STATEMENT OF

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ON

"IMPROVING QUALITY, LOWERING COSTS:

THE ROLE OF HEALTH CARE DELIVERY SYSTEM REFORM"

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Testimony of Jonathan Blum
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Chairman Harkin, Senator Whitehouse, Ranking Member Enzi, and distinguished Committee members, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services' (CMS) initiatives to improve our nation's health care delivery system.

In the 18 months since the Affordable Care Act became law, CMS has continued to strengthen the Medicare and Medicaid programs for the millions of Americans who rely on them, while implementing reforms that will ensure that we spend taxpayers' money wisely, improve health care quality, and control health care cost growth. Over the past year and a half, CMS has unveiled a series of rules and initiatives that will change the way Medicare pays hospitals, doctors, and other health care providers, to ensure that they are providing the kinds of high-quality care beneficiaries expect and deserve, at a cost our nation can afford. These changes will provide Americans with better health care by rewarding what works – such as improved care coordination – while also giving Medicare the tools to control costs over the long run – such as changing the way we pay doctors and other providers to reward efficient, quality care. We hope the entire health care system will adopt these new delivery system reform initiatives.

We have made major progress in strengthening Medicare over the last 18 months while implementing the Affordable Care Act. At a time when other health care costs are rising faster than inflation, Medicare costs are stable. Following the implementation of the Affordable Care Act, growth in Medicare per capita spending has declined significantly. Overall, Medicare Part D, Medicare Advantage (MA), and Medicare Part A premiums will remain virtually the same for 2012 as in 2011, even as beneficiaries enjoy new benefits, and Medicare Part B premiums in 2012 will be lower than previously projected. Meanwhile, on November 4, 2011, CMS

announced that so far this year, 22.6 million beneficiaries in fee-for-service Medicare have used preventive services that are now provided at no cost to them, including the new free Annual Wellness Visit.[1] Additionally, more than 2.2 million beneficiaries have saved in total over $1.2 billion (an average of $550 per person) on their prescription drugs, thanks to a 50 percent discount on their covered brand name prescription drugs in the donut hole.[2] For 2010, nearly 4 million seniors who reached the prescription drug donut hole received a $250 rebate check to help them afford the cost of their prescription drugs.[3] Thanks to these benefits and the reforms in the law, a senior enrolled in the fee-for-service Medicare program could save more than $3,500 over the next ten years.[4]

With the new provisions in the Affordable Care Act, CMS has the opportunity to work with both the public and private sectors to make real advancements in the nation's health care delivery system to improve the quality of life and quality of care for our beneficiaries and other Americans. With over 100 million people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP), CMS has an important role to play in improving the delivery of health care in our nation.

Our Current Delivery System is Fragmented and Expensive

Our nation has top-notch doctors and other health care providers, and leads the world in health care technology and cutting edge treatments. Yet the system in which these talented people work falls short far too often. Our delivery system is fragmented, leaving patients in the care of multiple doctors, each sometimes unaware of how the other is treating the patient. Medical errors can occur as a patient moves from one care setting to another, or is prescribed different medications that interact. For too long, our current system focused on caring for the sick, doing little to keep people healthy in the first place. As a result, our health care system is expensive and does not necessarily produce the best health care results. It is one of CMS' top priorities to lead the transformation of the delivery of care, so that all our beneficiaries receive high-quality

[1] http://www.cms.gov/apps/media/press/release.asp?Counter=4158&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&sr

[2] http://www.cms.gov/apps/media/press/release.asp?Counter=4158&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&sr

[3] http://www.hhs.gov/news/press/2011pres/03/20110322a.html

[4] http://www.hhs.gov/news/press/2011pres/03/20110322a.html

care that is coordinated among their doctors and specialists, and which also avoids errors and saves money.

In order to achieve this goal, CMS has already established initiatives that encourage health care providers to deliver high-quality, coordinated care at lower costs. CMS is transforming from a passive payer of services into an active purchaser of high-quality, affordable care through these newly established initiatives. Since the passage of the Affordable Care Act, CMS has already rolled out many reforms that promote improved care, such as the Medicare Shared Savings Program, Hospital Value-Based Purchasing (VBP), and the strengthened Medicare Advantage 5-Star Rating program. Now that we have moved forward with these reforms, we expect further care improvements and cost savings over the next several years as these programs are implemented fully. Building on this work, CMS is focusing on the next set of priorities for reforming our care delivery system. Those priorities include new ways of rewarding efficiency and improving beneficiary care, investing in patient safety and care coordination, and improving the quality and lowering the cost of care for the millions of Americans enrolled in Medicare, Medicaid, and CHIP.

Success at CMS: Rewarding Quality and Coordinating Care

Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality of care and a more innovative care delivery system designed to improve their health outcomes and reduce costs. Below are a few examples of the delivery system reforms we have initiated since the passage of the Affordable Care Act.

Investing in Quality Care

Hospital payments account for the largest share of Medicare spending, and Medicare is the largest single payer for hospital services. Earlier this year, CMS established the new Hospital Value-Based Purchasing (VBP) Program, which will change how CMS pays hospitals for inpatient acute care. This program, which ties payment to value, is expected to foster higher-quality care for all hospital patients across our country's health system.

In FY 2013, CMS will implement the new budget-neutral, value-based incentive payments. These payments will reward hospitals based on their overall performance on a set of quality measures that are linked to clinical processes of care and patients' experiences of care. National bodies of experts, including the National Quality Forum, have endorsed these measures, and CMS will post the hospitals' scores related to those measures on the Hospital Compare website.[5] The program aims to help patients receive higher-quality care and see better outcomes.

Under the program, CMS will score hospitals based on their performance on each measure relative to other hospitals, as well as on how a hospital's performance on each measure has improved over time. CMS will use the higher of a hospital's improvement and achievement score on each measure to determine a total performance score, which will then be translated into an incentive payment. In addition to rewarding excellence, hospitals will be given an incentive for continuous improvement of care delivery. In the future, CMS plans to add new measures that focus on improved patient outcomes and prevention of hospital-acquired conditions. CMS may replace measures that reach very high compliance scores, continuing to raise the bar and spur quality improvements. This redirection of funds will provide a strong incentive for quality improvement, which we expect will result in significant savings for Medicare, taxpayers, and enrollees over time.

Promoting Coordinated Care to Improve Care and Create Savings

CMS has established initiatives to ensure that Medicare patients get the right care, in the right place, at the right time. A key part of CMS' work in this area is a multi-part initiative built around Accountable Care Organizations (ACOs), which bring together doctors, hospitals and other health care providers to better coordinate care for patients. ACOs are an innovative service delivery model being used by CMS and in the private sector and communities across the country. If ACOs improve quality of care and lower costs, health care providers, as well as Medicare, can share in the savings. Those savings will help to shift payment incentives toward rewarding quality and value rather than volume of care. Provider participation in ACOs is purely voluntary, and beneficiaries will continue to have all their same benefits, including their ability to see any Medicare provider.

[5] www.hospitalcompare.hhs.gov

CMS released the Medicare Shared Savings Program final rule (CMS-1345-F) on October 20, 2011. Under this program, providers who voluntarily form an ACO and meet quality standards based upon patients' outcomes and care coordination, as well as other measures, may share in the savings they achieve for the Medicare program. ACOs that commit to share in savings and losses for the duration of the agreement may receive a higher share of any generated savings.

The publication of this rule followed months of soliciting feedback and receiving comments from stakeholders across the country. Stakeholder groups have generally responded favorably to the newly-published rule. For example, the American Medical Association (AMA) stated that they are pleased that "the final rule on Medicare ACOs includes many of the important changes recommended by the AMA to allow all interested physicians to lead and participate in these new models of care."[6] The American Medical Group Association (AMGA) said that "AMGA is very pleased that CMS listened and responded with noteworthy changes. AMGA believes ACOs have the potential to improve quality of care while bending the cost curve."[7] The National Association of Public Hospitals and Health Systems said that the rule "will allow hospitals and other providers to more easily participate in the program, and should add to the success of this initiative and future innovations in health care delivery system reform."[8]

In addition, CMS is using its new authorities through the Center for Medicare and Medicaid Innovation (the Innovation Center) to test alternative payment models and prepare organizations to provide accountable care. These initiatives include:

- **The Pioneer ACO Model**, which is designed for health care organizations and providers with experience in coordinating care for patients across settings. The model will allow these provider groups to move more rapidly to a population-based payment model on a track consistent with, but separate from, the Medicare Shared Savings Program. The model is designed to work in coordination with private payers, multiplying the effectiveness of the program and aligning provider incentives. This has the potential to

[6] http://www.ama-assn.org/ama/pub/news/news/final-aco-rule.page
[7] http://www.amga.org/AboutAMGA/News/article_news.asp?k=534
[8] http://www.naph.org/Main-Menu-Category/Newsroom/2011-Press-Releases/NAPH-Supports-Final-ACO-Rule-Changes.aspx

improve quality and health outcomes for patients across the ACO, and achieve cost savings for Medicare and patients.

- **The Advance Payment ACO Model,** which will provide additional support to rural and physician-based ACOs who want to participate in the Medicare Shared Savings Program, but lack the start-up resources to build the necessary infrastructure, such as new staff or information technology systems. The advance payments would be recovered from any future shared savings which ACO earns through performance.
- **The Accelerated Development Learning Sessions**, which are available for providers interested in learning more about the steps necessary to become an ACO. The Innovation Center is holding these convenient and free sessions in a variety of cities, with some sessions available online. To date, the Innovation Center has hosted two sessions: 67 organizations attended the first session held in Minneapolis in June 2011 and 39 attended the second session in San Francisco in September 2011. The Innovation Center will be hosting a third and final session on November 17 and 18, 2011 at CMS Headquarters in Baltimore.

Together, these initiatives provide a broad range of options and support that reflect the varying needs of providers embarking on delivery system reforms.

Improving Transparency to Empower Beneficiaries

Medicare Advantage

Enrollment in the Medicare Advantage (MA) program continues to grow. In 2012, MA plans project that MA enrollment will increase by 10 percent.[9] CMS is focused on strengthening and improving MA so that its plans provide good value to beneficiaries and the program remains robust. CMS has streamlined plan offerings so that beneficiaries have choices among plans that are meaningfully different from one another. In addition to improvements to the 5-star plan quality rating system, the Affordable Care Act allows CMS to deny a plan's bid should the total cost to beneficiaries, including premiums and out-of-pocket costs, increase more than 10 percent from the prior year.

[9] http://www.hhs.gov/news/press/2011pres/09/20110915a.html

The results show that when CMS strengthens our oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices offering better benefits. In 2012, MA premiums are, on average, 4 percent lower than in 2011 and 11 percent lower than in 2010.[10] As part of CMS' national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries. For the first time in 2012, CMS will reward those MA plans with higher quality scores, based on its 5-Star rating system. CMS is also allowing 5-Star MA and Part D plans to continuously market and enroll beneficiaries throughout the year.

Our goal is for plans to improve their quality scores over the next several years and to encourage more beneficiaries to enroll in high-quality plans. In 2011, we have seen a 5 percent increase in enrollment among Medicare Advantage plans with a four or five star rating.[11]

Physician Quality

As part of CMS' broader strategy to encourage health care providers to adopt practices that can improve patient care, CMS is continuing to strengthen the Physician Quality Reporting System by rewarding physicians for reporting quality measurement data. The final physician fee schedule rule for 2012 (CMS-1524-FC) updates a number of physician incentive programs including the Physician Quality Reporting System, the e-Prescribing Incentive Program, and the Electronic Health Records Incentive Program.

Freeing Doctors to Focus on Patients, Not Paperwork

CMS and the Department of Health and Human Services (HHS) have also started work to help doctors begin using Electronic Health Records (EHRs) through the EHR Incentive Program. EHRs help providers communicate with each other about a patient's care. EHRs make it easier for physicians, hospitals, and others to assess a patient's medical status and make sure that care is appropriate. They can help doctors avoid redundant paperwork and ensure patients get the correct tests and medications. HHS also issued administrative simplification rules (CMS-0032-IFC) to improve the use of electronic standards to help eliminate inefficient manual processes.

[10] http://www.hhs.gov/news/press/2011pres/09/20110915a.html
[11] http://www.healthcare.gov/news/factsheets/2011/02/medicare02102011a.html

We estimate that these changes will save providers and health plans $12 billion over the next 10 years.[12] More important, greater use of EHRs will free providers to spend more time with their patients. An April 2010 study in *Health Affairs* found that simplifying administrative systems could save four hours of professional time per physician and five hours of support staff time every week.[13] This commonsense streamlining means fewer phone calls between physicians and health plans, lower postage and paperwork costs, and fewer denied claims. Overall, adoption of EHRs means physicians can cut through the red tape and spend more time and resources administering quality care to their patients.

Next Steps: Investing in Innovation, Improving Care, and Saving Money

CMS has already made tremendous progress toward achieving the Affordable Care Act's goals of lowering Medicare costs and improving care – and we are doing even more. With the established foundation detailed above, CMS is moving forward to employ other new tools made available by the Affordable Care Act to reform our nation's health care delivery system. The programs and initiatives described below will bring us closer to the goal we all share -- a high-quality, affordable, patient-centered health care delivery system that effectively prevents or treats illness without waste or duplication.

Investing in Innovation to Deliver Quality Care

The key to building a sustainable health care system in our country will come from innovations and improvements in how we deliver health care. CMS has started this work by changing our hospital payment systems and Medicare Advantage programs to reward quality care and coordination, instead of simply paying providers for offering more services. We also recognize that there is a great richness of innovation occurring in local communities and through multiple efforts underway to provide care for people, often at a lower cost.

In section 3021 of the Affordable Care Act, Congress created the Innovation Center to test innovative payment and service delivery models to reduce program expenditures, while

[12] http://www.gpo.gov/fdsys/pkg/FR-2011-07-08/pdf/2011-16834.pdf

[13] Blanchfield, Bonnie, James Heffernan, Bradford Osgood, et. al. "Saving Billions of Dollars – And Physicians' Time – By Streamlining Billing Practices." *Health Affairs*. April 29, 2010. http://content.healthaffairs.org/content/early/2010/04/29/hlthaff.2009.0075.full

preserving or enhancing the quality of care for those entitled to Medicare and Medicaid. The health reform law gives the Innovation Center flexibility in selecting and testing innovative payment and service delivery models, enables it to work with Medicare, Medicaid, and CHIP programs to better serve beneficiaries and reduce costs, and provides $10 billion in direct funding for activities initiated in fiscal years 2011 through 2019 to support this mission. The Affordable Care Act also allows the Secretary of HHS to expand, through rulemaking, the scope and duration of models proven effective after evaluation, including implementation on a nationwide basis. In order to expand a model, the Secretary must determine that the model improves the quality of patient care without increasing spending or reduces spending without reducing the quality of care, and the CMS Actuary must certify that expanding the program will lower costs (or at least not increase costs). The following sections describe, in more detail, the Innovation Center's initiatives.

Bundling Payments to Promote Efficient, Quality Care

Medicare currently makes separate payments to providers for each service related to an illness or course of treatment, often leading to fragmented care with minimal coordination across providers and health care settings. Under the Innovation Center's Bundled Payments for Care Improvement initiative, CMS will test various models to link payments for multiple services that patients receive during an episode of care. For example, instead of a surgical procedure and follow-up care generating multiple claims from multiple providers, the entire team will be compensated with a "bundled" payment that provides incentives to deliver health care services more efficiently while maintaining or improving quality of care. Research has shown that bundled payments can encourage providers to collaborate to improve the patient's experience of care during a stay in an acute care hospital and during post-discharge recovery.

Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals, and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. On August 25, 2011, CMS invited providers through a *Federal Register* notice (CMS-5504-N) to apply to test and develop four different models of bundling payments. Depending on the particular model, providers have flexibility in selecting

conditions to include, developing the health care delivery structure, and determining how to allocate payments among participating providers. Because of the potential for reducing the cost of care through improvement, health care providers will be able to streamline and improve their coordination to provide savings to the Medicare Trust Funds. By giving providers the flexibility to determine which model of bundled payments works best for them, we believe it will be easier for health care providers of different sizes to participate in this initiative, thus encouraging more providers to test and develop innovative models to coordinate care and produce savings.

Preventing Costly Conditions and Complications

CMS launched the Partnership for Patients: Better Care, Lower Costs, a new public-private partnership, to improve the quality, safety, and affordability of health care for all Americans. More than 6,200 organizations, including over 2,800 hospitals, have joined the initiative. Partnership for Patients brings together leaders of major hospitals, employers, physicians, nurses, and patient advocates, along with State and Federal governments, in a shared effort to make hospital care safer, more reliable, and less costly.

The two goals of this new partnership are to:

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40 percent compared to 2010. Achieving this goal would mean approximately 1.8 million fewer injuries to patients with more than 60,000 lives saved over three years.
- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would decrease so that hospital readmissions would be reduced by 20 percent compared to 2010. Achieving this goal would mean more than 1.6 million patients would recover from illness without suffering a preventable complication requiring re-hospitalization within 30 days of discharge.

It is our belief that achieving these goals will save lives and prevent injuries to millions of Americans. They have the potential to save up to $35 billion across the health care system, including up to $10 billion in Medicare savings, over the next three years. Over the next ten

years, this partnership could reduce Medicare costs by about $50 billion and generate billions in Medicaid savings.[14] These improvements will help put our nation on the path toward a more sustainable health care system.

Improving the Front Lines of Care

In recent months, CMS has launched several new initiatives that seek to partner with our colleagues on the front lines of health care delivery. Through investments in primary care and medical homes, and seeking direct feedback from clinicians in the field, we will move our health care system into the 21st century. The Innovation Center's current initiatives include:

- **The Comprehensive Primary Care (CPC) Initiative**, which fosters collaboration between public and private health care payers to strengthen primary care. The CPC initiative will test two models simultaneously – a service delivery model and a payment model – to see how primary care practices coordinate care for their patients.
- **The Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration**, which is operated by the Innovation Center in partnership with the Health Resources and Services Administration to test the effectiveness of teams of doctors and other health professionals working in community health centers to coordinate and improve care for up to 195,000 Medicare patients. Five hundred FQHCs in 44 States are participating in the demonstration, which will operate between November 2011 and October 2014.
- **The Innovation Advisors Initiative**, which is currently accepting applications for up to 200 health professionals to undertake intensive efforts to expand their health systems skills and knowledge, apply what they learn in their organizations and areas, and work with CMS to test new models of care delivery in their own organizations and communities. Developing these innovation leaders expands the reach of the Innovation Center and has the potential to improve patient care and reduce costs.

Expanding and Promoting Partnerships to Improve Care for Medicare-Medicaid Enrollees

A top priority for CMS is improving the quality and lowering the cost of care for the 9 million Americans enrolled in both Medicare and Medicaid (known as "dual eligibles" or Medicare-

[14] http://www.healthcare.gov/compare/partnership-for-patients/index.html

Medicaid enrollees). The Affordable Care Act created the new Federal Coordinated Health Care Office, referred to as the Medicare-Medicaid Coordination Office, to more effectively integrate benefits between the two programs and to improve the coordination between the Federal Government and States for Medicare-Medicaid enrollees. Through our work and with our State partners, our efforts are advancing access to seamless, coordinated care programs for Medicare-Medicaid enrollees.

Beneficiaries who are dually enrolled in Medicare and Medicaid are typically low-income seniors and people with disabilities. Although most have complex care needs, too often their care is fragmented, resulting in poor health outcomes and increased costs. These beneficiaries, their families, and their caregivers would be better served by improved coordination that ensures their complex care needs are met through seamless, person-centered approaches. To that end, the CMS Medicare-Medicaid Coordination Office has advanced new initiatives designed to align the two programs' rules and policies and develop and test demonstrations across the country.

Most recently, the Medicare-Medicaid Coordination Office announced a new opportunity for States to participate in demonstration projects designed to improve the quality of care for Medicare-Medicaid enrollees. These approaches provide States the opportunity to share in reduced costs that result from improved quality. CMS is pleased to report that 37 States and the District of Columbia have indicated interest in exploring ways to implement these demonstrations in their States. Across the country, States are proposing new ways to better serve their Medicare-Medicaid enrollees. These initiatives vary regionally and in their approach, ranging from using health homes that provide total care management to expanding existing programs to meet all of an individual's needs by incorporating behavioral health and long-term supports and services, as well as making current coordinated care models available to new populations. Over the next several months, CMS will work with States to identify the most appropriate proposals for implementation that are most likely to reduce costs while improving quality of care for vulnerable beneficiaries.

Looking Forward

In a year and a half since the passage of the Affordable Care Act, CMS has made major progress in implementing its delivery system reforms. This effort is part of the Administration's commitment to making the health care system better for millions of Americans. Before the Affordable Care Act, we included investments in health information technology, prevention, and research in the Recovery Act to lay the foundation for this type of system. And since enactment, we have proposed additional ideas as part of the President's Plan for Economic Growth and Deficit Reduction. By strengthening our programs and making sure we are spending taxpayer dollars wisely, we are ushering in a new day for American health care consumers. We will continue to build on these reforms in the years to come.

The many new services, initiatives, and reforms I have highlighted are important and immediate steps to improve the coordination and affordability of health care for all Americans. CMS has a responsibility to improve access, quality, and efficiency of care for all our beneficiaries, while protecting the fiscal integrity of our programs in the long term. We are committed to working with our partners in the private sector, States, and beneficiaries to improve care coordination, increase patient safety, offer beneficiaries more information and more control over their care, and achieve better outcomes at a lower cost. As we tackle care fragmentation, we are moving towards better-aligned incentives for higher-quality, integrated care. These efforts to improve the quality of care will provide real improvements for CMS' beneficiaries and all Americans.