

Geriatrics Review Syllabus (GRS)

FINANCING, COVERAGE AND THE COSTS OF HEALTH CARE Richard G.

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KEY POINTS

- Medicare comprises 4 benefits: Medicare Parts A, B, C, and D.
 - Medicare Part A covers hospital, skilled nursing-home, home-health, and hospice services.
 - Medicare Part B covers physicians, nurse practitioners, social workers, psychologists, therapists, laboratory tests, and durable medical equipment.
 - Medicare Part C provides the benefits offered under Medicare Parts A and B through Medicare Advantage (MA) plans, which are managed care plans. Most MA plans also offer Medicare Part D benefits.
 - Medicare Part D covers some of the cost of prescription medications.
- Medigap supplemental insurance plans are available that cover Medicare Part A and Part B deductibles and co-insurance costs, as well as preventive care and other health-related goods and services.
- Medicaid is a joint federal and state program that provides health insurance (including long-term custodial care in nursing homes) to people of all ages who have low incomes and limited savings.

MAJOR DELIVERY AND PAYMENT INITIATIVES

With the enactment of the 2010 Patient Protection and Affordable Care Act (the ACA), new delivery models are continually being tested and implemented to improve quality and lower costs for older Americans. In particular, coordinated care models such as accountable care organizations (ACOs) and the patient-centered medical home (PCMH), as well as bundled payment arrangements, have grown out of the need to improve health outcomes for older Americans while decreasing costs.

The ACA established the Center for Medicare & Medicaid Innovation (CMI), charged with reducing costs in Medicare, Medicaid, and the Children's Health Insurance Program while preserving or enhancing quality of care. CMI has been tasked with developing, testing, and supporting new delivery models to increase coordination of care and improve quality, along with new payment systems to encourage more value-based care and move away from fee-for-service payment.

Accountable Care Organizations (ACOs)

ACOs are groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high-quality care to patients. The goal of coordinated care is to ensure that Medicare beneficiaries, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors. When an ACO succeeds in both delivering high-quality care and spending health care dollars more wisely, it will

share in the savings it achieves for the Medicare program. Currently, Medicare offers several ACO programs:

- [Medicare Shared Savings Program](#)—a program that helps Medicare fee-for-service program providers become an ACO
- [Advance Payment ACO Model](#)—a supplementary incentive program for selected participants in the Shared Savings Program
- [Pioneer ACO Model](#)—a program designed for early adopters of coordinated care

Bundled Payments for Care Improvement

Historically, Medicare has made separate payments to providers for each service they perform for beneficiaries during a single illness or course of treatment. This approach, commonly referred to as fee-for-service (FFS), results in fragmented care with minimal coordination across providers and health care settings. Rather than incentivizing quality, the FFS system rewards the quantity of services offered. Bundled payments have been shown to align incentives for providers (hospitals, postacute care providers, physicians, and other practitioners). This system of reimbursement allows providers to work closely together across all specialties and settings. As a result, in the beginning of 2013, to provide higher quality and more coordinated care at a lower cost to Medicare, the Centers for Medicare & Medicaid Services (CMS) introduced the Bundled Payments for Care Improvement initiative. The initiative includes 4 innovative new payment models focused on financial and performance accountability for episodes of care (see [Table 1](#)):

- Model 1 focuses on the acute care inpatient hospitalization. Awardees agree to provide a standard discount to Medicare from the usual Part A hospital inpatient payments.
- Models 2 and 3 involve a retrospective bundled payment arrangement in which actual expenditures are reconciled against a target price for an episode of care.
- Model 4 involves a prospective bundled payment arrangement, in which a lump sum payment is made to a provider for the entire episode of care (<http://innovation.cms.gov/initiatives/Bundled-Payments>).

Table 1—Bundled Payment Models

	Model 1	Model 2	Model 3	Model 4
Episode of care	All acute patients, all DRGs	Selected DRGs, hospital plus postacute period	Selected DRGs, postacute period only	Selected DRGs, hospital plus readmissions
Services included in the bundle	All Part A services paid as part of the MS-DRG payment	All nonhospice Part A and B services during the initial inpatient stay, postacute period, and readmissions	All nonhospice Part A and B services during the postacute period and readmissions	All nonhospice Part A and B services (including the hospital and physician) during initial inpatient stay and readmissions
Payment	Retrospective	Retrospective	Retrospective	Prospective

SOURCE: www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-01-30-2.html (accessed Sept 2015)

Other ACA Changes

- Partial closure of the coverage gap in the Medicare Part D prescription drug benefit, which began in 2011, with 50% of the cost of branded pharmaceuticals covered during the coverage gap
- Extended coverage for preventive care services, as well as elimination of the co-payment requirements for some services
- Expansion of Medicaid (beginning in 2014), in which many more Medicare beneficiaries have been qualified as dually eligible, eliminating much of their out-of-pocket expenditures
- Changes in provider reimbursement, including decreases for Medicare Advantage Plans and increases in reimbursement to primary care physicians through Medicare and Medicaid

Appreciation of these changes starts with an examination of the beginning of the current health care system for older adults. This foundation began in 1965, the year that the U.S. government passed legislation designed to improve access to acute health care for old, disabled, or poor people. During the decades that followed, the resulting Medicare and Medicaid programs expanded, evolved, and spawned thousands of supplemental commercial insurance plans. Today, a complex and often confusing array of personal payments, public programs, and private insurance plans (see [Figure 1](#)) pays for, and thereby determines, much of the health care that older Americans receive.

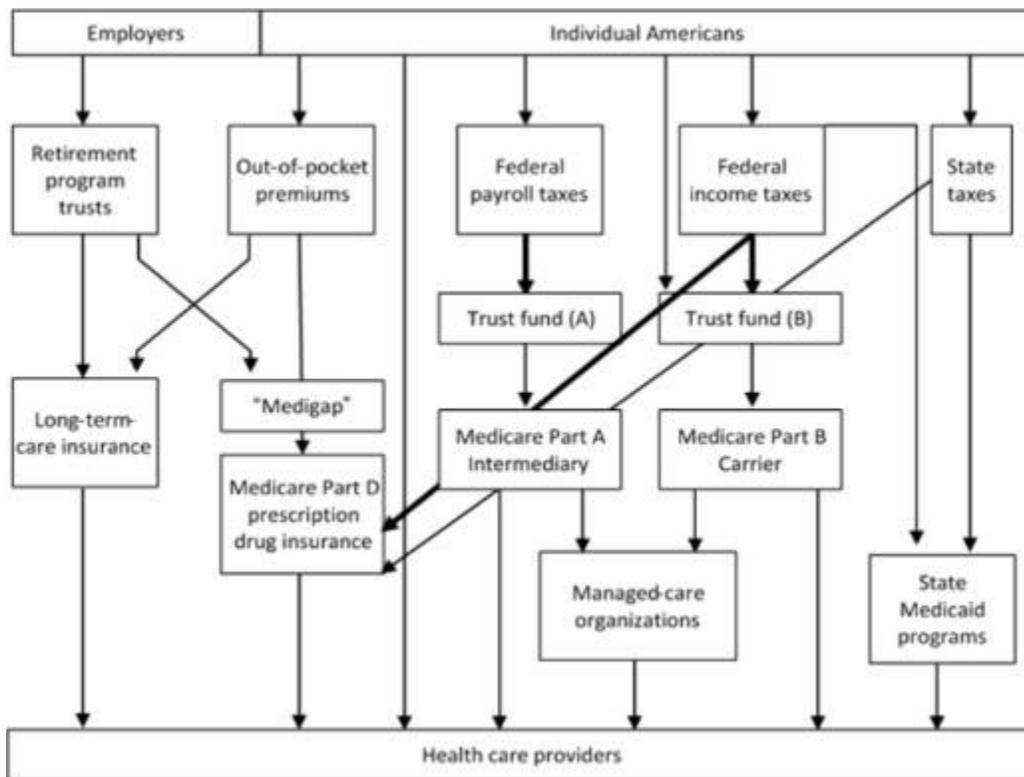
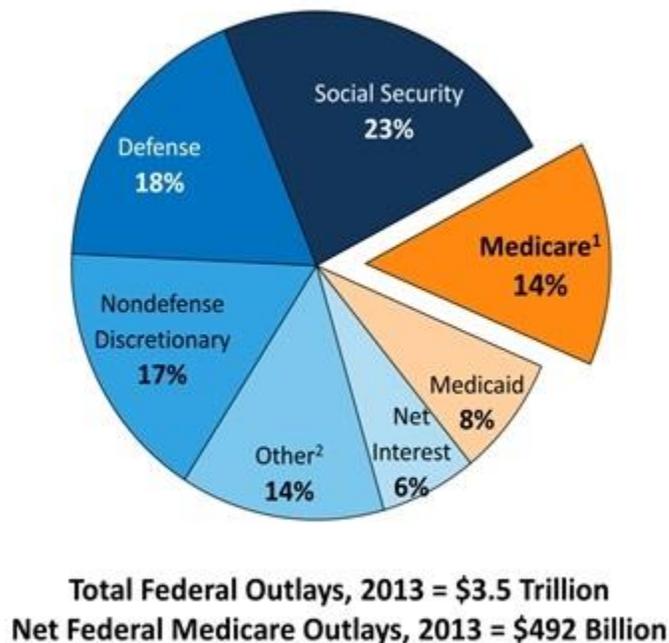


Figure 1—The Flow of Funds for the Health Care of Older Americans

MEDICARE

Medicare is a federal insurance program run by CMS, which pays health professionals and organizations to provide primarily acute health care for Americans who are ≥65 years old, disabled, or suffering from end-stage renal disease. As originally enacted, Medicare comprises two separate FFS plans (Part A and Part B), each of which pays predetermined amounts for specified health-related goods and services that are needed by its beneficiaries. More than 47 million Americans are covered by both plans, which is 15% of the total U.S. population. The net federal Medicare outlays in 2013 were \$492 billion, which represented 14% of the federal budget (Figure 2). Concerns are centered around the large outlay of dollars by the federal government, because this is expected to reach \$858 billion in 2024 (Figure 3).

Medicare as a Share of the Federal Budget, 2013



NOTE: All amounts are for federal fiscal year 2013. ¹Consists of Medicare spending minus income from premiums and other offsetting receipts. ²Other category includes spending on other mandatory outlays minus income from offsetting receipts.
 SOURCE: Congressional Budget Office, Updated Budget Projections: 2014 to 2024 (April 2014).

Figure 2—Medicare as a Share of the Federal Budget, 2013

Reference: <http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/> (accessed Jan 2016)

Net Medicare Spending, 2010-2024

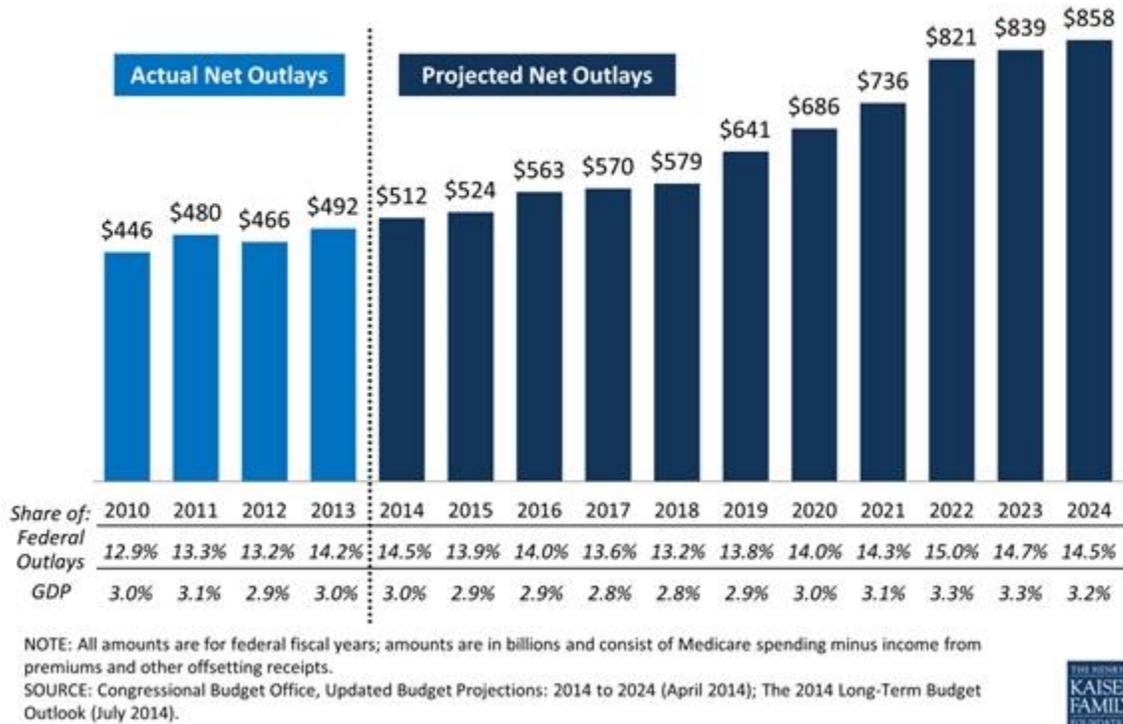


Figure 3—Net Medicare Spending, 2010–2014

Reference: <http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/> (accessed Jan 2016)

Parts A and B

The Medicare FFS program, the nation’s largest health insurance plan, is administered by private organizations under contract to CMS. Called Medicare Administrative Contractors, they enroll providers, educate them about coverage and appropriate billing, answer beneficiary and provider inquiries, and detect fraud and abuse. However, the primary task is prompt and accurate payment of the 4.4 million claims submitted daily for Medicare-covered services, costing more than \$1 billion per day.

Older Americans (and their spouses) who have had Medicare taxes deducted from their paychecks for at least 10 years are entitled to coverage through Part A without paying premiums. Others may be able to purchase Part A coverage (for up to \$411/month in 2016, depending on how long they had Medicare taxes deducted from their paychecks).

Medicare Part B uses other regional insurance companies (“carriers”) to pay physicians, nurse practitioners, social workers, psychologists, rehabilitation therapists, home-care agencies, ambulances, outpatient facilities, laboratory and imaging facilities, and suppliers of durable medical equipment for the Medicare-covered goods and services they provide.

At age 65, older adults become eligible for Part B coverage if they are entitled to Part A coverage or if they are citizens or permanent residents of the United States. To obtain this coverage, eligible

older adults must enroll in Part B and pay premiums, usually by agreeing to have these amounts deducted from their monthly Social Security checks.

Physicians must choose among three options for participating in the FFS Medicare program: participation, nonparticipation, and private contracting. For each Medicare-covered service provided, a participating physician submits a claim to the Part B carrier, accepts Medicare's fee for the service (80% of its preestablished "allowed" amount), and bills the patient or the patient's secondary insurer for no more than a 20% co-insurance payment. Physicians electing nonparticipation status can bill patients directly for up to 15% more than 95% of Medicare's allowed amounts. The patients pay the physicians and then submit their requests to Medicare for partial reimbursement (ie, for 80% of 95% of the allowed amounts). For services not covered by Medicare, the physician may bill the patient, if the patient agrees in advance in writing.

A small minority (<1%) of physicians choose to "opt out" of Medicare altogether and enter into "private contracts" (also known as "concierge practice") with their older patients. Such opt-out decisions apply to all their patients; they may not be made on a case-by-case or patient-by-patient basis. Under private contracts, Medicare carriers (and Medigap insurance plans) pay nothing, and patients pay physicians the full amount of the fees specified by the contracts. Private contracts must meet specific requirements:

- The physician must sign and file an affidavit agreeing to forego receiving any payment from Medicare for items or services provided to any Medicare beneficiary for the following 2-year period.
- Medicare does not pay for the services provided or contracted for.
- The contract must be in writing and must be signed by the beneficiary before any item or service is provided.
- The contract cannot be entered into at a time when the beneficiary is facing an emergency or an urgent health situation.

In addition, the contract must state unambiguously that by signing the private contract, the beneficiary:

- Gives up all Medicare payment for services furnished by the "opt-out" physician.
- Agrees not to bill Medicare or ask the physician to bill Medicare.
- Is liable for all of the physician's charges, without any Medicare balance billing limits.
- Acknowledges that Medigap or any other supplemental insurance will not pay toward the services.
- Acknowledges that he or she has the right to receive services from physicians for whom Medicare coverage and payment would be available.

To opt out, a physician must file an affidavit that meets the above criteria and is received by the carrier at least 30 days before the first day of the next calendar quarter. There is a 90-day period after the effective date of the first opt-out affidavit, during which physicians may revoke the opt out and return to Medicare. Once physicians have opted out of Medicare, however, they cannot submit claims to Medicare for any of their patients for a 2-year period. Physicians who opt out of Medicare still have their Medicare Part D medications covered through that program. It is the office visit and related charges for services provided directly by that physician that are not covered by Medicare.

Neither Part A nor Part B of the Medicare program covers routine dental or foot care, hearing aids, eyeglasses, orthopedic shoes, cosmetic surgery, care in foreign countries, or custodial long-term care at home or in nursing homes. Part B covers some preventive services (see [Table 2](#)).

Table 2—Health Insurance Coverage for Older Americans 2015

	Fee-For-Service Medicare		Supplemental Coverage			
	Supplemental Coverage		Medicaid^a	Part D	Medigap Insurance	Medicare Advantage Insurance (Part C)
	Part A	Part B				
Covers the cost of:						
Hospitals	100% ^c	—	100% ^c	—	\$550–\$1,100	100%
Postacute care in skilled-nursing facility	100% ^d	—	—	—	—	100%
Hospice	100% ^e	—	—	—	—	—
Home care (“medically necessary”)	100%	100%	—	—	—	100%
Durable medical equipment	80% ^f	80% ^f	20%	—	20%	100%
Diagnostic laboratory tests	—	100%	—	—	—	100%
Diagnostic imaging tests	—	80%	20%	—	20%	100%
Physicians, nurse practitioners	—	80%	20%	—	20%	100%
Outpatient PT, OT, ST	—	80%	20%	—	20%	100%
Outpatient services, supplies	—	80%	20%	—	20%	100%

Emergency care	—	80%	20%	—	20%	100%
Ambulance services	—	80%	20%	—	20%	100%
Preventive services	—	^g	20%	—	20%	^{g, h}
Outpatient mental health care		50%	50%	—	50%	100%
Custodial care in nursing home	—	—	100%	—	—	—
Hearing, vision services	—	—	ⁱ	—	ⁱ	ⁱ
Outpatient medications	—	—	ⁱ	50%–95% ⁱ	ⁱ	ⁱ
Additional costs to patient:						
Deductibles	\$1,260 ^k	\$147 ^l	—	\$320	ⁱ	
Monthly premiums	—	\$105–\$335	—	\$33 ^m	ⁱ	ⁱ

NOTE: PT = physical therapy; OT = occupational therapy; ST = speech therapy

^a Under the Balanced Budget Act of 1997, state Medicaid programs were given the option whether or not to pay deductibles and co-insurance costs.

^b Some Medicare Advantage plans require members to pay deductibles and co-payments.

^c After the beneficiary or secondary insurer pays the Part A deductible plus \$315 per day for days 61–90 of each benefit period

^d For the first 20 days of care in a skilled-nursing facility after a hospital stay of at least 3 days: \$144.50 per day for days 21–100 of each benefit period

^e Patient makes co-payments of \$5.00 per outpatient prescription and 5% of cost of respite care.

^f When patient is receiving Medicare-covered home care

^g 100% of allowed cost of fecal occult blood test, Pap smear interpretation, prostate-specific antigen test, blood tests for diabetes and cardiovascular disease, and influenza and pneumococcal vaccinations; 80% of allowed cost of mammograms and clinical examination of breast and pelvis (no deductible applies); after the annual Part B deductible has been paid, 80% of allowed cost of a general physical examination at age 65, glaucoma screening, sigmoidoscopy or colonoscopy or barium enema, digital rectal examination (men), measurement of bone mass, hepatitis B

vaccination, and diabetic education and equipment (coverage subject to change by health reform legislation)

^h Some Medicare Advantage plans cover additional preventive services.

ⁱ Benefits and costs vary widely among Medigap insurance plans, state Medicaid plans, prescription drug plans, and Medicare Advantage Plans.

^j Starting in 2011, the coverage gap (“doughnut hole”) will gradually be closed over the next 10 years. In 2015, anyone reaching the donut hole receives a 55% discount on brand-name formulary drugs while in the coverage gap.

^k Per benefit period (first 60 days after hospital admission)

^l Annually

^m Basic premium for 2015; premiums vary by plan. In addition, there is an additional program required for those with individual incomes >\$85,000 (joint >\$170,000), which is an additional payment on top of the standard monthly premium.

Beneficiaries pay out-of-pocket for the following (rates are for 2016):

- Monthly premiums for Part B (standard premium is \$104.90 but can be as high as \$335.70, depending on income)
- Part B annual deductible (\$166)
- Part A deductible (\$1,288 per benefit period)
- Co-insurance payments (usually 20%) for goods and services for which Medicare or other insurance pays only a portion
- The full cost of those goods and services not covered by Medicare or other insurance

Although most retirees who signed up for Medicare Part B in 2016 paid \$104.90 each month, premiums for wealthier retirees ranged from \$170.50 for individuals earning between \$85,000 and \$107,000 annually to \$389.80 monthly for single tax filers with incomes greater than \$214,000 annually.

Part C

As an alternative to traditional FFS Parts A, B, and D, Medicare beneficiaries can instead elect to enroll in a Medicare managed-care plan, an option known as Part C or Medicare Advantage (MA). MA plans, operated by private insurers, hold contracts with CMS specifying that for each Medicare beneficiary they enroll, they will provide at least the standard Medicare Part A, B, and D benefits in return for fixed monthly capitation payments. Plans operate on a risk-adjusted basis for each member based on the ICD diagnoses that are provided. As a result, plans are paid more for individuals with more diagnoses that require a higher level of care. Effective October 2015, ICD-10 diagnosis codes went into effect.

To attract enrollees, most MA plans also cover additional benefits and charge low or no premiums, deductibles, and co-payments. The average premium in 2016 was \$32.50 per month. The plans achieve cost savings by managing their enrollees’ use of services within their networks of providers, with whom they negotiate price discounts in return for patient volume. Each January, MA plans have the option of changing their premiums, benefits, and provider networks—or of discontinuing their plans altogether.

There are several types of MA plans:

- Medicare Health Maintenance Organizations (HMOs)—insurance companies that accept capitation payments from CMS and provide or purchase Medicare-covered health services
- Preferred provider organizations (PPOs)—alliances of providers that accept capitation payments and deliver Medicare-covered health services to their enrolled patients
- Provider-sponsored organizations (PSOs)—partnerships of physician groups and hospitals that accept capitation payments and deliver Medicare-covered health services to their enrolled patients
- Private FFS plans—plans that may charge beneficiaries a premium, that pay providers more liberally than the original Medicare FFS program does, and that allow physicians to charge their patients co-payments of up to 15%
- Special needs plans (SNPs)—plans designed for patients with certain chronic diseases or other special needs, such as those who have both Medicare and Medicaid or who live in certain institutions
- Medical savings accounts—accounts into which Medicare beneficiaries can make tax-deductible contributions and out of which they can withdraw funds to purchase routine health-related goods (including medications) and services (including long-term care insurance) from any Medicare provider; linked to the medical savings account is a catastrophic insurance policy that limits the individual beneficiary's out-of-pocket expenses for health care to \$6,000/year.

Between October 15 and December 7, beneficiaries covered by Medicare Part A and Part B have the option of joining any MA plan operating in their area; they cannot be denied enrollment because of any health problems except end-stage renal disease. Between January 1 and February 14, beneficiaries enrolled in an MA plan can switch to original Medicare. Enrollees must continue to pay their monthly Medicare Part B premiums to Medicare, plus any additional premium that the MA plan charges to cover additional services, and they must obtain their health care services from the plan's provider network. They have the option of leaving the plan at any time and returning to the FFS Medicare program.

The ACA was passed in 2010. By August 2014, MA premiums fell 10% and enrollment increased 38% to more than 15 million beneficiaries, with almost 30% of Medicare beneficiaries enrolled in an MA plan.

Part D

In 2003, the U.S. Congress passed and President George W. Bush signed a sweeping Medicare reform bill that included an option (Medicare Part D) for beneficiaries to purchase insurance coverage for outpatient prescription medications. The Part D option is open to all Medicare beneficiaries, whether enrolled in traditional FFS or MA. Part D benefits can be purchased as stand-alone policies or as sponsored by MA plans. For most Medicare beneficiaries, there is a dizzying array of plans from which to choose, with premiums, deductibles, co-payments, and formularies differing from plan to plan. CMS set up a Medicare Prescription Drug Plan Finder (www.medicare.gov/find-a-plan/questions/home.aspx [accessed Jan 2016]), in which enrollees can enter their location and medications to compare Part D options available to them.

Part D coverage policies create further confusion for many beneficiaries by having different levels of coverage apply to cumulative yearly prescription drug expenditures. Many plans have a relatively small deductible; the maximal allowable deductible by law in the standard 2016 Medicare Part D benefit is \$360, an increase of \$40 from the 2015 deductible. Some plans may have a lower deductible or no deductible at all.

As originally implemented, Part D provided no coverage when prescription drug costs exceeded a specified yearly amount, a policy known as the “coverage gap” or “doughnut hole.” Under the ACA, Medicare gradually began closing the doughnut hole, including giving a \$250 rebate to all Part D beneficiaries who entered the doughnut hole in 2010, providing discounts on brand-name drugs and generic drugs in the doughnut hole beginning in 2011, and phasing in additional discounts for brand-name and generic drugs to close the doughnut hole completely by 2020. In 2016, anyone reaching the donut hole (\$4,850 maximum out-of-pocket amount in 2016) receives a 95% discount on brand-name formulary drugs; after this point, the plans cover 95% of the ensuing additional drug costs. Moving forward, the coverage gap cost-sharing levels for the beneficiary will be reduced annually until 2020, when the level is then set at 25%, which is consistent with cost-sharing levels of coverage before hitting the gap.

It is important for prescribers to appreciate that the standard Medicare Part D benefit changes each year. Some aspects (eg, the initial deductible and period of time before getting to the catastrophic point) change, such that patients experience an increase in their out-of-pocket expense. This could result in adherence issues as patients are forced to pay more out of pocket at different times during the year.

Hospice

Hospice is a benefit under Medicare Part A, providing a wide range of medical coverage for patients deemed to be within 6 months of death. Medicare hospice beneficiaries can receive drug coverage under the hospice benefit or under Part D, the circumstances for which were clarified by CMS in 2013. Hospice is responsible for covering all drugs for the palliation and management of the terminal and related conditions. Drugs covered under the Medicare Part A per diem payment to a hospice program, therefore, are excluded from coverage under Part D. Part D covers prescription drugs for problems unrelated to the terminal condition.

There may be some drugs that were for treatment of the terminal illness and/or related conditions before the hospice election that will be discontinued upon hospice election, having been determined by the hospice interprofessional group, after discussions with the hospice patient and family, that those medications may no longer be effective in the intended treatment, and/or may be causing additional negative symptoms in the individual. These medications would not be covered under the Medicare hospice benefit, because they would not be reasonable and necessary for palliation of pain and/or symptom management; they would not be covered by Part D either, because of the hospice group’s determination that they are not medically necessary for palliation.

In 2014, CMS issued revised guidance stating that it expects Part D sponsors to use hospice prior authorization only on 4 categories of drugs (analgesics, antiemetics, laxatives, and antianxiety drugs) identified as nearly always covered under the hospice benefit. Careful review of medications and communication with the hospice and Medicare Part D plan is critical to assure timely access and appropriate coverage for medications for hospice patients.

Medigap

Medigap supplemental plans fill some of the holes in the insurance coverage provided by Medicare Part A and Part B. Private insurance companies offer FFS Medigap plans of 12 types (A through L), classified according to the benefits they offer. For new Medicare beneficiaries at age 65, the premiums for A-level (basic) plans across the United States vary considerably. These policies cover a person’s Part A and Part B co-insurance costs, eg, 20% of Medicare’s allowed fees for durable medical equipment and physicians’ services. B-level plans cover Part A and Part B co-insurance, plus the Part A deductible. Each successive level of Medigap policy provides additional benefits and costs more. J-level plans cover co-insurance, deductibles, care in foreign countries, and preventive services. Less expensive Medigap coverage can be obtained by purchasing plans that require the

insured to pay high deductibles (F- and J-level plans only) or plans that cover the services of only selected physicians and hospitals (“Medicare SELECT” policies). Medigap policies do not cover long-term care, dental care, eyeglasses, hearing aids, or private-duty nursing. They also do not cover out-of-pocket costs for MA plans.

Within 6 months of their initial enrollment in Medicare Part B, beneficiaries are entitled to purchase any Medigap policy on the market at advertised prices. After this open enrollment period, Medigap insurers can refuse to insure individual beneficiaries or charge them higher premiums because of their past or present health problems.

Medicaid

Medicaid is a joint federal and state program that provides health insurance to people of all ages who have low incomes and limited savings. The exact criteria for Medicaid eligibility and the benefit packages provided by Medicaid programs vary considerably from state to state. For persons qualifying for both Medicaid and Medicare, known as *dual eligibles*, most Medicaid programs pay for Medicare Part B premiums and some pay for Medicare deductibles and co-insurance costs. Most important, Medicaid pays for long-term custodial care in nursing homes for those who qualify. Several states offer fixed capitation payments to managed-care organizations that are willing to provide Medicaid and Medicare benefits to residents who are dually eligible (ie, for Medicaid and Medicare).

In 2016, the cost of medications for beneficiaries who qualify for Medicaid is \$2.95 for generic products and \$7.40 for branded ones. The dual-eligible beneficiaries have no premium or coverage gap; in fact, beneficiaries who are nursing-home eligible have no out-of-pocket expense for any Part D-covered medication.

The ACA extended the opportunity for states to expand Medicaid coverage to all nonelderly individuals with incomes below 133% of the federal poverty level in 2014. The Supreme Court ruled that this expansion of Medicaid is optional rather than mandatory. In states electing to expand Medicaid, the federal government pays 100% of the cost for newly eligible individuals from 2014 through 2016. The reimbursement rate to those states declines to 95% in 2017 and will be reduced gradually to 90% after 2019.

Dual Eligibles

Medicare and Medicaid, which were initially developed in 1965 as two distinct programs, jointly provide benefits to 9 million dual eligibles because their circumstances qualify them for both programs. Despite the notable differences between Medicare and Medicaid, the line separating the programs has become blurred over the years. For example, Medicaid used to provide prescription drug coverage for dual eligibles, but the Medicare Part D provision of the Medicare Modernization Act of 2003 shifted that responsibility to Medicare as of January 2006.

Although eligible for benefits, many low-income individuals do not receive Medicaid. Some do not meet their state’s income and asset eligibility criteria, and others are likely eligible but have trouble navigating the application process. Poor health literacy is an especially common problem among dual eligible, who often do not understand their plan or its benefits.

Women, African-Americans, Hispanics, and disabled Medicare beneficiaries <65 years old make up a relatively large share of the dual-eligible population. Dual eligibles tend to have more functional and cognitive limitations and correspondingly greater medical need than beneficiaries enrolled in Medicare or Medicaid alone. As a result, they account for a disproportionate share of Medicare and Medicaid spending. Constituting just 15% of the Medicaid population, dual eligibles account for 39% of total Medicaid spending. They make up 21% of the Medicare population, yet are responsible for 36% of Medicare spending.

Considering the significant level of need and the limited resources of dual eligibles, it is perhaps not surprising that long-term care expenses account for an overwhelming share of medical expenses on behalf of this population, with dual-eligible individuals spending 70% of their Medicaid dollars on long-term care services.

Despite the high level of need that dual eligibles typically have, they are all too often subjected to uncoordinated payment systems in Medicare and Medicaid. To address this dysfunction and to improve coordination between Medicare and Medicaid, the ACA established the Federal Coordinated Health Care Office within the CMS. The ACA also created CMI to develop and implement innovative payment and service delivery models for recipients of Medicare, Medicaid, and the Children's Health Insurance Program, including those who are dually eligible.

One possible approach to integrating Medicaid and Medicare financially is to give each state a yearly block grant intended to fund all services used by state residents who are enrolled in either or both programs. States that spend less on Medicaid and Medicare services than the amount funded through the block grant would be permitted to keep the difference, but states that spend more on Medicaid and Medicare services than the amount of the block grant would be obligated to make up the difference. Another suggested approach is to have Medicare bear full financial responsibility for dual-eligible beneficiaries.

While the Federal Coordinated Health Care Office has begun its work, other measures and programs have been enacted with the purpose of improving care for dual eligibles. For example, Section 3309 of the ACA contains provisions for eliminating cost-sharing for certain full-benefit, dual-eligible individuals. In addition, effective January 1, 2012, all cost-sharing under Medicare Part D is waived for full-benefit, dual-eligible individuals who would require institutionalization if not for access to home-based and community-based services.

Extensive information about all the options is available to consumers at each state's medical assistance office, at 1-800-MEDICARE (1-800-633-4227) or 1-877-486-2048 for hearing-impaired TTY users, and at the Medicare Personal Plan Finder (www.medicare.gov).

Veterans Administration (VA) Benefit

The VA provides a medical benefits package to all enrolled veterans. This comprehensive plan provides a full range of preventive outpatient and inpatient services within the VA health care system. Also, once enrolled in the VA's health care system, veterans can be seen at any VA facility across the country.

Those VA facilities include a system comprising 153 medical centers, 773 ambulatory care and community-based outpatient clinics, 260 vet centers, 136 nursing homes, 45 residential rehabilitation treatment programs, and 92 comprehensive home-based care programs—all providing medical and related services to eligible veterans. These facilities provide inpatient hospital care, outpatient care, laboratory services, pharmaceutical dispensing, rehabilitation for a variety of disabilities and conditions, mental health counseling, and custodial care. They employ about 200,000 full-time-equivalent employees, including more than 13,000 physicians and nearly 55,000 nurses. Although the VA system is a closed system—meaning that all care is provided through VA facilities and providers—there are some exceptions. Veterans who are Medicare beneficiaries can use the Medicare system as well. In addition, the VA is increasing partnering with outside providers to extend the services available to veterans.

FINANCING OF CARE AT DIFFERENT SITES

This section describes, through the eyes of both patients and providers, how the various programs influence the day-to-day care of older adults. It illustrates their effects during a year in the life of Mrs. Rose Murat, an imaginary 79-year-old retired schoolteacher who lives with her 83-year-old husband

in a small, older home. Mrs. Murat has hypertension, coronary artery disease, and mild heart failure, for which she takes hydrochlorothiazide, metoprolol, lisinopril, and nitroglycerin, with total drug costs of \$1500 per year. She is covered by traditional Medicare Parts A and B. Mrs. Murat has also purchased a Part D drug plan, for which she pays annual premiums (\$383), deductibles (\$360), and co-insurance (25% of her remaining medication expenses = \$285). As a result, her total out-of-pocket medication costs were reduced 34% from \$1,500 to \$1,028 per year (from \$125 to \$83 per month). For the primary advantages and disadvantages of each of Mrs. Murat's coverage options, see [Table 3](#).

Table 3—Advantages and Disadvantages of Four Types of Health Insurance

Type of Insurance	Primary Advantages	Primary Disadvantages
Fee-for-Service Medicare (Parts A, B, and D)	Traditional Medicare benefits, choice of any provider that participates in the Medicare program, partial coverage for prescription medications	Cost of co-insurance, deductibles, noncovered goods and services (eg, eyeglasses, hearing aids)
Medicaid	Coverage of co-insurance, deductibles, and some benefits ^a not covered by Medicare	Choice of providers restricted to a single network in some states
Medigap insurance	Coverage of co-insurance, deductibles, and some benefits ^b not covered by Medicare	Out-of-pocket monthly premiums may be expensive, depending on the coverage provided by the policy purchased
Medicare Advantage plan (ie, Part C)	Traditional Medicare benefits plus coverage of additional goods and services ^b	Choice of providers restricted to a network; potential for changes in premiums, co-payments, deductibles, benefits, and providers at the discretion of the plan

^a Under the Balanced Budget Act of 1997, state Medicaid programs were given the option whether or not to pay deductibles and co-insurance costs.

^b Some Medicare Advantage plans require members to pay deductibles and co-payments.

Outpatient Care

Mrs. Murat sees her physician quarterly for monitoring of her chronic conditions.

Fee for Service

Under the Medicare FFS system, providers obtain the fairest possible reimbursement by understanding and following CMS's payment system, which is based on evaluation and management (E&M) codes.

For each Medicare-covered service provided, the provider submits to the regional Medicare carrier the appropriate E&M code and the ICD code that indicates the diagnosis for which the service was provided. Entries in the medical record, which are subject to audit, must document that the data

collection and medical decision-making aspects of the service conform to standards established for the E&M code submitted. By providing and documenting services efficiently, providers can maximize their FFS reimbursements within the limits imposed by the Medicare fee schedules.

Were Mrs. Murat newly enrolled in Medicare, she would be eligible for a preventive visit. The “Welcome to Medicare” preventive visit, also known as the Initial Preventive Physical Examination, is offered free of charge to all new Medicare beneficiaries within their first 12 months of Medicare as a means for individuals to develop a personalized plan to prevent disease, improve their health, and help stay well. During this visit, physicians are responsible for the following:

- Recording and evaluating medical and family history, current health conditions, and prescriptions
- Checking blood pressure, vision, weight, and height (to get a baseline)
- Making sure each patient is up-to-date with preventive screenings and services, such as cancer screenings and shots
- Ordering further tests, depending on general health and medical history

After Mrs. Murat has been enrolled in Medicare Part B for longer than 12 months, she is eligible for a yearly Medicare Annual Wellness Visit to develop or update a prevention plan based on current health and risk factors. This visit is covered once every 12 months.

At the end of her quarterly office visit, Mrs. Murat asks for advice on joining a managed care organization that has been marketing an MA plan in her county. She is impressed by the MA plan’s offer of free eyeglasses, hearing aids, and preventive check-ups, all of which she has purchased out-of-pocket in the past. Her options are as follows: staying with traditional FFS Medicare as her only coverage, keeping FFS Medicare and applying for either Medicaid or supplemental (Medigap) coverage, or exchanging her FFS Medicare coverage for membership in the MA plan (see [Table 2](#)). Depending on the Murats’ income, savings, and state of residence, they may also qualify for a Medicare assistance program that pays for some combination of their Medicare premiums, deductibles, and co-insurance costs. Some older Americans may have additional health insurance options through the federal Department of Veterans Affairs or through their (or their spouses’) present or previous employer or union.

Managed Care

Mrs. Murat’s primary care provider, knowledgeable about her health and prognosis, can help her choose the plan(s) that will cover the goods and services she needs, both now and in the future. If she can obtain what she is likely to need from the MA plan’s network of providers, joining the plan might be her best option, because it will likely cover eyeglasses, hearing aids, and preventive services, and she can avoid paying the usual Medicare deductibles and co-insurance. Data about the quality of care and satisfaction of enrollees in local MA plans are available at the Medicare Personal Plan Finder.

If Mrs. Murat needs health care that is not available from the MA plan’s network, or if she is reluctant to change providers, retaining the flexibility of her traditional FFS Medicare coverage (which covers her use of any provider that participates in the Medicare program) might be a better choice, especially if she also qualifies for Medicaid or buys a Medigap policy. Information from Medicare’s information line or from the Medicare Personal Plan Finder would help her compare the prices and coverage of the Medigap policies available in her area.

The primary care provider’s recommendations to Mrs. Murat are likely to be influenced by the characteristics of the different plans she is considering. For instance, if the primary care provider is not in the MA plan’s service network, he or she would likely point out to Mrs. Murat that her enrollment in the MA plan would require her to select a new primary care provider. If the primary

care provider is in the MA plan's network, Mrs. Murat's enrollment might change (ie, probably reduce) the payment for her care. The payments would depend on the type of plan involved. If it is a group or independent practice association model, the MA plan may pay providers "discounted FFS," ie, possibly less than Medicare Part B would pay for each service, or it may pay primary providers a fixed capitation amount each month to cover specified services. If these services are limited to primary ambulatory care, the capitation amount will be relatively small. Plans may choose to reward primary care providers with bonus payments for efficient and effective use of resources for the patients for whom they are responsible. If the covered services also include specialty and inpatient care, the capitation amounts will be considerably larger, and the provider will have incentives to use these services judiciously because he or she will have to pay for them, at least in part.

Regardless of the payment mechanism, the crucial question is whether the amount of payment suffices to support high-quality care. For example, if capitation rates are below the aggregate cost of the services they are intended to cover, the provider will feel pressure to take on more patients and to limit the amount of service that each patient receives. Similarly, if FFS amounts are too small, the provider will feel pressure to schedule more visits and procedures and to reduce the time devoted to each patient. Each provider should, therefore, monitor carefully and continually the many changing elements in the practice environment (eg, payment schedules, covered services, expenses, patients' and families' expectations, population demographics) to help determine the numbers and types of services appropriate for each older patient.

Inpatient Care

Four months later, Mrs. Murat awakes dysarthric and unable to feel her left hand. Her face is asymmetric, and her left arm and left leg are weak. Her husband calls 911. The ambulance rushes her to the nearest emergency department, where the physician on duty diagnoses a right hemispheric stroke and admits her to the hospital. Mrs. Murat may qualify for the Community Care Transitions Program, which provides transition services to high-risk Medicare beneficiaries. In addition, she may fall under a program monitoring hospital readmissions. This program directs CMS to track hospital readmission rates for certain high-volume or high-cost conditions, while using financial incentives to encourage hospitals to undertake reforms needed to reduce preventable readmissions.

Fee for Service

If Mrs. Murat had retained traditional Medicare as her only health insurance, she would have to pay Medicare's required deductibles (in 2016, \$147 per year under Part B for the ambulance and the emergency medical care, plus \$1,260 under Part A for the hospital admission) and co-insurance amounts (20% of Medicare's allowed charges by physicians and the ambulance service). She would also have to pay any ambulance charges in excess of Medicare's approved fee. If she had supplemented her Medicare coverage, her Medicaid or private Medigap coverage would cover some of these deductibles and co-insurance payments, and she would not be transferred to another hospital for insurance reasons.

When Mrs. Murat is admitted to a hospital, the hospital would submit its claim for emergency and inpatient care, which would be based on the diagnosis-related group (DRG) of her discharge diagnosis, to Medicare's Part A regional intermediary insurance company. The involved physicians and the ambulance service would submit their E&M-coded claims to Medicare's Part B regional insurance carrier. The intermediary and the carrier would pay their shares of these costs and, if Mrs. Murat had supplemental coverage, they would forward requests for payment of the balances to the state Medicaid program or to Mrs. Murat's Medigap insurance company. Ultimately, CMS would reimburse the intermediary from the Medicare Part A Trust Fund and the carrier from the Medicare Part B Trust Fund.

Managed Care

If Mrs. Murat had joined the MA plan, the MA plan would pay for the ambulance, emergency, and physician services; in most cases, it would pay the hospital a prenegotiated lump sum or a per diem fee to cover all of her inpatient care. The amount of this lump sum would be determined by the DRG of her discharge diagnosis, in this case, stroke. If the admitting hospital had no contract with her MA plan, Mrs. Murat would probably be transferred to a hospital in the plan's provider network as soon as she was medically stable. Depending on the MA plan's benefit package, she might be responsible for co-payments and deductibles for some of these services.

Postacute Rehabilitation

After 4 days of stabilization, evaluation, and rehabilitation, Mrs. Murat is deemed stable enough for discharge from the acute care hospital. She has improved somewhat, but she is still mildly hemiparetic and dysarthric, and she is apathetic and easily fatigued. Because her days in the hospital are fewer than the average number of hospital days associated with the DRG of her discharge diagnosis (ie, 5.9 days), CMS regards her "early" discharge as a "transfer." This permits CMS to reduce the amount it pays the hospital for her care. The consulting neurologist advises Mrs. Murat and her husband that her progress during the next few weeks will determine her potential for functional recovery. Mr. Murat asks the neurologist to recommend a rehabilitation facility for his wife.

Fee for Service

If Mrs. Murat could participate in rehabilitative therapy, Medicare Part A would pay for 20 days of postacute rehabilitation, in either a rehabilitation facility or a transitional (postacute) care unit of a nursing home. Mrs. Murat's admission to either type of postacute care unit would be reimbursed by Medicare under the Prospective Payment System (PPS). The Medicare PPS was implemented under the Balanced Budget Act of 1997 to control the increasing costs of subacute care. The PPS payment rates are adjusted for case mix and geographic variation in wages and cover all costs of providing covered skilled-nursing facility services (routine, ancillary, and capital-related costs). Per diem payments for each admission are case-mix adjusted using a resource utilization group system (RUGS) based on data from resident assessments and relative weights developed from staff time data. In addition, rates are based on geographic adjustment—the labor portion of the federal rates is adjusted for geographic variation in wages using the hospital wage index as well as an annual update; payment rates are increased each federal fiscal year using a skilled-nursing facility market basket index.

Mrs. Murat's RUGS category would determine the daily rate that Medicare Part A would pay the facility for the first 2 weeks of her care as long as she was demonstrating progress in rehabilitation. After 2 weeks, a nurse would reevaluate her status, update her plan of care, and adjust her RUGS category, thereby adjusting Medicare's payments to the facility for the next 2 weeks. Under this prospective payment system, the facility would be responsible not only for Mrs. Murat's nursing, rehabilitative, and social services but also for the costs of her medications, laboratory tests, and visits to an emergency department not resulting in admission to the hospital.

Using nursing-home rates, Medicare Part B would pay 80% of the allowed charges for the postacute medical care provided by Mrs. Murat's physician. Any postacute care related to an inpatient surgical procedure would be the responsibility of the surgeon, who would receive a "global fee" to cover the surgery and all postoperative surgical care. The Murats would need to satisfy Medicare Part B's \$147 annual deductible and then make 20% co-insurance payments for the physician's care. Their out-of-pocket expenses would be reduced or eliminated by any Medicare supplements in effect, such as Medicaid, Medigap, or long-term care coverage.

Managed Care

If Mrs. Murat had joined the MA plan, her insurance coverage would include postacute rehabilitative care, probably at a nursing home in the MA plan's provider network rather than at a rehabilitation facility. Some nursing homes concentrate such high-acuity patients in transitional (or postacute) care units and provide them with coordinated rehabilitative (physical, occupational, and speech), social, and nursing services. Most homes, lacking such units, offer only custodial care supplemented by rehabilitative services as needed. The MA plan would also cover the physician's postacute services, but the Murats may be responsible for a deductible and co-payments.

More than 3 million Americans have long-term care insurance policies, but these policies pay for <2% of all nursing-home care. The high premiums for these policies, combined with consumers' uncertainty about needing long-term care in the future and their doubts about the policies' ability to cover the costs of long-term care in the future, have limited the growth of the long-term care insurance sector. Many middle-aged Americans believe they will retain good health and independence into old age; they appear to be relying on a combination of good fortune, social insurance (ie, Medicaid), and their personal assets to see them through their later years.

Home-Health Care

During the first 10 days of rehabilitative therapy, Mrs. Murat regains her ability to speak, and her left arm becomes stronger. During the next 8 days, however, she makes few additional gains. After 18 days, she is still unable to walk, cook, bathe, or dress herself without help. Her lack of continued progress toward functional independence will probably make her ineligible for coverage of additional rehabilitative services in either the MA plan or the FFS Medicare program. The Murats will have to pay for any future physical or occupational therapy on their own.

To obtain long-term care for Mrs. Murat's functional deficits, the Murats will need to choose between a home-health agency and a custodial nursing home. If Mrs. Murat returns home, neither the FFS Medicare program nor the MA plan will be likely to pay for a home-health aide unless she is homebound and requires the services of a registered nurse or rehabilitation therapist. However, local community agencies may be able to offer assistance. The Murats' choice of a home-health agency could be informed by comparisons of their local agencies' recent clinical performance, available at Home Health Compare (www.medicare.gov/HomeHealthCompare).

Fee for Service

In the FFS environment, if Mrs. Murat were homebound and dependent on skilled professional services, then traditional Medicare Part A would pay any Medicare-certified home-health agency a fixed fee to provide her with the services and equipment necessary to treat her primary diagnosis. Medicare Part B would pay her primary care physician 80% of the allowed charges for house calls, office visits, and care plan oversight services. In addition, Medicare Part B would pay her physician for home-health certifications and recertifications. The Murats would be responsible for the Part B annual deductible (\$147) and the 20% co-insurance payments, unless they had supplemental coverage through Medicaid, a Medigap policy, or a long-term care policy.

Managed Care

If Mrs. Murat's condition made her homebound and dependent on skilled professional services, her MA plan probably would pay a home-health agency a fixed fee to provide her with the services and equipment necessary to treat her primary diagnosis. The MA plan would also provide her with the services of a primary care physician.

Program for All-Inclusive Care of the Elderly (PACE)

If a health care organization in the area had contracted with CMS and the state Medicaid agency to create a Program for All-inclusive Care of the Elderly (PACE), it could provide community-based long-term care for dual eligibles whose disabilities qualified them for custodial care in a nursing

home. If she were eligible for Medicaid and she enrolled in PACE, Mrs. Murat would attend an adult day health care center several days each week and receive comprehensive outpatient, inpatient, acute, and long-term care from a salaried interprofessional team composed of a physician, a nurse practitioner or physician assistant, a nurse, a social worker, rehabilitation therapists, and other members of the PACE staff.

Nursing-Home Care

Three months after Mrs. Murat returns home, Mr. Murat, now 84 years old, suffers a myocardial infarction and is no longer able to care for his wife at home. Their daughter logs on to Nursing Home Compare (www.medicare.gov/NursingHomeCompare) to shop for a nursing home. After comparing the local facilities' nurse-to-resident ratios, results of recent quality-of-care inspections, and rates of pressure ulcers and behavior problems, she arranges for her mother to enter a high-quality nursing home in her neighborhood, at least until Mr. Murat recovers.

Fee for Service

The FFS Medicare program would pay 80% of the allowed charges submitted by Mrs. Murat's physician for visits to the nursing home. The Murats would be responsible for the Medicare Part B annual deductible (\$147) and the 20% co-insurance payments. Medicare would not cover any of the nursing home's per diem charges. See [Table 4](#).

Table 4—Eligibility and Coverage for Nursing-Home Services

	Eligibility	Room and Board	Physician Services	Medication
Subacute	For Medicare beneficiaries requiring skilled-nursing care after a 3-day acute hospitalization	Part A	Part B or C	Part A or C
Nursing care	ADL/IADL needs	Medicaid, long-term care insurance, private payment	Part B or C	Part D

Managed Care

If Mrs. Murat had joined the MA plan, one of the MA plan's physicians would provide her primary care in the nursing home. However, unless she was covered by Medicaid or a long-term care policy, she and her husband would be responsible for the nursing home's per diem charges for room, board, and other basic services (about \$200/day). After "spending down" their savings at this rate, the Murats might become sufficiently impoverished to qualify, if they had not qualified previously, for Medicaid coverage. If the Murats owned their house, some states would put a lien on it to recover some of its payments to the nursing home when the house was eventually sold.

End-of-Life Care

After residing in the nursing home for 6 months, Mrs. Murat suffers a massive stroke that leaves her physiologically stable but in a persistent vegetative state. Her husband reports that she had always said she would not want to go on living in such a condition if there were little hope of recovery. Mrs. Murat is unable to swallow thin liquids, and her husband says she would not want to be fed through any sort of tube. Her physician says that, with oral feeding, she is likely to live for several weeks. Her

husband agrees to enroll Mrs. Murat in a hospice program with the understanding that she will receive palliative care without life-prolonging interventions.

Optimally, a discussion of end-of-life care should occur before this change in condition. In fact, since the Patient Self-Determination Act (PSDA) was passed by the U.S. Congress in 1990, hospitals, nursing homes, home-health agencies, hospice providers, HMOs, and other health care institutions are required to provide information about advance directives to adult patients on their admission to the health care facility. Despite this, physicians can still provide discussions regarding advance directive planning as part of any physical examination, and health care facilities are required under PSDA to include this information on entry into their facilities.

After an end-of-life discussion, Mrs. Murat can be enrolled in hospice. Enrollment in hospice would require the traditional FFS Medicare program (Part A) to pay a Medicare-certified hospice program a daily fee that would cover all palliative care for the terminal diagnosis, including home care, medications, equipment, respite, counseling, and social services even if Mrs. Murat had enrolled in (and remained in) the MA plan.

If Mrs. Murat had remained in the FFS Medicare program, Part B would pay her primary care physician 80% of the allowed charges for home or office visits and care-plan oversight services. Mr. Murat would be responsible for the 20% co-insurance and small co-payments for outpatient prescription medications, as well as for respite care.

CHANGES IN THE FEDERAL FINANCING OF HEALTH CARE

The complex and evolving combinations of coverage and programs create difficult choices for older Americans and powerful incentives for the providers of their health care. The U.S. Congress and CMS continue to revise the Medicare program, making it important to stay alert for changes.

The Balanced Budget Act of 1997 (BBA 97)

BBA 97 required CMS to adjust capitation amounts according to enrollees' risk of requiring expensive health care. This resulted in higher capitation payments for high-risk enrollees and lower payments for low-risk enrollees. This risk-adjustment method is based on the diagnoses associated with beneficiaries' health care during a recent 12-month period.

BBA 97 provisions for improving the quality of health care for older Americans included the following:

- The Quality Improvement System for Managed Care (QISMC)
- The Healthcare Employers' Data Information System (HEDIS), which requires MA plans to monitor and report to CMS their rates of compliance with selected processes and outcomes of health care (eg, mammography and immunization against influenza)
- The Medicare Health Outcomes Survey, which requires MA plans to contract with third parties to survey a sample of their members and report information to CMS about their health status, functional ability, and satisfaction with their recent health care

CMS summarizes the information generated by all 3 systems and makes it available at the Medicare Personal Plan Finder to help older Americans make informed choices about Medicare's FFS program and its various managed care options.

Balanced Budget Revision Act of 1999

Within the first 18 months of the enactment of BBA 97, the quality of health care for older Americans began to erode, and the decreases in payments to providers proved to be steeper than projected. For example, Medicare payments for home-health care decreased by 45% between 1997 and 1999.

In response, Congress passed the Balanced Budget Revision Act at the end of 1999. This legislation restored some of the budget cuts made 2 years earlier, including \$4.5 billion to MA plans.

Medicare Modernization Act of 2003

The Medicare Prescription Drug Improvement and Modernization Act of 2003 required dramatic changes in the nature and scope of the Medicare program, including the following:

- The creation of the Medicare Part D program covering prescription medications
- Subsidies for employers who continue to provide their retirees with insurance that covers prescription medications
- Elimination of coverage for prescription medications by Medicaid
- Competition between traditional FFS Medicare and MA plans
- Higher premiums for Medicare Part B to be paid by beneficiaries with higher incomes
- Expanded coverage for preventive services
- Increased reimbursement rates to physicians and hospitals in rural areas

The American Recovery and Reinvestment Act of 2009

As part of the American Recovery and Reinvestment Act, funds were allocated with an aim to modernize the U.S. health care system through a new federal health care information technology leadership structure. Through incentive payments, providers are eligible for maximal payments of \$63,750 for those primarily involved in Medicaid and of \$44,000 for those in Medicare to adopt, implement, upgrade, or demonstrate certified electronic health record technology. To qualify, the electronic health record must meet or exceed the “Meaningful Use” standard, which includes clinical decision support, e-prescribing, exchange of health information, and quality reporting.

The Affordable Care Act of 2010

The areas of the ACA affecting older adults and those providing their care primarily were focused on increasing access and changing the current FFS reimbursement system. In the area of access, the ACA increased access to Medicare beneficiaries by eliminating out-of-pocket expenditures for many preventive screening studies, reducing the Medicare Part D coverage gap, and expanding Medicaid coverage, which increased the number of dual eligibles. The ACA also moved to change reimbursement from the current FFS system to systems that improve outcomes, such as those delivered through coordination of Medicare and Medicaid for dual eligibles, bundling reimbursement, and pay-for-performance. The CMI is dedicated to developing and implementing these new payment systems, likely to be delivered through organizations such as Accountable Care Organizations and Patient Centered Medical Home models.

The Future of Medicare and Medicaid

The CMI is evaluating many programs designed to improve the quality and outcomes of care for beneficiaries with chronic conditions. In most of these, CMS is paying provider and managed-care contractors capitated monthly fees for providing case-management or disease-management services to beneficiaries with specified chronic conditions, such as heart failure, diabetes mellitus, or other “special needs.” Many of these are based on the principle of “pay for performance,” which stipulates that CMS will pay the capitation fees only to the extent that the contractor attains pre-agreed on standards of performance, eg, performing certain diagnostic tests, reducing Medicare’s overall FFS payments, and satisfying beneficiaries with the services they provide.

Another Pay-for-Performance program is the Physician Quality Reporting System (PQRS), to be replaced by the Merit-Based Incentive Payment System (MIPS) in 2019. Physicians and other health care providers who report data about the quality of their care when they submit their bills to their Medicare carriers may earn bonuses of up to 1.5% of their total Medicare payments. CMS also sends them personal reports comparing their PQRS/MIPS data to that of peers nationwide. In 2015, there were 285 quality measures that could be reported, but some are specific to certain specialties. Incentive payments for each program year are issued separately as a single consolidated incentive payment in the following year. In January 2015, the U.S. Department of Health and Human Services established a goal of tying 30% of fee-for-service Medicare payments to value- or quality-based payment structures such as ACOs or bundled payments by the end of 2016, and a goal of increasing this percentage to 50% by the end of 2018.

The aging of the baby-boom generation, technology-driven increases in health care spending, and a decline in the number of workers per Medicare beneficiary will contribute to serious financial challenges for the Medicare program in the years ahead. Similarly, imminent sharp increases in the number of older Americans with serious disabilities will soon surpass states' ability to pay for their long-term care. To meet these challenges, the nation needs visionary geriatric providers able to develop and implement efficient and effective delivery systems to care for our older adults.

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The Affordable Care Act establishes programs to improve the care coordination between Medicare and Medicaid for the 9 million individuals who are eligible for both insurances; these individuals are commonly referred to as “dual eligibles.”