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STATEMENT OF

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ON

**THE IMPACT OF THE AFFORDABLE CARE ACT ON THE MEDICARE PROGRAM
AND MEDICARE BENEFICIARIES**

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U.S. House Committee on Ways and Means
Hearing on the Impact of the Affordable Care Act on the Medicare Program and Medicare
Beneficiaries
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Chairman Camp, Ranking Member Levin, and Members of the Committee; thank you for the opportunity to appear before you to discuss the Affordable Care Act. Millions of Americans across the country are already benefiting from this law, including more than 100 million people currently enrolled in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP). Over the last eleven months, the Centers for Medicare & Medicaid Services (CMS) has worked closely with doctors, nurses, other health care providers, consumer and patient advocates, employers, insurers, and interested citizens to deliver many of the law's key benefits to the American people: from establishing a new Patients' Bill of Rights that puts American consumers and their families back in control of their health care coverage, to sending \$250 checks to more than three million seniors and other beneficiaries who reached the Medicare Part D coverage gap in 2010, to new reforms that keep premiums down by bringing transparency and accountability to our health insurance markets.

Because of the Affordable Care Act, more Americans have affordable health insurance coverage, along with protections that help them keep coverage when they need it most – in times of health crisis and to manage chronic conditions. CMS has new tools to fight fraud that will return money to the Trust Funds and the Treasury. Medicare beneficiaries have new benefits and lower costs, including first-dollar coverage of key preventive benefits, assistance with prescription drug costs, and an annual Wellness Visit with the physician of their choice. We have met deadlines, established strong working partnerships, and begun laying the groundwork for reforms that will take effect in the years to come. This law means real improvements for Medicare beneficiaries, now and in the future.

That's why the House vote to repeal this law was unfortunate. At a time when there is so much more important work to be done to rebuild our economy, we cannot afford to re-fight this legislation, and in the process, take benefits away from individuals, bring back all the worst

practices of the insurance industry, raise premiums for families, increase health costs for businesses, and add more than \$1 trillion to the deficit by the end of the next decade.

As a pediatrician, I have witnessed both the best and the worst of the American health care system. I had the opportunity to practice pediatrics for 20 years in an organization that promoted integrated care, and saw firsthand the enormous difference that a doctor, nurse, and patient working together can make in health care outcomes. I have devoted my career to the belief that all patients deserve access to high quality health care, regardless of who they are or whether they live in a large city or a small rural community. High quality health care does not necessarily mean the most expensive health care. It means safe care, free from medical injuries, errors and infections; it means reliable care, based on the best available science; and it means person-centered care, in which each patient is treated with dignity and respect for his or her own unique preferences.

CMS can help lead health care improvement in many ways. With new provisions in the Affordable Care Act, CMS has the opportunity to work with others in both the public and private sectors to make real advancements in the nation's health care delivery systems that will improve the quality of life and quality of care for millions of Medicare beneficiaries and other Americans. We all agree that we want the highest quality health care system possible, a system that coordinates and integrates care, eliminates waste, and encourages prevention of illness. With over 100 million people currently enrolled in Medicare, Medicaid, and CHIP, and millions more gaining patient protections we oversee in private insurance, CMS has an important role to play in improving our nation's health care delivery system. We are striving to meet this challenge, while attending diligently to the crucial, day-to-day work of our operations and preserving and enhancing the integrity of our payments, our programs, and the Trust Funds.

Success at CMS

In the last several months, I've also gotten the chance to see this new law through the eyes of the people it helps every day. In talking to people from around the country and reading the letters I've received, I've learned firsthand how the law is giving Americans more freedom in their health care choices and more security in their coverage.

New Insurance Coverage Benefits

It has been only eleven months since the passage of the Affordable Care Act, but already Americans are seeing changes and benefits from the law. The Patients' Bill of Rights gives millions of Americans important new health insurance protections. For example, insurers can no longer cancel coverage when individuals get sick just because they made a mistake with their paperwork. Insurers can also no longer put lifetime dollar limits on essential benefits – limits that often meant coverage was gone when people needed it most. By 2014, most annual dollar limits on essential benefits will be a thing of the past.

In addition, more than 5,000 businesses, local governments, and unions are taking advantage of a new program under the Affordable Care Act that gives relief from soaring retiree health care costs. More than 4 million small businesses have been notified that they may be eligible for a tax cut to help them provide coverage for their workers – a benefit that's already making a difference. By slowing the growth of health care costs, the new law will free businesses to invest in their own growth and create new jobs.

The new law also holds insurers accountable and will help bring down premiums. It ensures every significant health insurance rate increase will undergo a thorough review and provides \$250 million in grants to States to bolster their rate review process. For the first time, insurers will be held accountable for the way they spend consumer premiums. The new medical loss ratio regulations released last year implement the statutory requirement that insurers spend at least 80 or 85 percent, depending on the market, of premium dollars on health care and quality improvement efforts instead of marketing and CEO bonuses. Those who don't meet the standard will have two choices: reduce premiums or send rebates to their customers. We are already seeing indications that these policies are causing insurance companies to think twice about their premium increases and, in some cases, reducing the size of their annual updates.

Beginning in 2014, the law will allow individuals, families, and small business owners to pool their purchasing power through new State-based Exchanges. Millions will qualify for tax credits to help them buy coverage through the Exchanges. Under the new law, it is estimated that a

family of four making about \$33,000 could save nearly \$10,000 in premiums, beginning in 2014, if they purchase coverage in the Exchange. A family of four making \$56,000 could save up to \$6,000 each year, by purchasing Exchange coverage. The Affordable Care Act has brought real change to the health insurance marketplace that has immediately benefited thousands of Americans, and will improve coverage and provide real savings for millions more.

Help for Medicare Beneficiaries

The Affordable Care Act is also making Medicare stronger and more sustainable. People with Medicare are getting improved guaranteed benefits every year, and Medicare's long-term sustainability is stronger as a result of efficiencies, new tools, resources to reduce waste and fraud, and slower growth in Medicare costs. These important changes will produce savings for the taxpayers and help to prolong the life of the Medicare Hospital Insurance Trust Fund. These changes will also benefit people with Medicare by keeping their premiums and cost sharing lower than under the law previously. Thanks to the Affordable Care Act, Medicare beneficiaries will enjoy better quality care, better access to care, and a more innovative care delivery system that will improve outcomes and reduce cost.

Here are just a few examples:

- **Helping Medicare beneficiaries maintain access to life-saving medicines:** As a result of new provisions in the Affordable Care Act, people with Medicare are receiving immediate relief from the cost of their prescription medications. To date, over 3 million eligible seniors and people with disabilities who reached the Part D prescription drug coverage gap in 2010 received help through a one-time, tax-free \$250 rebate check to help reimburse them for out-of-pocket costs in the Part D prescription drug coverage gap known as the "donut hole." In addition, every year until 2020, people with Medicare Part D will pay a smaller share of their prescription drug costs in the coverage gap. In 2011, eligible Medicare beneficiaries will get a 50 percent discount on covered brand name prescription drugs in the coverage gap and will only pay 93 percent of the cost of generic drugs in the coverage gap, versus 100 percent in 2010. By 2020, we will have closed the coverage gap.

- **Increased support for primary care:** Thanks to the Affordable Care Act, physicians have better incentives to provide vital primary care services to Medicare beneficiaries. The Affordable Care Act, beginning January 1, 2011, provides for a new 10 percent bonus payment for primary care services furnished by a primary care practitioner and for major surgical procedures furnished by a general surgeon in a health professional shortage area. Primary care practitioners of family medicine, internal medicine, geriatric medicine or pediatric medicine, as well as general surgeons, nurse practitioners, clinical nurse specialists, and physician assistants could be eligible to receive this new incentive.
- **Increased access to preventive care:** Thanks to the Affordable Care Act, people with Medicare can now get critical preventive care, like mammograms and colonoscopies, with no co-pay or deductible. Improving access to preventive care can improve early detection and treatment options, potentially reducing the cost of care and improving the health of our Medicare population in the long run.
- **New tools and authorities to fight fraud:** New authorities in the Affordable Care Act offer additional front-end protections to keep those who commit fraud out of Federal health care programs, as well as new tools for deterring wasteful and fiscally abusive practices, promptly identifying and addressing fraudulent payment issues, and ensuring the integrity of our programs. CMS is pursuing an aggressive program integrity strategy that will prevent fraudulent transactions from occurring, so the government will not need to depend as heavily on tracking down fraudulent providers and pursuing claims rife with fraud, waste, and abuse. CMS also now has the flexibility needed to tailor resources and activities in previously unavailable ways, which we believe will greatly support the effectiveness of our work.

The Affordable Care Act provides CMS with additional tools to help the Agency tailor interventions to address areas of the most significant risk. Enhanced screening requirements for providers and suppliers to enroll in Medicare, along with oversight controls such as a temporary enrollment moratorium and pre-payment review of claims for high risk providers, will allow the Agency to better focus its resources on addressing the areas of greatest concern and highest dollar impact.

Further, through the Health Care Fraud Prevention and Enforcement Action Team, or “HEAT,” CMS has joined forces with our law-enforcement partners at the Department of Justice (DOJ) and the Department of Health and Human Services’ (HHS) Office of Inspector General (OIG) to collaborate and streamline our efforts to prevent, identify, and prosecute health care fraud.

- **High quality Medicare Advantage benefits:** This year, CMS has improved its oversight and management of the Medicare Advantage (MA) program. The results for the 2011 plan year show that when CMS strengthens our oversight and management of MA plans, seniors and people living with disabilities will have clearer plan choices offering better benefits. In 2011, premiums are lower and enrollment is projected to be higher than ever before. In fact, the insurers that participate in Medicare Advantage have projected 5 percent growth in enrollment in this part of the program. As part of CMS’ national strategy for implementing quality improvement in health care, CMS is also working to create new incentives for all MA plans to improve the care they offer to Medicare beneficiaries.

Improving Coordination and Access to Care

In addition to giving Americans more control over their health care and strengthening Medicare, the Affordable Care Act provides for expanded access to and better integration of care for many Americans who need it.

“Integrated care” is the care we need when we have a chronic disease, or are journeying through the health care system from place to place or doctor to doctor. We want seamlessness. We want coordination. We do not want to keep having to tell our story over and over again to multiple providers, or to be afraid that one doctor will not know what medications another doctor has already given us. We know for sure that integrated care is better care – safer, more likely to get us to the treatments we really need, less likely to confuse us, and, overall, less costly than the opposite – disintegrated, fragmented care. The problem is that our fragmented care system has a lot of trouble offering us integrated care when we need and want it.

We need to help integrated care thrive in America. Too often, health care takes place in a series of fragments or episodes. We need to make it possible for entirely new levels of seamlessness, coordination, and cooperation to emerge among the people and the entities that provide health care, so as to smooth the journeys of patients and families – especially those coping with chronic illness – through their care over time and place.

Thanks largely to the Affordable Care Act, CMS has a new cross-cutting resource to accelerate progress in improving care access and coordination for Medicare, Medicaid, and CHIP beneficiaries, focusing on individuals, integration of care, and prevention: the Center for Medicare and Medicaid Innovation. The Innovation Center will test and study the most promising innovative payment and service delivery models. In doing so, the Innovation Center will work collaboratively with relevant Federal agencies and clinical and analytical experts, as well as local, national and regional providers, States and beneficiary organizations to identify and promote systems changes that could improve quality and outcomes for patients while containing or reducing costs.

The Affordable Care Act also established a Federal Coordinated Health Care Office to improve coordination of the care provided to beneficiaries eligible for both Medicare and Medicaid, also known as dual eligibles. This population consists of the most vulnerable and chronically ill beneficiaries, who represent 15 percent of enrollees and 39 percent of Medicaid expenditures and 16 percent of enrollees and 27 percent of Medicare expenditures. These individuals have not been well served by our current system. Dual eligibles need to navigate two separate systems: Medicare for coverage of basic health care services, and Medicaid for coverage of long-term care supports and services, and help with Medicare premiums and cost-sharing. The Federal Coordinated Health Care Office will work to better streamline care for dual eligibles, while ensuring they receive full access to the items and services that will result in better health care outcomes. Last December, we announced that States may apply for resources to support the design of new demonstration projects, with funding for up to 15 State program design contracts of up to \$1 million each. These design contracts will support the development of new models

that integrate the full range of acute, behavioral health, and long-term supports and services for dual eligible individuals.

In addition, the Affordable Care Act provides other immediate resources, including \$11 billion in funding for community health centers to increase services, improve facilities and train and support more health care professionals to work in the areas where they are needed most.

These combined efforts represent a new chapter for people with Medicare, who will have the benefit of a Medicare system that is more efficient and integrated and provides higher quality, more effective care.

Looking Forward

The many new services and reforms I have highlighted are important and immediate steps by which the Affordable Care Act improves access, coordination, and the affordability of health care for all Americans. However, there are even more exciting benefits that will come online in the near future that will improve the health care system for all Americans.

The Affordable Care Act includes unprecedented new tools that will enable us to reinvigorate our nation's focus on the quality, value, and outcomes of care, and help the public and the private sectors produce a new system that is better for patients, families, communities, and the health care workforce. These innovative provisions will enable CMS to work with our partners in the private sector to improve care coordination, increase patient safety, offer beneficiaries more information and more control over their care, and achieve better outcomes. The Act allows us to better align incentives for quality care and move towards seamless, integrated care. This will help health care providers and patients better tackle the problems of fragmentation and unreliability in care, which can erode health and satisfaction and add cost to taxpayers without adding anything of value to patients. These efforts to improve the quality of care will provide real improvements for both Medicare beneficiaries and all Americans.

To me, improving health care delivery has three major, overarching goals: first, providing better care for individuals – care that is more effective, more patient-centered, timely, and more

equitable; second, assuring better health for populations by addressing underlying causes of poor health, like physical inactivity, behavioral risk factors, and poor nutrition; and third, reducing costs by improving care, eliminating waste and needless hassles, reducing preventable complications in care, and coordinating care for patients who are journeying through the system. To be absolutely clear, I am talking about reducing costs while improving the quality of care individuals receive.

Securing Affordable Coverage for All Americans

The new insurance reforms produced by the Affordable Care Act require strong administrative support to be successful. To that end, we recently announced the shift of an important new office to CMS. The Office of Consumer Information and Insurance Oversight (OCIIO) was initially established under the HHS Office of the Secretary to facilitate the collaboration of experts within HHS, the Department of Labor, and the Department of the Treasury during initial policy and program development of OCIIO and the early stages of implementing the Affordable Care Act. As more Affordable Care Act initiatives become operational, we believe that CMS has the best resources to achieve successful implementation of these programs and authorities. In addition, this realignment under CMS will result in administrative savings and organizational efficiencies.

Over the last nine months, HHS had been developing a business plan for OCIIO based on the legislative requirements of the Affordable Care Act and implementing regulations. Through this process, HHS and CMS determined that moving OCIIO to CMS will help to capture the efficiencies afforded through the specific expertise and experience of both agencies. This will allow HHS to leverage CMS' infrastructure and to better ensure effective coordination of insurance programs and other insurance options available to the American people.

The new Center for Consumer Information and Insurance Oversight (CCIIO) within CMS will be responsible for making sure that the new insurance market rules, such as prohibitions on rescissions and on pre-existing condition exclusions of children, are followed. The new Center will, for example, oversee the new medical loss ratio rules and assist States in reviewing insurance premium rates.

The new Center will also oversee the development of the Health Insurance Exchanges (Exchanges), which will be operational in all 50 States in 2014. These Exchanges are central components of the Affordable Care Act and are the result of a concept that has a long history of bipartisan support. Under the Act, States have until 2014 to begin coverage in Exchanges for their citizens. As part of our partnership with the States, we are again providing resources to help them get these Exchanges up and running on time. We have provided Exchange Planning Grants to 48 States plus the District of Columbia, and we recently announced the availability of funds for States to begin the work to establish Exchanges. We will continue to work closely with governors, State regulators, and legislators to provide them with information and resources to complete this critical work on time. Millions of Americans will gain coverage through a qualified health plan in the Exchanges and many of these individuals will be eligible for premium tax credits. Exchanges will allow individuals to shop for coverage in a way that permits easy comparisons of coverage options based on price and quality.

Improving Care for Individuals

I strongly believe that every single American can and should always receive the highest quality care, no matter where they live or happen to seek care. CMS will continue its role as a leader and partner in encouraging safer and better care in hospitals, clinics, physician offices, and long-term care, and other settings. I know we can get there, because I have seen hospitals and other providers throughout our nation repeatedly demonstrate that bold and exciting progress is possible. CMS is working to make the “best care” in America the norm in health care, for everyone.

Several Affordable Care Act provisions will help CMS move in this direction. Here are a few examples:

- **Value-Based Purchasing (VBP):** Allows us to measure and reward excellence in hospitals, physician offices, and elsewhere. As we begin to implement the value-based purchasing reforms contained in the Affordable Care Act, we will be moving away from a system that rewards providers based on the volume and quantity of care they provide; rather, we will pay for value and quality of care. This approach puts the Medicare

beneficiary first and provides clear incentives for quality improvement by more prudently targeting Medicare dollars to providers who improve care.

- **Specific focus on Hospital-Acquired Conditions (HACs):** These conditions consist of complications that patients acquire while receiving care that is supposed to help them. Not all HACs are preventable, but a great number can be avoided. For example, the Centers for Disease Control and Prevention (CDC) has estimated that each year, almost 100,000 Americans die and millions suffer from hospital-acquired infections alone. In addition to pain, suffering, and sometimes death, these complications could add as much as \$45 billion to hospital costs paid each year by taxpayers, insurers, and consumers.¹ The HHS OIG has reported that 44 percent of adverse events experienced by Medicare beneficiaries in October 2008 were preventable, and that these complications cost the Medicare program an extra \$119 million in that one month.²

We know of hospitals in this country that, through improvements in their health care processes, have virtually eliminated some forms of infections that other hospitals still think are inevitable. To create incentives for hospitals to prevent such infections and other adverse events, the Affordable Care Act includes a Medicare payment reduction for hospitals that have a hospital-acquired condition rate that is much higher than average, beginning in fiscal year 2015. Prior to each fiscal year, affected hospitals will receive confidential reports regarding their HAC rate during the applicable period. In addition, the Secretary will publicly report the measures used for the payment adjustments on the Hospital Compare website,³ after giving hospitals the opportunity to review and submit corrections to such information. The Affordable Care Act also requires CMS to issue Medicaid regulations that apply Medicare HAC payment policies to Medicaid when appropriate.

¹ The Direct Medical Costs of Healthcare-Associated Infections in U.S. Hospitals and the Benefits of Prevention, March 2009, http://www.cdc.gov/ncidod/dhqp/pdf/Scott_CostPaper.pdf.

² Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries, November 2010, <http://oig.hhs.gov/oei/reports/oei-06-09-00090.pdf>.

³ <http://www.hospitalcompare.hhs.gov/>.

- **Reducing unnecessary hospital readmissions:** We know that about one in every five Medicare beneficiaries discharged from the hospital will be re-admitted within 30 days of discharge. The Medicare Payment Advisory Commission (MedPAC) estimates that Medicare spends \$12 billion annually on potentially preventable readmissions (based on 2005 data).⁴ Proper attention to care transitions, coordination, outreach, and patient education and support could all prevent readmissions and allow these patients to recover at home where they would prefer to be, rather than reentering the hospital with complications. The Affordable Care Act sets forth a course for hospitals to focus on reducing preventable hospital readmissions by linking financial incentives to readmission rates and by providing assistance and support to hospitals to improve transitional care processes. We will also make readmission rate information for all patients in each hospital participating in the program publicly available online.
- **Quality bonus payments in Medicare Advantage:** Beginning in 2012, the Affordable Care Act introduces quality bonus payments into the MA program as part of the national strategy for implementing quality improvement in health care. MA plans will be paid a quality bonus payment (QBP) based on their rating using CMS' 5-star quality rating system. To provide a strong incentive for MA plans to improve performance, CMS will pursue a national demonstration project running from 2012 through 2014 that rewards all the plans receiving three stars or higher with tiered QBPs. The demonstration will test whether providing scaled bonuses will lead to more rapid and larger year-to-year quality improvements in MA program quality scores, compared to the current law approach to computation of QBPs.
- **Medical Homes:** We must examine approaches to promote effective "home bases" for patients, rooted in primary care, to help patients navigate and understand the complex health care system on which they rely, and to help them be more proactive with prevention and detecting potential complications before any damage is done.

⁴ Medicare Payment Advisory Commission (MedPAC) Report to the Congress, June 2007.

- **Accountable Care Organizations (ACOs):** The Affordable Care Act directs CMS to establish a shared savings program that promotes coordination of services under the Medicare program and accountability for the quality of care delivered to a patient population through ACOs by January 2012. ACOs should be thought of primarily as a care delivery organization, and not just as a financing mechanism. Eligible ACOs are groups of providers and suppliers that meet the requirements for participation in the shared savings program, which include having an established mechanism for joint decision making. The program will encourage ACOs to make investments in infrastructure and redesigned care processes for high quality and efficient service delivery.

Better Health for Populations

Our system is often faulted for its focus on health care for the sick, instead of promoting better health for all. CMS is implementing a variety of initiatives that will encourage prevention and move towards the goal of improving the health of Medicare beneficiaries and the entire population. CMS can meaningfully contribute to improving prevention of a variety of health problems, including obesity and cardiovascular disease, as well as improving perinatal outcomes. In addition to expanding health insurance coverage, the Affordable Care Act provides meaningful and affordable coverage of preventive health services.

- **Annual Wellness Visit:** While Medicare already covers a comprehensive package of preventive benefits as well as a one-time “Welcome to Medicare” exam for new beneficiaries, before the enactment of the Affordable Care Act, Medicare did not cover annual check-ups for beneficiaries. As of January 1, 2011, Medicare now covers an annual “wellness visit” at no cost to the beneficiary, so beneficiaries can work with their physicians to develop and update a personalized prevention plan. This new benefit will provide an ongoing focus on prevention that can be adapted as a beneficiary’s health needs change over time.
- **Removing financial barriers to preventive services:** While Medicare covers a range of screening and preventive benefits, many of these services have been underutilized, in part because out-of-pocket costs have presented a financial barrier for beneficiaries. As of

January 1, 2011, all preventive services covered by Medicare that are recommended with an A or B rating by the U.S. Preventive Services Task Force are available to beneficiaries free of charge (without having to pay coinsurance or apply the Part B deductible) if the services are obtained from a participating physician or provider. These important benefits include tests and procedures that may either prevent illnesses or detect them at an early stage when treatment is likely to work best, such as screenings for breast, cervical, and colorectal cancers, and screenings for cardiovascular disease, diabetes, and osteoporosis.

- **More prevention in Federally Qualified Health Centers (FQHCs):** As of January 1, 2011, the scope of Medicare-covered preventive services furnished in FQHCs has significantly expanded. FQHCs provide primary care services for all age groups in medically underserved areas or medically underserved populations across the nation.

As we undertake these initiatives, it can be hard to visualize the exact type of systemic change that will result, and what it will mean to the millions of Americans who depend on Medicare for their health care. But I believe our efforts, taken together, will have a tangible, positive impact on the everyday lives of America's seniors.

Let's imagine one of the millions of Medicare beneficiaries who suffer from multiple chronic illnesses. She's 70 years old, and has high blood pressure and diabetes. She did not go for annual physicals, so her diabetes was not diagnosed for years. In previous years, she has hit the Medicare Part D coverage gap, so she has had trouble paying out-of-pocket for her medication. She breaks her pills in half to make them last longer, or sometimes skips doses altogether, which eventually lands her in the hospital. Her diabetes makes her more susceptible to infections, and like many Americans who are hospitalized, she contracts an infection, which requires an even longer hospital stay. She is finally discharged, but no one has coordinated follow-up care with her doctors. Without appropriate follow-up care, she is back in the hospital three weeks later. All of this care costs the Medicare program a great deal of money, not to mention the untold amount of unnecessary suffering that this person experiences.

The Affordable Care Act changes this story. Since free annual physicals provide an opportunity to focus on her personal risk factors, she receives a screening that identifies pre-diabetes before it progresses. In a post-Affordable Care Act world, our beneficiary is now able to afford all of her prescribed medications because her costs in the prescription drug coverage gap are lower. If she does need hospital care, her infection risk is reduced because the hospital has incentives to establish procedures to protect her from infections. Her care is coordinated upon discharge, because the hospital knows it will face a penalty if she is readmitted for a preventable condition. This woman is healthier, happier, and the Medicare program has paid less for her care. This is what the Affordable Care Act really means to America's seniors: care that is higher quality, better coordinated, and more affordable. This is why it is so important that the Affordable Care Act remain in place.

Stronger Program Integrity

This Administration is strongly committed to minimizing waste, fraud, and abuse in Federal health care programs. CMS recognizes the importance of having strong program integrity initiatives that will deter criminal activity and attempts to defraud Medicare. I share your commitment to ensuring taxpayer dollars are being spent only on legitimate items and services. Our beneficiaries deserve a Federal health care system that they can trust is secure, and the American public deserves to know that their tax dollars are not being wasted or misspent.

Due to prompt pay requirements in Medicare, our claims processing systems were built to quickly process and pay claims. CMS pays 4.8 million Medicare claims each day, approximately 1.2 billion Medicare claims each year. Nevertheless, with the new tools provided to CMS under the Affordable Care Act, we are steadily working to incorporate additional and better fraud and improper payment prevention activities into our claims payment and provider enrollment processes where appropriate so we can keep from paying improper claims in the first place.

As a part of our efforts, CMS is keenly focused on the President's ambitious goal of reducing the Medicare fee-for-service error rate by half by 2012. While continuing to be vigilant in detecting and pursuing problems when they occur, we are also pursuing prevention of improper payments

before they occur. We are reexamining our claims and enrollment systems to enhance our ability to prevent improper payments while still promptly compensating honest, hard-working providers. This overhaul includes: more prepayment review, promoting the electronic submission of medical records, and expanding the scope of post-pay medical reviews. When improper payments do occur, we are working to quickly identify and recover those payments.

CMS is currently integrating predictive modeling as part of an end-to-end solution that is transparent, measurable, and triggers effective, timely administrative actions. Innovative risk scoring technology applies a combination of behavioral analyses, network analyses, and predictive analyses that are proven to effectively identify complex patterns of fraud and improper claims and billing schemes. Given the changing landscape of Medicare and Medicaid fraud, any successful technology will need to be nimble and flexible, identifying and adjusting to new schemes as they appear.

CMS is very excited about the potential of new data analysis and prediction tools to improve the Agency's ability to prevent payment of fraudulent claims. Before CMS expands data analytic tools to prepayment claims application, we will apply the risk scoring engine to post-payment claims to rigorously test the underlying analytics. This will accomplish three things: First, it will help us ensure that these analytics will not produce false positives that would disrupt payments and business for legitimate claims from legitimate providers or interfere with beneficiary access. Second, we will identify the most efficient analytics in order to appropriately target resources to the highest risk claims or providers. Third, incorporating this approach to our pre-payment processes will likely require significant systems changes. Therefore, applying these analytics to post-payment data while the pre-payment integration is built will allow both refinement of the algorithms and identification of bad actors in near real time.

How Can We Get to Where We Want to Be

Building an improved Medicare program and health care delivery system must be a collaborative effort. CMS cannot do this alone, and neither can government as a whole. Achieving high quality care will require participation and leadership at all levels – including Congress, States, insurers, employers, health providers and professionals, organizations, associations, patients,

families and communities. CMS is working to partner extensively with all health care stakeholders in pursuit of our common goals for improving care for Medicare beneficiaries and all Americans.

States will have an integral role to play in the implementation of delivery system changes and other Affordable Care Act provisions. CMS is committed to ensuring that States have the tools they need to succeed at addressing these challenges. Just last week, the Secretary sent a letter to all State governors to address their concerns regarding current State fiscal conditions. HHS stands ready to immediately assist States with new “rapid response” teams, and the Secretary’s letter outlined several options for States to more efficiently manage their Medicaid programs. These options include managing care for high cost enrollees more effectively through new payment models and more coordinated care, purchasing drugs more efficiently, and improving Medicaid program integrity. Additionally, CMS has already conducted a number of outreach sessions and meetings with State stakeholders to discuss topics such as Medicaid payment practices, health homes, and primary care practice support. CMS will also rely on input from States as we design guidance and implement other changes and improvements.

Health care providers who are directly interacting with patients each day are crucial partners in this reform effort. They need stable and predictable payments in order to be able to play their key roles as foundations of delivery system reform. To ensure that Medicare beneficiaries continue to have appropriate access to necessary physician services, the Administration supports permanent, fiscally responsible reform to the Sustainable Growth Rate methodology for physician payment.

Conclusion

The Affordable Care Act has had a dynamic effect on Medicare beneficiaries and people with disabilities. Since last March, CMS has worked tirelessly to implement the many new programs and authorities that the Act has provided us. CMS has a responsibility to improve access, quality, and efficiency of care for all our Medicare beneficiaries, while protecting the fiscal integrity of this program in the long term. The Affordable Care Act has already had a positive impact on Medicare beneficiaries, as well as for the millions more who can now have greater

options and protections in their private health insurance. In the coming months, I look forward to working with Congress to continue that work and make sure that Americans can take full advantage of all the benefits, protections, and freedoms that the law has to offer.