Comments of CMS Acting Administrator Andy Slavitt at the J.P. Morgan Annual Health Care Conference, Jan. 11, 2016

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Thanks for the introduction. Glad to be here and speak about the major policy areas that will affect the health care sector in 2016. I am particularly glad to be here with Jim from AMA, because between us we are working on an incredible amount of change across the health care sector.

When they put a private sector guy in charge at CMS, I made clear my intention to talk regularly to the health care investor community. From my not-so-distant past, I remember how CMS often felt opaque to me, and I probably said more than once how helpful it would be to know CMS's agenda rather than divining them by poring through an often intricate set of regulations like they were Fed minutes.

I'm a believer in the maxim that it's always 90 percent about implementation, and possibly to the annoyance of my colleagues, it's a constant refrain from me. We only succeed if we bring the ideas behind the big legislation successfully to the kitchen table of the American family and the exam room of their physicians.

I'm blessed to be here now because in many ways the day-to-day work of CMS at this point in time is to start up new consumer and provider-facing capabilities and then scale them, nurture and mature them. It demands we change our culture and execute with clarity, with discipline, and with collaboration. Things we haven't always been known for.

2015 was a meaningful year for execution on a number of fronts. From committing publicly to change how we pay for care, to leading the largest data transparency initiative in health care, releasing tens of millions of lines of data and new consumer websites, to investing in the growth of Medicare Advantage, to seeing record levels of quality, safety and continued low medical trend. To implementing the ICD-10 changeover, the biggest event no one heard about. And of course expanding Medicaid into three new states, and we've now crossed 17 million newly insured since the start of the ACA and have had a strong start to our third open enrollment.

Through the year, I developed a view I will share with you of how CMS operates and a new cultural focus to execute most effectively. CMS works on three important levels.

First, setting policy and acting as a regulator to make sure the laws of Congress and the rules we set advance the interests of consumers and taxpayers. Here our most important job is to listen and learn, policy is often a blunt instrument and in the real-world it takes continual adjusting.

Second, we act as an operator, providing service to our beneficiaries, technical support to health care providers, and partnering with states and commercial health plans to deliver our programs. Our mantra here is to give people the tools they need to thrive in the face of significant change.

And third, we often operate as a market signaler, acting as a catalyst to bring together the disparate pieces of the health care to make improvement more rapidly and more efficiently such as how we pay for care.

So, 2016. Let me start with how we are advancing the agenda on how health care is delivered. To the 130 million Americans in the Medicare, Medicaid and CHIP programs, and by extension how care is paid for across all of health care, 2016 will be an enormous and pivotal year for progress and it's starting off with a bang.

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We announced today the participants in the Next Generation ACO model. In Next Gen, provider groups take full financial responsibility for a patient's care and have innovative options like telemedicine, home visits, and direct consumer incentive and engagement options. It's a model driven by all the lessons learned and feedback from previous participants and results. And the news is very good.

With 21 new Next Gen ACOs, there will be over 475 total ACOs with 30,000 physicians participating around the country, including 64 that are 2-sided or full risk, up from 19 just last year and of course zero before the Affordable Care Act.

My read of this news is that in 2016, we have not only more ACOs, but better ACOs. In total, 8.9 million Medicare FFS beneficiaries, or greater than 1 in 5, in 49 states and the District of Colombia, will now be a part of an ACO, with 1.6 million in better, more advanced models.

Many have wondered whether ACOs would succeed or would end up in the dustbin of health care's three-letter acronyms. As a recovering entrepreneur, I can certainly tell you that the execution in the first stage is often the hardest part. But today's news is strong evidence that ACO's will be part of ushering in the new wave of alternative payment models. They have demonstrated improvements in quality, patient experience and have been certified to reduce costs.

But it's important to remember where we are. Think of the Next Gen model like the second generation iPhone. There will still be progress and setbacks and we will continually improve.

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The implementation of the bipartisan MACRA legislation is a major item squarely on our punch list that has everyone's attention. At its most basic level it is a program that brings pay for value into the mainstream through something called the Merit-based incentive program, which compels us to measure physicians on four categories: quality, cost, the use of technology, and practice improvement.

The stakes are high for this program. As any physician will tell you, physician burden and frustration levels are real. Programs designed to improve often distract. Done poorly, measures are divorced from how physicians practice and add to the cynicism that people who build these programs just don't get it. Over the next several months, we will be rolling out details, but for now a couple of themes.

At its core, we need to simplify. We have the opportunity to sunset three old programs and align them together in a single new program. That program needs to be streamlined and simple to use so physicians can focus where they need to – on their patients.

We are designing from the outside-in. We started by working with front-line physicians, tech companies, and practice managers over a four day session and through an RFI to garner direct feedback on the right measures for each specialty and how to implement the program most simply. Jim and the AMA team were of significant help.

We are committed to building a program that is flexible and adapts around the goals of a provider's individual practice and patient population.

I would be remiss if I didn't add that like any good start up, we will start small and leave a lot of tool building opportunities to the private sector.

Let me dive a little deeper on the technology component. Now that we effectively have technology into virtually every place care is provided, we are now in the process of ending Meaningful Use and moving to a new regime culminating with the MACRA implementation.

The Meaningful Use program as it has existed, will now be effectively over and replaced with something better. Since late last year we have been working side by side with physician organizations across many communities — including with great advocacy from the AMA — and have listened to the needs and concerns of many. We will be putting out the details on this next stage over the next few months, but I will give you a themes guiding our implementation.

For one, the focus will move away from rewarding providers for the use of technology and towards the outcome they achieve with their patients.

Second, providers will be able to customize their goals so tech companies can build around the individual practice needs, not the needs of the government. Technology must be user-centered and support physicians, not distract them.

Third, one way to aid this is by leveling the technology playing field for start-ups and new entrants. We are requiring open APIs in order to the physician desktop can be opened up and move away from the lock that early EHR decisions placed on physician organizations so that allow apps, analytic tools, and connected technologies to get data in and out of an EHR securely.

And finally, we are deadly serious about interoperability. We will begin initiatives in collaboration with physicians and consumers toward pointing technology to fill critical use cases like closing referral loops and engaging a patient in their care. And technology companies that

look for ways to practice “data blocking” in opposition to new regulations will find that it won’t be tolerated.

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Medicaid is another significant item on our punch list this year. Over the last two plus years, over 13.5 million people have gained the security of Medicaid or CHIP coverage. But even as we are focused on helping interested states expand coverage, we are equally focused on rapidly modernizing Medicaid coverage so that it works as well or better than any insurance program.

This last year, we have released proposed or final rules to modernize how Medicaid managed care works, how states and CMS ensure access to care, and are working state by state on their plans to improve incentives for value-based care with delivery systems. Our priority this year is to attract new innovative companies to invest in the Medicaid IT space. From where I sit, investing in the future of Medicaid is one of the single best opportunities in the health care sector.

First, it’s big: Last month CMS permanently extended the 90 percent federal match for investments in Medicaid systems. Overall, CMS’ annual investment in state Medicaid IT is more than $5 billion. With over 30 states currently redesigning their Medicaid IT systems, 2016 will the most active year to date for Medicaid IT opportunities.

Second, the opportunity for innovation and differentiation is large and we are making it easier than ever: state investment is geared specifically towards technologies that are modular, reusable, and cloud-based. This opens up opportunities for innovative new entrants to disrupt this market. To assist potential new entrants in entering this solution space, today we are launching a one-stop-shop with a set of resources that will help private sector companies identify opportunities to participate in this important market. I will tweet this URL and a link to a blog with more details after this talk.

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The final significant item on the punch list is the health and long term stability of the Health Insurance Marketplaces. Stepping back, the Marketplace is still in the early stages. Consumers are still getting educated and health plans are experimenting with the right product and network designs. Even as the market meets today’s needs and signs millions of new consumers up in record numbers, we also pay attention to adjustments that are needed as the Marketplace matures. And today I want to talk about steps we are taking to move from a startup stage to a more mature stage.

We have an experienced team of leaders and actuaries from the private sector and many who come directly from our Medicare Advantage and Part D operations where we have set up and operate very successful large marketplaces already. We study the data and meet regularly with all market participants and take a strategic view to determine what adjustments are warranted. Our focus is simple – Marketplaces must be attractive to health plans to reach and build relationships with desirable consumers; the offerings need to be attractive to consumers so they

come and shop; and we need a predictable set of underwriting and other rules that compensate fairly for risk and keep the risk pool stable and balanced.

On the first point, we are seeing the characteristics of an attractive customer base for health plans to serve: A growing market; a younger population; and with high levels of engagement and responsiveness to new offerings. This Open Enrollment period, we've seen a significant influx of new consumers making it clear there is still a large untapped market to serve.

And the tax penalty is bringing more young and healthy consumers into the market. We are using a large portion of our marketing resources to make sure that consumers are aware of the increasing fee for people that go without insurance.

41% of all new consumers this Open Enrollment are under 35, compared to 38% a year ago. And if past patterns continue to hold, the percentage of young people will climb throughout the rest of Open Enrollment.

There are also high levels of consumer engagement– as over 60% of Marketplace consumers have made active decisions about their health insurance choices.

And even at this early stage we are beginning to see health care look and feel like many other retail markets where consumer preferences are creating meaningful consumer improvements. 90% of consumers have an average of three insurance companies to choose from translating into 50 plan options. Consumers can now pick a plan based upon the insurance their doctor accepts or the drug they are looking for. And the vast majority are getting direct services like primary care and generic drugs outside their deductible.

The presence of federal subsidies has exploded the universe of consumers in the individual market. A truly retail market with these type of organic innovations should bring in even more consumers, including higher income individuals who will be attracted to better experiences and better services.

Finally, moving into the third year and beyond, we are focused on continually maintaining and improving a set of marketplace rules that create a healthy, stable and balanced risk pool. These changes will lead directly to a stable rate environment and more affordability for consumers. I want to lay out some of the specific steps we are taking over the next 45 days.

First, we think it is critical to enforce the integrity of the Open Enrollment period. In the first two years of the Marketplace, a number of Special Enrollment Periods or SEPs were created as consumers were learning how to enroll in coverage for the first time. SEPs play an important role for consumers but we are making changes so that as the Marketplace matures, SEPs serve the purpose they are intended.

Last month, we announced the elimination of the tax season special enrollment period; and this week, we will be announcing that we will be eliminating certain other select SEPs and making the language on others clearer to prevent bad actors from signing people up for insurance

inappropriately. We have established an enforcement unit and have already terminated coverage for individuals who were improperly enrolled by certain brokers.

But lifting up, most importantly, consumers need to know that Open Enrollment– the next 20 days– is the time to get covered for potential illness and avoid the tax penalty.

Next, we are committed to making sure that risk adjustment works as it is intended to allow coverage of individuals with pre-existing conditions. This year we will be taking a number of steps. First, in response to health plan feedback, we will be providing early estimates of health plan specific risk adjustment calculations. Along with the newly launched backend automation, this will give plans more timely information in order to facilitate informed rate setting.

Second, on March 25, we are hosting a public conference to bring together all market participants to review the risk adjustment methodology so we can build in changes based on the first several years of experience. We have the tools to make certain the proper incentives exist to insure sicker populations.

And outside of risk adjustment, in the next 45 days you will see other announcements and more specificity intended to address the risk pool.

Overall, we're taking steps to move from a start-up period to a more normalized set of operating rules. The start-up stage of anything has unique challenges. The Administration and Congress recognized the challenges that were placed on health plans with building a stable marketplace over the first few years and passed a one-year moratorium on the Health Insurance Tax to assist with that transition.

Just as the reinsurance program, which has paid out $7.9 billion, at a 25% higher level than expected, has been a stabilizing force to date; the one-year tax holiday, of $13.9 billion will help stabilize premiums next year.

The actions we are focused on, while targeting health plans, are aimed at directly benefitting consumers as they enhance predictability and affordability. That is a critical goal as we move to the next stage of Marketplace evolution.

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Let me recap the themes in our 2016 agenda.

We maintain our cultural focus on listening and learning that we really launched in earnest this year. We have a number of start-up activities as well as areas where we must move to a more mature stage, which makes that focus even more important.

And we must execute in our role as a market catalyst and signaler– signaling that care delivery payments are changing, and reward people who provide the best care and we are pushing to a tipping point by 2018. Signaling that Medicaid, with the benefit of new innovation, will be a

priority area of growth and innovation; and signaling that we have the focus, the tools and the experience to continue to make sure the Marketplace remains healthy.

On a personal note, it is a great honor and very energizing to serve as a leader in CMS at a time when there is such a significant amount to execute on. Taking this assignment on for me after my time in the private sector has been invigorating and inspiring so far, even when all the missiles appear to be pointed directly at us.

Quite simply, it's because of the consumer — 130 million of them – many on fixed and low incomes who I wake up thinking about every day. When I took this job I decided to keep my email address public and I know now many of them wake up thinking about me.

I quickly realized how many people are just hoping for basic things, to have their family well taken care of when they're sick, to have them home and to lead as productive and healthy life as possible. Whether living with a disability, trying to afford a prescription, or hoping to keep coverage as they look for a better job. Millions more of you are counting on us making smart decisions now so that these programs work for you when you need them. And it's because of the people we serve that our punch list needs to be bold, clear and ultimately successful.

We are committed to continuing to working side-by-side with you to make this happen.

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