Introducing a Quotation or Paraphrase

Quotations and/or paraphrases should include the author's name or the title of the source, and a few words (signal phrase) to indicate its purpose in your paper.

Commonly used signal phrases:

according to	takes the view that	contends	maintains
acknowledges	comments	implies	
argues	compares	reasons	
asserts	confirms	states	
believes	declares	suggests	
claims	disputes	writes	

Examples: *In his book Smith writes...*

According to Jackson...

As Carnegie states...

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Change the following quotes into paraphrases. Use proper MLA in-text citations.

1. "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 cost 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."

2. "Uninsured people receive less medical care and less timely care, they have worse health outcomes, and lack of insurance is a fiscal burden for them and their families."

3. "Some have argued that competition does not work in health care because health care is different: it is complex, consumers cannot understand medical practice, services are highly customized, and insurers, employers, or government pay for most of the care. While health care indeed has many of these characteristics, so do other industries where competition works well."

Quote 1

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These search terms are highlighted: cms has continued to strengthen the medicare and medicaid programs Text-only version

Testimony

Statement by
Jonathan Blum
Director, Center for Medicare Management
on
Improving Quality, Lowering Costs: The Role of Health Care Delivery System
before
Committee on Homeland Health, Education, Labor and Pensions
United States Senate

Thursday November 10, 2011

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 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

Quote 2

Health Policy Briefs

THE URBAN INSTITUTE

DC-SPG no.1, November 2007

Why Health Insurance Is Important

Randall R. Bovbjerg and Jack Hadley

Having health insurance is important because coverage helps people get timely medical care and improves their lives and health. Some may believe that people always have access to medical care because they can always go to an emergency room. But even areas with well supported safety-net care do not remove barriers to access to the same extent as does having health insurance. "Coverage matters," concluded the Institute of Medicine (IOM) during a recent multiyear appraisal.[1] Indeed, the prestigious IOM estimated that lack of coverage was associated with about 18,000 extra deaths per year among uninsured adults.[2] Several points deserve emphasis.

Having health coverage is associated with better health-related outcomes.

1. Uninsured people receive less medical care and less timely care.

Overall, uninsured people get about half as much care as the privately insured, as measured in dollars spent on their care—even taking into account free care received from providers. This discrepancy holds true even when spending is adjusted for age, income, health status, and other factors.[3] (This finding and most information presented here do not come directly from District sources, for which data are often lacking. But most patterns are believed to be generally true of all locations.)

Uninsured adults get fewer preventive and screening services and on a less timely basis. Shortfalls are documented for many types of illness or condition, including screening for cervical and breast cancer as well as testing for high blood pressure or cholesterol. Cancers, for example, are more likely to be diagnosed at a later stage of illness, when treatment is less successful. Uninsured pregnant women use fewer prenatal services, and uninsured children and adults are less likely than their uninsured counterparts to report having a regular source of care, to see medical providers, or to receive all recommended treatment.

Shortfalls are particularly notable for chronic conditions. For instance, uninsured adults with heart conditions are less likely to stay on drug therapy for high blood pressure.[4]

Some uninsured people may decide not to obtain insurance precisely because they expect not to need medical care, so simple comparisons of the insured and uninsured can be misleading.5 However, many studies adjust for factors like age and health status that affect need for care. One recent study examined people who experienced an unintentional injury or a new chronic condition—times when care is more clearly needed. Uninsured individuals were less likely to obtain any medical care, and if they did receive some initial care, they were more likely to get none of the recommended follow-up care.[6]

2. Uninsured people have worse health outcomes.

The "bottom line" for uninsured people is that they are sicker and more apt to die prematurely than their insured counterparts. Conversely, having health coverage is associated with better health-related outcomes. Evidence comes from many studies using a variety of data sources and different methods of analysis.[7] Death risk appears to be 25 percent or higher for people with certain chronic conditions, which led to the IOM estimate of some 18,000 extra deaths per year.

Some complain that low health status may be a cause of uninsured status, rather than the other way around. (Note that this objection is the opposite of the complaint noted above that good health may promote uninsurance.) Again, however, as the IOM noted, several studies use statistical methods to adjust for this "reverse causation," and still find that lack of health insurance results in poorer health outcomes. The study of unexpected accidents and new chronic conditions also addressed this issue; its short-term follow-up showed that uninsured accident victims were more likely to have ended treatment without being fully recovered, and that those with chronic conditions still reported worse health status.[8]

3. Lack of insurance is a fiscal burden for uninsured people and their families.

Uninsured people do not benefit from the discounted medical prices that are routinely negotiated by

Quote 3

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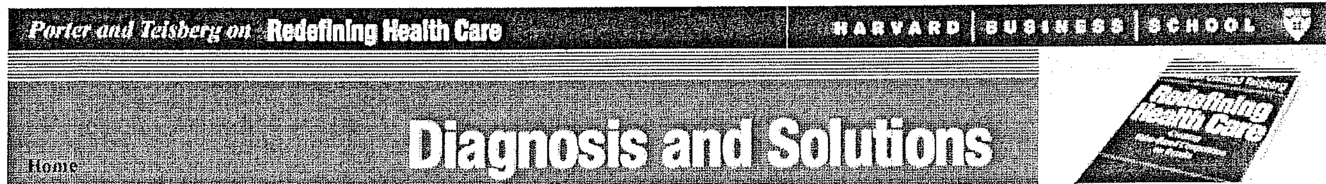

Identifying the Root Causes

Scoping the Problem | Identifying the Root Causes | How Reform Went Wrong | Value–Based Competition

Some have argued that competition does not work in health care because health care is different: it is complex, consumers cannot understand medical practice, services are highly customized, and insurers, employers, or government pay for most of the care. While health care indeed has many of these characteristics, so do other industries where competition works well. .

Others have argued that the problem in health care is too much competition. Competition is blamed for duplication, excess investment, and wasteful administrative costs. Competition from specialized hospitals or specialized outpatient facilities is seen as draining revenues from community hospitals. Competition among physicians is seen as driving the overprovision of services.

While these symptoms are real enough, the fundamental flaw in the health care sector is not competition, but the wrong kind of competition.

Zero-Sum Competition

Health care competition is not focused on delivering value for patients. Instead, it has become zero sum: the system participants struggle to divide value when they could be increasing it. Although health care offers tremendous value, the unnecessary costs of zero-sum competition undermine and erode that value. It is the zero-sum competition in health care that has created the unacceptable results detailed in Scoping the Problem: high costs, low or variable quality, under- and overtreatment, too many preventable errors in diagnosis and treatment, restrictions on choice, rationing of services, limited access, and a raft of costly lawsuits.

Zero-sum competition in health care is manifested in a number of ways, none of which creates value for patients:

- Competition to shift costs
- Competition to increase bargaining power
- Competition to capture patients and restrict choice
- Competition to reduce costs by restricting services

Competition at the Wrong Level

Why is competition in health care not focused on value? The most fundamental, unrecognized problem with the U.S. health care system is that competition operates at the wrong level. Competition is both too broad and too narrow. Competition is too broad because much competition now takes place at the level of health plans, networks, hospital groups, physician groups, and clinics. It should occur in addressing particular medical conditions. Competition is too narrow because it now takes place at the level of discrete interventions or services. It should take place for addressing medical conditions over the full cycle of care, including monitoring and prevention, diagnosis, treatment, and the ongoing management of the condition.

Value in health care is created or destroyed at the medical condition level, not at the level of a hospital or physician practice. A medical condition (e.g., chronic kidney disease, diabetes, pregnancy) is a set of patient health circumstances that benefit from dedicated, coordinated care. The term medical condition encompasses diseases, illnesses, injuries, and natural circumstances such as pregnancy. A medical condition can be defined to encompass common co-occuring conditions if care for them involves the need for tight coordination and patient care benefits from common facilities.

It is in addressing a particular medical condition that patient value is delivered. Today, multiple entities can be involved in patient care. It is at this level where huge differences in costs and quality persist and where the lack of competition allows providers with worse outcomes and higher charges to remain in business. And it is here where healthy competition would drive improvements in efficiency and effectiveness, reduce errors, and spark innovation.