



Innovations for Better Health and Stronger Medicare

Since the passage of the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) has taken critical steps forward to modernize and strengthen Medicare for today's seniors and for future generations. CMS has worked to:

Reform and Improve the Delivery of Health Care

Health care in the United States is fragmented, disorganized, too often fails to meet the patient's needs, leaving patients and clinicians frustrated and dissatisfied. Patients often must visit multiple doctors who do not always communicate with one another. This results in an inefficient use of resources, requiring patients and their families to navigate a complex medical bureaucracy and making it difficult for them to receive important medical services. Medicare pays \$17.4 billion each year for return trips to the hospital that could have been avoided if Medicare beneficiaries had received proper care. Preventable patient conditions also cost Medicare roughly \$30.8 billion each year in unnecessary hospital care.

The new Innovation Center, created by the Affordable Care Act and launched by Administrator Berwick, will help address these challenges by examining new ways of paying health care providers and delivering health care that can save money while improving the quality of care. CMS has also announced several new initiatives to make it easier for doctors to coordinate the care patients receive. These initiatives include:

- A demonstration project that encourages doctors and other health care professionals to work together as a team. Medicare, Medicaid, and private health plans will pool payments to these health care teams so fragmented payment sources no longer give providers financial incentives to fragment patient care.
- A new project to test the effectiveness of doctors and other professionals working in teams to treat patients at community health centers. Previous demonstrations have shown that providers working together in well-resourced health care systems can drive down costs and improve the quality of care, but until now this approach has not been available to community health centers serving vulnerable populations working with more limited resources.
- An option for state Medicaid programs to allow patients with chronic health problems to designate one provider as a "health home" that would help coordinate the care they receive. States that implement this option will receive additional financial resources from the federal government to support this care model and improve the quality of care.

- Demonstration opportunities for states to develop new delivery and payment models that integrate acute, behavioral, and long term services and supports for dual eligible beneficiaries. Today, dual eligibles are forced to navigate the two separate systems: Medicare for coverage of basic health care services and Medicaid for coverage of long-term care supports and services, Medicare premiums, and cost sharing. Working with states to improve the coordination and integration of the two programs is expected to result in improved health outcomes and beneficiary experience of care while also eliminating the cost shifting incentives that exist today.

Fight Fraud and Reduce the Medicare Improper Payment Rate

In the summer of 2010, President Obama pledged to cut the improper payment rate for Medicare claims in half by 2012. CMS is well on the way to meeting this goal, having already slashed the improper payment rate from 12.4% to 10.5%, reducing improper payments by approximately \$1.1 billion. To achieve these savings, further crack down on waste, fraud and abuse in Medicare and protect seniors, the Administration has:

- Analyzed Medicare data to focus medical review on error prone areas like overpayment for durable medical equipment rather than the previous “needle in a haystack” approach to reviewing data.
- Conducted in-depth probes of potentially fraudulent providers whose billing patterns have been identified as abnormal. By detecting these patterns early and examining them in depth, Medicare is able to prevent fraudulent activity before it occurs.
- Begun implementation of round one of competitive pricing for durable medical equipment and taken steps to significantly the program which is expected to save Medicare \$17 billion and Medicare beneficiaries \$11 billion over the next decade.
- Increased prepayment review to stop Medicare improper payments before they are made, rather than tracking down funds after the money is out the door.
- Created the Health Care Fraud Prevention and Enforcement Action Team (HEAT) to improve inter-agency collaboration on reducing and preventing fraud in federal health care programs. By deploying law enforcement and trained agency personnel HHS and DOJ to increase coordination, data sharing, and training among investigators, agents, prosecutors, analysts, and policymakers, Project HEAT has been highly successful in bringing health care fraud cases and prosecuting them quickly and effectively.

Implement the Affordable Care Act

The Affordable Care Act includes a series of Medicare reforms that will generate billions of dollars in savings for Medicare and strengthen the care Medicare beneficiaries receive. Implementing these changes will extend the life of the Medicare Trust Fund by 12 years, help cut costs for seniors and keep them healthy.

- Since the law was passed, CMS has begun work to implement many of the key cost saving provisions that will strengthen the Medicare Trust Fund. Key provisions that will save nearly \$8 billion within the next two years alone and approximately \$418 billion by 2019 include:
 - Reducing the number of avoidable hospital readmissions (\$8.2 billion over ten years)
 - Reducing hospital acquired infections (\$3.2 billion over ten years)
 - Bundling payments for End Stage Renal Disease treatments (\$1.7 billion over ten years)
 - Improving physician quality reporting (\$1.9 billion over ten years)
 - Implementing Accountable Care Organizations (\$4.9 billion over ten years)
 - Establishing the Independent Payment Advisory Board (\$23.7 billion over ten years)
 - Ending excessive Medicare Advantage payments to insurance companies (\$145 billion over ten years)
 - Implementing more accurate payment tools to reflect increased productivity and efficiency in many provider settings. (\$205 billion over ten years)
 - Modifying payments for advanced imaging services like CT scans (\$2 billion over ten years)
 - Expanding competitive bidding for durable medical equipment (\$17 billion over ten years)
 - Implementing program integrity measures to fight waste and fraud and protect taxpayer dollars (\$4.9 billion over ten years)

- As of October, CMS has delivered \$250 prescription drug rebate checks to more than 1.8 million seniors who entered the prescription drug coverage gap known as the donut hole. Next year, seniors who enter the coverage gap will receive a 50% discount on their covered brand-name prescription drugs while in the coverage gap.

- Next year, virtually all Medicare beneficiaries will be able to receive basic preventive services, like mammograms and colonoscopies, for free. CMS has implemented this new benefit in a final rule displayed on November 2 as part of the Physician Fee Schedule that will take effect on January 1, 2011.

- Analyses performed by Administration experts indicate that, thanks to the Affordable Care Act, the average senior enrolled in traditional Medicare will save more than \$3,500

over the next 10 years. Savings will be even higher – as much as \$12,300 over the next 10 years – for seniors and people with disabilities who have high prescription drug costs.

The Consequences of Repealing the Affordable Care Act

Congressional Republicans have proposed repealing the Affordable Care Act, which would have devastating consequences for seniors and Medicare. If the Affordable Care Act is repealed:

- The Medicare Trust Fund will be bankrupt in 2017.
- Seniors would pay more for their prescription drugs. The 50% discount on their brand name prescription drugs offered under the new law starting in January 2011 would be eliminated, resulting in higher drug costs for people enrolled in Medicare Part D plans.
- Seniors would pay out-of-pocket for preventive services. New provisions that make basic preventive benefits free for virtually all seniors would be eliminated if the new law is repealed.
- The deficit would increase. According to the Congressional Budget Office, the Affordable Care Act will reduce the deficit by more than \$100 billion by 2019. Deficit reduction will continue in future years, with the Act reducing the deficit by approximately \$1 trillion in the second decade. Repealing the Affordable Care Act would eliminate these deficit reductions.
- New and enhanced authority to prevent and punish fraud would be rolled back and the substantial return on the Act's investment in fighting fraud would be lost.

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