The Affordable Care Act: Lowering Medicare Costs by Improving Care
Efforts Will Save Over $200 Billion for Taxpayers Through 2016, Nearly $60 Billion for Beneficiaries in traditional Medicare

Introduction

The Affordable Care Act is the cornerstone of the Obama Administration's efforts to strengthen Medicare – lowering costs to make the program more sustainable, and at the same time improving the quality of care for seniors and people with disabilities on Medicare.

Millions of Americans are already benefiting from the health care law's improvements to Medicare:

- **Preventive benefits that are newly free of cost to people with Medicare, such as wellness visits and cholesterol checks.** Last year alone, 32.5 million Medicare beneficiaries used at least one preventive benefit without a deductible or co-pay.

- **Closing the prescription drug "donut hole" coverage gap.** More than 5.1 million seniors and people with disabilities have saved more than $3.2 billion in 2010 and 2011 on prescription drugs, an average of $635 each;

- **Investing more resources in health care fraud-fighting efforts**. Four years ago the federal government announced that it had recovered just over $1 billion in Fiscal Year 2007 due to anti-fraud efforts; this February, federal officials announced that for 2011, that amount is $4.1 billion, and $10.7 billion over three years, both all-time highs with the help of the Affordable Care Act.

In addition, thanks to the Affordable Care Act, the Centers for Medicare & Medicaid Services (CMS) is tying payment to quality standards, investing in patient safety, and offering new incentives for providers who deliver high-quality, coordinated care. As these important provisions are put into place, CMS is making the program more sustainable for Medicare beneficiaries and taxpayers through elements of the law. The Affordable Care Act:

- **Achieves short-term savings of over $200 billion in Medicare** through 2016 according to the independent CMS Actuary (see breakdown below), resulting in immediate benefit to the Medicare Trust Fund;

- **Lowers costs for beneficiaries in traditional Medicare by $59.4 billion** through 2016, and $208 billion through 2021, through lower premiums and out-of-pocket costs, according to the HHS Assistant Secretary for Planning and Evaluation;

- Ensures long-term savings by encouraging improvement in the quality and safety of care in hospitals, physicians' offices, and other settings;

Health Care Reforms from the Affordable Care Act	Savings from law's enactment through 2016
Reducing excessive Medicare payments to private insurers who operate in Medicare Advantage	$68 billion
Reforming provider payments, including improved productivity	$85 billion
Improving patient safety through the Partnership for Patients	$10 billion through 2013*
Cracking down on fraud and abuse in the Medicare system, and getting the best value for Medicare beneficiaries and taxpayers for durable medical equipment	$7.8 billion**
Additional provisions, including the net effect of expanded benefits, lowered payments for hospital acquired conditions, readmissions reductions, and adjustment to premium subsidies	$41 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.

Achieving Savings in the Short Term

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

Reducing Excessive Payments to Private Insurers in Medicare Advantage: $68 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 law, Medicare Advantage plans were paid about 14 percent more per patient than what the patient cost in traditional Medicare. Beneficiaries in traditional Medicare had to pay increased premiums to subsidize these overpayments. The Affordable Care Act levels the playing field by gradually eliminating most of this excess in payments to Medicare Advantage plans compared to Medicare's costs for beneficiaries in the traditional program. These changes will achieve an estimated $68 billion in savings through 2016.

CMS began to implement these payment reductions in 2011 and 2012 and this year began to provide payment incentives for quality improvement. To date for 2012, CMS reports that enrollment in Medicare Advantage has grown 17 percent relative to 2010, and average premiums have declined 16 percent. In addition, on average, there are 26 Medicare Advantage plans to choose from in nearly every county across the country, and 99.7 percent of Medicare beneficiaries have access to a Medicare Advantage plan.

Payment Updates Reflecting Improved Productivity: $85 Billion in Savings

Every year, the marketplace demands that industries across the economy use technology and innovative training to work faster and more efficiently. Similarly, the Affordable Care Act ties provider payments to these improvements in economic productivity. Medicare payment updates for hospitals, skilled nursing facilities, home health agencies, medical labs, inpatient rehabilitation facilities, 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. The CMS Office of the Actuary estimates that this change in payment updates to the Medicare provider payment rates will save approximately $85 billion through 2016.

CMS is also putting into place payment methods that reward quality of care delivered, not just the quantity of services provided. This year, hospitals will begin to see their payments tied to their performance on quality metrics, including patients' experience of care. Total payments will remain budget neutral, but align incentives and have the

potential to achieve savings through care improvements and greater efficiencies. In other Medicare fee-for-service payment rules, CMS has finalized quality measures for the first time as part of a transition to a more value-based payment system.

Investing in Patient Safety through the Partnership for Patients: Up to $10 Billion in Savings

Hospitals, physicians and other health care professionals are saving lives and saving money by working together to make care less fragmented and more coordinated. Last year the Administration launched a historic investment of up to $1 billion of Affordable Care Act funding for the Partnership for Patients, which is supporting public-private partnerships to improve the quality, safety, and affordability of health care for all Americans. Over 7,100 hospitals, doctors, and other providers have signed on as partners, and the initiative has established 26 hospital engagement networks, which will help identify solutions already working to reduce healthcare acquired conditions and work to spread them to other hospitals and health care providers.

The Partnership for Patients has set a goal for the nation of reducing preventable hospital-acquired conditions by 40 percent, preventing 1.8 million injuries and averting 60,000 deaths of hospital inpatients by the end of 2013. The partnership 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 and Getting Better Value for Durable Medical Equipment: **$7.8 Billion in Savings**

The centerpiece of CMS' anti-fraud campaign is prevention: keeping fraudulent actors out of Medicare and Medicaid in the first place. These efforts include stronger penalties to punish fraudsters, enhanced provider screening and enrollment requirements, better coordination of fraud prevention efforts, and new tools to target high-risk entities. CMS has implemented sophisticated analytic capability for Medicare, using credit-card-type technology to rapidly identify fraudulent billing patterns, and networks of criminals intending to steal from this program. These tough front-end tools 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 (HCFAC) program activities resulted in a record $4.1 billion in recoveries, in FY2011, and $10.7 billion over the last three years. Criminal prosecutions of health care fraud have also increased significantly, from 797 in 2008 to 1,430 last year.

Durable medical equipment is one area identified by the Government Accountability Office and the HHS Inspector General for which Medicare pays significantly more than other payers; this overpayment makes the program more susceptible to fraud, abuse, and unnecessary utilization. On January 1, 2011, CMS implemented a competitive bidding program for durable medical equipment and other supplies in nine metropolitan areas.

Under this new payment mechanism, Medicare has already achieved savings of $202 million in the first year, paying an average of 35 percent less for items such as power wheelchairs and oxygen supplies without any reduction in access to needed medical care. Because of the health care law, the program will expand to additional parts of the country over the next several years. Through 2016, the CMS Actuary estimates that savings will reach $5.2 billion for the Medicare program (and $27 billion through 2022).

Additional Affordable Care Act Provisions: Net of $41 Billion

The Affordable Care Act includes many other provisions that will shape Medicare spending and improve the way that health care is delivered. This includes the net effect of both assorted measures that achieve cost savings, and additional benefits like closing the donut hole, and offering more preventive benefits without cost-sharing for beneficiaries.

The additional savings provisions include a variety of changes, including reduced payments for hospital readmissions and hospital-acquired conditions, new quality reporting programs, reductions in payments for uncompensated care as the number of uninsured Americans shrinks dramatically, and adjustment to premium subsidies for high-income beneficiaries.

Achieving Long Term Savings and Quality Improvement

The savings we will achieve in the years ahead will lead to better care, better health, and more affordable health care. These savings will be the result of sustained efforts undertaken in cooperation with the private sector. The Affordable Care Act provides the tools to achieve this ambitious goal.

The Affordable Care Act places significant emphasis on high-quality care and patient safety. Under the law, Medicare will move beyond just paying health care claims to improving health and the quality and affordability of health care. CMS is helping promote a health care delivery system that will reduce avoidable hospital readmissions and, at the same time create incentives for a more person-centered approach. This improved health care system will significantly increase care coordination and quality and reduce redundancies, needless delays, and unwarranted referrals, thereby saving money and improving the quality of care.

While many of these new reforms are not yet mature enough to have demonstrated specific savings, they have the potential to dramatically transform the landscape of our health care system, putting us on a sustainable course by improving care .

In the first two years since enactment of the Affordable Care Act, CMS has taken great strides in implementing the foundation for a long-term reform of the health care delivery system. Much of these efforts are the result of the new CMS Innovation Center, which has already launched initiatives involving more than 50,000 health care providers that will touch the lives Medicare and Medicaid beneficiaries throughout the nation. As successful models are identified, they can be scaled up nationwide.

The Innovation Center leads CMS efforts to test new models of care so that care is more coordinated, resources are used more efficiently, and the health care system works better for patients, families, and providers. These innovative models of care include the following:

PRIMARY CARE TRANSFORMATION

Primary Care Bonus

In 2011 Medicare began paying a 10 percent incentive payment to primary care-focused physicians and practitioners for primary care services nationwide. This tilts the balance towards primary care, which is the foundation of efficient, coordinated care delivery systems across the country. Many private payers have begun to follow Medicare in this policy.

Comprehensive Primary Care Initiative

This model is a collaboration between public and private payers and primary care practices will support patient-centered primary care in communities across the country. Primary care practices will receive additional public and private funding for advanced primary care functions, and an opportunity to share net savings generated by this initiative. In return, participating practices will agree to give patients 24-hour access to care, create personalized care plans for their patients, and coordinate with other providers to ensure patients are getting healthy and staying well.

CMS has selected seven geographic markets to carry out the initiative. These markets were selected based on a pool of applicants which included private health plans, state Medicaid agencies, and employers. Approximately 75 practices per market will be selected, with an estimated total of 330,000 beneficiaries benefitting. This initiative will go into effect in late summer/early fall 2012.

Federally Qualified Health Center Advanced Primary Care Practice Demonstration

This demonstration is testing whether advanced primary care practice at community health centers can improve care and patients' health, and reduce costs. In October 2011, 500 community health centers in 44 States were selected to receive approximately $42 million over three years to improve the coordination and quality of care they give to people with Medicare and other patients, and work toward achieving certification as patient centered medical homes.

The initiative began last November, and approximately 200,000 Medicare beneficiaries are covered in this demonstration.

Multi-payer Advanced Primary Care Practice Demonstration

This demonstration is evaluating whether state-led, multi-payer collaborations to help primary care practices will reduce unjustified utilization and expenditures, improve the safety, effectiveness, timeliness, and efficiency of health care, increase patient decision-making and increase the availability and delivery of care in underserved areas.The demonstration started in July 2011.

Independence at Home Demonstration

The Independence at Home demonstration will encourage the use of in-home services that certain Medicare beneficiaries can receive. The demonstration will provide chronically ill patients with a complete range of primary care services in the home. CMS will join with medical practices to test the effectiveness of payment incentives to improve the care and reduce the costs for Medicare beneficiaries with multiple chronic conditions who require home-based care. Medical practices led by physicians or nurse

practitioners will provide primary care home visits tailored to the needs of beneficiaries with multiple chronic conditions and functional limitations.

The initiative is set to start this summer, serving up to 10,000 high-need beneficiaries.

ACCOUNTABLE CARE ORGANIZATIONS

Medicare Shared Savings Program

In the Shared Savings Program, groups of providers come together as accountable care organizations (ACOs) to improve care coordination for Medicare beneficiaries. ACOs may share in savings they generate for Medicare if they meet certain quality improvement measures.

In April 2012, 27 ACOs began participating in the Shared Savings Program serving an estimated 375,000 beneficiaries. Over 150 applications for the July 2012 Shared Savings Program start date have already been received.

Pioneer Accountable Care Organization Model

The Pioneer ACO model is designed to test the ability of organizations with experience providing coordinated care to patients to accept additional responsibility for the cost and quality of care their patients receive. The Pioneer ACO model tests the impact of different payment arrangements in helping these organizations achieve the goals of providing better care to patients, and reducing Medicare costs. Participating organizations must create similar arrangements with other private sector payers so that the ACOs care improvement efforts are aligned across all of its patients.

On January 1, 2012, 32 organizations began participating in the Pioneer ACO Model to test what can be achieved through highly coordinated care.

Advance Payment ACO Model

This initiative is testing whether pre-paying a portion of future shared savings will allow more physician-based and rural ACOs to participate in the Medicare Shared Savings Program, to improve care for beneficiaries and generate greater Medicare savings more quickly.

In the first round of ACOs announced in April 2012, five of the 27 groups are participating in this initiative, and more than 50 applications have been received for the July 1 start date.

Physician Group Practice (PGP) Transition Demonstration

Under the PGP Demonstration begun in 2005, physician groups earn incentive payments based on the quality of care they provide and the estimated savings they generate in Medicare expenditures for the patient population they serve. The PGP Demonstration helped create the pathway for a shared savings model and helped shape the design of the ACO Shared Savings Program.

Six of the original physician groups are continuing to participate in the new PGP Transition Demonstration, a two-year supplement to the original PGP Demonstration. Three of the original groups are now participating in the Pioneer ACO program.

BUNDLED PAYMENTS

Bundled Payment for Care Improvement Initiative

This initiative builds on episode-based payment models pioneered in the private sector by redesigning payment to incentivize care coordination. It offers providers four patient-centered episode-of-care models to choose from, allowing providers the flexibility to choose the conditions they believe make sense to bundle; decide how best to work together to deliver high-quality, coordinated episodes-of-care; and, in some cases, determine participating providers' share of payment. Applicants must propose a discount from the current cost of care for the episodes covered under the initiative, thereby helping ensure savings to the Medicare Trust Funds.

Accepted applications for the first model are currently under review, and applications are due in summer 2012 for the remaining three models.

MEDICARE-MEDICAID ENROLLEES

Financial Alignment Initiative

Partnering with the CMS Medicare-Medicaid Coordination Office, the Innovation Center is empowering States to test new payment and service delivery models that will help improve quality of care, and reduce the costs of care, for the nearly nine million people enrolled in both the Medicare and Medicaid programs. The first initiative in this effort was to award 15 States with design contracts of up to $1 million to develop new ways to meet the needs of this complex population. Early work with these 15 States confirmed that a key component of a fully integrated system would be testing new payment and financing models to promote better care and align the incentives for improving care and costs.

As a result, the Innovation Center and the Coordination Office announced a new initiative to move beyond the design phase and test new models of payment and care coordination in their States. Thirty-eight States and the District of Columbia have expressed interest in working with CMS, and testing of these new models will begin with the first beneficiaries expected to be enrolled beginning in 2013.

PAYING FOR PERFORMANCE

Hospitals

The first large-scale Hospital Value-Based Purchasing Program—which will pay over 3,500 hospitals nationwide according to whether they meet performance standards and how much they improve—takes effect for hospitalizations beginning on October 1, 2012. CMS is also strengthening its current pay-for-reporting program for hospital outpatient departments and—for the first time— extend pay-for-reporting to ambulatory surgery centers in 2014.

Physicians

CMS is continuing to strengthen the Physician Quality Reporting System through the 2012 Physician Fee Schedule as part of CMS' broader strategy to encourage health care providers to adopt practices that can improve patient care by providing physicians with incentives to voluntarily report quality measurement data.

Medicare Advantage Plans

CMS strengthened the Affordable Care Act's "five-star" plan bonus system with a demonstration that accelerates and increases the incentives for improvement in the quality of care provided to nearly 13 million beneficiaries.

Home Health Agencies

More than 100 Home Health Agencies that are part of the two-year Medicare Home Health Pay for Performance demonstration are getting nearly $15 million in shared savings from providing better care at lower cost.

CAPACITY TO SPREAD INNOVATION

Innovation Advisors Program

This program is creating a network of experts in improving the delivery system for Medicare, Medicaid and CHIP beneficiaries. These advisors will utilize their knowledge and skills in their home organizations or communities in order to improve health, improve health care, and lower costs through continuous improvement. Innovation Advisors work with other local organizations or groups to drive local delivery system reform; develop new ideas or innovations for possible testing or diffusion by the Innovation Center; and build durable skill in system improvement throughout their area or region.

In December CMS selected 73 individuals who have already started their six-month intensive orientation.

Health Care Innovation Challenge

Recognizing that many of the best ideas will come from physicians, other health care providers, and innovative thinkers in communities across the country, CMS is awarding up to $1 billion in grants to applicants who will put into practice the most compelling new ideas for rapidly delivering better health, improved care and lower costs to people enrolled in Medicare, Medicaid and CHIP. The initiative is also looking for new models of workforce development and deployment to support the transition toward high-value care.

The first awards, ranging from $1 million to $30 million over three years, are expected to be announced soon. Applicants include providers, payers, local governments, public-private partnerships and multi-payer collaboratives.

OTHER PROGRAMS

Strong Start for Mothers and Newborns

This initiative brings together multiple HHS agencies with outside groups devoted to the health of mothers and newborns including the March of Dimes, the American College of Obstetricians and Gynecologists (ACOG), and others to achieve the goals or reducing pre-term births, and reducing early elective deliveries. Launched in February. Strong Start is examining ways to disseminate best practices and support providers in reducing early electives deliveries prior to 39 weeks, and testing the effectiveness of enhanced prenatal care approaches to reduce preterm births for women covered by Medicaid and at risk for preterm births.

Strong Start is awarding grants to healthcare providers and coalitions to improve prenatal care to women covered by Medicaid. The grants will support the testing of enhanced prenatal care through several approaches under evaluation, including through

group visits with other pregnant women, at birth centers providing case management, and at maternity care homes where pregnant women have expanded access to better coordinated, enhanced prenatal care.

Medicaid Emergency Psychiatric Demonstration

This initiative will test whether Medicaid coverage for emergency service in certain institutions for mental diseases will enable States to increase the quality of care for people experiencing mental illness at lower cost, and will also test whether such expanded coverage reduces the burden on general acute care hospital emergency departments.

CMS has selected 12 States to participate in this demonstration.

Medicaid Incentives for Prevention of Chronic Diseases Program

The Medicaid Incentives for Prevention of Chronic Diseases program is a nationwide effort to test and evaluate the effectiveness of providing financial and non-financial incentives to Medicaid beneficiaries of all ages who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. The initiatives or programs are to be "comprehensive, evidence-based, widely available, and easily accessible." An application by a State for a grant under the program must address at least one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition.

Awards were made to ten States last year, and the program is underway.

Controlling Costs and Reducing Red Tape in the Health Care System

Independent Payment Advisory Board (IPAB)

Under the Affordable Care Act, IPAB is a fallback to Congress in ensuring Medicare remains solvent without shifting costs to beneficiaries or reducing the level of care that they receive. When Medicare growth per beneficiary exceeds a target (e.g., growth in nominal GDP per capita plus 1 percent starting in 2020), IPAB − an independent group of doctors, nurses, patients, and health care experts − will recommend to Congress policies to reduce the rate of growth to meet specified savings, while not harming beneficiaries' access to needed services. Congress would consider IPAB's recommendations or, if it disagrees, enact policies that achieve savings to hit the target. IPAB's policies are only a backstop if Congress fails to control high Medicare cost growth. IPAB is prohibited from recommending changes that would ration care or increase costs for beneficiaries.

Administrative Simplification

Unnecessary paperwork gets in the way of provider and patient interactions. Staff at doctor's offices spends hours every day on the phone with insurance companies rather than working on improving care. The Affordable Care Act addresses this problem and encourages seamless electronic interactions for payment, eligibility, and coverage transactions, among others. Among other items, the Affordable Care Act requires HHS to set standards for a unique health plan identifier, clear operating rules and a standard for electronic funds transfers. HHS has already issued proposals and interim final rules to streamline several of these interactions, which will save an estimated $16 billion across the health care sector over the next ten years.

Conclusion

The Affordable Care Act is already making a positive difference in the lives of millions of Americans with Medicare − lowering costs while giving their health care providers more incentive to better coordinate their care. Examination of the years ahead show that substantial savings will be generated for Medicare and for beneficiaries − all while improving the quality of care that patients receive.

As the law generates short-term savings, it also lays the groundwork for real reform of the health care delivery system − putting Medicare and the nation's health care system on a more sustainable path in a way that makes care safer and more accessible for all Americans.