



*A Passionate Voice for Compassionate Care*

## **STRENGTHENING MEDICARE**

### **THE ISSUE**

Since 1965, Medicare has been highly successful in achieving affordable health coverage for hundreds of millions of elderly and disabled Americans. Today Medicare covers over 62 million Americans, 15% of whom are adults under 65 with long term disabilities. According to the Kaiser Family Foundation, in 2016, half of all people on Medicare had incomes below \$26,200 per person and savings below \$74,450.

The Patient Protection and Affordable Care Act (ACA) included Medicare payment and delivery system reforms, such as value based purchasing, excess readmission penalties, accountable care organizations, payment bundling, and medical homes, which will help to reduce costs and improve the quality of care Medicare patients receive. This movement to transform health care delivery and payment systems pre-dates the ACA and has had broad bipartisan support. Medicare today is evolving from volume-based reimbursement toward a payment system based on value and outcomes. Continuing along this path presents both challenges and opportunities to increase access to care, through telehealth and other innovations, and to identify and measure the quality benchmarks most likely to increase health outcomes and reduce cost.

In addition, changes to entitlement programs such as Medicare are a central item in efforts to reduce federal spending and the deficit. The 2% “sequestration” cut in payments to Medicare providers required under The Budget Control Act of 2011 began in 2013 and was extended for two years (through 2025) in the Bipartisan Budget Act of 2015. Proposals to find additional budget savings have included eliminating Medicare bad debt payments; reducing Medicare funding for graduate medical education; reducing payments for post-acute care; raising the Medicare retirement age; increasing Medicare cost-sharing for all or high-income beneficiaries; and making Medicare a premium support program.

### **MINISTRY TRADITION**

In 1965, our nation made a commitment to protect the health and well-being of seniors by establishing the Medicare program. The mission of the Catholic health ministry, in accordance with the Ethical and Religious Directives for Catholic Health Care Services, compels us to be distinguished through “service to and advocacy for those people whose social condition puts them at the margins of our society and makes them particularly vulnerable to discrimination.” Continuing to preserve and strengthen that commitment to our nation’s seniors is a vital component of ensuring a more just and equitable health care system.

### **CHA’S POSITION AND ACTIVITIES**

- **Protect Care for Low-Income Beneficiaries**—CHA will work in partnership with other provider and consumer organizations to ensure that low-income seniors do not encounter reduced benefits or financial barriers to Medicare through increased subsidies, copays, or asset tests.

- **Improve Medicare access and care coordination** —CHA strongly supports efforts to coordinate and integrate person-centered health care services along the continuum of care and promote greater use of medical homes, care coordinators and chronic care management, especially for those dually eligible for Medicaid and Medicare.
- **Provide Adequate and Sustainable Financing**—Efforts to reduce the federal budget deficit should be equitable and balanced and must not have a disproportionate impact on Medicare beneficiaries and providers. Congress must continue to provide Medicare with adequate and sustainable funding to ensure the ability of health care providers, including providers of long term care services, to maintain quality and compassionate care for the 62 million Americans who rely on Medicare for their health care.
- **Delivery System Reforms**—CHA supports the transformation of our health care system to one that focuses on quality and outcome rather than volume. We will work with CMS and our members to ensure that alternative payment and delivery models, such as Accountable Care Organizations, Value Based Purchasing, Readmission Reductions and Bundling, are implemented successfully, without unintended consequences such as increasing disparities in care or creating disincentives to serve low-income or uninsured patients. We support efforts to prioritize, consolidate and align quality measures across payment systems, to increase use of and payment for telehealth services to expand access to care, and to incorporate appropriate methods of sociodemographic adjustment in quality reporting and payment programs.