SOLUTIONS BRIEFS

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Modernizing Health Programs for Fiscal Sustainability and Quality

Medicare and other major Federal health programs are crucial pillars of the health care system. Fiscal and demographic challenges threaten the financial sustainability of Medicare, requiring a broad effort to modernize the program. Innovative strategies, including value-based care and alternative payment models, have shown promise in reducing costs and improving the quality of care for patients. Policymakers have other tools to tackle Medicare's negative financial trajectory as well, such as reforms to Medicare Advantage (MA); adjustments to premiums, cost-sharing, and prescription drug payments; emphasizing primary care and care coordination; and streamlining regulations. To ensure the continued financial viability of the Medicare program, Congress should consider and evaluate these potential reforms.

Key Insights

- Medicare faces fiscal challenges as both an aging population and rising health care costs per beneficiary threaten its financial sustainability.
- Medicare cannot be considered in isolation: it affects the entire health care system, as relatively low Medicare reimbursement encourages cost shifting between commercial and government programs, including Medicaid.

- Congress can consider reforms to bolster the move towards value-based care, including evaluating Medicare Advantage risk-based contracts and benchmarks, increasing enrollee premiums for Medicare Part B, implementing uniform cost-sharing and out-of-pocket caps, encouraging primary and preventive care measures, coordinating benefits, and streamlining regulations.
- Value-based care and alternative payment models are innovative strategies that can realign incentives to reduce costs and promote higher quality care through a patient-centered approach. Investments in workforce, multi-payor alignment, and data infrastructure are crucial to realizing the benefits of value-based care.

Recommendations

These recommendations for Congress, the Centers for Medicare and Medicaid Services (CMS), and health care providers lay out potential options that collectively work together to achieve the broad transformations needed to set Medicare and other Federal health programs on a more sustainable fiscal path.

- Congress should consider a comprehensive package of reforms to address the impending financial insolvency of Medicare's Hospital Insurance (HI) Trust Fund, which may include adjustments to premiums, cost-sharing, and prescription drug payments.
- CMS should continue its implementation of value-based care and alternative payment models, including greater use of accountable care organizations.
- The CMS Innovation Center should regularly demonstrate to Congress and other policymakers that it is incorporating lessons learned from its testing of innovative payment and service delivery models to ensure value for money.
- Congress, CMS, and health care providers should make upfront investments in workforce and data infrastructure to effectively and efficiently implement value-based care and alternative payment models.
- Congress should evaluate and reform the payment methodology for Medicare Advantage plans to affirm that the plans are generating savings for the Medicare program and delivering value and high quality care to enrollees in Medicare Advantage.
- Congress, CMS, and health care providers should also emphasize primary care and care coordination to improve health outcomes and achieve savings in the long term.
- The Administration and Congress should assess strategies to streamline regulations and payment policies that add costs and administrative burdens to the health care system.

Background: Medicare's Fiscal Challenges

Medicare is a vital Federal health insurance program for the elderly and individuals with disabilities, providing coverage for hospital care, outpatient care, health care provider services, and prescription drugs for almost 67 million Americans. In 2023, Medicare had over $1 trillion in total expenditures, making it the largest health insurance program in the US.

Nevertheless, Medicare faces challenging headwinds as both an aging population and rising health care costs per beneficiary threaten its financial sustainability. These structural issues impact the Federal budget, the national debt, costs for beneficiaries, and reimbursement to providers as the Federal government, beneficiaries, and providers all struggle to adjust to incentives provided by Medicare's current financing structure.

A number of these issues impact Medicaid, the Federal-State health insurance plan for lower-income Americans and those with limited resources. The Congressional Budget Office (CBO) projects that Medicaid spending reached $607 billion in fiscal year 2024, with spending projected to rise even as total Medicaid enrollment is expected to decline from 92 million to 79 million people by 2034, in part because of Medicaid redeterminations following the pandemic and in part because of some states' more restrictive enrollment policies. But, given the number of people eligible for both Medicare and Medicaid and the important role of managed care organizations in state Medicaid plans (over 70% of people enrolled in Medicaid are in some type of managed care organization), lessons from Medicare reform can have a strong impact on the Medicaid program as well. Equally, the importance of primary care physicians to overall health and the important benefits of shifting to value-based care from a fee-for-service model can deliver strong improvements in the quality of care for Medicaid recipients.

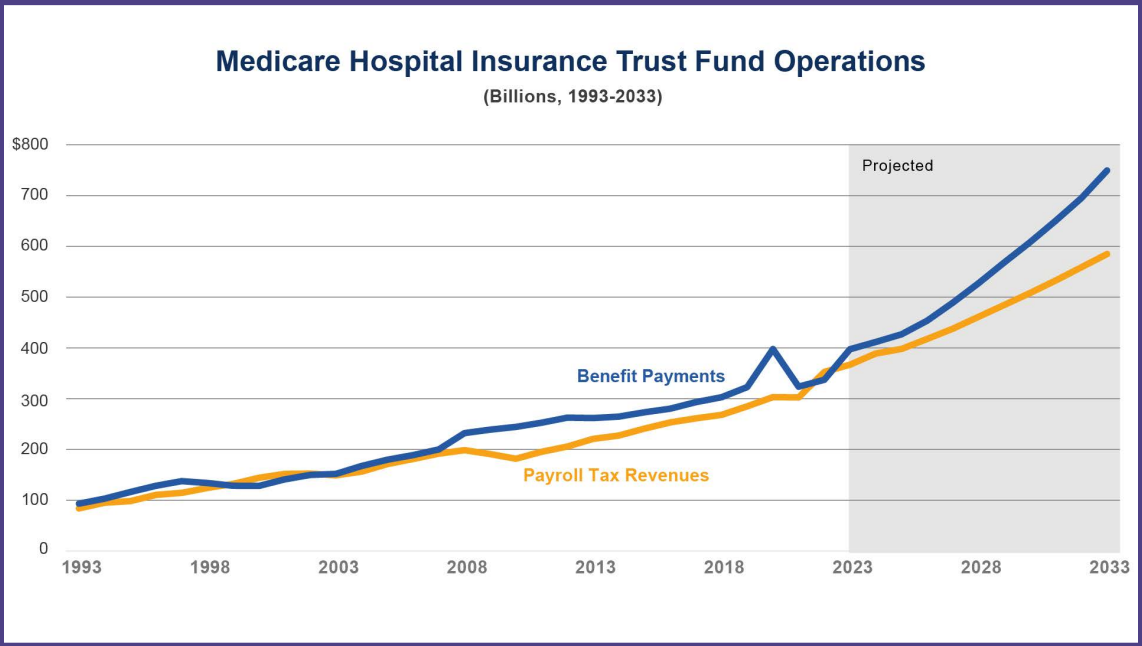
Impending insolvency of the Hospital Insurance Trust Fund

Medicare has two Trust Funds that the program uses to pay for enrollees' health care. The HI Trust Fund pays for Part A benefits, such as inpatient hospital services, hospice care, skilled nursing facility services, and home health services after a hospital stay. Payroll taxes on employers and employees are the primary revenue source for the HI Trust Fund. In 2023, HI Trust Fund total revenue was $415.3 billion and total expenditures were $403.1 billion (Figure 1).

The HI Trust Fund is meant to be self-financed through the dedicated funding source of payroll taxes. Since 2007, the HI Trust Fund balance as a percentage of annual expenditures has declined significantly. In its 2024 annual report to Congress, the Medicare Board of Trustees projects that the HI Trust Fund can pay full scheduled Part A benefits only until 2036, at which point Medicare will only be able to pay 89% of scheduled benefits after the reserves of the HI Trust Fund are depleted (see Figure 2 on page 6).

Figure 1

Medicare HI Trust Fund Benefit Payments Exceed Payroll Tax Revenues



Sources: 2024 Medicare Trustees Report, Medicare Board of Trustees, May 6, 2024; The Conference Board, 2024.

Medicare's Supplementary Medical Insurance (SMI) Trust Fund pays for Part B benefits, such as provider (including physician), outpatient hospital, home health care, and other services, as well as Part D prescription drug coverage. The major sources of revenue for the SMI Trust Fund are appropriations from the General Fund of the Treasury ($435.8 billion in 2023), and Part B and Part D premiums from enrollees, often paid separately, which totaled $150.1 billion in 2023 ($131.5 billion in Part B premiums and $18.6 billion in Part D premiums). In 2023, SMI Trust Fund revenues across both Part B and Part D were $609.3 billion, and total expenditures were $634 billion. Reserves of $187.9 billion at the end of 2023, held as assets in the SMI Trust Fund, covered the remaining balance.

For the SMI Trust Fund, the Medicare Board of Trustees projects that full scheduled benefits will be payable indefinitely because government contributions and beneficiary premiums are adjusted annually to assist in covering expected program costs. However, the Board remains concerned about the fast growth in Medicare Part B and Part D expenditures, which will put increasing pressure on the government and beneficiaries to fund these rising costs through higher General Fund transfers in the form of annual appropriations and through premiums, respectively.

Long-term trends pose fiscal challenges for Medicare

Medicare faces two main challenges driving raised expenditures. The first is an aging population, with members of the baby boomer generation reaching Medicare eligibility in

greater numbers. Combined with decreasing fertility rates and a proportionally smaller workforce to support payroll tax revenues, the number of workers per Medicare Part A beneficiary has declined dramatically over the past four decades, from approximately 4 workers per beneficiary in the period between 1980-2008 to 2.8 workers per beneficiary in 2023. The Medicare Board of Trustees projects this ratio to continue declining to 2.3 workers in 2040 before reaching only 2.1 workers in 2098. This disparity between beneficiaries and workers paying payroll taxes is a major reason for the looming insolvency of the HI Trust Fund and its long term negative actuarial balance (i.e., estimated income is insufficient to meet estimated HI Trust Fund obligations over the next 75 years).

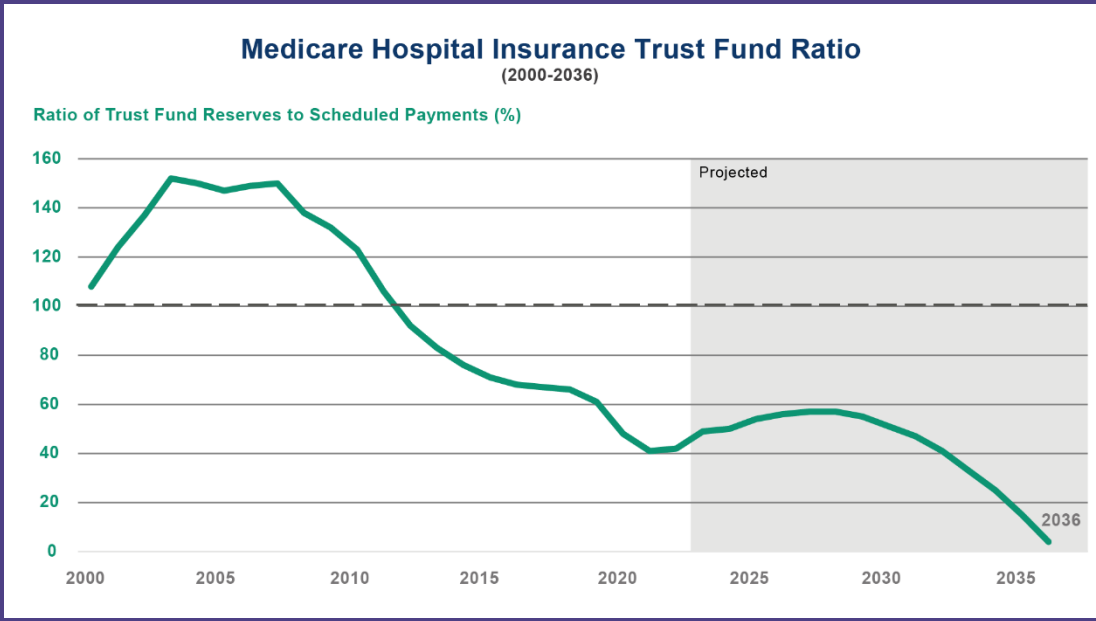
The second challenge is rising health care costs per beneficiary. The US already has the highest health care costs per capita compared to other advanced countries. Higher costs are tied to higher prices for most health care services and prescription drugs compared to other advanced economies—utilization of services is less of a factor because certain services, including physician consultations per capita and the average length of hospitals stays, are lower in the US compared to other advanced economies.

The Medicare Payment Advisory Commission (MedPAC) projects Medicare Part A and Part B spending to grow by 4.5% annually after subtracting expected economy-wide inflation. This spending growth is primarily driven by the greater number of beneficiaries in the program and the volume and intensity of services used, particularly for Part B. Further, the number of Americans over 80 is also expected to rise, from 25% of all seniors in 2020 to one-third of all seniors by 2060, sharply increasing the cost of care. MedPAC estimates that spending per Medicare beneficiaries ages 85 and older was $17,600 in 2020—driven by a greater number and complexity of health conditions that lead to higher ambulatory, inpatient, and prescription drug costs—compared to $10,100 for Medicare beneficiaries ages 65-74.

An aging population and rising health care costs per beneficiary put pressure on the Federal budget, which is already running sustained, record-breaking deficits. CBO projects Medicare spending to increase by 2.2% of GDP over the next 30 years, reaching 5.4% of GDP in 2054. Medicare will account for over two-thirds of Federal spending on major health care programs (i.e., Medicare, Medicaid, the Children's Health Insurance Program, and premium tax credits for health insurance purchased through Affordable Care Act marketplaces) in 2054. To finance this spending, the Federal government will continue issuing debt in the form of Treasury securities, which will in turn increase the costs of servicing the national debt and begin crowding out other spending priorities.

Figure 2

Projected Depletion of Medicare HI Trust Fund in 2036



Sources: 2024 Medicare Trustees Report, Medicare Board of Trustees, May 6, 2024; The Conference Board, 2024.

Since 2022, Congress and the President have enacted reforms such as the drug pricing provisions in the Inflation Reduction Act (IRA) to help restore the financial sustainability of the Medicare program. The IRA authorized Medicare to negotiate directly with drug companies to reduce the cost of and improve access to certain high expenditure, single source drugs without generic or biosimilar competition. In August 2023, CMS released a list of 10 drugs covered under Medicare Part D selected for the first cycle of negotiations. The list contains drugs used by more than 8.2 million Medicare beneficiaries to treat a variety of conditions, including cardiovascular disease, diabetes, autoimmune diseases, and cancer. Between June 2022 and May 2023, these 10 drugs resulted in $50.5 billion in total Part D gross covered prescription drug costs, representing about 20% of total costs in that category. Participation in the negotiations is voluntary; CMS announced in October 2023 that all companies that manufacture the drugs on the list chose to participate. In August 2024, the Administration completed its negotiations with manufacturers, estimating $6 billion in net savings for the Medicare program and a reduction of $1.5 billion in enrollee out-of-pocket costs in 2026. CBO estimates that the entirety of the IRA drug price negotiations conducted over several years would lower the deficit by $98.5 billion between 2022 and 2031.

The IRA also caps prescription drug costs for Medicare beneficiaries. Part D annual out-of-pocket prescription drug costs will be capped at $2,000 starting in 2025. When the prices of certain drugs covered under Medicare Part B and Part D rise faster than the rate of inflation, the IRA requires a rebate to Medicare. CBO estimates the rebates will reduce the deficit by $56.3 billion between 2022 and 2031. Pharmaceutical manufacturers have argued that these

reforms may reduce drug innovation and the funding available to spend on the research and development (R&D) of new prescription drugs.

Framework for Modernizing Medicare

Given the size and complexity of the Medicare program, this Solutions Brief presents a framework of principles to drive the modernization of Medicare to meet the needs of both current and future beneficiaries and bend the cost curve of increasing spending while promoting high quality care:

1. Identifying and treating health conditions early will save money both before individuals enroll in Medicare and in the long run for the Medicare program because future enrollees will be less likely to develop (or to have developed) long term chronic conditions.
2. Linkages to commercial insurance are crucial as hospital systems and other medical providers must develop additional revenue streams to balance relatively lower expected Medicare and Medicaid reimbursement, increasing the pressure on the Federal government and states to raise rates and putting an additional burden on commercial insurance to make up the gap.
3. A shift to value-based care will promote patient-centered care, improve the efficiency of providing that care, and realign incentives away from volume and towards quality and outcomes. A shift to value-based care before individuals enroll in Medicare will reduce costs to the Medicare program over time and will lead to greater fiscal solvency of the program.
4. Incentives should be aligned across an entire community and the health care system to facilitate effective implementation of reforms. Payors and health care providers should invest in practice transformation and business model transformation as well to ensure the reforms' success.

The principles above highlight the interactions between Medicare, other Federal health programs (notably Medicaid and veterans' medical care), and commercial insurance provided by private insurance companies. Future Medicare enrollees are now generally covered by commercial insurance and/or Medicaid before reaching Medicare eligibility, meaning that the policies of these other parts of the health care system will have a significant impact on the health of beneficiaries when they reach Medicare eligibility. Additionally, insurance companies participate in the delivery of Medicare and Medicaid benefits through managed care organizations and MA plans. Medicare reimbursement rates also often determine the benchmarks for Medicaid reimbursement in many states.

The interconnectedness of the US health care system thus demands a whole-system perspective. A major reason for the complexity and inefficiency of the US health care system has been a piecemeal approach to reform that either ignores or underestimates the externalities of policy changes within one part of the system. Incentives that reward volume instead of outcomes help drive the current predicament. For instance, acute care hospitals incur nonreimbursed costs when post-acute services are not available to transition patients

from the hospital before they can return home. Federal health programs are also not built to absorb the higher costs of innovative therapies, including biologics and new medications that offer improved quality of life and better health outcomes but that have very high costs. Additionally, supply chain issues for key medical supplies, such as IV fluids, as well as the impacts of natural disasters demonstrate the need for broad solutions that build resilience within the health care system.

Because of the multitude of entities involved in the health care system, policymakers face tradeoffs when evaluating and implementing Medicare reforms. Thus, policymakers should employ a whole-system approach that considers how each reform would impact patients, health care providers, hospitals, insurers, and other relevant stakeholders. Stakeholder engagement is crucial at every step of the process, both to identify initial barriers to implementation and to constantly assess progress towards stated goals. Reforms should be phased in to align with the deployment of financial, labor, and technological resources, and evaluation of reforms should occur once these resources have been fully deployed to provide sufficient time for expected cost savings and improvements to the quality of care.

In return for these commitments from policymakers, leaders of health care providers and other entities responsible for implementing innovative programs should be fully committed to the strategic goals of the program and embrace the necessary transformations of their operations. Education, training, and constant feedback from health care professionals tasked with serving patients will be crucial to modifying programs and assessing the tradeoffs of any innovative strategy. Moreover, engaging the patient perspective is essential, as many new strategies for the delivery of care require active patient participation. By facilitating patient engagement, health care providers and policymakers will ensure that patients remain at the center of any new approach to health care delivery.

Policy Options for a Comprehensive Reform Package

To address the impending insolvency of the Medicare HI Trust Fund, Congress should consider a reform package. The policy options below come from CBO, the nonpartisan agency that produces independent analyses of budgetary and economic issues to support the Congressional budget process. Innovative strategies, including value-based care and alternative payment models, can also be combined with targeted strategies such as reforms to MA, promoting primary care, and improving the coordination of benefits to reduce costs for the Medicare program and deliver higher quality care to Medicare beneficiaries.

Premiums, cost-sharing, prescription drug, and other Medicare policy options

Congress may consider premium adjustments and cost-sharing policy options to reduce Medicare's costs. One option is to increase base Medicare Part B premiums to 35% of expected Part B costs per enrollee, up from the current 25%. Combining this premium increase with a freeze on the income thresholds that determine the Income Related Monthly Adjustment Amount would result in $448 billion in savings to the Medicare program over 10 years, according to CBO. These premium increases would fall on Medicare enrollees and on State Medicaid programs that pay Part B premiums for dual enrollees in Medicare and Medicaid. While policymakers should be wary of increasing costs for Medicare enrollees in a time of high inflation, this type of policy can be included in a comprehensive package of

reforms to distribute the financial burden across all entities in the health care system (i.e., the Federal government, states, MA plans, enrollees, hospitals and other medical providers, and others).

Another option concerns cost-sharing within the Medicare program. CBO modeled two cost-sharing policy changes: first, replacing Medicare's current cost-sharing requirements with a single annual deductible of $850 for all Part A and Part B services, uniform coinsurance of 20% above the deductible, and an annual out-of-pocket maximum of $8,500; and second, restricting Medigap policies from paying any of the first $850 of an enrollee's cost-sharing obligations under Part A and Part B and limiting coverage to 50% of the next $7,650 of an enrollee's cost-sharing, for a maximum cost-sharing for the enrollee of $4,675. Including a three-year phase-in period, CBO estimates these changes would result in savings of $122 billion to the Medicare program over a decade. This option illustrates the fiscal effects of modifying cost-sharing for enrollees; policymakers should set specific deductible and cost-sharing thresholds to balance cost reductions while avoiding an undue financial burden on beneficiaries with lower incomes.

Finally, CBO assessed several policies to reduce prescription drug prices under Medicare Part D. CBO's analysis focused on the anticipated effect on average drug prices from approaches to cap prices, limit their growth, and promote price competition. CBO found large reductions in average drug prices of more than 5%, potentially substantially more, from setting maximum allowed prices based on prices outside of the US. CBO also identified small reductions of between 1-3% for expanding the Medicare Drug Price Negotiation Program by making negotiated prices available to all commercial purchasers and requiring manufacturers to pay inflation rebates for sales in the commercial market. While these options all reduce costs for patients and payors, manufacturers' expected revenue from drugs not yet approved would go down as well, affecting investments in R&D and decreasing the number of new drugs developed and introduced. As with the other options in this section, policymakers must consider these tradeoffs and balance the increase in savings with the reductions in pharmaceutical innovation.

Innovative Strategies

An innovative strategy to modernize Medicare and other Federal health programs—notably Medicaid, where over 70% of Medicaid recipients are in some form of managed care organization—is value-based care, which can be combined with alternative payment models to move away from a delivery system based on fee-for-service reimbursement. This strategy has the potential to both reduce costs for payors and improve the experience of beneficiaries. While systematic reforms require sufficient planning, resources, and dedication from all entities involved, the current trajectory of Federal health care spending is unsustainable, calling for comprehensive solutions to transform the way the health care system operates.

Value-based care and alternative payment models

In practice, value-based care means coordination and collaboration between physicians and other health care providers to focus on quality of care, provider performance, and the patient experience. Value-based care utilizes a model that focuses on the totality of the patient's medical and nonmedical factors that can affect outcomes and the patient's desires and

preferences for care. Physicians and other health care professionals regularly communicate to coordinate care across practices and appointments, with the goal of avoiding hospitalizations from conditions that were not identified and addressed in a timely manner.

From a patient's perspective, value-based care provides a holistic and integrated approach that asks contextual questions about the whole person instead of specific health issues. Under this care model, patients will spend more time interacting with health care professionals to identify the patients' goals and preferences regarding their own care plan. Value-based care often employs care coordinators (discussed further below) to follow up with patients and work through challenges with accessing services. Patients may receive additional educational resources and the opportunity to participate in disease prevention programs.

In turn, health care providers commit to the evaluation of quality of care and better individual health outcomes. Incentive payments, withholds, and value-based payments linked to quality of care and performance are often employed in value-based care. CMS also uses alternative payment models to promote quality and performance, including accountable care organizations (ACOs), bundled payment models, and primary care medical homes. All these methods differ from traditional fee-for-service arrangements, which are tied to the volume of services provided to patients.

CMS administers several pilot programs, or "models," that give incentive payments to providers for the quality of care they deliver to Medicare beneficiaries. CMS has set the goals for the models: better care for individuals, better health for populations, and lower costs. A few examples illustrate the various care settings and mechanisms CMS uses in the models. The End-Stage Renal Diseases Quality Incentive Program (ESRD QIP) links a portion of payment to renal dialysis facilities to facilities' performance on quality of care measures, the first value-based purchasing (VBP) program of its kind in Medicare. The ESRD QIP reduces payments to facilities by up to 2% for facilities that do not meet or exceed performance standards on applicable quality measures, with CMS scoring based on achievement compared to facilities nationally and improvement compared to that facility's performance the prior year.

Since 2018, CMS has administered a VBP program for skilled nursing facilities (SNF) to promote the quality of care SNFs provide to Medicare patients. As required by the 2014 Protecting Access to Medicare Act, all SNFs participating in the Prospective Payment System are subject to a withhold of 2% of a SNF's Traditional Medicare Part A payments. CMS assesses SNF performance on hospital readmission for both improvement and achievement and redistributes 60% of the withhold to SNFs as incentive payments. The other 40% bolsters the financial reserves of the HI Trust Fund.

CMS also has a similar value-based care program, the Hospital Readmissions Reduction Program (HRRP), to encourage hospitals to improve communication and care coordination with the goal of engaging patients and their caregivers in discharge planning and reducing avoidable hospital readmissions. CMS evaluates a hospital's relative performance through a ratio of predicted-to-expected unplanned readmissions for conditions including chronic obstruction pulmonary diseases, heart failure, and acute myocardial infarction. CMS then

adjusts payment based on the weighted average of a hospital's performance across the readmission measures.

CMS has set strategic goals that all Medicare fee-for-service and the vast majority of Medicaid beneficiaries will be in a care relationship, with accountability for quality and total cost of care, by 2030 and that all new models will make multi-payor alignment available by 2030. In 2024, approximately 13.7 million beneficiaries in Traditional Medicare are aligned to an ACO with accountability for quality and total cost of care, representing nearly half of all Traditional Medicare enrollees. Scaling up these programs by the end of the decade is tied to CMS's overall strategy to promote alignment, growth, and equity. In this context, alignment is key as health care providers interact not only with CMS-administered programs, but also with private commercial insurance and plans offered through the Affordable Care Act marketplace. Multi-payor alignment will facilitate the adoption and growth of value-based care, as providers will not have to navigate multiple requirements or incur excessive administrative burdens in order to transform their operations.

In this vein, CMS has continued its focus on promoting ACOs, which are groups of physicians, hospitals, and other health care providers that collaborate to deliver high-quality coordinated services and care, improve health outcomes, and manage costs. ACOs are responsible either for a specific geographical area and/or a specific patient population, such as those with chronic kidney disease. In an ACO, health care providers typically develop an individualized treatment plan for patients that considers their entire health history and a mutually determined plan of care. This patient-centered approach is the basis of the accountable care relationship. Providers also generally use certified electronic health record technology to access health information and quickly identify potential challenges and barriers to coordinating care.

As an incentive for ACO development, CMS allows ACOs to share in the savings they achieve by providing accountable care. The largest program is the Medicare Shared Savings Program (MSSP), which requires ACOs to be accountable for the quality, cost, and experience of care of an assigned Traditional Medicare beneficiary population. ACOs can select among various options to establish a financial arrangement that fits their organization. Through the coordination of services and investments in high quality and efficient service delivery, ACOs can receive performance payments that are tied to the savings generated by the Medicare program from the accountable care relationship. Approximately 11 million Medicare beneficiaries belong to an ACO in MSSP, and the program resulted in $2.5 billion in total earned shared savings in 2022.

Implementation considerations

Critical to achieving CMS's strategic goals is the CMS Innovation Center, also known as the Center for Medicare and Medicaid Innovation. Congress established the CMS Innovation Center in 2010 as part of the Affordable Care Act to test innovative payment and service delivery models to reduce program expenditures while preserving or enhancing the quality of care provided to enrollees in CMS-administered programs. Since then, the CMS Innovation Center has conducted over 50 model tests, impacting over 41 million beneficiaries and more than 314,000 health care providers nationwide. The CMS Innovation Center evaluates the results of these tests and advances best practices, which can then be incorporated into CMS

programs like MSSP and work to expand models that either reduce spending without impacting quality of care or improve the quality of care without increasing spending.

Yet, two key issues have emerged regarding the activities of the CMS Innovation Center. The first is the lack of significant savings to the program from the innovative models evaluated by the CMS Innovation Center. CBO conducted an analysis of the net spending associated with CMS Innovation Center activities between 2011 and 2020 and found that the Center spent $7.9 billion to operate its models, while only reducing benefits spending by $2.6 billion. In contrast, CBO initially projected in 2010 that the Center would produce net savings of $2.8 billion between 2010 and 2019. CBO now projects Center activities to increase net Federal spending by $1.3 billion between 2021 and 2030.

The failure to generate expected savings thus far is partly in line with independent research on CMS's value-based programs, which shows that they can reduce costs and improve quality of care, though some programs have mixed results and a modest impact. For example, ACOs participating in MSSP show great promise and produce net savings for Medicare while improving or maintaining quality of care. On the other hand, payment initiatives, such as the Hospital Value-Based Purchasing Program and episode-based payment programs, had mixed patient outcomes and have not yet yielded significant savings for Medicare. This outcome may reflect the complexity of the health care system, as innovation and experimentation are as much about learning best practices and improving models as they are about reducing costs in the short term. The mixed results could also reveal the need for improved coordination. Programs that have enjoyed success generally promote high levels of collaboration among multiple entities in the health care system, including private sector operators. As such, Congress and CMS should commit to further evaluation and oversight of the CMS Innovation Center by requesting regular updates on how it is incorporating lessons learned and best practices into future models.

The second key issue (which may impact the relatively low return from value-based care thus far) is the lack of value-based care arrangements and alternative payment models for primary care practices. As of 2023, fewer than half of primary care practices in the US participate in an alternative payment model. Yet primary care practices are essential to delivering value-based care and the accountable relationship, as they often have sustained relationships with patients and serve as patients' first contact when reporting symptoms of illness. CMS's strategic goals regarding accountable care will be challenging to achieve without the participation of primary care practices. To promote the inclusion of primary care practices, CMS should consider increasing its engagement with physicians and primary care practices to understand the barriers they face, such as a lack of capital and resources to collect and analyze data. Congress may also seek to extend the timeframe for evaluating models within Traditional Medicare to allow an ACO or health system to develop a level of expertise with a model and incorporate best practices and for CMS to gain further data about long term cost savings instead of prematurely shutting down models that do not produce significant savings within five to ten years.

Additionally, CMS should consider strategies that specifically address the needs of Medicare beneficiaries with disabilities and the small proportion of beneficiaries who incur the highest costs. In 2023, the National Institutes of Health (NIH) designated people with disabilities as "a population with health disparities in the rates of illness, morbidity, mortality, and survival,

driven by social disadvantage, compared to the health status of the general population," leading to greater NIH research in this area to address this population's health needs, including the role of the health system in providing comprehensive care, such as preventive care, that can improve their quality of life and reduce systemic costs.

Advances in the treatment of severe disabilities, such as those resulting from neurodegenerative diseases, have also improved the quality of life for these individuals and have allowed them to live longer. Among Traditional Medicare beneficiaries, the costliest 5% of beneficiaries accounted for 46% of annual Medicare fee-for-service spending in 2021, and the costliest 25% of beneficiaries accounted for 85% of spending. Given the disparities these Medicare beneficiaries face, CMS has an opportunity to both alleviate social disadvantages and achieve significant cost savings through the study of value-based care models specifically targeted at individuals with disabilities and the costliest beneficiaries. Further study is warranted to bring innovation and attention to these important populations.

Investments to Harness the Potential of Value-Based Care

To fully realize the potential of value-based care, alternative payment models, and other innovative methods to deliver care, the Federal government and entities such as hospitals and other medical providers should make the appropriate upfront investments in the health care workforce and data infrastructure. Without sufficient staff who are adequately trained in the tools and methods of value-based care, the implementation of these innovative models will be hindered, and their potential cost savings will fail to materialize. And without the proper data infrastructure to evaluate the delivery of care and health outcomes, both public and private payors will struggle to track the progress of implementation, identify interventions that are particularly effective, and diagnose areas for improvement. The challenges of an aging population and increasing enrollment in Medicare require long term planning that must begin now.

Workforce

Since the pandemic, the health care workforce in the United States has experienced profound challenges. Physician surveys from the American Medical Association (AMA) showed that more than 60% of physicians experienced at least one symptom of burnout in 2021. While this percentage of respondents experiencing burnout dropped to 48% in 2023, the high proportion of the physician workforce dealing with significant stress and fatigue greatly increases the risks of physician turnover and reductions in work hours that hamper the effective functioning of health care systems, with an estimated annual cost to the health care system of $4.6 billion. Despite the importance of primary care to overall health, primary care has become a relatively less attractive specialty, and pediatrics is one of the least preferred because of the high Medicaid population and associated lower reimbursement rates. Funding for Graduate Medical Education has not kept up with demand and teaching in the clinical environment lessens efficiency, effectively driving up costs for academic medical centers developing the next generation of doctors.

The challenges of the pandemic have exacerbated a workforce shortage in the health care sector that has failed to dissipate. In 2021, the American Hospital Association (AHA) warned of increases in vacancy rates for nursing personnel of up to 30% and staff turnover increases

from 18-30% for departments such as emergency, intensive care, and nursing. The AHA also cited a projection of a critical shortage of 3.2 million health care workers by 2026. A more recent analysis from the Kaiser Family Foundation (KFF) showed that health care employment overall reached prepandemic levels by the end of 2022. Nevertheless, actual health care employment is below the projected trend based on prepandemic growth rates, and employment in elder care facilities and SNFs is still below the levels from before the pandemic. The latter trend is particularly concerning as the US population ages and demand for care in these facilities grows over the coming decades.

Health care workers also face other challenges, including insufficient patient-provider time, organizational inefficiencies, and the uneven adoption of technology. To tackle these issues and increase recruitment and retention, health care systems should prioritize employee well-being and payors should commit to a comprehensive approach. Increasing employee engagement is key, as making workers believe they are respected and valued leads to lower turnover and increased retention. As for payors, New York's 2023 State Budget included millions of dollars in investments in the clinical workforce, such as relief for those pursuing education in high-demand health occupations, provider incentives to increase the number of physicians and nurses in underserved areas, workforce initiatives for the home- and community-based direct care workforce, and centralized efforts to expand training capacity statewide. States should consider multiple policies and investments to address systematic health care workforce challenges.

Team-based care has the potential to address many of these challenges. Under team-based care, the patient is at the center of the health care delivery process, with a team to coordinate care and assist the patient in delivering high quality outcomes. Teams can be led by physicians, advance practice registered nurses, or other qualified health professionals and should include team members relevant to the patient's needs and goals, such as specialists, social workers, pharmacists, and care coordinators. As the team coordinates and plans the patient's care, each team member will be able to work at the "top of their license," maximizing the skills and time of each health care professional. Clerical work and other administrative tasks can also be delegated to the appropriate team member, allowing for more time with patients, increasing motivation, and reducing burnout. Team-based care can be combined with value-based payment to align payments with metrics tied to team-based activities. A sufficient supply of primary care physicians and pediatricians will be key to providing the necessary access to team-based care.

Data infrastructure

The health care system must also develop better data infrastructure to harness the potential of value-based care and alternative payment models. Encounter and outcome data must be of sufficient quality to evaluate these new models and assess the cost-effectiveness of health care interventions. The entire health care system continues to move away from fee-for-service payment methodologies tied to the submission of claims and towards managed care, with the overall managed care market anticipated to grow to $4.37 trillion by 2028; Medicaid payments to managed care organizations already represented 52% of total Medicaid spending in 2021. As such, encounter data is becoming ever more crucial to evaluate managed care plans, which receive capitation payments on a per member per month basis.

Since 2012, CMS has required MA plans to submit a record of each encounter that MA enrollees have with a health care provider. MedPAC has analyzed the accuracy and completeness of these encounter data from MA plans, finding in its June 2024 report that MA plan encounter data continues to lack records of all items or services provided to MA enrollees. MedPAC attempted to validate these data submissions with other sources, such as HEDIS hospitalization data and utilization rates from MA plan bid data submitted to CMS and found wide variance in the data's completeness and accuracy.

CMS has worked to improve MA data quality and transparency in recent years, namely by adding data reporting requirements regarding the use of supplemental benefits and associated spending, the timeliness of prior authorization decisions, and use of prior authorization. Nevertheless, KFF found that MA plans often still do not report key data to CMS, such as the reason for prior authorization denials and detailed prior authorization data by type of service or enrollee characteristics. CMS also does not publish data that MA plans report on out-of-pocket spending and other payment information for Medicare covered services due to their commercially sensitive nature. This lack of data transparency may hinder the monitoring of MA plans and may obscure valuable information that Medicare enrollees could use to choose a particular MA plan or decide whether to join MA or remain in Traditional Medicare. Because this can implicate privacy issues, Congress may wish to examine how to promote the transparency of noncommercially sensitive data in a way that considers the interests of both Medicare enrollees and MA plans as well as CMS.

Recognizing the persistence of encounter data completeness and accuracy issues, MedPAC has reiterated its recommendations from 2019 to Congress and CMS to establish thresholds for the completeness and accuracy of MA encounter data, evaluate MA plans' submitted data and provide feedback—including comparisons to external data sources—to organizations, and apply a withhold to plan payments that would be paid out to MA plans that meet the established thresholds. This combination of clear standards and financial incentives linked to data submission holds promise, as MedPAC found that MA organizations can achieve higher levels of data completeness under these conditions.

Additional Reforms to Promote Fiscal Sustainability

CED has long advocated for a shift in health care from a fee-for-service model to one that promotes cost-responsible consumer choice among competing private health care plans. Such a shift would drive the system toward quality and affordable health care for all, in a more connected system that encourages strong patient care outcomes holistically through innovations such as team-based care. In addition to innovative strategies and associated investments, policymakers may also consider more targeted strategies to promote the fiscal sustainability of Federal health care programs, including reforms to MA, the promotion of primary care, the coordination of benefits, and analyzing how to streamline regulations.

Medicare Advantage

Enrollment in MA has grown dramatically in the past decade, with nearly half of Medicare beneficiaries now enrolled in an MA plan and the Federal government making an estimated $453 billion in payments to MA plans in 2023 to cover Part A and Part B services for MA enrollees. Given the size of the MA program and its rapid growth, CMS should conduct a

more thorough evaluation of MA risk-based contracts by increasing reporting requirements to determine whether MA plans deliver better outcomes while reducing costs for the Federal government. CMS already updates the payments to MA plans annually, primarily based on benchmarks (the maximum amount the Federal government will pay plans for an average person in each county) and a risk adjustment model that modifies payments based on enrollees' expected health care costs. In turn, the county-level benchmarks are based on the average spending on health care for Traditional Medicare beneficiaries in the county.

An analysis of MA plan bids and actual payments to plans reveals the importance of adjustments CMS makes to MA benchmarks and rebates CMS returns to plans if bids come in below the adjusted MA benchmarks. CMS makes two adjustments to MA benchmarks: 1) a quartile adjustment that reduces MA benchmarks in counties with high Traditional Medicare spending and increases benchmarks in counties with low Traditional Medicare spending and 2) Quality Bonus Program payments that increase MA benchmarks for plans with high quality scores. Moreover, when an MA plan bids below these adjusted MA benchmarks, the plan is awarded a monthly payment equal to its bid as well as a rebate equal to 50 to 70% of the difference between the plan bid and the adjusted MA benchmark, which must then be returned to enrollees through lower premiums, reduced cost-sharing, or increased supplemental benefits.

The researchers found that, despite reductions in adjusted benchmarks and payments to MA plans after policy changes tied to the Affordable Care Act in the early 2010s, adjusted benchmarks and payments have recently plateaued even as MA plan bids have consistently decreased over that time. The researchers also found that adjusted MA benchmarks are high relative to Traditional Medicare spending and that rebates to plans are growing due to low MA plan bids. In effect, Medicare payment policy that adjusts MA benchmarks and pays rebates to MA plans is generating additional money for MA plans to return to MA enrollees, instead of reducing overall MA payments and generating savings for taxpayers and the Federal government. This may help drive MA enrollment, but does not reduce Medicare costs.

To emphasize the importance of payment methodologies, MedPAC estimates that MA plan payments in 2024 are 22% higher than what Medicare would have spent to cover the same group of enrollees in Traditional Medicare, translating to $83 billion in additional spending. MedPAC attributes this gap to the effects of coding intensity and favorable selection in the risk-adjustment methodology CMS employs. MA plans have an incentive to record more health conditions for their enrollees than Traditional Medicare because higher risk scores increase MA plan payments. CMS's risk-adjustment model also overpredicts spending on MA enrollees when compared to Traditional Medicare, even for beneficiaries who have diagnoses coded with the same level of intensity, because beneficiaries with lower actual spending relative to their risk score tend to enroll in MA.

Considering the looming insolvency of the Medicare HI Trust Fund, Congress must evaluate whether the adjustments to MA benchmarks and the rebate policy associated with plan bids are delivering positive health outcomes for MA enrollees, particularly through supplemental benefits. (MA plans have the flexibility to offer additional benefits to address unmet enrollee needs through primarily health-related supplemental benefits, such as vision, dental, and hearing services, and special supplemental benefits for enrollees with chronic illnesses.) A

KFF review of the literature comparing MA and Traditional Medicare showed few significant differences across measures of beneficiary experience, affordability, service utilization, and quality, demonstrating the need for further evaluation. If policymakers are unsatisfied with the value that MA rebates to plans are providing to MA enrollees, Congress may consider reducing MA benchmarks or revising the MA benchmark adjustment methodology to generate savings for the HI Trust Fund and bolster its financial solvency. CBO estimates that a 10% reduction in MA benchmarks applied uniformly across all counties would reduce Medicare spending by $392 billion over a decade.

Primary care and care coordination

In addition to value-based care, encouraging primary care and preventive care often leads to improved health outcomes and potentially saves money in the long term. This is true for those in private insurance, Medicaid, and Medicare. Interventions such as immunizations, smoking cessation programs, promoting healthy lifestyle choices, and regular health screenings, including for chronic disease, help reduce costs by preventing hospitalizations and identifying health conditions early to reduce the more intensive treatments necessary to address chronic conditions and serious illnesses once they develop. Even when certain screenings result in higher net costs due to expensive behavioral health and cancer treatments, the improved health outcomes and quality of life for patients are worthwhile investments, particularly if those increased costs can be delayed through earlier interventions. Medicare covers a variety of preventive services and health screenings, and the program recommends enrollees receive a “Welcome to Medicare” preventive visit within the first 12 months of Medicare Part B enrollment and an annual “Wellness” visit thereafter. Team-based care is ideal for delivering preventive care, as the patient can receive adequate support to achieve their health care goals and the care team can monitor progress and identify health problems in a timely manner. Dental insurance is an additional example of prevention-focused care, with programs available to conduct risk assessments on patients and direct further preventive benefits to those at higher risk of oral health complications at no cost to patients or their employers, which can lead to a net reduction in costs due to decreases in claims for restorative services.

Care coordination is another strategy to improve the efficiency of the health care system and the patient experience. Private health insurers are increasingly employing care coordinators to assist their enrollees, and Medicaid has approved care coordination waiver programs, where dedicated staff assist patients with coordinating health care services. Care coordination for Medicaid patients has resulted in lower emergency department use, fewer follow-up visits, and lower probabilities of hospitalization. More research on the cost effectiveness of care coordination is still needed for Medicare and commercially insured populations. Addressing the social determinants of health may also provide savings through reduced charges for hospital admissions, emergency department visits, outpatient visits, and prescription drugs, though there is a concern of duplicating other government programs’ spending, particularly related to housing, nutrition, and education. Additionally, employing community health workers as care coordinators can be an effective method to build trusted relationships in underserved communities, facilitate access to services, and improve the quality and cultural competence of service delivery.

Evaluate regulatory costs

More broadly, the Administration and Congress should assess strategies to streamline regulations and payment policies that are adding costs and administrative burden to the health care system. The Food and Drug Administration's (FDA) regulatory approval of new pharmaceutical drugs could be reformed to reduce R&D costs for pharmaceutical manufacturers, the savings of which could then be passed on to beneficiaries and taxpayers. CBO estimates the average R&D cost per new drug to range from less than $1 billion to more than $2 billion per drug, including the costs for drugs which do not successfully receive FDA approval. Limiting costs related to medical malpractice, known as "tort reform," may also reduce premiums for medical liability insurance and reduce operational costs for health care providers. In 2009, CBO estimated that a typical package of tort reform proposals nationwide would reduce total US health care spending by roughly 0.5% and reduce Federal budget deficits by approximately $54 billion over ten years. Finally, Congress should enact a permanent legislative solution to the yearly adjustments that it has made to the Medicare physician fee schedule conversion factor to promote predictability and certainty of payments for physician practices. A permanent solution to the yearly "doc-fixes" Congress has passed recently to reduce last-minute cuts to physician payments would both greatly reduce the administrative burden for physicians and allow for better financial and operational planning for these health care providers.

Conclusion

Apart from a sizable increase in the payroll tax, no option by itself fully addresses the short term and long term challenges facing Medicare's HI Trust Fund. As such, Congress should consider a comprehensive package of reforms through bipartisan negotiations, which a bipartisan Fiscal Commission could facilitate. Congress should also protect vulnerable populations of older Americans by gradually phasing in any legislative changes to provide Americans approaching Medicare eligibility, health care providers, and health insurers sufficient time to adjust.

Medicare is a crucial health insurance program for the elderly and individuals with disabilities. Together with Medicaid, it accounts for the vast majority of Federal health spending. Given the impending depletion in 2036 of the HI Trust Fund that supports Part A coverage, it is vital that Congress address this issue quickly to allow for adequate time to phase in changes to Medicare. The longer the delays, the greater the chance that necessary legislative changes to preserve Medicare will be disruptive to beneficiaries, health care providers, and the broader economy.

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