Strengthening Medicare: Better Health, Better Care, Lower Costs
Efforts Will Save Nearly $120 Billion for Medicare Over Five Years

Introduction

The Centers for Medicare and Medicaid Services (CMS) and the Obama Administration are committed to strengthening Medicare, improving the health of seniors and the quality of the care they receive, and lowering costs.

The Affordable Care Act provides a breadth of new tools to help Medicare beneficiaries and taxpayers. CMS has already implemented a wide array of quality improvements and delivery system efficiencies: providing new preventive benefits, tying payment to quality standards, investing in patient safety, and offering new incentives for providers who deliver high-quality, coordinated care. These reforms lay the foundation for a broad reform of our health care delivery system. At the same time, CMS has also taken a series of actions independent of the health reform law that are aimed at saving money for taxpayers and beneficiaries and improving the quality of care.

These efforts have as their goal improving the care Americans receive, leading to better health, and lowering costs for patients, providers, and taxpayers. This report outlines these provisions and finds that they will save nearly **$120 billion for Medicare over the next five years.**

Health Care Delivery System Reforms	**Savings through 2015**
Reforming provider payments – rewarding quality and efficiency	$55 billion
Investing in patient safety – lowering hospital readmissions and hospital-acquired conditions	$10 billion through 2013*
Cracking down on fraud and abuse in the Medicare system	$1.8 billion**
Getting the best value for Medicare beneficiaries and taxpayers for durable medical equipment	$2.9 billion ($17 billion over ten years)
Reducing excessive Medicare payments to insurance companies	$50 billion

* Amount shown represents the reduction in Medicare expenditures that could be achieved if the CMS goals for reducing readmissions and hospital-acquired conditions are met.
** Estimated savings for Medicare program integrity provisions in the Affordable Care Act; does not include other, ongoing CMS initiatives.

While these programs are generating savings now, we also have an obligation to sustain the promise of Medicare to future generations of seniors and people with disabilities. This report outlines the broader path toward transforming the delivery of health care to ensure that health care for future generations remains affordable and provides a much higher quality of care.

Achieving Savings Now – Laying the Groundwork for Success

A number of critical Medicare policies in place now are laying the foundation for long-term success and savings. These steps reward quality, get better value for beneficiaries and promote savings through innovation.

Rewarding Quality and Efficiency: $55 Billion in Savings
CMS has begun to implement payment methods that reward quality of care delivered, not the quantity of services provided. CMS recently finalized new payment rules to establish a value-based purchasing program for inpatient hospital services that ties hospital payment to their performance on measures. In other Medicare fee-for-service payment rules, CMS has proposed to adopt quality measures for the first time as part of a transition to a more value-based payment system. These rules have the potential to achieve even greater savings through care improvements and greater efficiencies.

As we transition to a value-based payment system, the Affordable Care Act also ties provider payments to improvements in broader economic productivity. Medicare payment updates for hospitals, skilled nursing facilities, home health agencies, medical labs, clinics, ambulatory surgical centers, dialysis centers, ambulance services, and most other types of health care providers will be tied to the rate of growth in productivity in the economy at large.

These actions will produce savings, create incentives for greater efficiency in care delivery, and lay the groundwork for a long-term transformation of our health care system as well to make it safer and prevent injuries and unnecessary readmissions to hospitals which not only harm patients but increase overall health care costs. Realigning the way Medicare pays for care will help improve the quality of care that patients receive, and lower costs. The CMS Office of the Actuary estimates that the smaller payment updates to the Medicare provider payment rates will save approximately $55 billion over the next five years.

Investing in Patient Safety: Up to $10 Billion in Savings
Hospitals, physicians and other health care professionals are saving lives and saving money, by working together across the health care system to solve care challenges and improve patient safety. CMS recently launched an initiative to provide strong incentives for health care providers to develop and share solutions and make those pockets of innovation the norm. CMS announced a historic investment of up to $1 billion of Affordable Care Act funding in the Partnership for Patients, which will support public-private partnerships to improve the quality, safety, and affordability of health care for all Americans. To date, more than 2,500 organizations, including 1,200 hospitals, have signed a pledge to become part of the Partnership for Patients.

CMS has set a goal of reducing preventable hospital-acquired conditions by 40 percent, preventing 1.8 million injuries and averting 60,000 deaths of hospital inpatients over the

next three years. CMS is also targeting a 20 percent reduction in hospital readmissions, which would result in eliminating 1.6 million unnecessary rehospitalizations. In total, achieving these targets could save up to $35 billion across our health care system over three years, including up to $10 billion for Medicare alone.

Fighting Fraud, Waste, and Abuse: **$1.8 Billion in Savings**
The centerpiece of CMS' anti-fraud campaign is prevention: keeping fraudulent actors out of Medicare and Medicaid in the first place. In addition to enhanced provider screening and enrollment requirements, better coordination of fraud prevention efforts, and new tools to target high-risk entities, CMS is also developing sophisticated analytic capability, using credit-card-type technology to rapidly identify fraudulent billing patterns, and networks of criminals intending to steal from these programs. These tough front-end defenses are complemented on the back end by tough new rules and sentences for criminals pursued by the Inspector General and Department of Justice. To date, the Administration's priority on rooting out fraud and abuse is paying off. The Health Care Fraud and Abuse Control program (HCFAC) activities, including the Medicare and Medicaid Integrity Programs, resulted in a record $4 billion in recoveries, in FY2010. One HCFAC initiative, the HHS/DOJ Strike Force, has charged more than 1,000 individuals who collectively have falsely billed the Medicare program for more than $2.3 billion. The Affordable Care Act also provides additional tools to help prevent fraud and abuse that will achieve $1.8 billion in savings through 2015.

Better Value for Durable Medical Equipment: $2.9 Billion in Savings
Both the Government Accountability Office and the HHS Inspector General have identified durable medical equipment as one benefit for which Medicare pays significantly more than other payers; and this overpayment makes the program more susceptible to fraud, abuse, and unnecessary utilization. On January 1, 2011, CMS implemented competitive bidding mechanisms for durable medical equipment and other supplies in nine metropolitan areas. Under this new payment mechanism, Medicare is paying an average of 32 percent less for these items, such as power wheelchairs and oxygen supplies. CMS will rapidly expand the program over the next several years. Over the next five years, the Medicare Trust Fund is expected to save more than $2.9 billion, , and beneficiaries are expected to save an additional $700 million in out-of-pocket costs. Over ten years, the Medicare Trust Fund is expected to save more than $17 billion, with beneficiaries saving an additional $11 billion in out-of-pocket costs.

Ending Excessive Payments to Insurance Companies: $50 Billion in Savings
The Affordable Care Act reduces the practice of paying substantially more to private insurers that contract with Medicare, than it would cost Medicare to cover those individuals in traditional Medicare. Prior to enactment of the Affordable Care Act, Medicare Advantage plans were paid about 14 percent more per patient than it would cost the program had the patient remained in traditional Medicare. The Affordable Care Act levels the playing field by gradually eliminating Medicare Advantage payments to insurance companies in excess of Medicare's costs. These changes will achieve an estimated $50 billion in savings over the next five years.

CMS began to implement these payment reductions on January 1, 2011 and will continue to implement this provision while providing payment incentives for quality improvement beginning in 2012. Enrollment in Medicare Advantage plans continues to grow. To date for 2011, enrollment has grown 6 percent relative to 2010, and average premiums have declined 6 percent.

Achieving Long Term Savings and Quality Improvement – Transforming Our Health Care Delivery System

The savings we will achieve in the years ahead are part of an effort to provide better care, lead to better health, and lower costs through improvement.

The Affordable Care Act helps achieve that goal by placing significant emphasis on high-quality care and patient safety. Under the law, CMS will move beyond just paying health care claims to improve health and the quality and affordability of health care. CMS is working toward a health care delivery system that will reduce avoidable hospital readmissions and at the same time create incentives to foster a more person-centered health care approach. We envision health care truly becoming an integrated, collaborative approach as diagnoses, treatments, prescriptions, and patient interactions are captured, stored, and immediately available to relevant and appropriate health care providers. This improved health care system will significantly reduce redundancies, needless delays, and unwarranted referrals, thereby saving money and improving the quality of care

We have made a strong start in achieving the potential of the health care system :

Better Coordinated Care for Individuals Enrolled in Medicare and Medicaid. Patients enrolled in both Medicare and Medicaid (i.e., "dual eligibles) have some of the greatest health care needs in the country, and also incur the highest health care costs as a whole. Approximately 9 million Americans are enrolled in both Medicare and Medicaid. These individuals are a small percentage of the people who receive care through these programs (16 and 15 percent respectively) but account for a disproportionate amount of spending – 27 percent of Medicare spending and 39 percent of Medicaid spending.

With the creation of the Medicare-Medicaid Coordination Office, CMS has announced several initiatives that will improve coordination of care for these patients, resulting in better care, better health, and lower costs. Fifteen States across the country have been selected to design new ways to coordinate care for these individuals. States with promising designs will be given funding and technical assistance to implement new care models by CMS. CMS anticipates using lessons learned and best practices from this initiative to assist other States in their efforts to better coordinate care for dual eligible individuals. To further support these efforts, CMS is providing States with improved and faster access to Medicare claims data, to support care coordination efforts.

Center for Medicare and Medicaid Innovation: The Innovation Center is charged with testing innovative payment and service delivery models. The new Center, which began

operations on November 17, 2010, has already begun investing in innovative projects that have the potential to serve as national models, generating savings and potentially opening up transformative new payment methods. Early work under the management of the Innovation Center includes:

- **Federally Qualified Health Center (FQHC) Advanced Primary Care Practice Demonstration—**The Innovation Center announced a demonstration program to test the effectiveness of doctors and other health professionals working in teams to treat low-income patients at community health centers. Improved care coordination and investment in primary care team based care has shown cost saving in other settings and is expected to show similar results in Community Health Center setting. The demonstration will include up to 500 FQHCs and provide patient-centered, coordinated care to up to 195,000 enrollees in Medicare.

- **Multi-Payer Advanced Primary Care Practice Demonstration***:* Eight states were selected to participate in a demonstration project to evaluate the effectiveness of doctors and other health professionals across the care system working in a more integrated fashion and receiving a common payment method from Medicare, Medicaid, and private health plans. Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in this demonstration that will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries.

- **Medicaid Health Home State Plan Option:** Authorized by the Affordable Care Act, this new State plan option allows patients enrolled in Medicaid with chronic conditions to designate a provider as a "health home" to help coordinate treatments for the patient. States that implement this option will receive enhanced financial resources from the federal government to support "health homes" in their Medicaid programs. The Innovation Center will be assisting with learning, technical assistance and evaluation activities.

Accountable Care Organizations: CMS recently proposed rules to establish voluntary Accountable Care Organizations (ACOs) to enable health care providers to work together to coordinate care for an individual patient across care settings and is currently accepting comments from the public on this proposal. ACOs will be rewarded for lowering health care costs while meeting performance standards on quality of care and putting patients first. These provider-grown organizations have the potential to generate significant savings for the Medicare trust fund and allow providers themselves to share in the savings. CMS will also use its authority under the new Innovation Center to develop different types of payment systems that achieve similar outcomes.

Bundling Payments and Rewarding Quality Care for End-Stage Renal Disease Patients: CMS has implemented a new "bundled payment" for dialysis, which will also tie payments to the overall quality of care. This new system will improve patient care while reducing overall costs. With the establishment of the ESRD bundled payment and the ESRD Quality Incentive Program, CMS is taking its quality initiative one step further

by setting performance standards and tying payment to how facilities perform relative to these standards.

Broader value-based purchasing programs: While the hospital value-based purchasing program is in the first stages, CMS will expand its purchasing program to establish strong financial incentives for hospitals to reduce hospital acquired infections. Beginning in FY 2013, CMS will also use new payment incentives to reduce unnecessary readmissions.

Independent Payment Advisory Board (IPAB): Under the Affordable Care Act, IPAB analyzes the drivers of excessive and unnecessary Medicare cost growth. When Medicare growth per beneficiary exceeds a target (e.g., growth in nominal GDP per capita plus 1 percent starting in 2018), IPAB recommends to Congress policies to reduce the rate of growth to meet that target, while not harming beneficiaries' access to needed services. Congress must consider IPAB's recommendations or, if it disagrees, enact policies that achieve equivalent savings. The IPAB begins its work next year, and starting in 2015, will submit recommendations to Congress every year on how to best improve quality of care for Medicare beneficiaries while lowering costs. IPAB is prohibited from recommending changes that would ration care or increase costs for beneficiaries.

Expanding Use of Electronic Health Records: Adoption and meaningful use of electronic health records (EHR) will make it easier for appropriate physicians, hospitals, and others serving Medicare and Medicaid beneficiaries to assess a patient's medical status. EHRs may also help to reduce redundant and costly procedures. Medicare and Medicaid EHR Incentive Programs were established under the Recovery Act, and registration under the Medicare program opened January 3, 2011. States could also launch their programs under Medicaid on that date. As of April 30, more than 42,600 eligible providers have registered and more than $83 million has been paid out in Medicaid EHR incentives. Payments under the Medicare EHR Incentive Program are expected to begin to be issued this month.

Administrative Simplification: Unnecessary paperwork and redundancy get in the way of provider and patient interactions. The Affordable Care Act moves the nation's health system in a way that will encourage seamless electronic interactions for payment, eligibility, and coverage transactions. Already, the National Committee on Vital and Health Statistics, a Federal Advisory Board, has developed recommendations on standards for the electronic exchange of information that will reduce the clerical burden on patients, health care providers and health plans. Using those recommendations, the Affordable Care Act requires HHS to set up a health plan identifier, clear operating rules and a standard for Electronic Funds Transfer. With clearly delineated standards and rules, the burden of administrative work can be greatly reduced as innovative and safe technology becomes the norm as a result of the Affordable Care Act.

Promoting Prevention: The Affordable Care Act has made an annual Wellness Visit and many proven preventive services free for Medicare beneficiaries if the services are obtained by qualified and participating physicians or health care professionals. It also requires new private health insurance plans to cover preventive services without cost

sharing, so people will have fewer chronic and costly diseases when they turn age 65 and enroll in Medicare.

Conclusion

Using the tools provided in the Affordable Care Act and by taking other proactive steps to improve the quality of care for people on Medicare, we have generated substantial savings for Medicare. And initiatives that have been launched hold the promise of further reducing costs for beneficiaries and the Medicare program. We look forward to implementing these essential changes and continuing our work to strengthen Medicare for future generations.