STATEMENT OF

KATHLEEN SEBELIUS

SECRETARY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

ON

"MEDICARE'S FUTURE: AN EXAMINATION OF THE INDEPENDENT PAYMENT ADVISORY BOARD"

BEFORE THE

COMMITTEE ON THE BUDGET

UNITED STATES HOUSE OF REPRESENTATIVES

JULY 12, 2011

Chairman Ryan, Ranking Member Van Hollen, and Members of the Committee, thank you for the opportunity to discuss our Department's implementation of the Affordable Care Act. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).

Over the past 16 months, we have worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, Governors, State Insurance Commissioners, health plans, and interested citizens to deliver many of the law's key benefits to the American people, including Medicare beneficiaries. These benefits include improving seniors' access to affordable, life-saving medications; offering new preventive care benefits for Medicare beneficiaries; improving care coordination for beneficiaries eligible for both Medicare and Medicaid; and implementing new tools to fight fraud and return money to the Medicare Trust Funds and Treasury.

I am proud to say that we have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will have lasting effects in the years to come. This law means real improvements for the care of Medicare beneficiaries now, and a stronger and more fiscally sound Medicare program in the future.

Making Medicare sustainable is not about cutting program benefits or shifting costs onto seniors. Sustainability for Medicare requires fundamental changes to the way that health care is delivered – changes that will lead to better health, better care, and lower costs. The Affordable Care Act includes new policies and authorities that will make critically needed delivery system reforms while preserving Medicare's guarantees for seniors and people with disabilities.

Improved Value for Seniors and People with Disabilities

Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will help to improve outcomes and reduce cost. People with Medicare have already experienced improved benefits that help to keep them healthy and make prescription drugs more affordable. The important changes called for in the Affordable Care Act will also produce savings for taxpayers and extend the solvency of the Medicare Trust Fund. Medicare's long-term outlook is improved as a result of the development of new systems of health care delivery that will improve health care outcomes and cost efficiency, and provide more effective tools to reduce waste and fraud. These measures will also help people with Medicare by slowing the growth of their monthly premiums, and by keeping their copayments and deductibles lower than they would have been under previous law.

Here are just a few examples:

- **Improving Medicare beneficiaries' access to life-saving medicines:** As a result of new provisions in the Affordable Care Act, people with Medicare have already received immediate relief from the cost of their prescription medications. Nearly 4 million beneficiaries received a one-time, tax-free check for $250 after reaching the Part D coverage gap, or "donut hole," during 2010. In 2011, this benefit has improved dramatically. Beneficiaries now automatically receive a 50 percent discount on covered brand-name drugs in the coverage gap. Among beneficiaries who have reached the coverage gap, the average beneficiary has saved $545, for total savings of more than $260 million in the first five months this year. Further, 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.

- **Increased access to preventive care:** Thanks to the Affordable Care Act, people with Medicare now 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 that provides a focus on preventive care. As of June 10, about 5.5 million people with Medicare have accessed one or more of these preventive measures. 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 more 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.

- **High quality Medicare Advantage benefits:** This year, HHS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that these efforts are paying off: seniors and people living with disabilities have clearer plan choices that, on average, offer improved protections and stable benefits at lower premiums. Contrary to predictions of enrollment decline, 2011 MA enrollment is up six percent and average premiums are down six 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 traditional Medicare. As part of the Administration's 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. Beginning in 2012, CMS will implement a demonstration that builds on the quality bonus payments authorized in the Affordable Care Act by providing stronger incentives for plans to improve their performance, thereby accelerating quality improvements. These

enhanced incentives will help provide a smooth transition as MA payments are gradually aligned more closely with costs in the Medicare fee-for-service program.

- **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.

- **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. 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.[1] 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.[2]

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

[1] 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.
[2] Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf.

- **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.[3] Proper attention to care transitions, coordination, outreach, and patient education and support could all 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. Per the Affordable Care Act, the readmission rate information for all patients in each hospital participating in the program will publicly available online.

Better Care: A Partnership with States

The Affordable Care Act is beginning to improve the way care is delivered to Medicare beneficiaries. Too often, health care takes place in disconnected fragments. Instead, we should make it possible for new levels of coordination and cooperation to take place among the people and the entities that provide health care, in order to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and in different places.

For example, coordination is critically needed in providing care to more than 9 million beneficiaries who are eligible for both Medicare and Medicaid, also known as dual eligibles. The Affordable Care Act established a Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office, to improve coordination of the care provided to these beneficiaries. This population is among the most vulnerable and chronically ill beneficiaries: though they represent only 15 percent of Medicaid enrollees, they account for 39 percent of Medicaid expenditures. Similarly, they are 16 percent of Medicare enrollees but account for 27 percent of Medicare expenditures. Dual eligibles must navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services and help with Medicare premiums and cost-sharing.

The Medicare-Medicaid Coordination Office is working to better streamline care for dual eligibles by improving alignment between the two programs, sharing data that is critical to States' ability to manage care for these individuals, and supporting States' innovative approaches

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

to coordinating care for dual eligibles. The office has been hard at work. Some of its initiatives include:

- On May 11, 2011, the Medicare-Medicaid Coordination Office launched the Alignment Initiative, an effort to more effectively integrate benefits under the Medicare and Medicaid programs. Better alignment of the two programs can reduce costs by improving health outcomes and more effectively and efficiently coordinating care.

- Also on May 11, the Office announced a new process to provide States access to Medicare data to support care coordination for individuals enrolled in both Medicare and Medicaid. The ability to access both sets of information on beneficiaries covered by both programs enables States to better analyze, understand, and coordinate a person's experience.

- Partnering with the Center for Medicare and Medicaid Innovation, the Office has awarded contracts of up to $1 million each to 15 States to design person-centered approaches to coordinate care across primary, acute, behavioral health and long-term supports and services for Medicare-Medicaid enrollees.[4] The overall goal of this contracting opportunity is to identify delivery system and financial models that can be rapidly tested and, upon successful demonstration, replicated in other States.

On July 8, 2011, HHS announced new opportunities for partnering with States to improve quality and costs for Medicare-Medicaid beneficiaries. Specifically, we announced a demonstration program to test two new financial models designed to help States improve quality and share in the lower costs that result from better coordinating care for individuals enrolled in Medicare and Medicaid; a demonstration program to help States improve the quality of care for people in nursing homes by providing these individuals with the treatment they need without having to unnecessarily go to a hospital; and a technical resource center available to help them improve care for high-need high-cost beneficiaries.

Program Integrity

As we move forward with new and exciting benefits and care models, we are redoubling our efforts to minimize waste, fraud, and abuse in Federal health care programs. This Administration has put an unprecedented focus on reducing fraud and improper payments, and is making progress towards that end. A greater focus on program integrity is integral to the success of Medicare reform. In 2010, our collective efforts returned over $4 billion in health care fraud

[4] http://www.cms.gov/medicare-medicaid-coordination/04_StateDemonstrationstoIntegrateCareforDualEligibleIndividuals.asp#TopOfPage

resources to the Medicare Trust Fund, victim programs, and others. The Affordable Care Act offers 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 our programs. Recently, CMS consolidated Medicare and Medicaid program integrity efforts into one office, the Center for Program Integrity.

This organizational change, coupled with the new tools provided by the Affordable Care Act, enhances CMS's ability to improve its program integrity capabilities and jointly develop Medicare, Medicaid and CHIP anti-fraud and abuse policies. For example, many Affordable Care Act provisions, such as enhanced screening requirements for new providers and suppliers, apply across the programs. In addition, oversight controls such as authority for temporary enrollment moratoria and authority for a temporary withhold on payment of claims for new durable medical equipment suppliers based on risk, will allow us to better focus our resources on addressing the areas of greatest risk and highest dollar impact.

Further, on July 1, 2011, CMS implemented a new predictive modeling technology developed with private industry experts to fight Medicare fraud. Similar to the technology used by credit card companies, predictive modeling will help identify fraudulent Medicare claims prior to payment on a nationwide basis so we can begin to take action to stop fraudulent claims early on. This initiative builds on the new anti-fraud tools and resources provided by the Affordable Care Act. Together, these tools are helping us move beyond "pay and chase" recovery operations to an approach that prevents fraud and abuse.

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 Department of Health and Human Services' Office of Inspector General to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

Independent Payment Advisory Board

All of this work reflects this Administration's vision for improving the health of seniors and securing Medicare finances for the future. By reducing the underlying costs of the health care system and by improving the care our seniors receive, we can continue to serve today's beneficiaries while preparing for tomorrow's.

We also know that the future of Medicare requires continued vigilance and careful oversight, which is why we support the creation of a backstop mechanism to ensure Medicare remains solvent for years to come. The Independent Payment Advisory Board (IPAB) builds on the commitment we have made to our seniors' health.

The IPAB will consist of 15 health experts, including health care providers, patient advocates, employers, and experts in health economics. The Affordable Care Act provides for consultation between the President and Congressional leadership in appointing members of the Board, and appointments are subject to the advice and consent of the Senate. Their work will be objective and transparent.

The Board's primary responsibility will be to recommend improvements to Medicare. Recommendations of the IPAB will focus on ways to improve health care while lowering the growth in Medicare spending. For example, the Board could recommend approaches that would build on and strengthen the initiatives mentioned above, from reducing medical errors, to strengthening prevention and improving care coordination, or targeting waste and fraud.

At the same time, the law contains important limitations on what the Board can recommend. The statute is very clear: the IPAB cannot make recommendations that ration care, raise beneficiary premiums or cost-sharing, reduce benefits, or change eligibility for Medicare. The IPAB cannot eliminate benefits or decide what care Medicare beneficiaries can receive. Given the long list of additional considerations the statute imposes on the Board, we expect the Board will focus on ways to find efficiencies in the payment systems and align provider incentives to drive down costs without affecting our seniors' access to the care and treatment they need. The Board's recommendations are also just that – recommendations – unless Congress fails to act. Congress still has the authority to make final decisions.

Starting in 2014, Medicare will have specific benchmarks for per capita spending increases. These benchmarks will initially be set at the average of the increases in CPI and CPI-Medical. Beginning in 2020, the benchmark will be set at the rate of growth of GDP per capita + 1 percentage point. Given these benchmarks, the Medicare Actuary predicts that the IPAB will be needed mainly as a backstop. Through the Affordable Care Act and our program integrity efforts, we have already substantially reduced the rate of growth in projected Medicare spending. The Office of the Actuary predicts that per beneficiary spending in the Medicare program will grow at a rate below the GDP+1 percentage point benchmark throughout the 75 year projection period. Indeed, the Office of the Actuary predicts that over the next decade per beneficiary Medicare spending will grow at about the same rate as GDP per capita, including an allowance to raise future physician payments to avoid the cuts mandated by the Sustainable Growth Rate formula. That would be a substantially slower rate of growth in expenditures per beneficiary, over a 10 year period, than has ever before been seen in the Medicare program. In addition, the current Medicare spending baseline prepared by the Congressional Budget Office assumes that Medicare spending growth will not exceed the benchmark amounts over the next 10 years.

Of course, predictions are just that – predictions – and predictions are not always certain. Health care spending patterns – or the rate of growth in the benchmarks – could change. The IPAB backstop means that if Medicare spending growth does exceed growth in the benchmarks, the

IPAB will make specific recommendations, and Congress will then have the opportunity to take action. If Congress rejects IPAB recommendations, they will replace them with reforms that bring Medicare spending growth to or below the benchmark – achieving the same savings. The Board's recommendations will only go into effect if Congress accepts them, or if Congress fails to act. In other words, the IPAB recommendations are only implemented when excessive spending growth is not addressed, and other actions being taken are insufficient to bring spending to levels at or below the benchmark.

Experts across the country, including independent economists and the Congressional Budget Office, believe the IPAB is a needed safeguard. We agree, which is why the President's deficit reduction framework strengthens the Board. This will ensure that we protect Medicare's future without resorting to radical benefit cuts or cost-shifting to seniors and people with disabilities.

Conclusion

The accomplishments listed above are just some of the many benefits that the Affordable Care Act has provided. The Affordable Care Act has already had a positive impact on Medicare beneficiaries, as well as on the millions more who now have greater options and protections in their private health insurance. Our Department has worked hard to implement the many new programs and authorities that the Act has provided us. We take very seriously our responsibility to improve access, quality, and efficiency of care for all our Medicare beneficiaries, while protecting the long-term fiscal integrity of the Medicare program.