STATEMENT OF

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ON

STRENGTHENING MEDICARE AND MEDICAID: TAKING STEPS TO MODERNIZE AMERICA'S HEALTH CARE SYSTEM

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Chairman Baucus, Ranking Member Grassley, and Members of the Committee; thank you for the opportunity to appear before you to discuss ways to strengthen Medicare and Medicaid and modernize America's health care delivery system. The Affordable Care Act, passed by Congress and signed into law by President Obama in March of this year, is landmark health care legislation that is bringing comprehensive insurance reforms, expanded coverage, and enhanced quality of health care to all Americans. Millions of people across the country are already benefiting from this law, including the more than 100 million people enrolled in Medicare, Medicaid and the Children's Health Insurance Program (CHIP). Because of the Affordable Care Act, the fiscal future of Medicare is stronger, new tools to fight Medicare and Medicaid fraud are returning money to the Trust Funds and the Treasury, Medicare beneficiaries have new benefits and lower costs, and State Medicaid programs have additional resources and options to expand coverage, which is especially important in these challenging economic times.

As a pediatrician, I have witnessed both the best and the worst of the American health care system. I had the opportunity to practice pediatrics for 20 years in an organization that promoted integrated care, and saw firsthand the enormous difference that a doctor, nurse, and patient working together can make in health care outcomes. I have devoted my career to the belief that all patients deserve access to high quality health care, regardless of who they are or whether they live in a large city or a small rural community. High quality health care does not necessarily mean the most expensive health care. It means safe care, free from medical injuries, errors and infections; it means reliable care, based on the best available science; and it means person-centered care, in which each patient is treated with dignity and respect for his or her own unique preferences.

These core beliefs will continue to shape my work at the Centers for Medicare & Medicaid Services (CMS). As Administrator, protecting and strengthening Medicare, Medicaid, and CHIP is my top priority. And the Affordable Care Act has provided a number of important tools to

help achieve this goal. It explicitly protects the guaranteed Medicare benefits on which so many seniors and individuals with disabilities rely. It will not cut these guaranteed benefits, nor will it ration care. The Affordable Care Act does not prescribe a "one size fits all" approach to health care, because health care is first and foremost about caring for unique individuals. The Affordable Care Act incentivizes hospitals to improve the quality of care and prevent unnecessary readmissions, which are often harmful to patients.

CMS can help lead health care improvement in many ways. With new provisions in the Affordable Care Act, you have presented CMS with additional opportunities to work with others both in the public and private sector to make real improvements in the nation's health care delivery systems.

CMS can and should be a major force and a trustworthy partner for the continual improvement of health and health care in this country. We all agree that we want the highest quality health care system possible, a system that coordinates and integrates care, eliminates waste, and encourages prevention of illness. With over 100 million beneficiaries depending on us each day, CMS has an important role to play in improving our nation's health care delivery system. We are striving to meet this challenge, while attending diligently to the crucial, day-to-day work of our operations and preserving and enhancing the integrity of our payments, our programs, and the Trust Funds.

Immediate Benefits for People with Medicare

It has been only eight months since the passage of the Affordable Care Act, but already Americans are seeing changes and benefits from the law, including millions of people with Medicare and their families. Moreover, Medicare's long-term sustainability is stronger than ever as a result of efficiencies, new tools, resources to reduce waste and fraud, and slower growth in Medicare costs.

Here are just a few examples:

- **Helping Medicare beneficiaries maintain access to life-saving medicines:** As a result of new provisions in the Affordable Care Act, people with Medicare are receiving immediate relief from the cost of their prescription medications. To date, 1.8 million seniors and people with disabilities who have incurred high prescription drug costs have received immediate help through a tax-free $250 rebate check to help reimburse them for out-of-pocket costs in the Part D prescription drug coverage gap known as the "donut hole." In addition, every year, people with Medicare Part D will pay less for their prescription drug costs in the coverage gap. Beginning in 2011, eligible Medicare beneficiaries will get a 50 percent discount on brand name prescription drugs in the coverage gap. By 2020, we will have closed the donut hole.

- **Making Medicare strong:** The Affordable Care Act contains many cost-saving provisions that will make the Medicare program more accountable and efficient, protect the program from waste, and slow the growth in cost of the Medicare program. These important changes put Medicare on a path toward long-term sustainability and produce savings for the taxpayers by prolonging the life of the Medicare Hospital Insurance Trust Fund for an additional 12 years to 2029. These important changes will also benefit people with Medicare by keeping their premiums and cost sharing low.

- **New tools and authorities to fight fraud:** New authorities in the Affordable Care Act offer additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of the Medicare and Medicaid programs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, rather than simply tracking down fraudulent providers and pursuing fake claims. CMS also now has the flexibility needed to tailor resources and activities in previously unavailable ways, which we believe will greatly support the effectiveness of our work.

  The Affordable Care Act provides CMS with additional tools to help the Agency tailor interventions to address areas of the most significant risk. Enhanced screening requirements for providers and suppliers to enroll in Medicare, along with oversight

controls such as a temporary enrollment moratorium and pre-payment review of claims in high risk areas, will allow the Agency to better focus its resources on addressing the areas of greatest concern and highest dollar impact.

Further, through the Health Care Fraud Prevention and Enforcement Action Team, or "Project HEAT," CMS has joined forces with our law-enforcement partners at the Department of Justice and the HHS Office of Inspector General to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

- **Reducing improper payments:** While continuing to be vigilant in detecting and pursuing problems when they occur, we are also pursuing prevention of improper payments before they occur. We are reexamining our claims and enrollment systems to enhance our ability to prevent improper payments while still promptly compensating honest, hard-working providers. Due to prompt pay requirements in Medicare, our claims processing systems were built to quickly process and pay claims. CMS pays 4.8 million Medicare claims each day, approximately 1.2 billion Medicare claims each year. Nevertheless, with the new tools provided to CMS under the Affordable Care Act, we are steadily working to better incorporate fraud and improper payment prevention activities into our claims payment and provider enrollment processes where appropriate so we can prevent paying improper claims in the first place.

- **Reducing payment error rates in Medicare, Medicaid, and CHIP:** This Administration is strongly committed to minimizing waste, fraud, and abuse in Federal health care programs. We are keenly focused on the President's ambitious goal of reducing the Medicare fee-for-service error rate in half by 2012.

- **High quality, low-cost Medicare Advantage benefits:** This year CMS has improved its oversight and management of the Medicare Advantage (MA) program. The results for 2011, announced this fall, show that when CMS negotiates on behalf of beneficiaries and strengthens our oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices offering better benefits. In 2011, premiums are

lower and enrollment is projected to be higher than ever before. As part of CMS' national strategy for implementing quality improvement in health care, CMS is also instituting quality bonus payments for MA plans, providing an incentive for all plans to improve the care they offer to Medicare beneficiaries.

- **Improved customer service for people with Medicare:** I am proud of the hard work of CMS' staff to implement the provisions of the Affordable Care Act on time. Nevertheless, I also recognize that much work remains in the coming days to administer our Federal health care programs and to implement new changes in the law. CMS can set an example for improving the health care system by working to improve ourselves as an Agency. We need to continually simplify and streamline our operations and work to reduce waste, both internally and externally. Diligence, agility, teamwork, and creativity should infuse CMS' day-to-day actions as we remain mindful of the people we serve: public and private sector leaders, clinicians, hospitals, health centers, care organizations, and most importantly, the people who rely on our programs.

- **Reorganizing and streamlining CMS to prioritize coordinated program administration, innovation and fiscal responsibility:** Importantly, CMS underwent an internal realignment in April 2010, before I arrived, which consolidated Medicare operations in the Center for Medicare, as well as brought the bulk of Medicare and Medicaid program integrity activities under a new CMS Center for Program Integrity. Research and policy development functions have also been consolidated in a new Center for Strategic Planning. Because of this streamlining of operations, CMS is now able to pursue a more strategic and broader approach to program operations and program integrity functions at the Agency.

The Affordable Care Act

We can all agree that we want a high quality health care system. However, the problems of American health care lie in the design of the care systems in which the people who give care work. These systems need to be reformed in order to deliver the higher levels of reliability,

safety, and person-centeredness that we owe to ourselves and our neighbors. Instead, our care is often fragmented and of inconsistent quality, without enough focus on prevention of disease. Historically, we have focused health care efforts on treating diseases after they occur, paying too little attention upstream to preventing and mitigating the underlying causes of diseases.

We can address and solve these problems through sensible and effective changes in the systems through which we deliver health care. Merely trying harder in the current system is not likely to get us very far; any doctor will admit that he or she is already trying as hard as he or she can. Better integration of care, better designed services for our beneficiaries, better measurement tools, and a focus on continual improvement can all help bring us closer to the health care system that we want and the American people deserve.

Congress, led by many members of this Committee, recognized the need to improve health care quality in this country with the passage of the Affordable Care Act. The legislation, which this Committee worked so hard to fashion, has already begun to help bring better quality care to the American people.

The Affordable Care Act includes unprecedented new tools that will enable us to reinvigorate our nation's focus on the quality, value, and outcomes of care, and help the public and the private sector produce a new system that is better for patients, families, communities, and the health care workforce. These innovative provisions will enable CMS to work with our partners in the private sector to improve care coordination, increase patient safety, offer beneficiaries more information and more control over their care, and achieve better outcomes. The Act allows us to better align incentives for quality care and move towards seamless, integrated care. This will help health care providers and patients better tackle the problems of fragmentation and unreliability in care, which can erode health and satisfaction and add cost to taxpayers without adding anything of value to patients.

To me, improving health care delivery has three major, overarching goals: first, providing better care for individuals – care that is more effective, more patient-centered, timelier, and more equitable; second, assuring better health for populations by addressing underlying causes of poor

health, like physical inactivity, behavioral risk factors, and poor nutrition; and third, reducing costs by improving care, eliminating waste and needless hassles, reducing preventable complications in care, and coordinating care for patients who are journeying through the system. To be absolutely clear, I am talking about reducing costs while improving the quality of care individuals receive.

1. Improving Care for Individuals

It has been almost a decade since the Institute of Medicine published their seminal reports on medical errors and quality in our health care system, outlining the six aims for improvement. We are still trying to get there. I strongly believe that every single American can and should always receive the highest quality of care, no matter where they live or happen to seek care.
I want CMS to continue its role as a leader and partner in encouraging safer and better care in hospitals, clinics, physician offices, and long-term care settings. I know we can get there, because I have seen throughout our nation example after example of bold and exciting progress. CMS is working to make the "best care" in America the norm in health care, for everyone.

Several Affordable Care Act provisions will help CMS move in this direction. Here are a few examples:

- Value-Based Purchasing: Allows us to measure and reward excellence in hospitals, physician offices, and elsewhere.

- Specific focus on Hospital-Acquired Conditions (HACs): These conditions consist of complications that patients acquire from the care that is supposed to help them. Not all HACs are preventable, but a great number can be avoided. For example, the Centers for Disease Control and Prevention has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone. In addition to pain, suffering, and, sometimes death, these complications also add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and consumers. We know of hospitals in this country that, through improvements in their health care processes, have virtually eliminated some forms of infections that other hospitals still think are inevitable.

To create incentives for hospitals to prevent such infections, the Affordable Care Act includes a Medicare payment reduction for hospitals that have a hospital acquired condition rate that is much higher than average, beginning in fiscal year 2015. Prior to each fiscal year, affected hospitals will receive confidential reports regarding HACs during the applicable period. In addition, the Secretary will publicly report the measures used for the payment adjustments on the Hospital Compare website,[1] after giving hospitals the opportunity to review and submit corrections to such information. The Affordable Care Act also requires that Medicaid regulations incorporate State practices that prohibit payment for Health Care-Acquired Conditions and directs CMS to apply certain Medicare HAC payment policies to Medicaid when appropriate.

- Helping to reduce unnecessary hospital readmissions: We know that about one in every five Medicare beneficiaries who leave the hospital will be re-admitted within 30 days of discharge. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spends $12 billion annually on potentially preventable readmissions (based on 2005 data).[2] Half or more of these readmissions could be prevented with proper attention to care transitions, coordination, outreach, and patient education and support, allowing these patients to recover at home where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act sets a course for hospitals to focus on reducing preventable hospital readmissions by linking financial incentives to readmission rates and by providing assistance and support to hospitals to improve transitional care processes. Readmission rate information for all patients for each hospital participating in the program will be publicly available on the CMS website.

- Adult health quality measures: The Affordable Care Act establishes a process for the development of a set of core health care quality measures specific to Medicaid-eligible adults; these new quality measures will be finalized by 2012 and we expect routine reporting will take place on the quality of services measured in the core set. These

[1] http://www.hospitalcompare.hhs.gov/
[2] Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007.

efforts complement those to develop child health quality measures as directed under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

- Quality bonus payments in Medicare Advantage: Beginning in 2012, the Affordable Care Act introduces quality bonus payments into the MA program as part of the national strategy for implementing quality improvement in health care. MA plans will be paid a quality bonus payment (QBP) based on their rating using CMS' 5-star quality rating system. To provide a strong incentive for MA plans to improve performance, CMS will pursue a national demonstration project running from 2012 to 2014 that rewards all the plans receiving three stars or higher with progressively larger QBPs. The demonstration will test whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in MA program quality scores, compared to the current law approach to computation of QBPs.

2. Better Integration of Care

"Integrated care" is the care we need when we have a chronic disease, or are journeying through the health care system from place to place or doctor to doctor. We want seamlessness. We want coordination. We do not want to keep having to tell our story over and over again to multiple providers, or to be afraid that one doctor will not know what medications another doctor has already given us. We know for sure that integrated care is better care – safer, more likely to get us to the treatments we really need, less likely to confuse us, and, overall, less costly than the opposite – disintegrated, fragmented care. The problem is that our fragmented care system has a lot of trouble offering us integrated care when we need and want it.

We need to help integrated care thrive in America. Too often, health care takes place in series of fragments or episodes. We need to make it possible for entirely new levels of seamlessness, coordination, and cooperation to emerge among the people and the entities that provide health care, so as to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and place.

The transition from a fragmented system to an integrated person-centered delivery system will not be an easy one. The new system that we can imagine together is not a "one size fits all" model or the *status quo* repackaged; many different approaches will be needed to match the enormous diversity of settings, communities, and histories in this textured nation. We will need to ensure the space and time for these many, adaptive forms of integrated care to succeed.

The Affordable Care Act, thanks to many members of this Committee, contains important new opportunities to encourage and foster seamless, coordinated care. Here are a few important examples:

- Medical Homes: We must examine approaches to promote effective "home bases" for patients, rooted in primary care, to help patients navigate and understand the complex health care system that they may rely on, and to help them be more proactive with prevention and detecting potential complications before they do their damage.

- Health Homes: For Medicaid beneficiaries, we will work with States to establish coordinated services for individuals with chronic conditions that not only make health care seamless, but that effectively bridge to home and community-based services. The Affordable Care Act also requires States participating in the health home option to monitor avoidable hospital readmissions, linking better integration with quality improvement priorities.

- Accountable Care Organizations (ACOs): The Affordable Care Act directs CMS to establish a shared savings program that promotes coordination of services under the Medicare program and accountability for a patient population through ACOs by January 2012. ACOs should not be thought of only as a financing mechanism, but as a care delivery organization. Eligible ACOs are groups of providers and suppliers that meet the requirements for participation in the shared savings program, which include having an established mechanism for joint decision making. The program will encourage ACOs to make investments in infrastructure and redesigned care processes for high quality and efficient service delivery.

- Federal Coordinated Health Care Office: Dual eligibles are uniquely at risk for duplicative and uncoordinated care as a result of their enrollment in both Medicare and Medicaid, which function as distinct programs with different program structures. The Affordable Care Act establishes an office whose sole focus is better coordinating the care and needs of this medically needy population.

- Building infrastructure to help with integration: As part of our commitment to assist States in the implementation of the Affordable Care Act, CMS has proposed to increase the current 50 percent Federal match to a 90 percent Federal match for investments that States make through December 31, 2015 to streamline and upgrade their Medicaid eligibility systems. CMS has also provided States with guidance on how to establish IT systems to enroll individuals who qualify for Medicaid or CHIP, premium tax credits or cost-sharing reductions in the Exchanges available through the Affordable Care Act. These efficient technology investments will support a coordinated, consumer-oriented system for individuals, families and businesses to sign up for the health insurance plan that they choose. Providing States with early guidance and funding assistance will allow them to reduce barriers and duplication as they develop new systems.

3. Better Health for Populations

Our system is often faulted for its focus on health care for the sick, instead of promoting better health for all. CMS is implementing a variety of initiatives that will encourage prevention and move towards the goal of improving the health of the entire population. CMS can meaningfully contribute to improving prevention of a variety of health problems, including obesity, cardiovascular disease, and improving perinatal outcomes. In addition to expanding health insurance coverage, the Affordable Care Act provides meaningful and affordable coverage of preventive health services.

- Annual Wellness Visit: While Medicare already covers a comprehensive package of preventive benefits as well as a one-time "Welcome to Medicare" exam for new

beneficiaries, before the enactment of the Affordable Care Act, Medicare did not cover annual check-ups for beneficiaries. Beginning in 2011, Medicare will cover an annual "wellness visit" at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary's health needs change over time.

- Removing financial barriers to prevention services: While Medicare covers a range of screening and preventive benefits, many of these services have been underutilized, in part because out-of-pocket costs have presented a financial barrier for beneficiaries. Beginning in 2011, all preventive benefits covered by Medicare that are recommended with an A or B rating by the U.S. Preventive Services Task Force will be available to beneficiaries free of charge (without having to pay coinsurance or apply the Part B deductible). These important benefits include tests and procedures that may either prevent illnesses or detect them at an early stage when treatment is likely to work best, such as screenings for breast, cervical, and colorectal cancers, and screenings for cardiovascular disease, diabetes, and osteoporosis.

- More prevention in Federally Qualified Health Centers (FQHCs): Beginning in 2011, the scope of Medicare-covered preventive services furnished in Federally Qualified Health Centers will expand significantly. FQHCs provide primary care services for all age groups in medically underserved areas or medically underserved populations across the nation.

- Promoting tobacco cessation in Medicaid: Under the Affordable Care Act, States must provide pregnant women with Medicaid coverage of tobacco cessation services, including counseling and pharmacotherapy, as recommended by the 2008 Public Health Service (PHS) Clinical Practice Guidelines. States are not permitted to charge any form of cost sharing for these services. We are also encouraging States to provide tobacco cessation services for Medicaid enrollees who are not pregnant. Beginning in 2014, the

Affordable Care Act removes tobacco cessation drugs from Medicaid's excluded drug list.

Thanks largely to the Affordable Care Act, CMS has a new cross-cutting resource to test change and accelerate progress in pursuing the goals of better care, better health, and lower cost through improvement of care, focusing on individuals, integration of care, and prevention: the Center for Medicare and Medicaid Innovation. This Innovation Center will test and study the most promising innovative payment and service delivery models. The Innovation Center will work with relevant Federal agencies and clinical and analytical experts, as well as local, national and regional providers, States and beneficiary organizations to identify and promote systems changes that can improve quality and outcomes for patients while containing costs.

An Essential Component: Collaboration with the Public and Private Sectors

Building an improved health care delivery system has to be a collaborative effort. CMS cannot do this alone, and neither can government as a whole. Achieving a high quality of care will require participation and leadership from all: from Congress, States, insurers, employers, health professionals, organizations, associations, patients, families and communities. CMS should partner extensively with all health care stakeholders in pursuit of our common goals for improving care.

As a trustworthy partner, CMS will collaborate with private insurers, State health officials, Federal health programs, consumers, beneficiaries, researchers, and other stakeholders to help improve the quality of health care for people who benefit from our programs. CMS can participate by incentivizing quality and efficiency in our reimbursement payments for Federal health care programs and by assuring sound and useful measurements of progress to maximize the value of Medicare spending and promote improvement in health outcomes.

States will have an integral role to play in the implementation of delivery system changes and other Affordable Care Act provisions. CMS is committed to ensuring that States have the tools they need to succeed at addressing these challenges. To that end, CMS has already conducted a number of outreach sessions and meetings with State stakeholders to discuss topics such as

Medicaid payment practices, health homes, and primary care practice support. CMS will also rely on input from States as we design guidance and implement other changes and improvements.

Health care providers who are directly interacting with patients each day are a crucial partner in this reform effort. They need stable and predictable payments in order to be able to play their key roles as foundations of delivery system reform. To ensure that Medicare beneficiaries continue to have appropriate access to necessary physician services, the Administration supports a permanent revision to the Sustainable Growth Rate methodology payment system for physicians.

In addition, CMS is entering into a public-private collaboration with the Multi-payer Advanced Primary Care Practice Demonstration (MAPCP). This demonstration marks the first time that Medicare, Medicaid and private insurers will join in a partnership with States to transform health care delivery. Advanced primary care practices, often referred to as patient-centered medical homes, utilize a team approach to health care, with the patient at the center. Under this demonstration program, Medicare will participate in existing State multi-payer health reform initiatives that include participation from both Medicaid and private health plans. Implementing a common payment method across different payers will reduce administrative burdens, align incentives, and provide participating practices with the resources needed to function as advanced primary care practices. This type of collaboration, involving CMS, private insurers, States and local practices, is essential as we work to build new systems.

Conclusion

Strengthening Medicare and Medicaid must be a step-by-step, community-by-community effort. All of us share the goal of improving the quality of health care in this country and helping to make care more affordable and accessible for America's seniors, families, and children.

Many of the programs, new authorities, and unprecedented innovations that CMS is implementing and pursuing as a result of the provisions of the Affordable Care Act are ideas that had their genesis in this Committee. I know that you and your staff spent many months working

collaboratively to transform America's health care system. While the Affordable Care Act is now the law of the land, the work is not done. We still need your help.

I know that many members of this Committee—on both sides of the aisle—have criticized CMS for not being transparent enough or for being overly rigid in the applications of its rules. While the Agency is filled with wonderful staff who work extremely hard to ensure that Medicare, Medicaid, and CHIP beneficiaries receive the highest quality services, I know we must rise to this Committee's expectations. I pledge to each and every member that I, the senior CMS leaders, and all members of the staff will continue to be as open and transparent as possible, to be as responsive as we can to your suggestions, questions, and concerns, and to try to understand the perspectives of your constituents. We may not always agree, but we will always listen.

Making a better health care system a reality – a system truly capable of major improvements in health care, health and cost – will require that we work well and continually together. I look forward to working with all stakeholders, and with members of this Committee, as CMS joins your effort to improve our nation's health care delivery system.