

Affordable Care Act Update: Implementing Medicare Costs Savings

“This new law recognizes that Medicare isn’t just something that you’re entitled to when you reach 65; it’s something that you’ve earned. It’s something that you’ve worked a lifetime for, having the security of knowing that Medicare will be there when you need it. It’s a sacred and inviolable trust between you and your country. And those of us in elected office have a commitment to uphold that trust – and as long as I’m President, I will.

And that’s why this new law gives seniors and their families greater savings, better benefits and higher-quality health care. That’s why it ensures accountability throughout the system so that seniors have greater control over the care that they receive. And that’s why it keeps Medicare strong and solvent – today and tomorrow.”

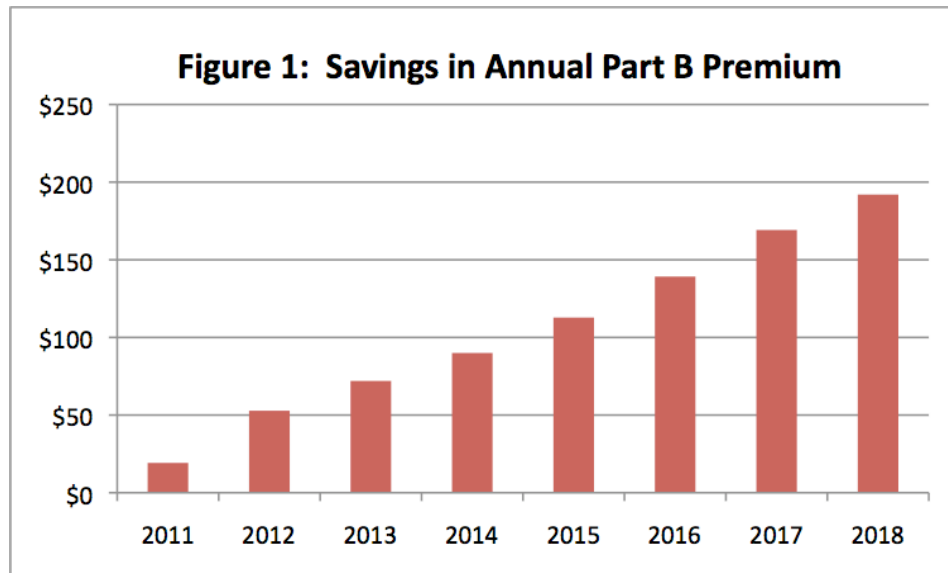
- President Barack Obama, June 8, 2010

Introduction

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. The new law protects guaranteed benefits for all Medicare beneficiaries, and provides new benefits and services to seniors on Medicare that will help keep seniors healthy. The law also includes provisions that will improve the quality of care, develop and promote new models of care delivery, appropriately price services, modernize our health system, and fight waste, fraud, and abuse. Implementing these changes extends the life of the Medicare Trust Fund by [12 years from 2017 to 2029](#), more than doubling the time before the exhaustion of the Trust Fund.

Since the law was passed more than four months ago, the Centers for Medicare and Medicaid Services (CMS) has begun work to implement many of the key cost saving provisions that will reduce Medicare spending more than [\\$575 billion over the next 10 years](#).¹ The highlighted Affordable Care Act provisions for which implementation has already advanced—along with the Administration’s ongoing efforts—will save nearly \$8 billion within the next two years and approximately \$418 billion by 2019. Taken together, the Medicare savings will lower beneficiaries’ Part B premiums by nearly \$200 annually by 2018.

¹ CMS Office of the Actuary, 2010.



Source: CMS Office of the Actuary, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended” (2010).

This report examines selected cost-saving provisions that CMS has already implemented or will be implementing very soon. All of them will strengthen Medicare and drive improvements in the health care system as a whole. Historically, Medicare has often led the entire health care system in the adoption of quality and payment innovation. For example, Medicare’s physician fee-schedule, Diagnosis Related Groups (DRG) for inpatient hospitals, and risk-adjustment systems for private plans encourage quality and efficiency, and have since been regularly used by private payers. The Affordable Care Act ensures that Medicare will continue to serve as a leader in driving the widespread adoption of innovative quality and payment strategies.

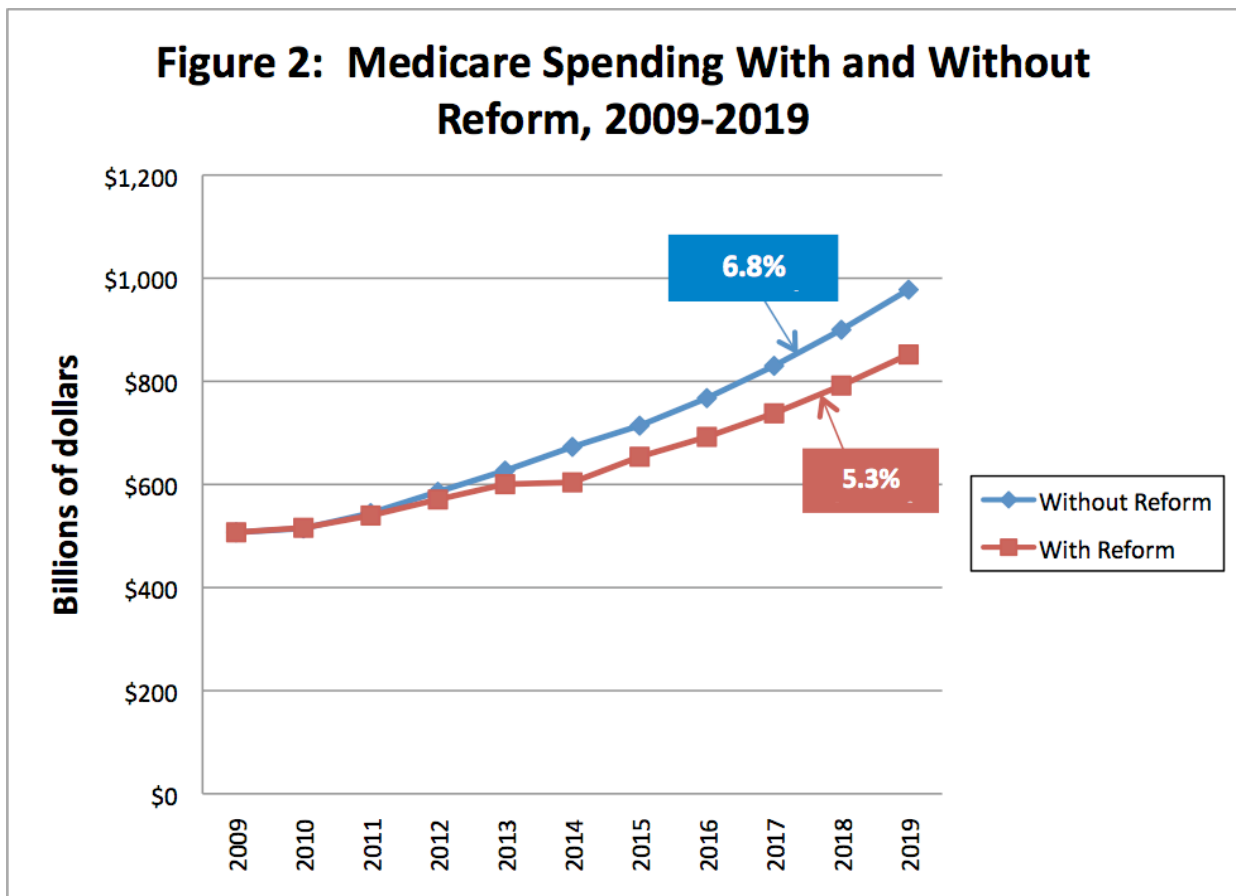
The Status Quo

The passage of the Affordable Care Act came at a critical time. The U.S. spent more than 16 percent of its Gross Domestic Product (GDP) on health care in 2009. Without reform, the nation’s already excessive health care spending would have reached unsustainable levels within the next few decades. The Congressional Budget Office (CBO) projected in 2009 that national health care spending would be [31 percent of GDP by 2035 and 46 percent of GDP by 2080](#). The Medicare Trustees projected in 2009 that the Hospital Insurance (HI) Trust Fund, which pays for Medicare services, [would be insolvent in eight years, by 2017](#). Beyond the threat health care costs pose to the nation’s budget as a whole, American families suffered from high health costs, spending over [24 percent of household consumption](#) dollars on health care.

Perverse incentives in existing payment structures that reward providers for the volume of services delivered, rather than quality of those services, are a primary driver of health care costs.

The combination of misaligned incentives and fragmented health care delivery have contributed to the U.S. having higher per capita and total health care spending than any other industrialized country, and also scoring among the lowest on key health indicators, such as infant mortality, obesity, and health system performance.

The Affordable Care Act will change these incentives and strengthen Medicare. Figure 2 illustrates Medicare’s fiscal outlook, both with and without the passage of the Affordable Care Act. Without reform, Medicare spending was projected to grow at an average annual rate of 6.8 percent, reaching an annual cost of roughly [\\$978 billion by 2019](#). As a result of these reform measures, projected annual growth in Medicare spending has been reduced to 5.3 percent, reaching [\\$852 billion by 2019](#)—a ten-year savings of over \$575 billion and a reduction of 13 percent in 2019 over previous baseline spending.



Source: CMS Office of the Actuary, 2010, and “National Health Expenditure Accounts” (2009).

Reforms to Lower Costs, Improve Quality

The Affordable Care Act and other advancements made by the Administration will transform our health care system into one that promotes greater value, by improving the quality of care and increasing efficiency. There is no single solution to reducing the rate of growth in health care

costs and the Affordable Care Act employs a wide range of strategies that can achieve the goal of greater value, including provisions to:

- Improve the quality of care,
- Reform our health care delivery system,
- Appropriately price services and modernize financing systems, and
- Fight waste, fraud and abuse.

CMS has already begun implementing a number of Affordable Care Act provisions that will save nearly \$8 billion within the next two years and \$418 billion within 10 years. Figure 3 outlines some of the provisions that will provide immediate improvements.

Figure 3: Selected Key Cost Containment Strategies in the Affordable Care Act

Cost Containment Strategies	Key Provisions	2010-2011 Cost Savings	Ten-Year Cost Savings
Improve the quality of care	- Reduces the number of hospital readmissions.	--	\$8.2 billion (1)
	- Reduces hospital acquired conditions.	--	\$3.2 billion (1)
	- Bundling payments for ESRD	--	\$1.7 billion (2)
	- Improves physician quality reporting	--	\$1.9 billion (1)
Reform our delivery system	- Promotes Accountable Care Organizations	--	\$4.9 billion (3)
	- Establishes the Independent Payment Advisory Board (IPAB)	--	\$23.7 billion (1)
	-		
Appropriately price services and modernize financing systems	- Ends overpayments to Medicare Advantage plans	\$5.3 billion	\$145 billion (1)
	- Makes improvements to productivity and market basket adjustments in certain provider settings.	\$1.4 billion	\$205 billion (1)
	- Modifies payments for advanced imaging services	\$0.2 billion	\$2.9 billion (1)
	- Competitive Bidding for Durable Medical Equipment	\$0.5 billion	\$17 billion (2)
Fight waste, fraud, and abuse	- The Affordable Care Act includes a range of provisions to reduce waste fraud and abuse such as expanding Recovery Audit Contractors (RACs); requiring face encounters with physicians before receiving certain services and requiring greater data matching capabilities	\$0.4 billion	\$4.9 billion (1)
Total of Selected Provisions		\$7.8 billion	\$418.4 billion

Sources:

- 1) CMS Office of the Actuary, “Estimated Financial Effects of the ‘Patient Protection and Affordable Care Act,’ as Amended,” (2010).
- 2) Centers for Medicare and Medicaid Services, 2010.
- 3) Congressional Budget Office, “Estimate of direct spending and revenue effects for the amendment in the nature of a substitute released on March 18, 2010” (2010).

Key Selected Provisions to Improve the Quality of Care ***Saves \$15 billion over 10 years***

CMS continues to take immediate steps to address quality of care issues where evidence shows unnecessary spending and the opportunity to improve outcomes.

- *Unnecessary hospital readmissions*
The Affordable Care Act creates a “hospital readmissions reduction program,” which will help hospitals smooth transitions for patients and reward hospitals that are successful in reducing avoidable readmissions. Beyond improving the quality of care for Medicare beneficiaries with chronic conditions—who comprise over 80 percent of all Medicare enrollees—the CMS Office of the Actuary (OAct) projects that this provision, when fully implemented, will reduce Medicare costs by \$8.2 billion from implementation through 2019. CMS continues to work with hospitals at the local level to reduce avoidable readmissions through its Quality Improvement Organizations, while developing regulations that will be issued next year. Readmissions are also reported on Hospital Compare at www.hospitalcompare.gov, and the use of transparency has proven to help to improve reported measures.
- *Hospital acquired conditions*
The Affordable Care Act imposes payment penalties on 25 percent of hospitals whose rates of hospital acquired conditions like bedsores, complications from extended use of catheters, and injuries caused by falls, are the highest. OAct projects that this provision will reduce Medicare costs by an additional [\\$3.2 billion over ten years](#). The positive effects of these provisions have the ability to extend to all payers and consumers that hospitals serve, and will ultimately improve the overall quality of care provided in hospitals. CMS has [issued new quality reporting mechanisms](#) to make such conditions more transparent to patients and providers.
- *Bundled payments for serving patients with End Stage Renal Disease (ESRD)*.
CMS recently finalized a new “bundled payment” system, which combines payment for dialysis related services and supplies that is projected to reduce Medicare spending by \$1.7 billion over ten years. CMS has also [proposed a quality incentive program](#) that is slated to begin in 2012.

- *Rewarding Better Care*

CMS will expand payments for value—in 2013—by rewarding better care for five of the most prevalent conditions. Physician payments will also become more closely linked to value with the launch of a physician value-based payment system and the implementation of a “value-modifier” that rewards physicians who deliver better care. The law also goes beyond these two critical areas by charting the path for initiating value-based payment strategies for all providers in Medicare, including skilled nursing facilities, home health care providers, hospice care, rehabilitation hospitals, and ambulatory surgery facilities. OAct estimates that the provisions to improve Medicare’s physician payment methodology will reduce Medicare costs by over [\\$1.9 billion over the next 10 years](#).

Over the next decade, these quality improvement initiatives will not only help hundreds of thousands of patients to experience better care, but will also reduce Medicare spending by more than \$15 billion over the next 10 years. More importantly, they represent a fundamental change in the way the program will lead the effort towards improved health outcomes not only for Medicare beneficiaries but for patients throughout the health care system.

Key Selected Provisions to Reform Our Health Care Delivery System

Saves \$29 billion over 10 years

The Affordable Care Act includes several key provisions that will promote broader integration and coordination of care that enable physicians and nurses to spend more time with their patients and reduce duplicative services. These models will improve health care delivery by promoting team-based care, developing new models of care delivery, and supporting improved provider performance with continuous feedback on meeting specific performance objectives.

- *Accountable Care Organizations*

The Affordable Care Act promotes team-based health care through Accountable Care Organizations (ACOs) under the Medicare shared savings program. ACOs create payment systems that encourage and support teams of physicians, hospitals, and other health care providers to collaboratively manage and coordinate care for Medicare beneficiaries. If these providers meet certain quality and efficiency benchmarks, they may receive a share of the savings. While the CMS Office of the Actuary (OAct) estimates that this provision will be budget neutral, the CBO has projected that it will reduce Medicare spending by nearly [\\$5 billion over the next ten years](#). CMS is working to make the program operational by January 1, 2012. Proposed rules will be issued later this year and CMS and its partner organizations will continue to hold public forums to foster ACO development and coordinate with on-going private sector efforts.

- *Center for Medicare and Medicaid Innovation*
To support the ongoing development of new models of payment and delivery, the Affordable Care Act establishes the Center for Medicare and Medicaid Innovation. The new law invests \$10 billion in this Center over the next 10 years to test payment and delivery innovations, identifying successes that could be expanded by the Secretary of Health and Human Services (either regionally or nationally). These funds will produce returns on investment and reduce Medicare spending over the long-term.
- *Independent Payment Advisory Board*
The Affordable Care Act also establishes the Independent Payment Advisory Board, or IPAB, to monitor the fiscal health of the Medicare program and to recommend payment policy revisions to contain Medicare cost growth. The IPAB begins its work in 2012 and will be required to submit its recommendations to Congress annually on how to best improve quality of care for Medicare beneficiaries, while reducing the rate of growth in Medicare costs. The IPAB's proposals on how to improve care and control program expenditures are binding when Medicare cost projections exceed certain targets, unless Congress acts to reduce expenditures in other ways. OAct projects that the IPAB will reduce Medicare costs by almost \$24 billion by 2019.

Taken together, these three delivery system reform provisions will generate approximately \$30 billion in savings and extend the life of the Medicare Trust Fund. These initiatives will, in addition, build the foundation for improvements in cost and quality in Medicare that can be extended to the entire health care system. The law stipulates that the IPAB will have to report to the public on system-wide health care costs, patient access to care, utilization, and quality of care.

Key Selected Provisions to Appropriately Price Services and Modernize Financing System Saves \$370 billion over 10 years

Despite being world leaders in medical technology, the American health care industry falls far behind other sectors of our economy in promoting the most efficient care. The Affordable Care Act takes steps to make Medicare more efficient by eliminating overpayments to insurance companies, adjusting reimbursement rates to levels that are appropriate, and changing payments to promote the delivery of efficient, high-quality health care.

- *Ending Overpayments to Medicare Advantage Plans*
A major inefficiency that the Affordable Care Act addresses is overpayments to private insurance plans that serve Medicare beneficiaries, known as Medicare Advantage plans. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare paid Medicare Advantages plans 14 percent (or \$1,000 per person on average) more for health services than they did under traditional Medicare, with no measured difference in health

outcomes. Ultimately, these overpayments cost all Medicare beneficiaries, including the [77 percent of seniors](#) who are not enrolled in a Medicare Advantage plan, more in the form of increased premiums. The Affordable Care Act takes immediate steps to align Medicare Advantage plan payments with costs under traditional Medicare while protecting Medicare's guaranteed benefits, and provides clear incentives for plans to improve the quality of care and outcomes provided to beneficiaries. Higher performing plans will qualify for payment bonuses beginning in 2012. CMS implemented the [first round of these changes](#) immediately upon enactment of the Affordable Care Act. When fully implemented, the CMS Office of the Actuary (OAct) projects that this improvement in payment accuracy will save Medicare \$145 billion over the next decade.

- *Improvements to productivity and market basket adjustments in certain provider settings*
The Affordable Care Act ensures that Medicare more accurately accounts for productivity when determining provider payments and revises annual payment updates in certain health care settings. CMS has already begun to implement these provisions, which will ensure that providers keep an eye towards efficiency while maintaining high-quality care. OAct estimates that this provision will reduce Medicare costs by nearly \$1.4 billion in the next two years and over [\\$205 billion over ten years](#).
- *Modified equipment utilization factor for advanced imaging*
Provisions in the Affordable Care Act address widely recognized areas of overutilization, such as advanced imaging services, which not only wastes resources but may also pose a danger to beneficiaries from needless exposure to radiation. OAct estimates that this provision, which more accurately pays for imaging, will save Medicare almost \$2 billion over ten years. CMS [recently issued](#) proposed rules that will be finalized later this fall.
- *Competitive Bidding for Durable Medical Equipment*
CMS also continues to implement competitive bidding for durable medical equipment (DME), which the Affordable Care Act accelerated. The agency [recently announced](#) that the bids it has received are nearly one-third lower than Medicare's current administratively set fee schedules. When fully implemented, this vitally important program is projected to reduce Medicare spending by more than \$17 billion.

This is only a partial list of the Affordable Care Act provisions that serve to modernize pricing and leverage existing technologies to make the health care sector realize efficiencies that nearly every other American industry has already achieved.

Key Selected Provisions to Fight Waste, Fraud and Abuse

Saves \$5 billion over 10 years

The Affordable Care Act takes several new and aggressive steps to combat waste, fraud, and abuse in the health care system. The law focuses on preventing fraud and providing CMS with powerful new tools to screen providers so bad actors are unable to bill Medicare in the first place. Ongoing efforts to fight fraud have been successful. In July, 94 people were charged for their alleged participation in schemes to collectively submit more than \$251 million in false claims to the Medicare program in the continuing operation of the Medicare Fraud Strike Force in Miami; Baton Rouge, La.; Brooklyn, N.Y.; Detroit and Houston.

- *Keeping bad actors out*

The new law provides CMS with aggressive new authorities and enhanced screening tools to ensure that only legitimate providers are enrolled in Medicare. CMS will screen providers as they enter Medicare and periodically re-screen and re-validate provider information. Screenings will be based on risk, and providers may be subject to on-site visits, criminal background checks, or even a period of probation with enhanced review of claims submitted to Medicare. The Secretary can impose a moratorium on enrollment of new providers where it is necessary to combat fraud, waste and abuse. Certain suppliers and providers will be required to post surety bonds based on the level of risk and volume of their billings to Medicare. CBO estimates that this provision will reduce Medicare costs by \$100 million. CMS is currently developing regulations to implement this provision.

- *Targeted and efficient anti-fraud activities*

The new law gives CMS the authority to target anti-fraud activities to geographic areas, provider types, or services based on the type or level of risk posed to the program. CMS will establish criteria to determine the level of risk posed and, by using advanced technologies, will be able to monitor and address issues in real-time. Depending on the threat, CMS may suspend payments based on credible allegations of fraud, or may use data analytics to identify areas for pre-payment review. Regulations to implement these provisions are under development at CMS.

- *New resources in the fight against fraud*

The Affordable Care Act provided CMS with \$350 million in new resources to boost anti-fraud activities. In addition, the law gave CMS new flexibility in how anti-fraud resources may be used; post-Affordable Care Act the Agency will be able to hire “boots on the ground” to knock on doors and conduct site visits of suspicious entities and will apply sophisticated new technologies and data analytics to identify and prevent fraudulent schemes.

- *Ensures patients have face-to-face encounters with their providers before receiving home health services or durable medical equipment use and ensures all providers who refer Medicare patients for services are enrolled in the program*

The Affordable Care Act included important protections against fraud in the areas of home health and durable medical equipment (DME), two areas where the Medicare program has been particularly vulnerable to fraudsters. First, all providers who refer a patient for home health or DME services must enroll in Medicare. Prior to the new law, individuals who referred a patient for such care or services did not have to be enrolled in the program, making it difficult to identify scam artists or providers who were participating in fraud rings to bill Medicare. Second, the law requires that patients have a face-to-face encounter with their physician, or where applicable, an eligible professional in order to be certified to receive home health services or DME items. CBO estimates that this provision will reduce Medicare costs by \$1 billion. CMS published an [Interim Final Rule](#) to begin implementing this provision on May 5, 2010.

- *Ensures transparency of ownership and ensures provider compliance with Medicare's requirements*

The Affordable Care Act includes new protections that require all providers to have compliance plans. This will ensure that providers are abreast of Medicare requirements and in compliance with them and can focus their attention on patient-care. In addition, the law includes provisions relating to transparency in nursing home ownership which will help protect beneficiaries from harm and ensure that entities that commit wrong doing are held accountable. New transparency requirements relating to physician-pharmaceutical relationships and pharmacy benefit manager relationships will also help prevent sham or inappropriate relationships between parties that could compromise patient care.

Taken together with other program integrity requirements, these provisions are projected to generate savings of nearly \$5 billion over ten years.

Conclusion

The passage of the Affordable Care Act marks a turning point in the unsustainable rate of cost growth in our health care system. Prior to reform, Medicare was marred by perverse incentives and inefficiencies that were obstacles to making meaningful quality improvements. This led to the hemorrhaging of billions of dollars in waste and misdirected resources. The Affordable Care Act reforms the Medicare program's payment and delivery systems to incentivize high-quality care, appropriately price services, modernize the health care sector, and fight waste, fraud, and abuse. The new law will generate significant cost savings in both the near term and the long term, will help drive system-wide cost-savings and quality improvement, and will improve the solvency of the Medicare Trust Fund by 12 years.