud in the fact that we have fundamentally changed how we pay providers to reward the best possible care, highest possible performance. I think without the strategy that the program will not live up to its promise to its beneficiaries.

Mr. CLAY. Thank you for that response.

Mr. Blum, can you explain the concept of risk selection?

Mr. BLUM. I think whenever you pay a capitated entity a fixed amount, they have incentives to market to and to encourage beneficiaries that will lose, that will spend the least amount of services in order to maximize profit. I think the long history of the private plan side of Medicare, that was the fundamental strategy, was to get paid a capitated rate and to find the healthiest beneficiaries that would have the least amount of services.

What I think the quality bonus payment structure does is changes that fundamental business model from a model that used to reward plans to avoid services to a model where plans are rewarded for providing services. I talked about what the goals of a five star plan are. But what a five star plan to me really is is a plan that provides more services, more help during beneficiaries' time of need, that works to keep beneficiaries out of the hospital, focuses on prevention, focuses on wellness.

I think this demonstration at the end of the day will demonstrate that we can fundamentally change the business model to the program to be one where we pay plans on average the traditional fee for service program, we see dramatic improvements in quality and performance and beneficiaries are more satisfied with the program.

Mr. CLAY. Mr. Chairman, I know my time is up, but let me thank the witness for his detailed responses on explaining the benefits of the ACA to all of us.

Chairman ISSA. I appreciate the gentleman clarifying that. I think if this hearing was only on the ACA and not on wasting \$8.3 billion, I would have appreciated his answer too.

Mr. CLAY. Well, but it is also an educational process here to let the American people know what the benefits are.

Chairman ISSA. No question at all. Clearly that story has not been told, Mr. Clay.

Mr. CLAY. But it is in the process of being told.

Chairman ISSA. It clearly is. So is the process of \$8.3 billion about to be wasted.

With that, we recognize the distinguished gentleman and former car dealer from Pennsylvania, Mr. Kelly. And by the way, you are a former car dealer. I don't want to hear that you are currently one, because you are a great Congressman.

Mr. KELLY. Still own the dealership, don't run it.

Thank you, Chairman. And I am, I agree with Mr. Clay, there is an evolving truth as we see in this Administration, as we continue to look at programs that are put into effect and we start to wonder, why did we really do this.

Let me ask you, Mr. Blum, if I could. Medicare waiver-only demonstrations must be budget neutral. And the applicants must supply information and assumptions supporting budget neutrality that CMS will use in preparing a waiver package for submission to the President's Office of Management and Budget. So OMB must approve the Medicare waivers before implementing the demonstration.

Who at OMB approved this obviously not budget neutral program?

Mr. BLUM. I think a couple of points, Mr. Congressman.

Mr. KELLY. I just need to know who at OMB.

Mr. BLUM. This program was implemented in the normal course of—

Mr. KELLY. So who at OMB? My question is, who at OMB? Do you know that? If you don't know, it is okay.

Mr. BLUM. Just follow the normal course—

Mr. KELLY. I am going to take, if you can't tell me who it is, that you don't know the answer.

So generally the Office of Management and Budget sends an approval packet for demonstration programs implemented by the Center for Medicare and Medicaid Services. Can we get a copy of the approval packet for the Medicare Advantage bonus demonstration by the end of the week? Is that possible?

Mr. BLUM. We are happy to work with you on that.

Mr. KELLY. Thank you. So that is a yes?

Mr. BLUM. We are happy to work with you, Congressman.

Mr. KELLY. That is a yes?

Mr. BLUM. We are happy to work with you.

[Laughter.]

Mr. KELLY. I love the way you guys don't answer.

Mr. Cosgrove, because the idea behind this is, there was \$8.3 billion spent on a program that has no control group, right? So if we are trying to prove something that is going to work, but then we don't really go after to find out if it is going to work, we just spend \$8.3 billion, what did the bonus distributions do to these programs,

or these plans that were working so well? Because I am looking at, it offset the effect of Medicare Advantage cuts by 71 percent in 2012. There must be some significance in why it is heavily loaded front.

Mr. COSGROVE. Let me talk about the timing of that and what it can show. This is certainly one of our concerns.

The bonus payments that are paid to plans this year were based on data that were collected from the period starting in January 2009 through June of 2010. So those data, which will determine payments this year, were collected before the demonstration was even announced by CMS in November of 2010 and well before the final version of the demonstration was announced in April of 2011.

So it is hard for us to understand how this can act as an incentive payment for plans.

Mr. KELLY. In my world, we call that bass backwards.

I am just trying to find out. Because we spend a lot of taxpayer money. We know it is not budget neutral. So what was the purpose of running this demonstration program? What is the relevance of it?

Mr. COSGROVE. We asked CMS what the purpose of it was. We were told that in part, it was to test a scaled bonus incentive system where the plans that moved up the quality rating continuum would get larger bonuses and that they also wanted to make sure that they expanded the bonuses down to average quality plans to get the lowest quality plans they thought was more incentive to increase.

It is not clear to us that that was implemented consistently, since in 2014, the only year that really makes a difference, four, four and a half and five star plans receive the same bonus percentage. And under the ACA, the lower quality plans would have had a greater incentive to increase to become four star plans.

Mr. KELLY. I was just reading through some of the testimony. If Medicare Advantage plans don't change benefit packages, the Medicare Advantage cuts are going to result in higher premiums by about \$1,800 per beneficiary, voters, by 2017. So if I can game that, if I can make it look good today, if I can soften, if I can sugar-coat it today, but once that sugar-coating wears off, I am going to find out that I am probably not going to be able to do a Medicare Advantage in the future, because the cost is just rising in such a fast rate, it is going to put it off the market.

Mr. COSGROVE. According to CMS regulations, these bonus payments that plans receive are to go to both enhance the benefit package that beneficiaries get or reduce cost-sharing or reduce their premiums.

Mr. KELLY. Okay.

Chairman ISSA. Would the gentleman yield? Mr. Blum, you didn't answer the gentleman's question on who approved waiving the budget neutral. When you come here representing the Administration, and it is a question I am sure you already knew could be asked, would you please answer it?

Mr. BLUM. We operated the payment notice to announce the demonstration through the normal courses, through a full comment period. I signed the payment notice, that authority is delegated to

me. But there is a major review and clearance process through the office and budget clearance process.

Chairman ISSA. I understand. The question had been, who at OMB approved the obvious non-budget neutral aspect of this program. Who at OMB.

Mr. BLUM. I work at CMS, and I can't speak to that.

Chairman ISSA. Do you know who at OMB approved it?

Mr. BLUM. No, I do not, sir.

Chairman ISSA. Do you know who in your organization above you approved it?

Mr. BLUM. The, I made a recommendation to the administrator at the time. And the administrator at the time was the approving official for CMS.

Chairman ISSA. And who was that?

Mr. BLUM. Dr. Don Berwick.

Chairman ISSA. Thank you.

We now go to the gentlelady from California, Ms. Speier.

Ms. SPEIER. Mr. Chairman, thank you.

Mr. Blum, tell us about your experience, your resume, your background before coming to CMS.

Mr. BLUM. I spent three and a half years working for the Office of Management and Budget, spent three and a half years working for the professional staff of the Senate Finance Committee, working about four and a half years in the private sector and have been at CMS for about three and a half years.

Ms. SPEIER. And certainly you know, as do the members of the House of Representatives, that the cost of Medicare is out of control and that we have to look at new ways of providing quality service and reducing the cost. One of the examples used by Togawandy was looking at McCallum, Texas, and El Paso, Texas, where we were spending twice as much money in McCallum, Texas for Medicare recipients, something like \$14,000 a year and \$7,000 a year in El Paso per Medicare recipient. And the quality of care, the demographics of the Medicare recipient were about the same. But yet it was about twice as expensive in McCallum. We found out it was because doctors were churning, that they were spending more money on services. And it so happened that the services were services they owned, home health care, MRIs, and that churning was having an effect. So isn't this particular pilot project an effort to see if we can get better quality of care by not necessarily using more services, and then incentivize the physicians who do provide that quality at lesser cost?

Mr. BLUM. I think our ultimate challenge with the Medicare program is to reduce overall cost, to ensure the program is stable and strong for current beneficiaries and future beneficiaries, while ensuring that beneficiaries have strong access to care and to ensure that the overall quality is improving. I think prior to the Affordable Care Act, the program had many vulnerabilities. Some of those vulnerabilities were that providers were paid for providing on a service by service basis. And oftentimes there was little value for those extra services. I think what we are doing right now in our overall strategy that was set forth by the Affordable Care Act is to change the fundamental business model for how providers interact with the health care program to focus on prevention, focus on get-

ting waste out of the system, focus on better coordinating care to ensure beneficiaries get better care and to reduce unnecessary hospitalizations, for example. This is the same goals, the same model that we are promoting and trying to encourage and trying to test how to do so as rapidly as possible. The program will add 10,000 new beneficiaries each business day. So we have a tremendous challenge, all of us together, to reduce the cost dramatically but at the same time figure out ways to incent better quality of care. Because I believe over the long term, that will be our only strategy to reduce the fiscal challenge that we face in the Medicare program.

Ms. SPEIER. The GAO has suggested that you don't have a control group or a comparison. How do you plan on making that kind of an evaluation if you don't have a control group? What are you going to use instead?

Mr. BLUM. I think we do have a control group. And we have identified in our response that we can assess those plans that are eligible for the bonus payments. I think the key point is that those plans have to submit the same quality information as the MA plans do to be eligible for the bonus payments. So really, I think the key measure is how has quality improved, how have patients experienced our care. And our demonstration is designed to test, as rapidly as possible, ways to dramatically improve the Medicare program. And I agree that the history of the demonstration program was to start small then expand and expand? And I don't personally believe that strategy has served the Medicare program or beneficiaries very well. Today we face a fiscal challenge, we face a quality of care challenge. And the old way of operating the Medicare program, in my view, won't be sustainable to both address the long-term fiscal challenge the program faces and the quality care chasm that has been in the program for too long. So while I respect the viewpoint that this demonstration is different from the past, in my own personal view, the past didn't serve taxpayers or beneficiaries very well.

Ms. SPEIER. I yield back. Thank you.

Chairman ISSA. I thank the gentlelady. We now go to the gentleman from Arizona, Mr. Gosar, for five minutes.

Mr. GOSAR. Thank you, Chairman. Mr. Cosgrove, is the \$8.3 billion being spent on this program coming from the general tax revenue or from the Medicare trust fund?

Mr. COSGROVE. It is coming from the Medicare trust funds.

Mr. GOSAR. So will any seniors face higher premiums for Medicare Part B because of the demonstration project?

Mr. COSGROVE. Yes. All seniors, those in the traditional fee for service program as well as those who are in the Medicare Advantage plans, will face slightly higher premiums because of this.

Mr. GOSAR. Well. Ms. Perez, my colleague here asked a question in regard to the jurisdiction of the Secretary. Isn't it true that the Secretary has to use prudent use of scientific method and mathematical statistical evaluations of proper studies when they do that role?

Ms. EMMANUELLI-PEREZ. Yes. Under Section 402 there is a requirement that the Secretary consult with experts with respect to those demonstrations.

Mr. GOSAR. So use a prudent method. So it was very misleading.
Mr. Blum, are you a mathematician?

Mr. BLUM. No, sir.

Mr. GOSAR. A statistician?

Mr. BLUM. No, sir.

Mr. GOSAR. And do you see any variance, you said, it hasn't worked very good. Do you believe that by the scientific method and by mathematics that we have achieved living longer today?

Mr. BLUM. My understanding is there is longer life span.

Mr. GOSAR. There is a longer life span. And it has to do with scientific method. It is about proven scientific process. It is a control group that works. That is what that man right there is talking to you about. We just don't throw that out, because it is proven over and over again. I am a science guy. You just don't manipulate data. That is the problem. So Mr. Cosgrove, you use mathematics and sound scientific method to do your methodology, do you not?

Mr. COSGROVE. Yes, we do.

Mr. GOSAR. So in your professional opinion, this does not satisfy that scientific method, does it?

Mr. COSGROVE. It does not, which is why we recommended canceling the demonstration.

Mr. GOSAR. I know my colleague over here was talking about if this program wasn't going into effect we would see some substantial cuts, would we not?

Mr. COSGROVE. Yes, we would. The ACA would have phased in over time, reduced payments to Medicare Advantage plans, and the demonstration, in this year, offsets 70 percent of those over the life of the demonstration. It offsets about a third.

Mr. GOSAR. So truth and consequences comes in what time this year? Open enrollment starts in October, is that true?

Mr. COSGROVE. That is correct.

Mr. GOSAR. So we would see this vast number getting this unexpected news about that time, would we not?

Mr. COSGROVE. Yes.

Mr. GOSAR. So it goes to my colleagues talking about that this does have political consequences, very interestingly done.

Mr. Blum, you said that CMS really doesn't have anything to do with compensation methods. Let me ask you a quick question. Isn't it true that all Medicare, Medicaid and all insurance rates are based off of Medicaid reimbursement rates set by CMS?

Mr. BLUM. For the traditional fee for service program, that is true.

Mr. GOSAR. For all of them. It is all of them. They are all based off of them. Actuarials are all based off of CMS' reimbursement rate.

Mr. BLUM. For our private plan payments, they are based upon plan bids. Plans submit bids.

Mr. GOSAR. Plan bids can be only accepted by what CMS actually does. So it is up to them independently, but it is set off CMS rates.

Mr. BLUM. Our actuaries review the bids.

Mr. GOSAR. Please go back and review insurance regulations. Who is to benefit from this, the plans or the physicians?

Mr. BLUM. Benefit? I am sorry?

Mr. GOSAR. With these types of benefits that you are giving the subsidies to, who benefits? Is it the physicians or is it the plans?

Mr. BLUM. Plans——

Mr. GOSAR. Plans. Very simple answer. Plans, right?

Mr. BLUM. Plans contracts separately with physicians that CMS does not oversee. So I can't speak to how plans change their compensation to physicians or hospitals based upon changes.

Mr. GOSAR. But they are also established by a rate that you establish, is that not true? Yes, it is.

Mr. BLUM. Sometimes plans follow our rate structure, but they are not required to do so.

Mr. GOSAR. They cannot be higher than that plan.

Mr. BLUM. They can be higher, they can be lower. Plans negotiate contracts separately with hospitals, physicians——

Mr. GOSAR. Let me ask another question, Mr. Blum. Is the private insurance marketplace being cost-shifted and is it going up?

Mr. BLUM. I can speak to the——

Mr. GOSAR. Is it going up? It is very easy. Come on, sir. You are not that naive. You know, and I don't carry government insurance, so I am very aware, has it gone up? Double digits every year?

Mr. BLUM. I track Medicare spending, so I can't speak to private sector. But I can say for Medicare——

Mr. GOSAR. You have to understand that. Because what you do is manipulating data. And if you don't see the bigger picture here, you are manipulating a small segment here to your benefit. And that is not to the benefit of the seniors or to the process, is that right?

Mr. BLUM. I believe that we are changing how we pay providers, and that is having tangible——

Mr. GOSAR. You are also changing the scientific method and methodology of how you conduct process that has proven over and over again to benefit not only statistical data, but also the scientific method, sir. Shame on you.

Chairman ISSA. The gentleman yields back. We now recognize the gentelady from the District of Columbia, Ms. Norton, for five minutes.

Ms. NORTON. Thank you, Mr. Chairman. I wanted to be here in time to ask some questions. I have just come out of another hearing.

I am interested in the star rating system and its application. We know that, let's take Medicare Advantage, of course, that this program serves 12 million of our seniors. I think it would be important to understand how the star rating system has, how it is used to help determine the quality of the plans that are offered. How is it derived?

Mr. BLUM. CMS collects a variety of measures from health plans that participate in the Medicare program. Those measures go through consensus based organizations to ensure that they represent fair and accurate ways to assess health plan quality.

We collect a mix of measures, of process measures, for example, how well is the plan providing customer service to their members. We collect outcome measures, our plan is doing a relative better job to manage, for example, blood levels for diabetes patients.

We also collect data on how satisfied beneficiaries are with their health plan. Then all these measures together get compiled to a star rating, with one star being the lowest quality and five star being the highest quality plans. Most of the plans today operate within the three and the three and a half range. To us, that is not acceptable for the long term. Our goal and our mission is to ensure that every beneficiary that wants to enroll in a private health plan has the opportunity to be in a four star, five star plan.

Based upon our measures that represents——

Ms. NORTON. Has the star rating affected enrollment in these plans?

Mr. BLUM. I believe that we are seeing positive movement from beneficiaries to plans that have higher star ratings. In addition to establishment payment incentives, we are trying to educate, best we can, to the beneficiary community what it means to be in a four star, five star plan. So I believe that our demonstration will change the business model.

But I think as important, possibly more important, that it will change how beneficiaries think about the program and choose which health plan to enroll in. Four star, five star plans, particularly five star plans, represent best in class and represent to us what every MEDICARE beneficiary should have the ability to sign up for.

Ms. NORTON. Let's look again at Medicare Advantage. I am looking now at a report from the Association of Health Insurance Plans. It says that there has been an 8 percent increase in the Medicare Advantage plan star rating. It also says that CMS has seen a 29 percent, that 29 percent of Medicare Advantage enrollees are indeed enrolled in the plans with four or more stars. That is up from, I believe it was 19 percent. So 19 percent to 29 percent.

How do you account for these fairly significant increases?

Mr. BLUM. I think my perception and perspective from studying the data is that we have sent a clear signal and a clear message that for plans that want to participate in the program for the long term, will have to dramatically increase their quality that they provide to their members and also their overall performance in the program. And this is a clear signal that that signal is sent both through payment incentives but also through our work in compliance to oversee the plans and our work to market or to educate beneficiaries on their plan options.

Ms. NORTON. Mr. Blum, the GAO criticism was that the bonus demonstration program extends bonuses to three star plans. And those of course are the plans that are only average under the rating system. Isn't that where the improvement is needed?

Mr. BLUM. I think that our payment policy should be, and this is a consistent principle throughout the Medicare program, is that we reward plans that both achieve the desired goal, but we also reward plans for steps in improvement. I think for us to dramatically change the program, we have to reward and incentivize not just the attainment but also to the improvement and send a clear signal throughout the plan community that they will do better, their beneficiaries will do better, if they rise up the quality scale.

I think a lot of folks have argued to CMS, well, why don't you just lower your standards. And this year, last year, we have

worked to improve the star rating to make it even a stronger standard what it means to be a four star, five star plan.

So we are setting our goals high, setting our values to be that every Medicare beneficiary should have access to best in class care, and creating the payment structure and figuring out the best way to do it as quickly as possible to ensure that every beneficiary in all parts of the Country have access to best in class care.

Chairman ISSA. I thank the gentleman.

Ms. NORTON. Thank you, Mr. Chairman.

Chairman ISSA. We now recognize the gentleman from Idaho, Mr. Labrador.

Mr. LABRADOR. Mr. Chairman, I yield back my time.

Chairman ISSA. Would you yield me the time?

Mr. LABRADOR. Yes.

Chairman ISSA. I thank the gentleman for yielding.

Mr. Blum, during CMS's comment period, well before the GAO study, you had 29 comments. If I understand correctly, 28 of them were from recipients, people who would get the money, isn't that true?

Mr. BLUM. The typical practice that our comment period, the majority of comments come from the plan community.

Chairman ISSA. Okay, so the people who would get the money, 28 out of 29, they kind of like getting the money, especially if you give it for Cs.

The one group that was not, in fact, a partisan in this was MedPAC. Isn't it true they reached a similar conclusion the GAO, opposing this plan, particularly as to scale?

Mr. BLUM. I think it is fair to say that consistent with other demonstrations that have been done, kind of a national basis, they raised concerns about can CMS—

Chairman ISSA. Right. And isn't it true that you didn't take any of their recommendations?

Mr. BLUM. I think we worked hard to develop that—

Chairman ISSA. Please, Mr. Blum. I don't want to hear about worked hard. Did you take their recommendations? You are under oath?

Mr. BLUM. CMS decided to finalize the demonstration.

Chairman ISSA. Okay. You didn't take their recommendations, is the answer.

Mr. Cosgrove, are you an only child?

Mr. COSGROVE. No, I am the youngest of three.

Chairman ISSA. Okay. I am one of six. And my family couldn't afford to give me grades, money for As and Bs and Cs. But I have an only child son. So we set up a program and we paid him extra bonuses when he got As, a little bit less when he got Bs.

He asked me for money for Cs and something for Ds. And we gave him something for Ds, we took away the money he would have gotten for Bs.

Isn't it true that this plan essentially rewards 90 percent of all participants, effectively neutralizing the real benefit in years one and two and three of moving up and getting better?

Mr. COSGROVE. It certainly does reward plans that enroll about 90 percent of beneficiaries. In that sense, it also lessens the incentives for plans to move up, that is correct.

Chairman ISSA. So years one and two, moving up doesn't accomplish anything, because those years are already in our tail lights. Year three, threes, fours, four and a half, fives, all get paid the same, so no incentive for moving up, correct?

Mr. COSGROVE. Yes.

Chairman ISSA. So the aspirations and the hope of Mr. Blum are not in this study.

Based on science, based on experience of past demonstration projects, is there any reason that this plan couldn't be done on a much smaller scale, and thus be as effective for less money?

Mr. COSGROVE. No. That is what we think a well designed demonstration would be, would be to start off small without spending over \$8 billion.

Chairman ISSA. So any amount greater than the amount necessary to reach the conclusion that the demonstration project hopes to reach any amount greater than that is by definition waste, because it is unnecessary?

Mr. COSGROVE. We recommended that the provisions of the ACA be put into place, and that those incentives and the effect of those incentives be studied. That would have cost \$8.3 billion less than what we are spending now.

Chairman ISSA. Mr. Blum, earlier you were asked about an approval packet on the demonstration programs from OMB, and whether you would deliver that package to this Committee. Would you deliver the approval packet for demonstration programs to this Committee?

Mr. BLUM. We will be happy to work with you.

Chairman ISSA. No. Will you deliver it?

Mr. BLUM. I will be happy to check into the answer. I personally can't commit to that, but I will be happy to check into it for you.

Chairman ISSA. You will check into it. Are you aware that that packet has already been requested by Senator Hatch?

Mr. BLUM. I am not aware personally, but I can definitely check into it.

Chairman ISSA. Okay. Understand that that packet will be the subject of this Committee's formal request, if it not granted by the end of the week through this request. So please take that back with you.

Mr. BLUM. Will do.

Chairman ISSA. Now, at the beginning of this hearing, I made some fairly strong statements, statements about \$8.3 billion basically buying favors in an election. None of you are here to comment on that, that is a conclusion I reached.

But Mr. Cosgrove, I want to ask you, because you have been at GAO for a long time, were you in a similar role when Republicans promised to ratchet down the cost of Medicare in the past and scored it some years ago through savings? Did you look at those?

Mr. COSGROVE. I have been working on Medicare issues, Medicare payment issues, for more than 15 years.

Chairman ISSA. So isn't there a tendency under Republicans and Democrats, not this \$8.3 billion that clearly is designed to ward off an event that would occur this year otherwise, but in Affordable Care, something Mr. Clay talked about it, it promised to get reduc-

tions through spending less. And it in fact set forward to pay less, so it is scored to pay less.

Isn't it true that the history in your experience of all these plans to pay less ultimately end up being shored up by Congress later because the savings, for the most part, doesn't occur over the long run? Isn't that the general history of health care under Medicare that says, we will pay less, including what Dr. Gosar talked about, how we have been paying doctors less and seeing the effect?

Mr. COSGROVE. Congress, over time, from both sides, from both kinds of Administrations, recognized that Medicare spending is unsustainable and has taken steps to try to reign it in. There is always pushback from providers.

Chairman ISSA. Right. So the history has been, like the Affordable Health Care Act, they score in the out year savings, claim they are going to pay less, tell people, like in this case, Medicare Advantage, that they are going to take you from 14 percent premium down to 7 percent and eventually to flat-lining you with a fee for service. But historically, there is a tendency to then backfill it for political reasons.

Mr. COSGROVE. Historically when cuts have been enacted, then some subsequent legislation has often restored at least some of the payments, that is true.

Chairman ISSA. So when we look at what is being called a demonstration project, and Ms. Perez made it clear that it doesn't fit 402 requirements under the legal authority for that, is this effectively backfilling by an executive fiat the monies that otherwise would be taken under the Affordable Care Act?

Mr. COSGROVE. It is replacing, in this year, in 2012, it is replacing 70 percent of the payments that otherwise would have been reduced, would have been recovered from plans.

Chairman ISSA. Last number, if you know it. If you take away the retroactivity of this year, how much of that \$8.3 billion would not be spent? In other words, if you say, we are not going to touch this year because this year, these plans can't do anything about it, how much of this \$8.3 billion would be saved?

Mr. COSGROVE. That is a number that we haven't estimated.

Chairman ISSA. But it is more than a third, because the bonuses are front-end loaded to this year, right?

Mr. COSGROVE. The bonuses are front-end loaded. There is some tail effect in the out years, and so having to do with enrollment. But yes.

Chairman ISSA. So it is safe to say it is more than a third, probably more than \$3 billion that will be given away this year for no performance change possible since it is retrospective analysis?

Mr. COSGROVE. That is correct.

Chairman ISSA. Thank you.

Mr. Cummings, do you have any final questions? The gentleman is recognized.

Mr. CUMMINGS. Mr. Blum, I have sat here and listened very carefully. I want you to address this whole issue of the, I know you have talked a lot about your objectives and things you have seen. You believe that we are providing more services as opposed to avoiding services. You said that, right? Is that right? Is that what you are seeing or is it?

Mr. BLUM. We are seeing a fundamental change in how health care services are provided to be one where we are paying for value rather than volume, and to create much more stronger structures to better coordinate care, better manage care, to best serve beneficiaries for the long term.

Mr. CUMMINGS. The folks from the GAO, I think, are saying, I don't think they are denying that what you just said is true. Denying or admitting it. But the question seems to be, what in this process says that what you are doing is resulting, is the causal effect of the results you just talked about? To me, that is the key. I have listened to all this, and that seems to be the key here.

Help me with that.

Mr. BLUM. I agree. That is our fundamental challenge to how we manage this program for the long term. I think for too long the program has simply paid for services without any measures of quality, without any measures—

Mr. CUMMINGS. Answer my question. Give me the causal connection between this program, what you are doing, and the results you are seeing. Do you follow what I am saying? Because to me, that is the key. I think that is what these folks are concerned about, too. It is not that, nobody is saying it is not happening. The question is, what is the causal connection. The question then becomes, would it have happened anyway? Do you follow what I am saying?

Mr. BLUM. Sure. Well, I think the causal connection is that when you reward and incent improvements that you change how businesses and how plans invest in their beneficiaries, and structures their health plans. Rather than providing fewer services when beneficiaries are in their time of need, the causal relationship is providing more services, better services during their time of need that I believe will lead to higher quality ratings but also will lead to lower bids, because plans now can better manage services, beneficiaries will be healthier, beneficiaries will require fewer services over the long term.

So it is a self-reinforcing proposition.

Mr. CUMMINGS. But to go back to what Mr. Cosgrove said, if you are giving awards before you get the, before you even the effect is supposed to be felt, how does that measure? Do you follow me? You have to get to that, because that is what they are talking about.

Mr. BLUM. I think we have to look at a whole host of different measures and outcomes. Clearly, we want to see changes in the performance measures as being collected by CMS. I think at the end of the demonstration, what we really want to see is has there been a fundamental change in those quality measures. I think a key point is that the demonstration was announced in 2010. That already has changed behavior.

Mr. CUMMINGS. Right there, I think you are helping me now. How so? What you just said, I want to understand that. You announced it, you are saying it had an effect. How do you conclude that?

Mr. BLUM. I think it sent a very strong message from the agency to every health plan that, your mission and your challenge and your opportunity is to serve your beneficiaries better. That is not just maximizing profit by serving your beneficiaries less, but it is

better service, better quality, better outcomes, will create the business model to sustain this program over the long term.

We believe this will also yield savings to taxpayers over the long term. We are on track to bring the overall payments down to 100 percent of fee for service over the next 10 years. But I believe that we are going to see the program continue to grow and more important, that quality of care will be improved.

Mr. CUMMINGS. Would it have been better to say, we are going to do that, as opposed to we are doing it? I think that goes back to what they are saying. It is one thing to say, we are going to make a payment, when you do these things. It is another thing to say, we are going to pay you all along. Go ahead. I really need the answer to that.

Mr. BLUM. Really, the payment structure is, once the plan can demonstrate that it has improved, it has increased, and this is designed to provide a higher payment as planned to move up that quality scale. We believe this is going to produce faster results and better care in a much quicker time frame than the Affordable Care Act's policies than what this demonstration.

I just want to respond to the Chairman that we are happy to provide the OMB package today. I want to clarify my answer to you.

Chairman ISSA. Thank you.

Mr. BLUM. We are happy to provide that to you.

Mr. CUMMINGS. Thank you very much. You have been very helpful.

That last piece, what you just explained, helps me tremendously. Thanks.

Chairman ISSA. Thank you.

We now go to the gentleman from South Carolina for five minutes.

Mr. GOWDY. Mr. Chairman, thank you. I want to apologize to the Chairman and the witnesses for being detained in Judiciary longer than I had hoped or expected to be. And with that, and in light of the Chairman's most recent line of questioning, I would be thrilled to yield my time to the Chairman.

Chairman ISSA. I thank the gentleman for yielding.

Mr. Blum, I appreciate the packet being delivered. The Ranking Member asked you if, in light of the fact that all of this money for the first two years will be retrospective, whether you thought it had any effect. You said that in fact, you thought it already had an effect.

Do you have any scientific data, or any data that you can deliver to us to show that effect?

Mr. BLUM. Not scientific, quantifiable effect. But I can give you my impressions.

Chairman ISSA. But you are not a scientist, you are not a physician.

Mr. Cosgrove, have you, do you have any numbers to indicate that they have, A, already had an effect that is positive, or B, that the majority of this \$8.3 billion being spent for what has already occurred and can't be changed is going to have an effect, in contrast to putting the money into a later period in which it could have an effect?

Mr. COSGROVE. There is no way for me to determine that. We don't know what would have occurred had CMS allowed the ACA provisions to go into place in the first place.

Chairman ISSA. Right. But you are a microeconomist. And whether you are taking macro or micro, there is always this supply and demand really works because people move toward the reward and away from the punishment, if you will.

In this case, the majority of these dollars are being provided for something in which no action changes. Let's just focus quickly on year three. In year three, the year in which there is an opportunity to change, isn't it true that as designed, CMS is in fact providing no incentive to be different than you are today? In other words, if you are a three today and you are a three in year three, you are going to end up with exactly the same amount of money, aren't you?

Mr. COSGROVE. CMS does extend the bonus payments down to three star plans. Under ACA, only four star plans and above would receive a bonus.

Chairman ISSA. So under what Congress passed, which would cost less, three star programs would be working to become four star, not just because they are going to track clients and because they are going to be probably better, which the rating would imply, but because they would then be eligible for a bonus, is that right?

Mr. COSGROVE. Yes, that is the incentive.

Chairman ISSA. But under the President's plan, or Secretary Sebelius' plan, that won't be the case. The fact is, you will be paid to be mediocre, you will be paid for Cs.

Mr. COSGROVE. You will be paid for being an average plan, yes.

Chairman ISSA. So Mr. Blum, you repeatedly used the words four and five star. If Mr. Cosgrove is correct, isn't it true you are paying for Cs? You are paying for not improving under this \$8.3 billion utilization?

Mr. BLUM. I would characterize the payment philosophy as to they are paying for improvement.

Chairman ISSA. Wait a second. Characterize? What in your plan gives me, look, I am an old businessman. Tell me where I get one dollar more for improving if I am today a four, if I am today a three. Just assume I am a B student or a C student. What is the differential if I go from being a three to a three and a half in your plan?

Mr. BLUM. I forget the specific parameters. There are higher payments as plans move up the scale. And again, our test is by creating that ladder, by creating that pathway, do we get faster performance, faster improvements than had we not created that scale.

Chairman ISSA. Okay. Since you came here to testify on this \$8.3 billion, I am assuming that if people improve, and you pay them more, it will go beyond the \$8.3 billion? The bonus structure is such that the \$8.35 billion can't be a static number, that there is actual improvement, you are going to pay more.

Mr. Cosgrove, you have looked at this. If the threes today, which are going to be paid based on being threes today for that first year, and the second year, but in the third year, if they become three and a half or four, doesn't that mean that the \$8.3 billion is higher?

Mr. COSGROVE. If plans improve more than the actuaries expected, yes, absolutely. The payments would be higher.

Chairman ISSA. Okay. In your reviewing this, how much of this \$8.3 billion was scored for actual improvement versus, if you will, the static amount paid out based on their current performance over the next three years?

Mr. COSGROVE. I don't think I have it broken down year by year. But the first two years, where the bulk of the payments are made, are not for improvement, but they are for past performance.

Chairman ISSA. So the majority of it will be paid for no performance of the remaining, that tail end, let's call it, 20 percent or less.

Mr. COSGROVE. Right.

Chairman ISSA. The majority of it would be paid for just being a three or above. So it would be a fraction of that 20 percent, no more than 5 or 10 percent that could possibly be available for the improvement portion?

Mr. COSGROVE. I don't know what the percentages are, but that is in the right direction.

Chairman ISSA. Okay. So again, we are paying for the static, we are paying for what you have already done. I still reach the same conclusion that in fact this is politics. Or it is wanting to cover up the sins of the Affordable Care Act.

I thank the gentleman for yielding, I will now recognize myself for my final second round. I don't want to go beyond that.

Mr. Blum, you have talked a lot about improvement, improvement. And you have talked about the 10 years. The 10 years you are talking about of getting to 100 percent.

Let me ask you a question. I know you are not a scientist, I know you are not a statistician, I know you are not a doctor. But having been a business man, what is it that would take an insurance company and their working with doctors who presumably in many cases are working with conventional Medicare payments and so on, what takes 10 years? Why in the world wouldn't you have a target of getting to it in three years, if you know?

Mr. BLUM. I believe that we should have a goal to pay as low as possible price to our health plans as possible.

Chairman ISSA. No, no, that is not the question. Right now you are looking for performance change where Medicare Advantage under ACA is going to get to getting no premium. That is what many of us who voted against the Affordable Care Act really latched onto, the whole idea that you are not going to pay any more for these private ones. And that was in ACA. In other words, you scored, you were going to get down to flat payments.

So one of my questions is, you keep talking about 10 years. But the first three years you are effectively un-ringing the bell, you are undoing the cuts that were in the Affordable Care Act through this demonstration project. Isn't that essentially for 90 percent, maybe Mr. Cosgrove can be analytical in this, this funding, this demonstration project essentially undoes for this coming year most of the cuts that would have occurred under the Affordable Care Act. Isn't that true? Seventy percent of them.

Mr. COSGROVE. That is absolutely correct, yes.

Chairman ISSA. Okay. So the very first year we have a chance to get savings, something that people did know about since 2010,

we are undoing it and all 28 companies who commented favorably were recipients of essentially a bailout against ACA, probably because it wasn't realistic.

Now, Mr. Blum, the Affordable Care Act, passed by your party and your party alone, mandated certain things, although it gave authority for certain things to be done, and you believe you are asserting the authority. If you wanted to throw out something that President Obama, your boss, and Secretary Sebelius, put into the Affordable Care Act, if you wanted to change it, why didn't you come back to Congress? In other words, if you wanted to go off of the plan you actually wanted, this new one, why wouldn't you come to Congress for it?

Mr. BLUM. I think there is a long history within the Medicare program to test and to pilot through demonstrations——

Chairman ISSA. No, no, look. We are long past the facade that this is a demonstration program. You are flat changing what ACA said and you are changing it by billions and billions of dollars in an election year. Why didn't you consider coming back to Congress, or did you consider coming back to Congress and basically asking for the authority to change ACA to this \$8.3 billion election year bailout?

Mr. BLUM. Our goals, again, was to figure out ways to demonstrate to ourselves, to the Congress, how to create this rapid improvement. I think part of the reason the Congress gave——

Chairman ISSA. Oh, please, stop. You have just heard the non-partisan part of this group say you are not paying for improvement, that the vast majority of this \$8.3 billion is for non-improvement. As a matter of fact, it is for periods of time in which no improvement is possible.

One of the amazing things, and I will close, one of the amazing things is you can come with your prepared statement and you can say that which is not true. Now, an honest way to come to the Congress is, look, we screwed up. We would destroy Medicare Advantage if we didn't bail it out. So we came up with a scheme to bail it out. That is what you did. You came up with an \$8.3 billion scheme, and particularly about \$4 billion of it for this year, to keep Medicare Advantage from imploding. You probably had many of these companies come to you and say what the catastrophic effects of legislation passed in haste on a partisan basis would do.

So instead of honestly saying, look, we need to backfill it the way Republicans and Democrats have backfilled estimates that didn't turn out to be right, what this imperial Administration is doing is simply saying, we will ignore what the 402 provision is, we will simply say it means what we think it means and you can't stop us. We will take money, steal it effectively from future payments, steal it from seniors both in and out of Medicare Advantage, so that you can have a good year this year.

That is what you have done. I am really distraught that Congress probably doesn't have the authority or the ability to stop you from raiding the Medicare trust fund.

But seniors need to understand: the \$8.3 billion you are taking, because ACA was screwed up, because Obamacare was screwed up when it came to what it was going to do to Medicare Advantage, the \$8.3 billion you are taking is going to be paid by seniors both

in and out of Medicare Advantage. The 75 percent of seniors that aren't in Medicare Advantage are going to have to pay for it in the years to come.

You are going to do that, and at least you could be honest and tell the truth here. I don't want to shoot the messenger, but quite frankly, you came with a message that the non-partisan witnesses here say simply isn't true, not even in Washington.

With that, I would like to thank you for your testimony. We stand adjourned.

[Whereupon, at 11:50 a.m., the committee was adjourned.]

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Chairman Darrell Issa Hearing Preview Statement “GAO Report: The Obama Administration’s \$8 Billion Extralegal Healthcare Spending Project” July 25, 2012

Obamacare was rushed through the House of Representatives and Senate by the Democratic majority in each chamber. Many conceded they did not even read its entire contents, choosing instead to learn about the bill’s consequences after the fact. One of those consequences is major cuts in the popular Medicare Advantage program serving seniors. These cuts mean many seniors will lose coverage that they enjoyed prior to the law’s enactment.

Acknowledging the politically unpleasant nature of these cuts, and acting in the wake of the 2010 mid-term elections, the Obama Administration announced plans for an unprecedented demonstration project to restore most of the law’s cuts for the period immediately before the 2012 election. The Administration appears to have been worried that seniors would revolt against the law’s cuts to Medicare Advantage.

It now appears the Obama Administration enacted this demonstration without adequate legal authority or proper construction of a true demonstration project. The project will not produce useable data and was implemented on a massive scale—larger than all other pilot programs combined. This can be seen as nothing more than a wholesale remake of Medicare Advantage by fiat, not legislative instruction. The government’s own non-partisan watchdog—the Government Accountability Office—has pointed out these flaws and called for its immediate cancellation.

The public has a right to know: was this demonstration in fact designed to offset Obamacare’s massive cuts to Medicare Advantage ahead of an election, and was the Administration playing politics with seniors healthcare. Today’s hearing will shed light on these issues and begin the process of holding accountable to the public those unelected decision-makers who took these actions.

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Written Statement of Professor Jeffrey S. Lubbers
Professor of Practice in Administrative Law
Washington College of Law
American University

House Committee on Oversight and Government Reform
Hearing
“GAO Report: The Obama Administration’s \$8 Billion Extralegal Healthcare Spending
Project”

July 25, 2012

Mr. Chairman and Members of the Committee:

I am Professor of Practice Administrative Law at American University’s Washington College of Law, and have been working in the field of Administrative Law for many years. The opinion that follows is my own, and does not necessarily represent the views of my Law School or of any of my other affiliations.

Your staff has asked me for my opinion as to the legality of the Centers for Medicare & Medicaid Services (CMS) plan to conduct a nationwide demonstration from 2012 through 2014, known as the Medicare Advantage (MA) Quality Bonus Payment Demonstration, designed to test an alternative method for calculating and awarding bonuses under the MA program. During those years, this would substitute for the changes made by the 2010 Patient Protection and Affordable Care Act as amended (PPACA) to the MA program. The PPACA would modify the MA program by reducing spending on the program through a series of adjustments to the payments to approved MA plans. The payments would be reduced overall, but higher ranked plans would receive bonuses based on their high rankings. The announced Demonstration Program would, only from 2012 to 2014, modify the modifications by, among other things, allowing bonuses to slightly lower ranked plans.

A March 21, 2012 GAO report, available at <http://gao.gov/products/GAO-12-409R>, criticized this Demonstration Program as more costly than the PPACA provisions and raised question about the Program’s efficacy in meeting CMS’s stated research goal. In its response, CMS disagreed with the GAO’s conclusions on both counts. On July 11, 2012, GAO’s General Counsel then wrote to the HHS Secretary stating that it was “concerned about the agency’s legal authority to undertake the demonstration.” See <http://gao.gov/assets/600/592303.pdf>.

I will not opine on the wisdom of the Demonstration Program as compared to the PPACA provisions. I will suggest, however, that the law gives HHS very broad authority to conduct demonstration programs in this area and, in my view, the Proposed MA Quality Bonus Payment Demonstration fits comfortably within that authority.

This conclusion is based on the language and the legislative history of section 402(a)(1)(A) of the Social Security Amendments of 1967 as amended, codified at 42 U.S.C. § 1395b-1(a)(1)(A), which authorizes the Secretary to develop and engage in experiments and demonstration projects

to determine whether, and if so which, changes in methods of payment or reimbursement . . . for health care and services under health programs established by [the Social Security Act] . . . would have the effect of increasing the efficiency and economy of health services under such programs through the creation of additional incentives to these ends without adversely affecting the quality of such services.

The legislative history for this provision appears to be even more permissive: “The Secretary of [HHS] is authorized to experiment with various methods of reimbursement to organizations, institutions, and physicians, on a voluntary basis, participating under medicare, medicaid, and the child health programs which offer incentives for keeping costs of the program down while maintaining quality of care.”¹

Despite this obviously broad authority, GAO argues that HHS is constrained by the need to show, *in advance*, that the Demonstration Program could lead to findings that could “increase the efficiency and economy of health services without reducing quality.” HHS, in its reply, suggested that the Program’s extension of bonus payments to medium-ranked MA plans is based on the premise that “improved quality results in improved health outcomes, and thus in savings over time.” (HHS response, at page 36 of March 21 GAO report.) GAO also points to what it considers some other inherent flaws in the HHS’s data-gathering plans.

I don’t know who is right about this. Perhaps some of GAO’s arguments should give CMS pause. However, to me, this amounts to a methodological disagreement, not a legal one. To use an analogy, if an agency has the statutory authority to conduct a survey on an issue within its jurisdiction and GAO opines that the survey is not well designed and any results would not likely be very helpful to the agency’s eventual policymaking, that would hardly, in and of itself, be a comment on the *legality* of the survey.

Indeed, the Sixth Circuit has broadly construed the Secretary’s authority to undertake demonstration programs under § 1395b-1(a)(1)(A), in *American Academy of Ophthalmology, Inc. v. Sullivan*, 998 F.2d 377 (6th Cir. 1993). GAO attempts to distinguish this case as involving the use of section 402’s waiver authority rather than the broader demonstration program provision. But I think that distinction cuts the other way. The court explicitly referenced the broader provision, and it upheld the Secretary’s action even though the program included a waiver of the payment methodology otherwise applicable to cataract surgeries. This type of narrowly targeted demonstration project seems to provide the Secretary the sort of discretion that could disadvantage certain types of practitioners, yet the waiver provision in section 1395b-1(b) was added in 1972, according to the court, “to expand the Secretary’s waiver authority to the current text in order to permit a wider variety of demonstration projects to test alternative payment schemes.” *Id.* at 384.²

¹ As cited in the GAO’s July 11 letter at 3, n.7.

² Indeed it is not surprising that GAO could find no cases challenging the broader programmatic type of demonstration program envisioned under 1395b-1(a)(1)(A) because, unlike in the *American Academy of Ophthalmology* case involving a waiver covering a particular medical procedure, it would be almost impossible for anyone to have standing to challenge a broad demonstration program.

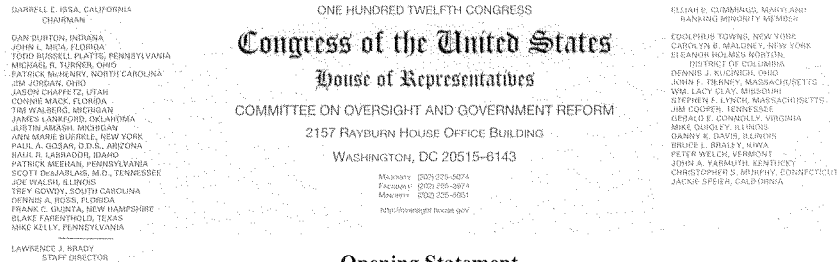
In the end, the Sixth Circuit upheld the challenged demonstration program, first finding the statute clearly gave the agency the authority, and second, using the familiar *Chevron* deference test:

Even if the Court agreed with the plaintiffs that there was some ambiguity in the statute or that the statute was silent on the issue, the Court does not simply impose its own construction on the statute as would be necessary in the absence of an administrative interpretation. Under these circumstances, where the agency's construction is reasonable, the Court must defer to that construction even if it may not be the only or even most reasonable one.

The court also noted that the waiver program was optional for both practitioners and beneficiaries—just as the (MA) Quality Bonus Payment Demonstration is optional for MA plans.

In short, GAO's misgivings notwithstanding, I have no trouble finding the Demonstration Plan to be amply within the authority given to CMS by Congress.

Thank you for the opportunity to provide my views on this important issue.



Opening Statement
Rep. Elijah E. Cummings, Ranking Member

**Hearing on "GAO Report: The Obama Administration's
 \$8 Billion Extralegal Healthcare Spending Project"**

July 25, 2012

I would like to thank the witnesses for coming here today to testify before the Committee. This is an important topic, and I am grateful for the opportunity to hear your views.

I think we can all agree that we need to continue reforming our healthcare system so that we pay for value rather than volume, and encourage prevention as well as treatment.

The Affordable Care Act works towards these goals in a number of ways. For example, it provides seniors with free preventive care, including wellness visits and cholesterol checks. Last year, more than 32 million seniors used at least one preventive service under Medicare without paying deductibles or co-pays. This saves lives and lowers costs to the program.

The Affordable Care Act also makes reforms to the Medicare payment system to align payments with better performance and outcomes. One innovation is the quality bonus payment program that provides incentives for Medicare Advantage plans to improve the quality of care by establishing bonus payments to plans that achieve certain quality standards.

The Center for Medicare and Medicaid Services (CMS) initiated a demonstration program to test an alternative method for these bonus payments in order to examine ways to generate quicker and more significant quality improvements in the plans.

The Government Accountability Office (GAO) has raised a number of concerns about this demonstration program. GAO disagrees with how CMS structured the program, and it has methodological concerns about the way CMS will measure the results.

CMS responded that it believes the program will incentivize plans to improve the quality of care and increase efficiency. CMS also believes GAO's methodological concerns can be addressed.

As this back and forth demonstrates, there is no scandal here. This is a legitimate and substantive disagreement about how best to structure bonuses to incentivize quality care and how to design a demonstration program to achieve its intended results in an effective manner.

In our efforts to research this issue, we contacted a legal expert, Professor Jeffrey Lubbers, a Professor of Administrative Law at American University. I request unanimous consent to enter his statement into the record.

Professor Lubbers reviewed GAO's concerns, as well as the legislative history and case law relating to the Secretary's authority. He concluded that the disagreement between GAO and CMS "amounts to a methodological disagreement, not a legal one." He found that "the law gives HHS very broad authority to conduct demonstration programs in this area and, in my view, the Proposed MA Quality Bonus Payment Demonstration fits comfortably within that authority."

In my opinion, today's hearing title is misleading. It suggests that GAO has accused the Secretary of Health and Human Services of doing something illegal. In fact, GAO questioned the authority for HHS to conduct this program based on GAO's underlying policy and methodology concerns about the program's design.

This type of rhetoric affects the tone and tenor of this hearing and makes it more difficult to engage in a reasoned debate focused on the merits or flaws of the demonstration program.

We can do better than that. Let's focus on the substantive discussion. Let's discuss GAO's concerns with the program and CMS' responses to those concerns. This is the hearing I hope we will have today.

Thank you.

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

**MEDICARE WAIVER
DEMONSTRATION
APPLICATION**



DISCLOSURE STATEMENT: According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0880. The time required to complete this information collection is estimated to average 80 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, Attn: Reports Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

Form CMS-10059 (08/06)

MEDICARE WAIVER DEMONSTRATION APPLICANT DATA SHEET

Applicant Legal Name		Date Submitted	
Address		Date Received by CMS	
City	County	State	ZIP Code

Name, telephone number and address of person to be contacted on matters involving the application.

Descriptive Title of Applicant's Project	Project Duration (mm/dd/yyyy)
	From _____ To _____

Proposed Project

Type of Applicant

- ☐ Academic Institution ☐ Individual ☐ Profit Organization
☐ Not for Profit Organization ☐ Other, please specify _____

Areas Affected by Project (cities, counties, states)

Applicant's Medicare Provider Number(s)	Applicant's Employer Identification Number
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Is The Applicant a Medicare Provider/Organization in Good Standing?

- ☐ Yes ☐ No If "No," attach an explanation

To the best of my knowledge and belief, all data in this application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the terms and conditions of the award and applicable Federal requirements if awarded.

Type Name and Title of Authorized Representative	Telephone Number (include area code)
Signature of Authorized Representative	Date Signed (mm/dd/yyyy)

MEDICARE WAIVER DEMONSTRATION APPLICATION

This application provides an opportunity for eligible organizations to apply to participate in Medicare-waiver-only demonstrations sponsored by the Centers for Medicare & Medicaid Services (CMS).

CMS conducts Medicare-waiver-only demonstrations to test innovations that have been shown to be successful in improving access and quality and/or lowering health care costs. These demonstrations may involve new benefits, fee-for-service or Medicare Advantage payment methodologies, and/or risk sharing arrangements that are not currently permitted under Medicare statute.

Section 402 of Public Law 92-603 grants CMS the authority to waive Medicare payment and benefit statutes to conduct these demonstrations. Demonstrations may also be initiated as a result of Congressional mandate.

BUDGET NEUTRALITY

Medicare-waiver-only demonstrations must be budget neutral. Budget neutrality means that the expected costs under the demonstration cannot be more than the expected costs were the demonstration not to occur. Applicants must supply information and assumptions supporting budget neutrality that CMS will use in preparing a waiver package for submission to the President's Office of Management and Budget (OMB). OMB must approve Medicare waivers before implementing the demonstration.

DUE DATE

Applications will be considered timely if we receive on or before the due date specified in the "DATES" section of the demonstration solicitation. Applications must be received by 5 P.M. EST/EDT on the due date.

Only applications that are considered "timely" will be reviewed and considered by the technical review panel.

APPLICATION SUBMISSION

An unbound original and 2 copies plus an electronic copy on cd-rom must be submitted. Please note that applicants may, but are not required, submit 10 copies to assure that each review panel member receives the application in the manner intended by the applicant (e.g., collated, tabulated, color copies, etc.).

The original and all copies, including the electronic copy, of the APPLICATION should be MAILED to the following address:

Department of Health and Human Services, Centers for Medicare & Medicaid Services, ATTN: (Insert project officer name listed in demonstration solicitation and name of demonstration), Medicare Demonstrations Program Group, Office of Research, Development & Information, Mail Stop C4-17-27, 7500 Security Boulevard, Baltimore, Maryland, 21244.

Applications must be typed for clarity in 12 point font and 1 inch margins and should not exceed 40 double-spaced pages, exclusive of the cover letter, executive summary, forms, and supporting documentation.

Because of staffing and resource limitations, and because we require an application containing an original signature, we cannot accept applications by facsimile (FAX) transmission.

FOR FURTHER INFORMATION

Please contact the project officer listed in the demonstration solicitation and/or visit the CMS website at www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp#TopOfPage. Additional information about the demonstration, for example, fact sheets, design reports, solicitations, application materials, press releases, and question and answer documents will be periodically posted on the website. Be sure to check the website frequently if applying for a demonstration to be sure you have the most current information available.

MEDICARE WAIVER DEMONSTRATION APPLICATION

APPLICATION CONTENTS OUTLINE

To facilitate the review process, applications should be arranged in the following order:

1. Cover Letter
2. Medicare Waiver Demonstration Applicant Data Sheet
3. Executive Summary
4. Problem Statement
5. Demonstration Design
6. Organizational Structure & Capabilities
7. Performance Results
8. Payment Methodology & Budget Neutrality
9. Demonstration Implementation Plan
10. Supplemental Materials

CMS may provide start-up funds to cover implementation costs associated with the demonstration. If start-up funding is available, it will be announced in the demonstration solicitation. If requesting start-up funds, please include the Application for Federal Assistance Standard Forms 424 after the Medicare Waiver Demonstration Applicant Data Sheet in the application and indicate the amount of funds requested in the cover letter. The Application for Federal Assistance Standard Forms 424 can be found at http://www.grants.gov/agencies/approved_standard_forms.jsp

APPLICATION REQUIREMENTS

We will use all the information you submit in the application review process. For specific details regarding the demonstration for which you are applying, please refer to the solicitation. Your application must include the following information.

Cover Letter: Please be sure to identify the demonstration, indicate the target population and geographic location of the demonstration (for example, urban or rural), the CMS provider numbers assigned to the applicant, contact person, and contact information.

Medicare Waiver Demonstration Applicant Data Sheet: Complete, sign, date, and return the Medicare Waiver Demonstration Applicant Data Sheet found at the beginning of this application.

Executive Summary: Provide a 4 page summary of the key elements of the proposal (for example, Sections 4, 5, 6, 7, 8, 9 under "Application Contents Outline").

Problem Statement: Describe Medicare's current coverage and payment policy, and describe how or why changes to current policy would lead to reductions in Medicare expenditures or improvements in Medicare beneficiaries' access to and/or quality of care. Provide local examples. Describe the policy rationale for the proposal, who will benefit and why, and any previous experience with the proposed intervention.

Demonstration Design: Describe the intervention including the scope of services covered and/or benefit design, and payment methodology including financial incentives and/or risk sharing arrangements. Indicate how eligible beneficiaries will be identified, targeted, and enrolled in the demonstration (if applicable).

If applicable, describe the study design. Identify the intervention and comparison groups, and how Medicare beneficiaries will be assigned to each group.

Describe the process for notifying beneficiaries about participation in the demonstration and provide copies of informed consent, and beneficiary notification and communication materials to be used.

MEDICARE WAIVER DEMONSTRATION APPLICATION

Organizational Structure & Capabilities: Describe your governance structure, and management and clinical teams, and their prior success in implementing the proposed/similar intervention. Provide an organizational chart that describes the functional and reporting lines of major departments and/or entities.

Demonstrate that infrastructure exists to implement and carry out the demonstration project. Provide copies of reports from clinical, financial, and management information systems and describe how they will be used to support implementation.

Provide copies of applicable Federal and State licenses. Indicate if the applicant is a Medicare provider in good standing. Describe any other applicable accreditation, credentialing, and/or certification processes and results.

Provide documentation of your organization's financial viability that will enable it to participate actively and successfully in the demonstration; for example, a formal audit opinion from the past 3 years or the balance sheet from the past 3 years with a summary description. If there are any financial concerns, explain how your organization has resolved or will address these problems.

Performance Results: Describe your systems and processes for monitoring clinical, financial, and operational performance. Identify key metrics collected, provide quantitative performance results, and describe how you use this information to continuously improve quality, access and efficiency; correct deficiencies; and satisfy beneficiaries, providers, and/or payers.

Payment Methodology & Budget Neutrality: Please indicate the proposed payment amount and method. Proposed payments may be based on Medicare fee-for-service or Medicare Advantage rates, methodologies, or some combination, and may involve risk sharing.

Describe in detail any risk sharing arrangements. Provide a revenue and expense statement by year for the life of the demonstration.

Demonstrate that the proposed intervention is budget neutral. Provide expected, best, and worse case scenarios. Include all supporting cost effectiveness, evidence, and assumptions used for the calculations.

Demonstration Implementation Plan: Describe your implementation strategy, including tasks, resources, and timeline to implement the demonstration. Identify internal system and process modifications required to implement the demonstration. Describe your recruitment strategy and contingency plans for achieving beneficiary participation thresholds. Identify the individuals and staff responsible for implementing the demonstration and attach biographies.

Supplemental Materials: Include in this section copies of supporting materials requested or referenced throughout the application.

EVALUATION PROCESS

We will convene technical review panels that may include outside experts, in addition to our staff to review all of the applications. Panelists will receive a copy of the application along with a technical summary. Panelists will be asked to numerically rate and rank the application using evaluation criteria contained in the demonstration solicitation.

Applicants should review the demonstration solicitation for the specific evaluation criteria to be used by panelists to assess proposals, as well as additional information on the evaluation process and selection of awardees.

Statement of Congressman Gerald E. Connolly (VA-11)
Committee on Oversight and Government Reform
GAO Report: The Obama Administration's \$8 Billion Extralegal Healthcare Spending Project

July 25, 2012

The Republican narrative for today's hearing is overtly political, substantively superficial, and ultimately counterproductive in advancing a goal that Democratic and Republican Members should wholeheartedly support: lowering our Nation's healthcare costs, while enhancing healthcare delivery for the American people.

In deciding to continue the unfortunate practice of employing an inflammatory hearing title better suited for a conspiracy theory than a serious oversight proceeding, the majority has once again squandered an opportunity to work in a bipartisan, productive fashion. Worse, in placing rhetoric over facts, and political narrative over analysis, Republicans distract this Committee and the public from focusing on the truly important issue at hand—carefully examining the findings of the Government Accountability Office's (GAO) review of the Medicare Advantage Quality Bonus Payment Demonstration Program to determine the best path forward.

Although one would never know it from the Chairman's hyperbolic accusations of 'extralegal' actions to implement a 'wholesale remake of Medicare Advantage by fiat,' GAO has actually provided the Committee with a thoughtful, well-reasoned analysis of the most effective and efficient bonus payment system for Medicare Advantage, decisively finding that the Medicare Advantage quality bonus payment system established by the Patient Protection and Affordable Care Act is superior to the demonstration program developed by the Department of Health and Human Services' Centers for Medicare and Medicaid Service – at least in regard to achieving cost-savings and enhancing efficiency.

This point is worth repeating, unlike my colleagues on the other side of the aisle, rather than advocating ending the demonstration program and repealing the Affordable Care Act; GAO has explicitly recommended that the Centers for Medicare and Medicaid Services cancel the demonstration to allow the original requirements of the Affordable Care Act to take effect. Given the gusto with which my Republican colleagues have flaunted the GAO's findings, I can only assume they share the belief that the Affordable Care Act's Medicare Advantage provisions should go forward. I feel comfortable speaking for all my Democratic colleagues in expressing my pleasure that Republicans have finally embraced the Affordable Care Act with such passion that they are incensed by the Executive Branch's failure to implement the Act precisely as written.

I look forward to examining the lessons CMS has learned from its early efforts with the demonstration program and GAO's subsequent review, and working with CMS to ensure GAO's recommendation is either implemented, or the demonstration is sufficiently modified, to address their concerns and ensure the Affordable Care Act is effectively implemented.