STATEMENT OF

JONATHAN BLUM

DEPUTY ADMINISTRATOR AND

DIRECTOR, CENTER FOR MEDICARE

CENTERS FOR MEDICARE & MEDICAID SERVICES

ON

CMS EFFORTS TO STRENGTHEN THE MEDICARE PROGRAM

BEFORE THE

UNITED STATES HOUSE COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,

SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS AND THE NATIONAL ARCHIVES

JULY 12, 2011

U.S. House Committee on Oversight and Government Reform
Subcommittee on Health Care, District of Columbia, Census and the National Archives

Hearing on CMS Efforts to Strengthen the Medicare Program
July 12, 2011

Chairman Gowdy, Ranking Member Davis, and Members of the Subcommittee, thank you for the invitation to discuss efforts to preserve and strengthen the Medicare program. The Administration is committed to protecting and strengthening the Medicare program, which will provide care to approximately 50 million Americans in 2012.

Since its passage more than 16 months ago, the Affordable Care Act has been reducing Medicare costs while improving the overall quality of care provided to Medicare beneficiaries. The Centers for Medicare & Medicaid Services (CMS) has already implemented many of the savings provisions contained in the Affordable Care Act, extending the solvency of Medicare. These provisions include slowing the growth in Medicare costs through smaller annual updates in provider payments and reducing overpayments to Medicare Advantage (MA) plans while creating new incentives for MA plans to improve the care they offer. Further, we have plans to reduce hospital-acquired conditions and preventable hospital readmissions. The Affordable Care Act created the Center for Medicare and Medicaid Innovation (the Innovation Center) to test and evaluate innovative payment and service delivery models. In addition, the Affordable Care Act is building a stronger Medicare program by providing new preventive benefits, improving access to life-saving prescription drugs, and increasing support for primary care. CMS is also streamlining and building a more efficient Medicare program by decreasing fraud, waste, and abuse in our programs, implementing competitive bidding for durable medical equipment, and improving how Medicare pays for physicians' services. Due to many of these changes made by the Affordable Care Act, the 2011 Trustees report notes that general revenue as a share of Medicare funding is projected to fall below the 45 percent threshold from 2013 through 2021 – less than two years from now.

True improvements to our nation's health care system, including the Medicare program, must involve fundamental changes to the way that health care is delivered and financed – changes that will improve quality, better coordinate care, and lower costs.

The Affordable Care Act's Historic Changes Will Reduce Medicare Costs

The Affordable Care Act includes new policies and authorities that reduce Medicare spending and make important delivery system reforms, while improving Medicare benefits for seniors and people with disabilities. These important changes are projected to decrease Medicare spending by approximately $500 billion over ten years, producing savings for the taxpayers and prolonging the life of the Medicare Hospital Insurance Trust Fund until 2024. From a historical perspective, over the past decade, Medicare spending has grown at an overall annual rate of 7.6 percent. However, with the reforms and new provisions in the Affordable Care Act, which bend the cost curve downward, current law projections show Medicare costs rising at a slower rate of 5.3 percent —or 2.9 percent per capita—over the next ten years. This is about the same rate as the growth in the general US economy. These changes will also benefit people with Medicare by reducing their premiums and other out-of-pocket costs.

Smaller Provider Payment Updates: The Affordable Care Act applies an annual productivity adjustment to Medicare rates for most categories of providers paid under Medicare's traditional fee-for-service program. These adjustments mean that affected providers' annual payment updates will be adjusted by a factor equal to a ten-year average of productivity growth in the economy at large.

Leveling the Playing Field for Medicare Advantage Plans and Promoting Quality: In 2011, MA plans are paid on average about 10 percent more than the costs of care provided by the traditional Medicare program.[1] The Affordable Care Act phases-out these extra payments so that plans will be paid on average what it costs to provide care through the traditional fee-for-service program. At the same time, CMS is implementing new payment incentives that will promote quality improvement and reward plans that provide the greatest quality outcomes. Despite the

[1] http://www.medpac.gov/documents/Mar11_EntireReport.pdf

payment reductions, enrollment in MA plans continues to grow – enrollment increased 6 percent from 2010 to 2011 and average MA premiums declined by 6 percent from 2010 to 2011.

Reimbursement Incentives to Improve Safety and Quality:

- Specific focus on Hospital-Acquired Conditions (HACs)**:** These conditions consist of complications, including infections, that patients acquire while receiving 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 (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone.[2] In addition to pain, suffering, and sometimes death, these HAC complications could add as much as $45 billion to hospital costs paid each year by taxpayers, insurers, and consumers.[3] The Department of Health & Human Services' Office of the Inspector General has reported that 44 percent of adverse events experienced by Medicare beneficiaries in the October 2008 sample month were preventable, and that these complications cost the Medicare program an extra $119 million in that one month alone.[4]

  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 and other adverse conditions, the Affordable Care Act includes a Medicare payment reduction for hospitals in the top quartile of all hospitals with regards to selected hospital-acquired conditions under the inpatient prospective payment service system beginning in fiscal year 2015. Consistent with our commitment to transparency, information for consumers, and the Affordable Care Act, the Secretary will publically report information regarding HACs of each affected hospital on the Hospital Compare website. Those hospitals will

[2] Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002. March 2007. http://www.cdc.gov/ncidod/dhqp/pdf/hicpac/infections_deaths.pdf
[3] The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.
[4] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

have an opportunity to review, and submit corrections for, the information to be made public prior to the information being publically reported.

- Reducing unnecessary hospital readmissions: We know that about one in every five Medicare beneficiaries discharged from 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.[5] Proper attention to care transitions, coordination, outreach, and patient education and support could prevent unnecessary readmissions and allow at-risk patients to recover at home, where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act provides for a payment adjustment for inpatient hospital services to encourage the reduction of certain readmission rates and also provides financial incentives for certain hospitals partnering with community-based organizations to improve transitional care processes. Beginning in FY 2013, Medicare inpatient prospective payments to a hospital will be reduced based on the hospital's percentage of preventable Medicare readmissions for three high volume procedures. Per the Affordable Care Act, the readmission rate information for all patients in each hospital participating in the program will be publicly available online.

Delivery System Reforms through the Center for Medicare and Medicaid Innovation: The Affordable Care Act provides CMS a new cross-cutting resource to accelerate reforms of the delivery system and to potentially make Medicare and Medicaid more efficient. The Center for Medicare and Medicaid Innovation (the Innovation Center) will test and evaluate innovative payment and service delivery models. In doing so, the Innovation Center will work collaboratively with relevant Federal agencies, clinical and analytical experts, local, national, and regional providers, States, and beneficiary organizations to identify and promote systems changes that could improve quality and outcomes for patients while containing or reducing program expenditures.

[5] Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007. (2005 data).

Under these new authorities, the Administration recently launched the *Partnership for Patients: Better Care, Lower Costs*, a new, national public/private effort to help save thousands of American lives and billions of dollars for taxpayers, employers, and hospitals by working over the next three years to reduce preventable injuries and complications in patient care.

The two goals of this new partnership are:

- Keep hospital patients from getting injured or sicker: By the end of 2013, decrease preventable hospital-acquired conditions by 40 percent compared to 2010.
- Help patients heal without complication: By the end of 2013, decrease preventable complications during a transition from one care setting to another, so that all readmissions would be reduced by 20 percent compared to 2010.

Achieving these goals would mean over three years approximately two million fewer injuries to hospital patients, more than 60,000 lives saved, and avoiding more than 1,600,000 hospital readmissions due to complications prevented. In the process of pursuing these goals we will develop, study, and refine models for spreading effective health care practices that will potentially translate to future efforts at large-scale improvement.

Building a Stronger Medicare Program

While reducing Medicare costs, the Affordable Care Act has strengthened the Medicare program for its beneficiaries. Beneficiaries are already receiving tangible benefits from the provisions that have been implemented.

New Preventive Benefits for People with Medicare: Thanks to the Affordable Care Act, people with Medicare are eligible to receive critical preventive care, like mammograms and colonoscopies, with no coinsurance or deductible. Beneficiaries also have access to a new annual wellness visit starting this year. As of June 10, about 5.5 million people with Medicare have accessed one or more preventive measures and at the end of June, we launched a new awareness effort– *Share the News, Share the Health* – to highlight Medicare's preventive benefits and encourage Medicare beneficiaries to take advantage of these potentially lifesaving services. Improving access to preventive care can improve early detection and treatment options,

potentially reducing the cost of care and improving the health of our Medicare population in the long run.

Improving Medicare Beneficiaries' Access to Life-saving Prescription Drugs: As a result of new provisions in the Affordable Care Act, people with Medicare have already received relief from the cost of their prescription medications. Beneficiaries now automatically receive a 50 percent discount on covered brand-name drugs in the Part D coverage gap, or "donut hole," and almost half a million individuals enrolled in Medicare's prescription drug benefit who have reached the donut hole have saved an average of $545 each, for total savings of more than $260 million so far this year. People with Medicare Part D will pay a smaller share of their prescription drug costs in the coverage gap every year from now until 2020, when the coverage gap will be closed.

For 2010, nearly 4 million eligible seniors and people with disabilities who reached the donut hole received help through a one-time, tax-free $250 rebate check to help reimburse them for out-of-pocket drug costs. In addition to improved coverage, premiums for beneficiaries enrolled in Medicare Part D beneficiaries have stayed essentially flat in 2011. Average monthly premiums for Part D coverage rose less than $2 in 2011, from $29 in 2010 to around $30.50 this year.

Improvements in Medicare Advantage: This year, we have improved our oversight and management of the MA program. The results for the 2011 plan year show that when CMS strengthens its oversight and management of MA plans, people with Medicare have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to projections of enrollment decline, in 2011 MA enrollment is up 6 percent and average premiums are down 6 percent compared to 2010, while benefit and cost-sharing levels remain roughly the same. Access to MA remains strong, as more than 99 percent of Medicare beneficiaries have a choice of MA plans as an alternative to Original Medicare. We expect continued strong enrollment growth in MA plans in 2012.

Increased support for primary care: Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. Beginning January 1, 2011, the Affordable Care Act provides for new 10 percent bonus payments for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners in family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants are eligible for these new incentive payments.

Effective Management of the Medicare Program

In addition to implementing the new benefits and changes included in the Affordable Care Act, CMS strives for continual improvement in our day-to-day operations. We are making a number of improvements in the Medicare program to make the program run more efficiently and effectively.

Strengthening Program Integrity — Preventing Fraud, Waste, and Abuse:

This Administration has put an unprecedented focus on reducing fraud and improper payments, and is making progress towards that end. By 2012, the President has committed to cutting the Medicare fee-for-service error rate in half. Enhanced screening requirements for providers and suppliers to enroll in Medicare, Medicaid, and the Children's Health Insurance Program, along with oversight controls such as a face-to-face requirement for home health and hospice services and the authority to impose temporary enrollment moratoria will allow us to better focus our resources on addressing the areas of greatest concern and highest dollar impact. We are also adopting predictive modeling technology used by the private sector to prevent improper payments and fight fraud in our programs.

Building on these new fraud fighting authorities included in the Affordable Care Act, the President's FY 2012 Budget Request proposes a variety of additional legislative initiatives to preserve the Medicare Trust Funds by preventing and detecting fraud, waste, and abuse. These proposed enhanced authorities include:

- Pre-payment, or earlier, review of power wheelchair claims, which would help lower the high error rate associated with this equipment;
- Retaining a portion of collections from Recovery Auditors, which would allow CMS to implement additional corrective actions to prevent future improper payments;
- Additional authority to exclude providers affiliated with sanctioned entities from Federal health care programs;
- Limits on the discharge of health care fraud debt in bankruptcy proceedings, to ensure that fraudsters cannot exploit bankruptcy law to avoid repaying the Federal government;
- Penalties for the illegal distribution of beneficiary identification numbers, to help deter individuals and enterprises that sell these ID numbers for use in fraudulent billing schemes; and
- Requiring the recovery of erroneous payments made to insurers participating in Medicare Advantage.

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

Competitive Bidding for Durable Medical Equipment, Prosthetics, Orthotics and Supplies: CMS has implemented Round 1 of competitive bidding for durable medical equipment in 9 areas around the country and the program has been successful, by all measures. Before moving forward, CMS made a number of improvements to help suppliers better navigate the bidding process. We also made great efforts to ensure small businesses were a part of the competitive bidding program, and those efforts were achieved: 51 percent of the contract suppliers are small businesses. Competitive bidding has reduced prices by an average of 32 percent below previous prices, resulting in lower out-of-pocket costs for beneficiaries, and billions of savings for the Medicare program. Beneficiaries are now receiving affordable durable medical equipment from well-vetted suppliers, all with no change in beneficiary access and health outcomes so far. CMS is working to expand the program to an additional 91 areas by 2013.

End Stage Renal Disease Bundled Payment System: The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required CMS to develop a new, fully bundled End Stage Renal Disease (ESRD) prospective payment system for renal dialysis services furnished to Medicare beneficiaries on or after January 1, 2011. Under the new payment system, notwithstanding a four-year transition period, Medicare makes a single prospectively determined payment to the dialysis facility that pays for all items and services furnished during a dialysis session, including ESRD drugs and other items and services that were separately payable under the previous payment methodology (with the exception of certain oral drugs until 2014).

The new ESRD bundled payment system seeks to target payments and incentives towards better patient care and clinical outcomes. The new system promotes efficiency and flexibility for dialysis facilities thereby increasing desirable clinical outcomes. Most importantly, the new system eliminates the financial incentives to over-utilize separately billable items to maximize facility profits. In addition, the new system focuses payments towards more costly patients, thereby reducing incentives to "cherry pick" patients.

Bundled ESRD payments also seek to ensure high quality of care for patients receiving dialysis. MIPPA required an ESRD quality incentive program (QIP) along with the ESRD bundled payment system. The QIP is designed to improve patient outcomes by establishing payment incentives for dialysis facilities to meet performance standards established by CMS.

Reforms to the Physician Fee Schedule: On July 1, 2011, CMS issued a proposed rule that would update payment policies and rates for physicians and non-physician practitioners for services paid under the Medicare Physician Fee Schedule in calendar year 2012. Changes in the proposed rule include:

- Potentially misvalued code initiative: CMS is significantly expanding the potentially misvalued code initiative, an effort to ensure Medicare is paying appropriately for physicians' services and more closely managing the payment system. This year, CMS is focusing on the highest volume and dollar codes billed by physicians and on the evaluation and management codes to determine whether these codes are appropriately valued. In the past, CMS has targeted specific codes for review that may have affected a

few procedural specialties like cardiology, radiology, or nuclear medicine but not taken a look at the highest expenditure codes across all specialties.

- Advanced imaging services: CMS is proposing to extend the multiple procedure payment reduction (MPPR) policy that currently applies to the technical component (TC) of advanced imaging services to the professional component (PC) of those services – specifically, computed tomography (CT) scans, magnetic resonance imaging (MRI), and ultrasound. This proposal reflects CMS' belief that there are efficiencies in physician work, especially in the pre- and post-service periods, when more than one advanced imaging service is furnished to a patient in one day. This proposal, which would affect about 100 types of services, would be the first time the imaging MPPR was applied to the physician work component of services, though an MPPR has long been applied to the work component of surgical procedures. Under this proposed policy, full payment would be made for the most expensive procedures (TC and PC), and both the TC and the PC payment would be reduced by 50 percent for subsequent procedures furnished to the same patient, on the same day, in the same session. CMS estimates that this would reduce payments for these services by about $200 million, which would be redistributed to other services paid under the Medicare physician fee schedule.

The Medicare "45 Percent Trigger"

CMS has undertaken a series of initiatives to stabilize Medicare's long-term finances, through implementation of reforms authorized in the Affordable Care Act and ongoing changes in the program to promote more efficient operations. When discussing long-term Medicare solvency, it is useful to remember that three sources of revenue finance nearly all of Medicare's expenses: payroll taxes, which pay for most of Part A (hospital insurance); beneficiary premiums, which cover about 25 percent of Part B (outpatient care) and Part D (prescription drug coverage) costs; and general revenues, which offset the remaining costs, including 75 percent of Parts B and D. As health care is increasingly delivered in outpatient settings and with the 2006 start of the prescription drug benefit, general revenues as a share of total Medicare funding have grown over time.

The Medicare Prescription Drug, Improvement, and Modernization Act – best known for establishing Medicare Part D – contained a provision commonly referred to as the "45 percent trigger." The Act requires the Medicare Trustees to issue a "funding warning" if, for two years in a row, they project that general revenues will exceed 45 percent of Medicare funding in the current year or in any of the next 6 years. While it is true that the 2011 Trustees' report issued a funding warning, it notes that general revenue as a share of Medicare funding is projected to fall below the 45 percent threshold from 2013 through 2021 "due to changes made by the ACA."[6]

Some argue that a "funding warning" is not the best way to understand Medicare's financial position, since the portion of Medicare costs financed by general revenues is misleading as a metric of Medicare solvency. Other metrics, including the rate of growth in Federal spending on Medicare, are more meaningful. For example, if Medicare spending increased sharply, but the increases were financed proportionately by general revenues and non-general-revenue sources, the 45 percent threshold would not be exceeded and the warning would not be triggered, even though Medicare solvency could be affected.

In addition, the formula used to construct the "general revenue" percentage does not treat all "savings" proposals equally, based on their effect on Medicare solvency. Proposals that increase beneficiary premiums, payroll tax revenues, or Social Security taxes help avoid triggering a funding, while policies that reduce overall program expenditures by the same amount – and reduce both the numerator and denominator of the formula – are less likely to have the same impact on lowering the proportion of Medicare financed by general revenues.

Rather than responding to a single metric that may not be a good measure of solvency, the Administration believes it is important to focus on how we can reduce the overall cost of Medicare to the Federal government and to beneficiaries, while increasing the value, efficiency, and quality of care provided to Medicare beneficiaries. The fact that a growing percentage of Medicare financing comes from general revenues is on its face no more problematic than the fact that financing for veteran's benefits or many other Federal programs comes from general

[6] 2011 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. https://www.cms.gov/ReportsTrustFunds/downloads/tr2011.pdf

revenues. Our real challenge is to improve Medicare's long-term sustainability by fundamentally changing our country's health care delivery and to lower its costs. Reducing costs, however, does not mean shifting them to beneficiaries or other payers – it means increasing the value of care received by people with Medicare.

Conclusion

One of CMS' priorities is to improve the quality and efficiency of health care for Medicare beneficiaries. We are confident that the reforms made by the Affordable Care Act, coupled with ongoing efforts to improve CMS programs and operations, will continue to ensure that Medicare remains strong for the beneficiaries who rely on it for their health care needs. Despite the improvements and progress that we have made, we recognize that protecting and improving the Medicare program will be an ongoing challenge and that we have more work to do. No one should doubt the Administration's ongoing commitment to ensuring that Medicare remains strong. We look forward to continuing to work with Congress on our ongoing efforts to preserve and protect Medicare for future generations.