



STATEMENT OF

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ON

DELIVERY SYSTEM REFORM: PROGRESS REPORT FROM CMS

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Statement of Jonathan Blum on
Delivery System Reform: Progress Report from CMS
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Chairman Baucus, Ranking Member Hatch, and members of the Committee, thank you for this opportunity to highlight the efforts of the Centers for Medicare & Medicaid Services (CMS) to strengthen the Medicare program and improve our health care delivery system. Since the passage of the Affordable Care Act nearly three years ago, CMS has worked tirelessly to implement the reforms to the health care delivery system envisioned by Congress and your Committee. While work remains to be done, I am pleased to report that we are making significant progress on transforming the Medicare program and promoting quality nationwide.

The Affordable Care Act included important reforms to improve the quality of health care for Medicare and Medicaid beneficiaries and, in doing so, lower costs for taxpayers and patients. These reforms include incentives and tools to help providers avoid costly mistakes and readmissions, keep patients healthy, and make sure Medicare and Medicaid payments reward excellent care and not simply the provision of more low-value services. In addition, a number of reforms promoted by this Administration, including competitive bidding programs, change how we approach waste, fraud and abuse and improving the accuracy of our payments. These payment changes and investments will strengthen our health care system, ensuring quality care for generations to come – not just for Medicare and Medicaid beneficiaries, but for all patients that depend on our health care system.

Medicare beneficiaries are already starting to enjoy better quality of care through innovative care delivery systems designed to improve their health outcomes and reduce costs. Affordable Care Act reforms are contributing substantially to recent reductions in the growth rate of Medicare spending per beneficiary¹ without reducing benefits for beneficiaries. Growth in national health expenditures over the past three years was lower than any time over the last 50 years. Fraud recoveries have increased to a record \$4.2 billion in 2012, and \$14.9 billion over

¹ ASPE Issue Brief: “*Growth In Medicare Spending Per Beneficiary Continues To Hit Historic Lows*” for full report please visit: <http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.cfm>

the last four years. Medicare beneficiaries have gained access to additional benefits, such as increased coverage of preventive services and lower cost-sharing for prescription drugs.

We are also observing a decrease in the rate of patients returning to the hospital after being discharged. After fluctuating between 18.5 percent and 19.5 percent for the past five years, the 30-day all-cause readmission rate dropped to 17.8 percent in the final quarter of 2012. This decrease is an early sign that our payment and delivery reforms are having an impact.

The Affordable Care Act tied payment to private Medicare Advantage plans to the quality of coverage they offer for the first time. Since those payment changes went into effect, seniors have been able to choose from a broader range of Medicare Advantage plans, and more seniors have enrolled in higher-rated plans.

People with Medicare will have access to 127 four and five-star Medicare Advantage plans, 21 more top-performing plans than the previous year. Additionally, 30 percent of stand-alone prescription drug plans available to beneficiaries received a star rating of 4 or higher. More than 37 percent of Medicare Advantage enrollees are now enrolled in a four- or five-star plan.

Growing numbers of physicians and other providers are participating in new payment initiatives that reward higher-quality and lower-cost care. In 2012, we launched the first cohort of Medicare Accountable Care Organizations (ACOs), groups of providers working together to promote accountability for a patient population and redesigning care processes for high quality and efficient service delivery. To date, more than 250 Medicare ACOs are in operation, available in almost every State. CMS estimates that these organizations serve about four million Medicare beneficiaries.

Moving Away from a Delivery System that is Fragmented and Expensive

These early successes are occurring in the face of historical challenges in the current health care delivery system. Our nation enjoys access to world-class physicians and health care systems, and the United States leads the world in health care technology and cutting edge treatments. Yet the system in which these talented people work falls short far too often. Our delivery system is

often fragmented, leaving patients in the care of multiple doctors, each sometimes unaware of how the other is treating the patient. Furthermore, our data demonstrate that there is little apparent relationship between the cost a payer pays for care and the quality of the care a patient receives. Medicare spending per person varies widely throughout the country.²

To begin to address these longstanding challenges, CMS is implementing initiatives to encourage health care providers to deliver high-quality, coordinated care at lower costs. These reforms are enabling us to pay for value, not simply the quantity of care provided, while promoting patient safety and seeing that care is better coordinated across the health care delivery system. CMS has also implemented a number of reforms to crack-down on fraud and ensure that payments are accurate. In effect, the Medicare program has been transformed from a passive payer of services into an active purchaser of high-quality, affordable care.

The Affordable Care Act provided CMS with valuable tools to help us research and demonstrate care improvements care and lower costs through the creation of the Center for Medicare and Medicaid Innovation (CMS Innovation Center). The CMS Innovation Center is focused on testing new payment and service delivery models, evaluating results and advancing best practices, and engaging a broad range of stakeholders to develop additional models for testing.

The CMS Innovation Center enables CMS to quickly and efficiently develop models and expand those that prove successful at reducing program expenditures while preserving or enhancing quality of care. Some of the models being tested by the CMS Innovation Center include efforts to reduce unnecessary hospital admissions among residents of nursing homes; improve care coordination for beneficiaries with end-stage renal disease (ESRD); decrease premature births; and incentivize primary care providers to offer high-quality, coordinated care. While the work of the CMS Innovation Center tests many payment and service delivery models, these initiatives are only a part of our efforts to build a health care delivery system that will better serve all Americans.

² Centers for Medicare & Medicaid Services (2011). *Health Expenditures by State of Residence*. Retrieved (December 2011) at <http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip>.

Paying for Value

We know that when Medicare bases its payments solely on the number of services provided and not on the quality of care, beneficiaries may receive duplicative tests or services that may not improve their health. CMS has launched several initiatives to more closely link payments with quality outcomes and promote value-based care. Value-based health care relies on the concept that buyers should hold providers of health care accountable for both cost and quality of care.

Improving Quality in the Hospital Setting

CMS has implemented two programs to strengthen incentives to improve the quality of inpatient care provided to Medicare beneficiaries enrolled in the traditional fee-for-service program.

First, as required by the Affordable Care Act, beginning in October 2012, Medicare began adjusting payments to acute care hospitals according to how well they meet Medicare's quality standards. These standards are consistent with evidence-based clinical practice for the provision of high quality care. Hospitals are scored on improvement as well as achievement on a variety of quality measures. The higher a hospital's performance score during a performance period, the higher the hospital's value-based incentive payment will be for a subsequent fiscal year. The Hospital Value-Based Purchasing Program is a carefully crafted program that incorporated significant stakeholder feedback. The Hospital VBP Program will redistribute an estimated \$963 million to hospitals based on their quality performance in the FY 2013 payment year.

Second, the Affordable Care Act established the Hospital Readmissions Reduction Program, which reduces Medicare payments to hospitals that have high rates of readmissions beginning in October 2012. Currently, we measure the readmissions rates for three very common and very expensive conditions for Medicare beneficiaries—heart attack, heart failure, and pneumonia. We publish hospital performance on these measures on our website. Beginning in fiscal year 2015, we will have the authority to expand the program so that additional measures could be included, and we expect that the program will have an even greater impact. Though the payment adjustments took effect only recently, hospitals have been preparing for this program for some time and results suggest it is already having a positive impact. After five years of relative

stability, the Medicare readmissions rate began to drop across the country in the final quarter of 2012.

Value-Based Payments for Physicians

The Affordable Care Act also required CMS to develop a physician value-based payment modifier and apply it to all physicians and groups of physicians by 2017. The value modifier is an adjustment to payments under the Physician Fee Schedule based upon the quality of care furnished compared to cost. CMS will begin to apply the value modifier to groups of physicians, starting with groups of 100 or more eligible professionals in 2015 based upon performance during calendar year 2013.

To help physicians understand how their payment could be affected by the value modifier, in December 2012, CMS made available approximately 95,000 quality and resource use reports to individual physicians practicing in groups of 25 or more in nine States.³ Later this year, CMS plans to provide all groups of physicians with at least 25 eligible professionals a report on the quality and cost of care they provide and showing how their payment could be affected by the value modifier.

Strengthening Medicare Advantage through Quality Improvement

A high-quality, successful Medicare Advantage Program is an important part of our health care delivery system. With this in mind, CMS is committed to making Medicare Advantage quality, performance, and other data widely available so beneficiaries can choose a plan that best meets their individual health care needs. Nearly 100 percent of Medicare beneficiaries enjoy access to a Medicare Advantage plan. In 2013, on average, there are 26 Medicare Advantage plans to choose from in each county. Since 2010 when the Affordable Care Act was passed, Medicare Advantage premiums on average have fallen 10 percent and enrollment has climbed by an expected 28 percent by the end of this year.

³ Note: The nine States are California, Illinois, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, and Wisconsin.

To help promote value in the Medicare Advantage program, CMS created the Medicare Plan Ratings – a five star system to quantify the quality and performance of Medicare Advantage plans. The Affordable Care Act expanded the use of star ratings, linking the ratings with payment, and requiring CMS to award bonus payments to Medicare Advantage plans with at least four stars beginning in 2012.

CMS has built on this bonus system through the Medicare Advantage Quality Bonus Payment Demonstration, which began on January 1, 2012. Under the Affordable Care Act’s structure, five star plans receive the same quality bonus incentive payments as four star plans, but under the temporary demonstration in effect, better performing plans receive a higher bonus. For the 2013 plan year, people with Medicare had access to 127 five- and four-star plans, 21 more top-performing plans than the previous year. Overall, the average plan star rating has also improved. The raise in ratings suggests plans are motivated to improve further under the demonstration, thereby providing higher quality outcomes to beneficiaries and greater value to the Medicare program.

This investment in Medicare Advantage quality is already paying dividends, with more beneficiaries selecting high quality plans. An independent analysis by Medicare Payment Advisory Commission (MedPAC) staff⁴ shows that the share of Medicare Advantage plans with higher quality ratings has increased since the program began. Additional research has shown that the higher the quality ranking, the more likely it is that a beneficiary will enroll in a specific program.⁵ From 2009 to 2012, the percentage of Medicare Advantage beneficiaries enrolled in four- or five-star plans has increased from 16 percent in 2009 to 37 percent in 2012.

Bundled Payments

CMS recently launched the Bundled Payments for Care Improvement initiative, a new payment model developed by the CMS Innovation Center. Traditionally, Medicare makes separate payments to providers for each of the individual services they furnish to beneficiaries for a single

⁴ MedPAC Staff Briefing: “*The Medicare Advantage program: Status report; recommendations on special needs plans*” <http://www.medpac.gov/transcripts/MA%200113%20Presentation%20public.pdf> (Page 8)

⁵ Journal of American Medical Association: “*Association Between Medicare Advantage Plan Star Ratings and Enrollment*” <http://media.jamanetwork.com/news-item/higher-quality-rating-for-medicare-advantage-plan-associated-with-increased-likelihood-of-plan-enrollment/>

illness or course of treatment. This approach can result in fragmented care and a lack of coordination across health care settings. Research has shown that bundled payments can align incentives for providers – hospitals, post-acute care providers, physicians, and other practitioners– allowing them to work closely together across all specialties and settings.⁶

The Bundled Payments for Care Improvement initiative is composed of four broadly defined models of care, which link payments for multiple services beneficiaries receive during an episode of care. Over the course of the three-year initiative, CMS will work with participating organizations to assess whether the models being tested result in improved patient care and lower costs to Medicare.

Improving Quality in Dialysis Facilities

An End-Stage Renal Disease (ESRD) Quality Incentive Program (QIP) ties Medicare payments directly to facility performance on quality measures, resulting in better care at lower cost for nearly 500,000 Americans with kidney disease. Over the past 35 years, CMS has instituted a series of quality initiatives to improve dialysis care. The ESRD QIP is mandated by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) and is the nation's first pay-for-performance QIP. This first-of-its-kind program provides the ESRD community with the opportunity to enhance the overall quality of care that ESRD patients receive as they battle this devastating disease.

And this month, CMS announced the Comprehensive ESRD Care Initiative, a new model from the Innovation Center that will provide incentives for dialysis centers, nephrologists, and others to work together to improve not just dialysis, but the entire care experience for ESRD patients. Through this new initiative, CMS will partner with groups of health care providers and suppliers – ESRD Seamless Care Organizations (ESCOs) – to test and evaluate a new model of payment

⁶ Cromwell J., Dayhoff DA., McCall NT, et al. Medicare Participating Heart Bypass Center Demonstration: Final Report. Prepared by Health Economics Research, Inc. 1998.

Abt Associates, Inc., Medicare Cataract Surgery Alternate Payment Demonstration: Final Evaluation Report, Cambridge, Mass: Abt Associates, Inc; 1997.

Casale A.S. et al. ProvenCare: A Provider-Driven Pay-for-Performance Program for Acute Episodic Cardiac Surgical Care, *Annals of Surgery*. 2007;(246) 4:613-621.

Medicare Acute Care Episode Demonstration.

<http://www.cms.gov/DemoProjectsEvalRpts/downloads/ACESolicitation.pdf>.

and care delivery specific to Medicare beneficiaries with ESRD. Participating ESCOs will be clinically and financially responsible for all care offered to its patients, not only dialysis care or care specifically related to a beneficiary's ESRD.

Protecting Patient Safety and Promoting Better Care

In addition to promoting value, we are also striving to make the health care system safer for patients. Medical errors can occur as a patient moves from one care setting to another, or is prescribed different medications with potentially dangerous interactions. Better coordination among doctors and specialists and across health care settings protects patients from errors while also reducing unnecessary duplication. CMS has undertaken several efforts to promote better care and improve patient safety. These programs focus on assisting health care providers in delivering coordinated, high quality care to their patients. These programs not only will help save money for patients and taxpayers, but we believe they will save lives.

Partnership for Patients

The nationwide Partnership for Patients initiative aims to save 60,000 lives by averting millions of preventable hospital-acquired conditions (HACs) and reducing preventable hospital readmissions over the next three years, while providing savings to Medicare and Medicaid by reducing complications and readmissions during the transition from one care setting to another. Over 3,700 hospitals, as well as physicians' and nurses' organizations, consumer groups, employers, and other major stakeholders, have pledged to help achieve the Partnership's goals. Additionally, 26 Hospital Engagement Networks, which work at the National, regional, State, or hospital system levels, are identifying best practices and solutions in reducing HACs and readmissions and disseminating information to health care providers and institutions, nationwide. Examples include preventing adverse drug reactions, pressure ulcers, premature deliveries, childbirth complications, and surgical site infections.

The Community-based Care Transition Program, also part of the Partnership for Patients, supports 82 participant organizations working in partnership with Community Based Organizations in 33 States to help high-risk Medicare beneficiaries make successful transitions

from hospital to home or to another post-hospital setting. Hospitals are a logical focal point for efforts to reduce readmissions, since the quality of care during a hospitalization and the discharge planning process can have an impact on whether a patient will continue to heal or return. However, it is clear that there are multiple factors along the care continuum that affect readmissions. The Community-based Care Transition Program helps identify the key drivers of readmissions for a hospital and its downstream providers, taking the first step towards implementing the appropriate interventions necessary for reducing readmissions.

Additional Efforts to Increase Patient Safety

The Partnership for Patients builds on other CMS efforts to leverage payment policy in support of patient safety. Since 2008, CMS has eliminated additional payment for HACs (cases in which certain conditions were not present on admission).

In 2012, CMS added additional HACs to the list of conditions that would warrant CMS eliminating additional payments.⁷ While Medicare pays hospitals the standard rates for the original admission, we no longer pay hospitals for the additional costs associated with the care and treatment of these HACs. To further reduce HACs and improve patient quality, starting in FY 2015, hospitals with high overall rates of HACs will see their payments reduced. CMS has issued similar guidelines for Medicaid.

CMS created the Hospital Compare Website⁸ to promote transparency and to better inform health care consumers about a hospital's quality of care. This tool shows a hospital's performance on a wide variety of quality measures, including certain measures of healthcare infections. In the coming years, additional measures will be added to the Hospital Compare website, making this an even richer source of information for consumers.

⁷ A complete list of HAC categories and their corresponding complication or comorbidity (CC) or major complication or comorbidity (MCC) codes finalized for FY 2013 can be found at: <http://www.cms.gov/Medicare/Medicare-fee-for-service-Payment/HospitalAcqCond/Downloads/HACFactsheet.pdf>

⁸ For more information on the Hospital Compare Website please visit: <http://www.medicare.gov/hospitalcompare>

Accountable Care Organizations

Accountable Care Organizations (ACOs) are one of the Affordable Care Act's key reforms to improve the delivery of care. ACOs are groups of doctors and other health care providers that have agreed to work together to treat individual patients and better coordinate their care across care settings. They share—with Medicare—any savings generated from lowering the growth in health care costs while improving quality of care including providing patient-centered care.

In just over a year, over 250 ACOs were formed and are working to improve the care experience for more than four million Medicare fee-for-service beneficiaries nationwide. This is approximately eight percent of all beneficiaries in the Medicare program, and will grow over time as existing ACOs choose to add providers and more organizations are approved for participation in the program. They are located in 47 States and territories—from the most remote community in Montana to as far away as Puerto Rico.

The new ACOs include a diverse cross-section of physician practices across the country. Roughly half of all ACOs are physician-led organizations that serve fewer than 10,000 beneficiaries. Approximately 20 percent of ACOs include community health centers, rural health clinics and critical access hospitals that serve low-income and rural communities. Participation in an ACO is purely voluntary for providers, and we will accept applications annually for the Shared Savings Program to allow more providers to come together and work to improve the quality and cost efficiency of care our Medicare FFS beneficiaries receive.

The Shared Savings Program requires that participants—which can be providers, hospitals, suppliers, and others—coordinate care for all services provided under Medicare FFS and encourages investment in infrastructure and redesigned care processes. ACOs that lower their growth in health care costs, while also meeting clearly defined performance standards on health care quality, are eligible keep a portion of the savings they generate for the program. As a result of these efforts we are seeing providers developing strategies to work together to redesign care process, promote preventive care, and better coordinate services for patients with chronic disease and high risk individuals.

In addition to the ACOs participating in the Shared Savings Program, the CMS Innovation Center is testing a different payment model for ACOs, the Pioneer ACO model. The Pioneer ACO model is designed for health care organizations that have experience coordinating care for patients across care settings. This model tests alternative payment models that include escalating levels of financial accountability. One purpose of the Pioneer ACO model is to inform future changes to the Shared Savings Program. Thirty-two organizations are participating in the testing of the Pioneer ACO model.

The Innovation Center is also testing the Advance Payment ACO model. The Advance Payment ACO model examines whether and how pre-paying a portion of future shared savings could increase participation in the Shared Savings Program from entities such as physician-owned and rural providers with less capital. Through the Advance Payment ACO Model, selected participants receive upfront and monthly payments, which they can use to make important investments in their care coordination infrastructure. It is our hope that the assistance the Advanced Payment Model provides to smaller and rural practices will result in expanding access to this coordinated care effort to more fee-for-service Medicare beneficiaries. Currently 35 ACOs are participating in this model.

Comprehensive Primary Care Initiative

CMS is also working to strengthen primary care by improving care coordination. Approximately 500 primary care practices⁹ in 7 markets are participating in the Comprehensive Primary Care initiative- a multi-payer model testing the effectiveness of enhanced payments to primary care practices in improving care coordination for people enrolled in Medicare and Medicaid. CMS consulted extensively with other payers to design a model that would be suitable for adoption by Medicare, commercial, and Medicaid payers.

Under this initiative, primary care practices are given the resources they need to transform their practices to better serve their patients, such as developing care plans and using a team based approach to care. Participating practices receive an additional payment from CMS and are

⁹ For a full list of participating practices please visit: <https://data.cms.gov/Government/CPC-Initiative-Participating-Primary-Care-Practice/mw5h-fu5i>

eligible for shared savings beginning in the second year of the initiative, in addition to enhanced payment the practice might receive from other payers.

Coordination of Care for Medicare-Medicaid Enrollees

CMS is also focused on the coordination of care for those individuals who qualify for both the Medicare and Medicaid programs. While Medicare and Medicaid are separate programs, a growing number of people—known as Medicare-Medicaid enrollees or dual eligibles—depend on both programs for their care. To meet their needs effectively, both programs need to work together.

Today, more than 10 million Americans¹⁰ are enrolled in both the Medicare and Medicaid programs; nearly two-thirds are low-income elderly and one-third are people who are under age 65 with disabilities. In many cases, they are among the poorest and sickest people covered by either program.¹¹

Currently, the majority of Medicare-Medicaid enrollees must navigate three sets of rules and coverage requirements (Medicare fee-for-service, a Medicare prescription drug plan, and Medicaid) and manage multiple identification cards, benefits, and plans. As a result of this lack of coordination, care often is fragmented or episodic, which can result in poor health outcomes for a population with complex needs. It also leads to misaligned incentives for payers and providers, resulting in cost-shifting, unnecessary spending and an inefficient system of care.

Under the Affordable Care Act, Congress established the Federal Coordinated Health Care Office, also known as the Medicare-Medicaid Coordination Office (MMCO), to more effectively integrate Medicare and Medicaid benefits and improve the coordination between the Federal and State governments for this vulnerable population. We are continuing to make progress in our efforts to create a more streamlined system that delivers quality, cost-effective care. Among

¹⁰ Data Analysis Brief: Medicare-Medicaid Dual Enrollment from 2006 through 2011, Prepared by the Medicare-Medicaid Coordination Office, February 2013 http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/Downloads/Dual_Enrollment_2006-2011_Final_Document.pdf

¹¹ Kaiser Family Foundation, Medicaid's Role for Low-Income Medicare Beneficiaries, May 2011 Report *available at* <http://www.kff.org/medicaid/upload/4091-08.pdf>; Kaiser Family Foundation.

them, CMS has announced agreements with Ohio, Massachusetts, Washington, and Illinois to test new models to better align the Medicare and Medicaid programs. We have undertaken numerous initiatives to further our work to improve care coordination and quality of care for Medicare-Medicaid enrollees, including developing new tools to gain a better understanding of the population, increasing States' access to Medicare data for their Medicare-Medicaid enrollees, and partnering with organizations to reduce avoidable hospitalizations.¹² I know the Committee heard from my colleague Melanie Bella in December on the important work of the Medicare-Medicaid Coordination Office.

Electronic Health Records

The American Recovery and Reinvestment Act of 2009 provided support to physicians and other providers who adopt electronic health records. These electronic health record systems are making it easier for physicians, hospitals, and others serving Medicare and Medicaid beneficiaries to evaluate patients' medical status, eliminate redundant and costly procedures, and provide high-quality care. More than 185,000 eligible health care professionals—roughly one-third—and over 3,500 eligible hospitals—roughly two-thirds—have already qualified for incentive payments. These investments in electronic health records will help speed the adoption of many other delivery system reforms, by making it easier for hospitals and doctors to better coordinate care.

Improving Physician Payments

While we must all work together to address the long-term imbalance of the Sustainable Growth Rate, CMS has made important strides to improve the accuracy of our physician payment system and to emphasize the value of primary care in our physician fee schedule. Through the misvalued code initiative, CMS has taken a much more aggressive stance in updating payment codes that are over-valued. CMS has added new payment codes to pay for care transitions, recognizing the value that results from coordinated care following a hospital admission. And we

¹² For more information on CMS's agreements with Ohio, Washington, and Massachusetts and other States' proposals, please visit: <http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialModelstoSupportStatesEffortsinCareCoordination.html>

have also implemented enhanced payments for primary care visits, consistent with the Affordable Care Act.

Payment Accuracy

Ensuring payment accuracy is another vital piece of our efforts to control the growth of Medicare costs. Preventing errors, fraud and other waste in our programs preserves scarce resources that can be better invested in efforts to improve health care. Over the last two years, CMS has implemented powerful new anti-fraud tools provided by Congress, as well as designed and implemented large-scale, innovative improvements to our Medicare and Medicaid program integrity strategy to shift beyond a “pay-and-chase” approach by focusing new attention on preventing fraud. Simultaneously, CMS is using the same innovative tools to strengthen our collaboration with our law enforcement partners in detecting and preventing fraud. The Administration’s efforts are paying off, with a record \$4.2 billion in fraud recoveries collected in 2012, totaling \$14.9 billion over the last four years.

Every workday, Medicare pays out more than \$1 billion from some 4.6 million claims, and is statutorily required to pay claims quickly, usually within 14 to 30 days. Medicaid is administered by States within the bounds of Federal law, and CMS partners with each State Medicaid program to support program integrity efforts. The 56 separate State-run Medicaid programs process 4.4 million claims per day. Preventing fraud in Medicare and Medicaid involves striking an important balance: protecting beneficiary access to necessary health care services and reducing the administrative burden on legitimate providers, while ensuring that taxpayer dollars are not lost to fraud, waste, and abuse.

Building upon traditional program integrity efforts to detect and prosecute fraud, CMS has implemented a “twin-pillar” approach to fraud prevention in Medicare. The first pillar is the new Fraud Prevention System (FPS), which applies predictive analytic technology to incoming claims prior to payment to identify aberrant and suspicious billing patterns. The second pillar is the Automated Provider Screening (APS) system, which is designed to identify ineligible providers or suppliers prior to their enrollment or revalidation. Since March 2011, CMS validated or revalidated enrollment information for nearly 410,000 Medicare providers and suppliers under

the enhanced screening requirements of the Affordable Care Act. Because of revalidation and other proactive initiatives, CMS has deactivated 136,682 enrollments and revoked 12,447 enrollments. Together these innovative new systems, the FPS and APS, are growing in their capacity to protect patients and taxpayers from those intent on defrauding our programs. CMS is evaluating many of the tools used in Medicare for opportunities to transfer the knowledge and lessons learned to the Medicaid program.

In addition, CMS implemented a demonstration that requires prior authorization for power mobility devices (PMDs) for beneficiaries who reside in seven States¹³ with high incidence of fraud and improper payments. It is designed to develop and demonstrate improved methods for the investigation and prosecution of fraud associated with these items. Through the use of prior authorization, this demonstration will also help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. Most important, the program will assist in preserving a Medicare beneficiary's ability to receive quality products from accredited suppliers.

We are also working to implement and expand competitive bidding for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) which enables the Medicare program to pay a fairer and more accurate price for equipment used by beneficiaries. In the past, Medicare has paid for DMEPOS items using a fee schedule that is generally based on historic supplier charges from the 1980s. Numerous studies from the Department of Health and Human Services Office of Inspector General and the Government Accountability Office have shown these fee schedule prices to be excessive, and taxpayers and Medicare beneficiaries bear the burden of these excessive payments.¹⁴

Under the DMEPOS Competitive Bidding Program, DMEPOS suppliers compete to become Medicare contract suppliers by submitting bids to furnish certain items in competitive bidding

¹³ The seven States in the demonstration are California, Illinois, Michigan, New York, North Carolina, Florida and Texas.

¹⁴ See, for example, *Comparison of Prices for Negative Pressure Wound Therapy Pumps*, OEI-02-07-00660, March 2009; *Power Wheelchairs in the Medicare Program: Supplier Acquisition Costs and Services*, OEI-04-07-00400, August 2009; *Medicare Home Oxygen Equipment: Cost and Servicing*, OEI-09-04-00420, September 2006.

areas. The new, lower payment amounts resulting from the competition replaces the fee schedule amounts for the bid items in these areas. The CMS Office of the Actuary estimated that the program would save the Medicare Part B Trust Fund \$26.2 billion and beneficiaries \$17 billion between 2013 and 2023.

The first round of the DMEPOS Competitive Bidding Program went into effect in nine areas of the country on January 1, 2011. In January 2012, CMS initiated bidding for a major expansion of the DMEPOS Competitive Bidding Program in Round 2, which will result in the application of competitively-bid prices in far more areas across the country, saving money for beneficiaries and taxpayers. Round 2 is scheduled to go into effect in 91 major metropolitan areas on July 1, 2013 and is projected to result in average price reductions of 45 percent as compared to the current fee schedule prices. The payment amounts for a new competitively-bid national mail-order program for diabetic testing supplies that is being implemented for both retail and mail-order suppliers at the same time as Round 2 are projected to result in average savings of 72 percent. The national mail-order competition will include all parts of the United States, including the 50 States, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, and American Samoa.

Conclusion

CMS has taken the charge that this Committee and Congress gave to us to reform our nation's health care delivery system very seriously. The Agency has been working diligently to implement the changes and innovations included in the Affordable Care Act in a timely manner and has already made real progress, demonstrated by decreasing readmissions to hospitals and a reduced growth in Medicare costs. It is important to remember that these changes help not only Medicare beneficiaries, but all patients across the health care delivery system. As hospitals take action to prevent infections and lower the rate of preventable readmissions, all hospital patients will benefit from safer care. However, more work remains to be done to make Medicare sustainable for the long-term and improve the overall delivery of care. We look forward to working with this Committee to continue to reduce health spending and increase care quality for patients.