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A PATHWAY TO IMPROVING CARE FOR MEDICARE PATIENTS WITH CHRONIC CONDITIONS

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BEFORE THE

COMMITTEE ON FINANCE
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

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A PATHWAY TO IMPROVING CARE FOR MEDICARE PATIENTS WITH CHRONIC CONDITIONS

THURSDAY, MAY 14, 2015

U.S. SENATE,
COMMITTEE ON FINANCE,
Washington, DC.

The hearing was convened, pursuant to notice, at 10:07 a.m., in room SD–215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Crapo, Thune, Burr, Isakson, Scott, Wyden, Cantwell, Menendez, Carper, Cardin, Brown, Bennet, Casey, and Warner.

Also present: Republican Staff: Erin Dempsey, Health Care Policy Advisor; and Katie Simeon, Health Policy Advisor. Democratic Staff: Hannah Hawkins, Research Assistant; Elizabeth Jurinka, Chief Health Policy Advisor; and Matt Kazan, Health Policy Advisor.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH, CHAIRMAN, COMMITTEE ON FINANCE

The CHAIRMAN. The committee will come to order.

Today's hearing signals the Finance Committee's first step in a bipartisan process that will continue over the next 6 months. Ranking Member Wyden and myself and other members of the committee have expressed strong interest in understanding the impact chronic care coordination programs have on Medicare. Chronically ill patients account for a large percentage of Medicare spending.

In 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, while 14 percent had six or more. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending. In fact, fee-for-service Medicare spent an average of more than $32,000 per beneficiary with six or more chronic conditions compared to an average of around $9,000 for all other patients.

Left unresolved, this situation can only get worse. Researchers at the Centers for Disease Control and Prevention found an increasing number of adults between 45 and 64 years of age—members of the baby boom generation—living with multiple chronic conditions, signaling even higher future spending for the Medicare program.

We have to find ways to provide high quality care at greater value and lower cost, all without adding to our burgeoning deficit. The good news is that the successful Medicare Advantage program

gives beneficiaries the option to receive covered benefits from private plans that are incentivized to manage care across all settings. That explains why 15.7 million beneficiaries, or 30 percent of Medicare participants, chose a Medicare Advantage plan in 2014.

I am concerned that ongoing payment cuts and changes to the risk adjustment and quality measurements may be putting these plans at a disadvantage. Traditional fee-for-service Medicare still fails to properly incentivize providers who engage in labor- and time-intensive patient care coordination. While disease management and chronic care coordination have been widely used by private-sector health insurers, their application in fee-for-service Medicare has been largely restricted to demonstration programs.

Since Obamacare became law, there has been an increased focus on programs like Accountable Care Organizations and medical homes. But for more than a decade, the Centers for Medicare and Medicaid Services, or CMS, has piloted numerous demonstration programs to find out what does and does not work, and they want to find out what really works to improve health outcomes for patients with chronic diseases.

These demonstration programs have shown, at best, mixed results. According to one Congressional Budget Office report, CMS paid 34 programs in six major demonstrations to provide disease management or care coordination services in traditional Medicare. On average, these 34 programs had little or no effect on hospital admissions or Medicare spending.

Now, I know that the Obama administration is actively pursuing new care coordination programs through the Center for Medicare and Medicaid Innovation. My hope is that this research will yield long-term results. By identifying cost-effective, data-driven ways to improve patient health, policymakers can better target scarce Federal resources to get more value for the dollars spent. But developing and implementing new policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a daunting challenge.

The lack of success in past demonstration programs underscores the inherent limitations of traditional Medicare's fee-for-service payment system, one that rewards providers for delivering increased volume of services, but does not incentivize them to coordinate medical care. Additionally, programs that try to improve outcomes for patients with chronic conditions struggle to identify successful interventions that motivate individuals to alter their health habits. Beneficiaries often have physical and cognitive challenges that limit their ability to effectively communicate with multiple providers.

So I think this committee understands that we have a very difficult task in front of us. There are no easy answers. That is why I am looking forward to hearing from our panel of expert witnesses.

I want to thank Dr. Conway and Dr. Miller for appearing before us today. They will help us understand which care coordination efforts are most effective, which policies have failed, and explain why. But the committee is not stopping there. After this hearing, we plan to take two additional steps to address these important issues.

First, today I want to announce that Ranking Member Wyden and I have appointed Senators Johnny Isakson and Mark Warner to form a full Finance Committee chronic care reform working group. We have tasked this bipartisan group with studying these complex issues and producing an in-depth analysis of potential legislative solutions. Their recommendations will serve as a foundation to develop bipartisan chronic care legislation. And we cannot pick two better people on the committee to do this.

Second, in the coming days, Senators Isakson and Warner, along with Ranking Member Wyden and I, will issue a formal invitation requesting all interested public and private-sector stakeholders to submit their ideas on ways to improve outcomes for Medicare patients with chronic conditions. Stakeholder input is critical for this committee to work toward the goal of producing bipartisan legislation that can be introduced and marked up in the Finance Committee later this year.

So, as you can see, today's hearing is just the first step in our efforts to address these issues, but it is an important step.

I look forward to an informative discussion, and I think it is important to point out that Senator Wyden has raised these issues and has done a good job in bringing them to the forefront.

[The prepared statement of Chairman Hatch appears in the appendix.]

The CHAIRMAN. With that, I will now turn to Senator Wyden for his opening remarks.

OPENING STATEMENT OF HON. RON WYDEN, A U.S. SENATOR FROM OREGON

Senator WYDEN. Thank you very much, Mr. Chairman. Let me thank you for your leadership on this.

I want colleagues to know that once again Chairman Hatch is stepping up and providing real leadership on one of the great challenges of our time. This is in line with his work on CHIP and a whole host of other important health issues. I want you to know, Mr. Chairman, I am very much looking forward to working with you on this.

Ten months ago, the Finance Committee came together to discuss what I consider to be one of the premier challenges of our time—addressing the chronic illnesses that dominate America's flagship health program, Medicare. Chronic illnesses—heart disease, diabetes and cancer, among others—now account for almost 93 percent of Medicare spending. This was not the case when Medicare began in 1965. Back when Medicare began, its primary purpose was to help individuals with catastrophic health events that put them in the hospital.

That picture is now turned upside down. It has been hard to get precise numbers from that particular era, but we do know this much. In 1970, according to the Centers for Medicare and Medicaid Services, 64 percent of total Medicare spending was devoted to care provided to patients in the hospital. By 2010, that number had dropped to 26 percent. So we are talking about a program that has been a lifeline for millions of older people and a program that has changed very dramatically since the program was enacted in 1965.

Today, the vast majority of Medicare dollars are spent caring for patients living with multiple persistent chronic health conditions that require a variety of services. It is a good thing that care is being provided outside the hospital.

What we have to recognize is that, too often, this care is poorly coordinated and needlessly costly. With a trend this clear, it is time for both parties to tackle this issue head on. And we are fortunate, colleagues, to have Chairman Hatch make this a priority for the Senate Finance Committee.

I also want to point out that last month the Congress took an important step by ending the broken Sustainable Growth Rate formula. Throwing that program, which was called SGR, in the junk bin of history accomplished two major things. First, it engraved in stone the principle of rewarding medical care that provides quality over quantity; and second, it cleared the legislative logjam that has blocked the Congress from taking a close look at how Medicare could be tuned to work better for patients and encourage providers to improve the care that they deliver.

So it is going to be essential to build on that progress, to build on the progress of getting rid of this outdated reimbursement formula, this formula that was common sense-defying. We now need to build off the progress of eliminating that to address the challenge of treating chronic illness.

Since our hearing last July, I have held a series of roundtables around my State to hear what the committee can do to make Medicare work better when it comes to chronic illness. I have received a number of valuable comments along the way, and I intend to work closely with Chairman Hatch, Senator Isakson, and Senator Warner to offer what, in my view, are a host of key principles that ought to be part of any attempt to more effectively care for patients with multiple chronic illnesses.

Let me make a kind of start at that this morning. First, Medicare needs to encourage teams of providers to coordinate care for their patients with chronic conditions. Those with multiple chronic illnesses often have a half-dozen doctors, but those doctors may not communicate to provide the most efficient care. This is a situation that ought to be turned on its head in favor of a holistic approach that encourages providers to work together to make our patients healthy.

Working with multiple doctors is especially challenging for those who live in rural communities. Treating multiple chronic conditions is hard to do anywhere, but it is even more difficult when doctors and specialists are 80 miles apart. Families that face chronic health issues should not have to add a whistle-stop tour of doctors' offices to their challenges.

Second, the Congress needs to make life easier for providers who want to coordinate care, whether that means more information about patients, improved access to innovative technologies, or other measures that promote flexibility in our health system. At the same time, accountability is critical to ensure that providers are successfully treating patients while also providing savings from coordinating care.

As Chairman Hatch noted, I have been passionate about this issue for some time, but now, with the input and efforts of the

whole Finance Committee, I believe that we can craft a bipartisan solution that really gets at the heart of the challenges posed by chronic illness.

So I am very pleased to be teaming up with Chairman Hatch on a plan that begins with this working group and ends with legislation being passed out of this committee. The working group will develop policy options to address how Medicare can work better for Americans with chronic illness, and we are very lucky to have that effort co-chaired by Senator Isakson and Senator Warner. They have been dogged in this issue. I commend them for it. I also want to take note that Senator Bennet and others have demonstrated an eagerness to dig into this issue and come up with real meaningful reforms.

One last point, if I might, Mr. Chairman. We have gotten a lot of valuable feedback from patients and providers, but this morning I want to take special note of Stephanie Dempsey of Georgia, who was a witness at our hearing last July. Ms. Dempsey was dealing with heart disease, lupus, arthritis, and a seizure disorder, and I am sorry to say that she passed away in December due to these conditions. I talked with Ms. Dempsey's mother this morning, Mrs. Nancy Carter, also of Georgia, to convey the committee's sympathies with the family, to say how much we admired Ms. Dempsey's courage, her passion, and her intelligence.

I will close by saying I believe Ms. Dempsey will be an inspiration to all of us, and we should remember what she said at our hearing. She said, and I quote, "I am confident that you will not forget me and countless other people when you develop policies that will help all of us. Our goals are all the same: to live long, healthy, and productive lives."

I just wanted to use this morning, because I know Mrs. Carter and family are paying attention to this, to let them know that we are dedicating our efforts to Stephanie Dempsey, who spoke so eloquently for millions who have these chronic illnesses, and we are going to work on this in a bipartisan fashion until we have the reforms necessary to help the millions of patients who needlessly suffer in this fashion.

Thank you very much, Mr. Chairman.

[The prepared statement of Senator Wyden appears in the appendix.]

The CHAIRMAN. Thank you, Senator.

I would like to now welcome our expert panel. Neither witness here today is a stranger to the Finance Committee. Both are extremely well-versed in Medicare payment policy and delivery system reforms. Members on both sides of the aisle, I want you both to know, really respect your hard work, and we rely heavily on your policy advice and counsel, both of you.

First we will hear from Dr. Patrick Conway, Acting Principal Deputy Administrator, Deputy Administrator for Innovation and Quality, and Chief Medical Officer at the Centers for Medicare and Medicaid Services.

Second, we will hear from Mark Miller, Executive Director of the Medicare Payment Advisory Commission, otherwise known as MedPAC. This nonpartisan Federal agency advises Congress on Medicare payment, quality, and access issues. This committee de-

pends heavily on MedPAC, as you know, Dr. Miller. We thank you and your talented policy team for your dedicated service.

As we get started today, I want to remind you that your prepared statements will automatically be included in the record, and I would urge you, if you can, to limit your oral remarks to 5 minutes, but I am not going to be a stickler on that if you need more time.

So we will start today with Dr. Conway, and then we will go to Dr. Miller. We are grateful to have both of you here.

STATEMENT OF PATRICK CONWAY, M.D., M.Sc., ACTING PRINCIPAL DEPUTY ADMINISTRATOR, DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY, AND CHIEF MEDICAL OFFICER, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES, BALTIMORE, MD

Dr. CONWAY. Thank you. Chairman Hatch, Ranking Member Wyden, and members of the committee, I want to thank you for inviting me to discuss the Centers for Medicare and Medicaid Services' work to improve care for beneficiaries with chronic disease, and I want to thank you for your leadership in this area.

In 2010, as you said, more than two-thirds or 24.1 million fee-for-service beneficiaries had at least two or more chronic conditions. Improving care for Medicare beneficiaries with chronic conditions is a goal that is foundational to CMS's work. We want to create a payment environment that promotes value over volume to encourage better chronic care management in both fee-for-service and Medicare Advantage, and to test innovative models of chronic care delivery through the Innovation Center.

Earlier this year, Secretary Burwell announced measurable goals and a timeline to move the Medicare program and the health care system at-large toward paying providers based on quality rather than the quantity of care they provide to patients. This initiative will align Medicare payment systems to appropriately promote and reward care management for persons with chronic conditions. At the same time, CMS continues to make improvements to the Medicare fee-for-service payment systems as value-based payment models are developed.

In 2013, CMS adopted a policy to pay Medicare providers separately for care transition services that are important for ensuring care continuity and preventing hospital readmissions. Building on this work, we adopted a policy in 2015 to pay separately for non-face-to-face care management services furnished to beneficiaries with two or more chronic conditions. Providers will now be paid for expanding access, developing care plans, and coordinating care with other providers. CMS is also taking strides to improve chronic care management in the Medicare Advantage (MA) program. Last year we added new regulations that allow MA organizations to offer beneficiaries rewards and incentives for participating in activities that promote improved health.

The Affordable Care Act ties payment to Medicare Advantage plans to the quality of the coverage and the care they provide, including how effectively they coordinate care. Medicare Advantage plans that receive a 4-star or 5-star rating receive a bonus pay-

ment, and, in 2015, 60 percent of MA enrollees were enrolled in a 4-star or 5-star plan compared to an estimated 17 percent in 2009.

Finally, I would like to highlight just a few of the new payment service delivery models focused on improving quality and enhancing care management and care coordination that CMS is testing through the Innovation Center.

First, CMS recently announced results from the second independent evaluation of the Pioneer Accountable Care Organization (ACO) model, demonstrating that it has generated savings of $384 million in its first 2 years. Pioneer ACOs are experienced groups of providers that work together to deliver high-quality coordinated care. They are held accountable for total cost of care and can share in savings to Medicare if they hit financial and quality targets.

Medicare beneficiaries who are in Pioneer ACOs, on average, report more timely care and better communication with their providers, use inpatient hospital services less, and have fewer tests and procedures. The CMS Office of the Actuary recently certified that the Pioneer ACO model met the stringent criteria for expansion under the Innovation Center authority based on improving quality and lowering costs.

Second, the Comprehensive Primary Care initiative is a multipayer partnership between Medicare and Medicaid, private health care payers, and primary care practices in seven States and regions across the country. This initiative focuses on providing advanced primary care for those at greatest risk, including Medicare beneficiaries with multiple chronic conditions. Results from the first year suggest that CPC demonstrated decreases in both hospital admissions and emergency department visits as well as high quality.

Third, created by the Affordable Care Act, the Independence at Home demonstration uses home-based primary care designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. Practices are providing home-based primary care to chronically ill beneficiaries. The care is tailored to an individual patient's needs and preferences, with the goal of keeping them from being hospitalized.

To close, providing coordinated care to individuals with multiple chronic conditions can be complex and require significant coordination that may not always occur in our fragmented health care delivery system. CMS is committed to improving care for Medicare beneficiaries with chronic disease, while increasingly transitioning our payment systems to reward the value of care delivered, not volume.

We hope this work will not only improve care for Medicare beneficiaries, but will help inform efforts to improve coordination across Medicaid and other payers. As a practicing physician who will take care of patients with multiple chronic conditions this weekend, I know the importance of this work personally.

We look forward to working with you to continue to improve the Medicare program, and I look forward to your questions, and thank you again for your leadership in this area.

[The prepared statement of Dr. Conway appears in the appendix.]

The CHAIRMAN. Thank you so much.

Dr. Miller, we will take your statement.

STATEMENT OF MARK E. MILLER, Ph.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION (MedPAC), WASHINGTON, DC

Dr. MILLER. Chairman Hatch, Ranking Member Wyden, distinguished committee members, I am Mark Miller, Executive Director of the Medicare Payment Advisory Commission. As the chairman acknowledged, we were created to provide independent advice on a range of Medicare issues. And on behalf of the commissioners, I would like to thank you for asking us to testify today.

The Commission's work in all instances is guided by three principles: to assure that beneficiaries have access to high-quality care, to protect the taxpayer dollar, and to pay providers and plans in a way to accomplish these goals.

All of the testimony and the opening statements acknowledged the complexity and cost of caring for patients with multiple chronic conditions. The Commission has made a number of recommendations in fee-for-service, Accountable Care Organizations, and for Medicare managed care plans that support chronic care coordination, and I will highlight a few for you today.

The problem with fee-for-service is that our siloed payment systems fragment care by paying on the basis of the setting rather than on the needs of the beneficiary. A few ideas in fee-for-service: the Commission has recommended that there be a continuation of the 10-percent payment bonus for certain primary care providers and services, but the Commission went further and recommended that these payments be made on a per-beneficiary basis instead of a per-visit basis. The Commission believes that paying on a per-beneficiary basis gives the provider greater flexibility to plan and coordinate care around the beneficiary.

The Commission recommended readmissions penalties for hospitals, skilled nursing facilities, and home health agencies that have excessive rates of potentially avoidable readmissions. These penalties create an incentive across the setting to coordinate care, even in a fragmented fee-for-service environment. They protect the beneficiary through care coordination and the taxpayer by avoiding unnecessary admissions. And the Congress has implemented the hospital penalty, and although unpopular, it has resulted in reduced readmission rates.

Turning to managed care plans and Accountable Care Organizations, ideally our payment systems would set payment in advance so that the provider knows what they are working with and the risk to the taxpayer is mitigated. We would establish quality objectives to protect the beneficiary and then give providers latitude to plan, coordinate, and care in a seamless fashion.

The Commission has made several recommendations with respect to managed care plans, and I will note a couple here. With respect to special needs plans, which focus on beneficiaries with chronic conditions, we recommended continuation of the institutional special needs plans that focus on beneficiaries that have a nursing level of care need. It recommended the continuation of dual-eligible special needs plans, but only in the case where the plan integrates Medicare acute-care services and Medicaid long-term care services and supports.

But probably most importantly, the Commission recognizes that regular managed care plans account for the vast majority of chronic care beneficiaries who are enrolled in managed care plans. The Commission recommended greater flexibility for these plans to design specific service packages around chronic condition patients. This is a flexibility they currently do not have.

Another issue, and it was mentioned in the opening remarks, is risk adjustment. This is critical to provide incentives for plans and providers so that they are willing to take the sickest of beneficiaries. The Commission has outlined for the Secretary a set of changes to the risk-adjustment system that better support the plans that are enrolling beneficiaries with chronic conditions, and I can talk more about that in questions.

With respect to Accountable Care Organizations, the Commission has made a number of recommendations after discussing changes with the Accountable Care Organizations, and I will mention a couple here today: make beneficiary attribution prospective, and prospectively set the financial performance benchmarks. The idea here is give the ACOs a firm handle on the populations they are responsible for and the financial benchmarks they are trying to achieve.

For the select ACOs that are willing to accept both up-side and down-side risk, give them greater tools to manage their populations. Allow them, for example, to forgive the beneficiary's copayment when they see an ACO primary care provider. This will help draw the beneficiary into the ACO network.

Another example is to relieve the at-risk ACOs of certain fee-for-service regulatory requirements, such as the home-bound definition or the skilled nursing facility 3-day rule. This will allow the ACO to more seamlessly manage the beneficiary's episode.

In closing, the Commission has consistently made policy recommendations that move away from a fragmented fee-for-service system toward a coordinated delivery system.

I look forward to your questions.

[The prepared statement of Dr. Miller appears in the appendix.]

The CHAIRMAN. Thanks to both of you.

Senator Grassley has to leave for a very important meeting, so I am going to have him go before I do. After Senator Grassley, we will go to Senator Wyden.

Senator GRASSLEY. I thank you very much, Mr. Chairman, because that is quite an accommodation. I appreciate it.

First of all, it is important to thank the chairman and the ranking member for holding this hearing and thank the witnesses for the very important testimony that you folks have given.

The presumption of this hearing is that Congress should consider policies to improve chronic care coordination. The Agency for Health Care Research and Quality defines care coordination as "a conscious effort between two or more participants involved in a patient's care to facilitate appropriate delivery of health care services." Care coordination becomes more important as we look at care for individuals with multiple chronic conditions. I think we all understand that.

The question that I want to ask relates to when we should start providing care coordination. In Medicare, there are people with multiple chronic conditions and people without multiple chronic

conditions. So my first question is, if you can give me a rough idea, what percentage of people without multiple chronic conditions today are likely to develop multiple chronic conditions later? If you could answer that shortly, then I want to go on to say something else.

Dr. CONWAY. Thank you, Senator, for the question. I will start.

In terms of, first, the care coordination and when to provide services, we think care coordination is relevant across beneficiaries, but it is most relevant in that population with multiple chronic conditions.

I can tell you, from our Accountable Care Organizations, they stratify their patients based on the level of severity and the chronic condition severity of their patients. They will deliver a very high level of services, and this is true in the Medicare Advantage environment as well, to those with multiple chronic conditions. But also, even for patients without chronic conditions, they will deliver preventive care and other care to try to prevent chronic conditions from being developed.

In the Medicare population, because of the trajectory of aging, we know the number of multiple chronic conditions goes up significantly. So, for example, in the over-75 age group, the majority of beneficiaries in the Medicare program do have multiple chronic conditions.

Senator GRASSLEY. So then, since we know that there is a likelihood that people on Medicare will develop multiple chronic conditions, what type of care should we be providing them today that would reduce the onset and severity of multiple chronic conditions?

Dr. MILLER. I will start off here. I cannot speak to the clinical progression and what particular types of services might be needed, but what you could read into that answer and certainly into my answer is the flexibility to go at the patient populations depending on where they are.

I would completely reinforce Patrick's point that what you see is a big shift, as you get multiple chronic conditions, in the expenditures and the complexity of that particular patient and the difficulty of taking care of them. And what we are trying to say is, within the payment systems, allow the providers to tailor their approaches to the patients depending on where they are. And again, Patrick, I think, said much the same thing.

Over here you are focused on prevention. Over here, where you have multiple chronic conditions, you may have very specific approaches tailored to clusters of populations who have multiple chronic conditions and certain kinds of multiple chronic conditions, and it is the flexibility that I think we are looking for.

I will stop there.

Senator GRASSLEY. Did you want to say something? Because I think you have answered my question. I just want to sum up that I put in some bills related to diabetes prevention and obesity reduction. Both of these bills are geared toward reducing the offset of expensive chronic conditions.

So my summation would be, I do believe in the value of chronic care coordination, but I think it must be considered as part of a continuum of care that is provided through Medicare to all beneficiaries, and we need to continue to transform Medicare into a pro-

gram that is geared toward delaying the onset of chronic conditions and the severity of them when they do occur. Our payment and care models then must be built to achieve those goals.

I thank you for your answers to my questions, and I thank you for your courtesy, Mr. Chairman.

The CHAIRMAN. Thanks, Senator Grassley.

We will turn to Senator Wyden, and then, after Senator Wyden is through, I will take my turn.

Senator WYDEN. Thank you very much, Mr. Chairman. I know both of us are going to be juggling with the trade bill that we want to get passed on the floor.

Let me see if I can start it this way, Dr. Miller. In 1970, you could have one patient under one roof with a broken leg and that was pretty representative of Medicare circa 1970. And I am showing my age, but I was co-director of the Oregon Gray Panthers back in 1974, so I remember those days.

Now, you have a patient with diabetes and perhaps a heart problem, and they are involved with four doctors, and they have six prescriptions. In Oregon at these roundtables, I heard again and again that that patient is just bouncing back and forth between various providers and systems and often ends up back in the hospital.

So I would like to start this discussion—and you have heard, and Chairman Hatch has indicated, that this is going to be a whole committee effort, which I think is very, very good news.

In your view, what needs to be done to coordinate the chaos that I just described? Because I think that chaos is really representative of the challenge we are going to be tackling under Senator Isakson's and Senator Warner's leadership.

It is no longer one roof, one patient with a broken leg.

Let us have Dr. Miller start.

Dr. MILLER. Either way you want to start. I think what I would say is that what will be key is how you construct the payment systems and the incentives. I think one of the difficulties which was acknowledged early on is that there has been a lot of looking at specific types of models, and the results have been somewhat mixed.

I think at a very summary level, I think you see some improvement in quality, less clarity in terms of consistent and large savings—not a lot of evidence on that front.

So I think the Commission's view is, you need to think of the way that you construct the payment model to allow flexibility, whether it is through, let us say for this conversation, a managed care plan or Accountable Care Organization, that allows the providers to come together and organize around groups of chronic condition beneficiaries and innovate in the kinds of interventions that they are going to undertake, which should involve the kinds of things that we seem to see—team care, that type of thing.

But recognize that there may be different strategies with different populations, and different strategies with different communities. So that is why I think we are talking about the flexibility angle.

Senator WYDEN. Dr. Conway, is there anything you would like to add?

Dr. CONWAY. I think I would cull out three areas, Senator Wyden, and you hit on these in your opening statement, I think: payment, care delivery, and information.

On the payment side, I think it is aligning incentives—I agree with Dr. Miller—with accountability at the provider level for cost of care and quality of outcomes, whether that is in the fee-for-service environment, as we move to alternative payment models which are increasing significantly, or in the Medicare Advantage environment, having incentives aligned with better care for patients.

In the care delivery system, I think it touches on things like integration of mental and behavioral health with physical health. It touches on that which I know your State has done a lot of work on, integrating with the social support systems and the broader health system to support people in their homes and improve their health outcomes.

Then the last area is information. We continue to work on getting the quality and cost information out that providers and patients and consumers need. We need to continue that journey so people have the data and the information they need at the point of care to improve care delivery.

Senator WYDEN. Thank you very much. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Dr. Conway, according to a January 2012 Congressional Budget Office report, CMS paid 34 programs in six major demonstrations to provide health coordination and disease management services in fee-for-service Medicare. Now, CBO's review of the demonstrations noted that, on average, these 34 programs had little to no effect on hospital admissions or Medicare spending.

Now, my question is, are current CMS chronic care demonstrations and pilot programs going to produce different outcomes, and can you explain in detail what makes them different?

Dr. CONWAY. Thank you, Senator, for the question. I am familiar with that report. Those demonstrations pre-dated the Innovation Center, but let me talk to you about what we think we have learned and how we are trying to adjust to improve results over time.

Many of those demonstrations included care management that was not integrated into the practice of medicine, so into hospitals, physician offices. So, for example, you had nurse care managers calling patients at home, trying to deliver care outside of integrated delivery systems.

And then let me touch on what we are trying to do differently moving forward. One, in our programs, we focus on accountability for total cost of care and quality in an ACO environment for a population over a long time span and a bundled payment environment for an episode of care. So we are really focused on the outcomes we want to achieve, which Dr. Miller alluded to, as opposed to incremental changes on the margin in fee-for-service.

Two, the data analysis and feedback cycle in CMS and in the Innovation Center is much more rapid, and we have the flexibility to adjust these models as we learn. So, for example, in our Accountable Care Organization program, as we learned what worked and

what did not work in the financial model, we could make adjustments.

Three, we set up a learning environment with all the models that we are testing currently. So, for example, in our Comprehensive Primary Care initiative, those 500-plus practices are learning from each other. So we will have a practice in Arkansas teach other practices in Arkansas what they are doing to improve care management, and we think this learning system, where providers are teaching best practices to each other, is critical.

And then lastly, just from an evaluation method standpoint, we are analyzing monthly or quarterly data, depending on the model, and putting out annual evaluation reports. We have a much more rapid-cycle analysis and learning environment in the Innovation Center.

The CHAIRMAN. Well, thank you.

Dr. Conway, you mentioned in your testimony that CMS has implemented two new transitional care management billing codes and one chronic care management billing code as part of the Medicare physician fee schedule rulemaking process. Now, my understanding is that the use of these codes has been relatively low. CMS did issue updated guidance to clarify when providers should bill for the service, in an effort to increase the number of paid claims.

But can you tell us if current use has increased? If not, what is CMS doing to address that problem?

Dr. CONWAY. So first, on the transitional care management code from 2013, its uptake was not as robust as we would have liked. As you alluded to, we have tried a couple of tactics to try to improve the utilization of those care management services and appropriate coding. One was educating providers, so education and outreach through various physician organizations and others that reach physicians and clinicians in the field. Two was the guidance you alluded to, guidance on when and how to bill for those codes.

So the uptake is not as robust as we would have liked. We want it to increase over time, and increase because of appropriate care coordination and delivery.

On the chronic care management code, that just went into effect in 2015. So we are starting the process now to educate providers on the appropriate use of that code for care management services delivered to beneficiaries.

The CHAIRMAN. Dr. Miller, you discuss a proposal to waive or reduce cost-sharing for Medicare beneficiaries that identify with an ACO which operates using two-sided risk. In your opinion, how effective would this policy be, given that many beneficiaries have supplemental Medigap policies or employer retiree coverage that often make them insensitive to cost-sharing changes?

Dr. MILLER. You have definitely put your finger on another issue that gets implicated in this. So we think the signal in and of itself would be good for giving the beneficiary an incentive to go there. But you are right, if they have first-dollar coverage, then that signal is going to be a lot weaker.

The Commission made recommendations a couple of years ago on first-dollar coverage when it made a broad traditional fee-for-service benefit redesign, and we made recommendations about dis-

couraging first-dollar coverage so that precisely these kinds of incentives would have a more clear signal.

It does kind of open another set of issues. You are right, in the absence of those kinds of changes, those signals will be weaker.

Can I say one other thing about the question?

The CHAIRMAN. Sure.

Dr. MILLER. On the transitional and the chronic care management codes—which we have made comments on and do not have any difficulty with—I would just also remind the committee that we have made a recommendation on per-beneficiary payment for primary care providers and services.

Those payments, if the Congress were to act on them, would flow to the providers in a sense automatically and give them greater resources to organize care around the patient. So that is another mechanism that you can use to get at some of the issues that you were just talking to Dr. Conway about.

The CHAIRMAN. Thank you so much.

Senator Bennet, you are next.

Senator BENNET. Thank you, Mr. Chairman. Thank you very much for holding this hearing and for your leadership on the trade bill.

The Finance Committee has heard from a number of providers regarding the Medicare Advantage changes to the risk-adjustment model that determines how plans are paid when a person is sicker or has more major chronic conditions than a healthy senior.

A number of Senators, including the majority of this committee, believe that CMS is moving forward with a model that will disproportionately hurt plans serving low-income members by removing codes for chronic illnesses, conditions like diabetes and kidney disease. Ultimately, this could be disastrous for seniors with chronic conditions in Medicare Advantage receiving the right kind of coordinated care that you are testifying about.

I wonder, Dr. Conway and Dr. Miller, do you have any suggestions for CMS as to how they might more appropriately capture the health care costs and needs of chronically ill, vulnerable beneficiaries?

Dr. MILLER. Yes. There are two suggestions that we have made that we think go right at this. They are a little bit technical, but I will explain them at a very high level. So one is——

Senator BENNET. I will explain them to Senator Warner later, so you can go ahead. I am just kidding. [Laughter.]

Dr. MILLER. If you need a hand with that——

Senator BENNET. Thanks.

Dr. MILLER. So, in the risk-adjustment system, really quickly, you get an adjustment if you have a chronic condition. So there is a bump for diabetes, there is a bump for congestive heart failure.

So what we did is, we went through and did an analysis that said—and this is as simple as it sounds—if you also enter a variable that says how many chronic conditions you have, that provides an additional bump, and it is this whole exchange that we have been having about, as the chronic conditions accumulate, at about the fifth chronic condition, there is a big jump in the cost of the beneficiary. So if you enter that factor into the risk-adjustment sys-

tem, it makes an adjustment for the plans that have a lot of people with multiple chronic conditions.

I will not take you through this one, but another one is parsing how you measure fully dual beneficiaries versus partially dual beneficiaries. We think for those plans that are taking disproportionate shares of fully dual beneficiaries, the adjustment is working against them a bit.

It is a bit technical, but there is an issue there. I will stop.

Senator BENNET. Dr. Conway?

Dr. CONWAY. Yes. So first, I want to thank Mark and MedPAC for that recommendation. We actually are actively looking now internally at both of those recommendations about the risk-adjustment model and the risk-adjustment model broadly. Our goal is the one that you both described. We want to pay appropriately in Medicare Advantage for health plans that take care of beneficiaries with multiple chronic conditions. We are looking at both of those recommendations currently in addition to the risk-adjustment model broadly.

Senator BENNET. I appreciate that, and we look forward to working with you in the weeks ahead.

Dr. Miller, as you know, we passed, thank goodness, an SGR repeal bill last month in an effort to move away from the current fee-for-service system that we all know rewards volume over quality.

Does that bill get rid of the fee-for-service barriers to coordinating care that you talk about in your testimony, and what more needs to be done outside of the SGR bill that we should consider as a committee to continue to drive us away from rewarding volume instead of quality?

Dr. MILLER. I think what I would say is, it gives you a framework to move in that direction. What I think will be critical is how, in the end, the law is operationalized to define what qualifies as an alternative payment model.

So there are certain criteria in the bill that say X percent of your revenues have to be at risk, the models have to have certain characteristics, and either the policy process can water that down and define alternative payment models as relatively weak models or say, no, there is a certain rigor here and you have to clear a hurdle in order to get into the alternative payment model to get that higher payment.

So what I would say to you is, and we are ready to work with you on this, I think there should be a lot of effort put in by CMS, the committee, and ourselves in defining what those criteria are.

Senator BENNET. I think the last thing that people on this committee want is for it to be watered down.

I do not know, Dr. Conway, if you have anything to add.

Dr. CONWAY. We agree. I think the definitional elements on alternative payment models, building from the statute, are critical, and we want to define them in a way that maximally improves quality and has the potential for smarter spending.

Senator BENNET. Thank you. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Bennet.

Senator Warner?

Senator WARNER. Thank you, Mr. Chairman. And let me also thank you and Ranking Member Wyden for allowing me and my

good friend, Senator Isakson, to take on this challenge. This is an area that I know Senator Isakson and I have worked on a great deal, and we will try to educate Senator Bennet on the process as well. [Laughter.]

The CHAIRMAN. We are grateful to you for doing that and also for your willingness to educate Senator Bennet.

Senator WARNER. Which, let me assure you, Mr. Chairman, is an enormous challenge. [Laughter.]

But I think one of the things that we all hear is that we know the current system is not working. We are pretty good at reimbursing for individual procedures, but we are still trying to wrestle through how we manage both this enormous benefit and the challenge of the aging process and chronic illnesses.

I think, Mr. Chairman, one of the things that you brought up and Dr. Miller responded to is really something that we have to grapple with a little bit. I am very excited about the risk-sharing activities. But if the patients do not have some skin in the game, then the ability to have some of those market-driven forces in terms of risk-sharing really is not going to be able to be fully tested. So I hope one of the things we are able to look at is some of these questions around first-dollar coverage.

I also was very interested in your comment—I cannot recall whether it was Dr. Miller or Dr. Conway who mentioned this—about the idea that, on some of these payment models, we are looking at a per-beneficiary payment system rather than a per-visit, which to me makes, again, enormous sense in terms of moving away from quantity and again toward quality.

One of the things that we have seen an enormous growth in is the emergence of both technology in digital health and enormous growth of devices and other tools. As we try to think how we not only better coordinate the medical professional component, Dr. Conway, what is CMS doing in thinking about these other tools that are kind of rushing into the marketplace—one, how we evaluate them and, two, we really do not even have much of a payment structure at all for these tools that could be potentially very, very beneficial on the case management side?

Dr. CONWAY. Yes. Thank you for your question, Senator. First, just briefly, both on the per-member per-month or per-beneficiary per-month issues in the consumer arenas, we would love to work with you and MedPAC. We also think they are critically important.

On tele-health and technology, remote monitoring, let me tell you a few things we are doing, and we are happy to work on more. In our ACO environment, in the Pioneer ACO and now especially with our next generation ACO—which we have not talked about today but really moves to prospective attribution and prospective payment models—we have waivers in place where both tele-health and remote monitoring, technologies to monitor patients in the home, can be much greater utilized. And I can tell you, Accountable Care Organizations are utilizing them, things as simple as remote scale monitoring for congestive heart failure, so you are managing patients outside of the visit.

In our Comprehensive Primary Care initiative, we have practices, including rural practices, that are using remote technology to monitor patients in distant environments and rural settings and

managing patients through nurse care managers, with physicians and nurse practitioners on the care team remotely. We think that is critical. And then broadly, in our heath care innovation awards, we have a number of awards directly testing tele-health or remote monitoring technology. So we think this is an area that is ripe for improvement, and we would love to work with you in this arena.

Senator WARNER. One of the things—I want to get to one other question—that I would think we might want to explore is the enormous growth in digital wearable devices, I think generally more geared toward, obviously, a very different population, kind of the Fitbit population. I think the notion of trying to put out signals to the wearables, digital wearables, could play a role in the chronic care population that could spark a lot of innovation and is something that we ought to explore.

Let me, in my last seconds, ask—maybe, Dr. Miller, you could comment on this too. One of the things we have to grapple with as we look at those numbers north of five chronic diseases, how we do a better job of management, is kind of the type of wraparound services that really, again, do not fall within a classic definition of health care delivery—again, some of these case management tools.

How are we going to work through that, again, as we try to move away from the fee-for-service model? But clearly these wraparound services can, in the long run, both improve the quality of life for the patient and save the government money.

Dr. MILLER. I think—and I am beginning to sound like a broken record—when you try to do things like tele-medicine or add, let us say, a social service in a fee-for-service environment, you come to a lot of complexity in defining what is and what is not acceptable, and, if you do not do the payment system right, you can get a lot of generation of unnecessary services or potentially outright fraud.

Alternatively, if you shift the payment system to put the provider at risk and allow the flexibility to say, look, this tele-monitoring will actually help me, they are going to go after the innovations that I think you are talking about and integrate them into the care.

If you give them the flexibility to say, this is a social service—this is not about a medical service, this is about a social service—that this particular multiple chronic condition beneficiary needs, such as transportation to their appointment, and you give them that flexibility in an environment that mitigates the risk to the taxpayer, that is where I think you will get the innovation.

A key thing is shifting how we pay for these things.

The CHAIRMAN. Thank you.

Senator Menendez?

Senator MENENDEZ. Thank you, Mr. Chairman. Thank you both for your testimony.

Dr. Conway, as you know, chronic conditions disproportionately impact communities of color, and significant disparities exist in their prevalence, treatment, and successful management. For example, among the top chronic conditions affecting Medicare beneficiaries relative to their white peers, Latinos are 65 percent more likely to be diabetic and 15 percent more likely to be obese. African-Americans are 40 percent more likely to die from a stroke.

American Indians and Alaska Natives are 15 percent more likely to have heart disease.

So in your testimony, you mention the program CMS is undertaking to promote better care coordination in chronic condition management via physician payment incentives, care delivery initiatives, and improved information-sharing, and that is all good. However, I did not see you touch on, in your testimony, any efforts underway to engage beneficiaries on a population-wide basis.

Are you aware of any ongoing demonstration projects or other initiatives that are specifically targeting minority beneficiaries to help improve awareness, diagnosis, and treatment of chronic conditions?

Dr. CONWAY. We do have some programs that target those important populations, so let me speak to some of those.

One, in our Million Hearts initiative, which is centered around cardiovascular disease, one of the major foci is on minority populations, including Latino populations, because of, as it sounds like you know, the larger disease burden in the cardiovascular arena.

In the diabetes arena, everything in our core programs, from a program called Every Diabetic Counts—which focuses on reducing disparities in diabetes care and preventing diabetes in minority populations—to a diabetes prevention program which was mentioned earlier delivered through the YMCA, is trying to focus on safety net areas and areas that serve high proportions of minority populations.

So we actually have a foundational principle in the CMS quality strategy of eliminating disparities. It is a critical issue, as you know, and our focus is to serve these populations well and attempt to eliminate disparities.

Senator MENENDEZ. Well, I appreciate that answer. I am not quite sure that satisfies me. Let me ask you this. What are you doing to engage with minority populations about chronic condition management and to specifically focus on the unique challenges that affect these communities, including language barriers and cultural competency?

Dr. CONWAY. So, in the cultural competency and language barrier areas, we are trying to address these issues in a number of ways. One, in programs like ACOs or advanced primary care and other programs I spoke about today, one of the underlying principles in all of these is patient and consumer engagement, including issues like cultural competency and language barriers.

So it is a focus in our learning environment around these models. It is a foundational principle, if you will.

And then in things like our Health Care Innovation Awards, we culled out as a priority in those awards, innovations that focused on reducing disparities, and made multiple awards focused directly on reducing disparities. So we are happy to work with you and the committee if there are other things that we should be doing in this arena.

Senator MENENDEZ. I do think there are other things we should be doing, and I know the Congressional Hispanic Caucus has a series of ideas as well. So we would love to engage with you.

One final question to you, Dr. Miller. You talked in your testimony about how 69 percent of Medicare fee-for-service beneficiaries

with two or more chronic conditions account for 98 percent of hospital readmissions. Given what we know about the link between multiple chronic conditions and a lower socioeconomic status, it is reasonable to assume that what we call sometimes the "frequent flyer" population, accounting for nearly all hospital readmissions, are also of lower socioeconomic status.

Your testimony also mentioned the hospital readmission reduction program, which works to improve care coordination and reduce other preventable readmissions. Research has indicated that 77 percent of hospitals that treat a disproportionate share of lower-income beneficiaries were penalized under this program, compared to just 36 percent of hospitals that treat fewer low-income patients. This research is borne out in New Jersey, where our hospitals were penalized despite being known as some of the best in the country.

So my question is, MedPAC and others have looked into ways to better account for socioeconomic status in the hospital readmission program. Can you discuss MedPAC's current thinking on the issue of socioeconomic status considerations in the hospital's readmission program?

Dr. MILLER. Yes, I can. I appreciate it. So again, we are short on time, but I think I would go at this in the following way. Number one, I think the Commission's position is, when you measure readmissions, you should not adjust in such a way that the disparities are hidden. Some people approach it and say, just adjust the measure and then, if you have more poor folks, the measure will not look as bad because it will adjust for the fact that a hospital is dealing with a lot of poor people.

So the Commission's view is, no, those disparities should stay present because we should be focused on trying to correct them, because poor people should get good care as well. However, on the penalty, what we have said is, that should be moderated depending on the amount of poor people that you have in the hospital. And what we would say is, you stratify the hospitals into categories based on the percentage of their people who are poor, for example, and then you adjust the penalty in a way that is less aggressive for the poor hospitals and more aggressive for the hospitals that have, as a percentage, fewer poor. And so we would moderate the impact of the penalty that way.

And the other thing—I am sorry, I just want to get this last point out—that this leaves in place is that, within your category, you still have pressure to improve because, even though you are not under as much pressure as a hospital that has less poor people, there are, in fact, hospitals that have lots of poor folks but have low readmission rates. And so there is still pressure for that hospital to improve their readmissions.

Senator MENENDEZ. What I would like to hear, Mr. Chairman, is, where is the status of the implementation of that thinking?

Dr. MILLER. Well, that is in the hands of the Congress.

Senator MENENDEZ. That is not a MedPAC decision? That is a congressional decision?

Dr. MILLER. We make recommendations to the Congress and to the——

Senator MENENDEZ. Right. But that is your recommendation.

Dr. MILLER. Yes, it is.

Senator MENENDEZ. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Carper?

Senator CARPER. Thanks, Mr. Chairman. This is a great hearing, and we appreciate very much our witnesses being here.

The CHAIRMAN. It is a good hearing.

Senator CARPER. Dr. Conway, I think you wear three hats. I do not know if we give you three paychecks on payday.

Dr. CONWAY. You do not, sir. [Laughter.]

Senator CARPER. We will have to do something about that. Thanks for working so hard, both of you.

In my old job as Governor, I championed preventive screenings and wellness programs as a way to get better health outcomes and try to keep costs in check. I was encouraged—in fact, I pushed to make sure that we took the same approach in the Affordable Care Act by giving seniors free annual checkups and preventive care, especially for chronic conditions such as heart disease, high blood pressure, Alzheimer's disease, and obesity. However, as you know, these programs only work if seniors and their doctors know about these benefits and actually take advantage of them.

Give us a sense of how many seniors you think are taking advantage of these free screenings and these preventive services? And maybe you all could tell us what CMS is doing to ensure that seniors and their docs understand these benefits and take advantage of them.

Dr. CONWAY. First of all, Senator, thank you for your leadership in this arena. Dr. Miller may have the exact number memorized. I apologize. I will have to get back to you with the exact number, but it was—at last count, I believe it was 5 million and growing. But we should get back to you with the exact number.

Senator CARPER. If you could, I would appreciate that very much.

Dr. Miller, do you want to give us the exact number?

Dr. MILLER. I do want to give you the exact number. I just do not have it. I am sorry.

Senator CARPER. I am pleased to hear it is about 5 million, and I am pleased to hear it is growing. And we will just wait for something in writing. That would be good.

Next, a question on nutritional counseling services. Over two-thirds of our senior population is overweight or obese, and 13 million seniors in this country are obese, meaning they are more likely to suffer, as you know, from heart disease, high blood pressure, stroke, arthritis, and other chronic conditions.

In 2013, I am told that less than half a percent of these seniors—that is about 50,000 seniors—received free weight loss counseling from their doctors. Why do you suppose so few seniors take advantage of nutritional counseling? Is CMS doing anything to help more seniors and their physicians take advantage of weight loss counseling? What else should we be doing here on our side of the dais to ensure that docs and their patients know about these services and take advantage of these benefits?

Dr. CONWAY. Thank you for the question.

I will answer from two of my hats at CMS. So first, in the coverage arena, based on the statute that you supported, we have now

covered, with no cost-sharing, the USPSTF-recommended* prevention services, including, as you alluded to, obesity counseling.

We do want the rate of that counseling to go up. So we are taking a multi-pronged approach. One is education and working with physicians and clinicians. Two is really encouraging team-based care so physicians or clinicians can work with dietitians and others to deliver counseling. In addition, on the Innovation Center side, we have some models directly focused on obesity and obesity prevention; for example, the diabetes prevention program that was mentioned.

We also, in our various payment models—because obesity, as you alluded to, is a risk factor for exacerbation of other diseases, our primary care medical home models are working on obesity and obesity prevention as well, and thinking about this as an important focus.

The last thing I will mention is, we have a population health group in the Innovation Center that is working on a couple models on broader population health issues in the cardiovascular arena, but also in broader community-based intervention. So, some of those could address obesity as well.

Senator CARPER. Dr. Miller, do you want to add anything? Do you approve that message?

Dr. MILLER. I approve that message.

Senator CARPER. I would just say to my colleagues, including the Senator from Washington, we have 13 million people in our country who are obese, 13 million, and the year before last, less than ½ of 1 percent of those folks—that is 50,000 seniors—actually received free weight-loss counseling from their doctor.

That is crazy, and we need to do something about it, and I appreciate your efforts. And we on this side, we need to do more, and I certainly intend to do that.

The last thing I would like to mention is root causes, and let me just ask, what is CMS doing to reduce obesity and smoking rates among seniors? What else should we be doing to address these two root causes for so many of the chronic conditions that are affecting Americans?

Dr. CONWAY. So, obesity and smoking rates are critical issues. Our Million Hearts initiative focuses directly on decreasing smoking. We are partnering with CDC in this initiative, the ABCS,† of which the S is smoking reduction. We are working with States and the Medicaid programs on smoking cessation programs. One of them has been published from Massachusetts on decreasing smoking rates.

We recently put out a paper on CMS's role in population health. So, we do believe that CMS and Medicare and Medicaid have an important role as payers to improve the long-term health of the population.

Senator CARPER. Good. Let me just say, in this country, Mr. Chairman, in this country, we are pretty good at focusing on symptoms of problems. We do not always focus on root causes of problems, and it is clear as the noses on our faces what is the root

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*United States Preventive Services Task Force.

†Aspirin for those at risk for heart attack and stroke; blood pressure control; cholesterol management; and smoking cessation.

cause of a bunch of the health care problems we have, whether it is obesity or whatnot, and we are trying to do some things. Some of them are succeeding. We just need to figure out what works and do more of that.

Thank you so much.

Senator ISAKSON [presiding]. Thank you, Senator Carper.

Senator Hatch has asked me to finish the hearing for him, since he had to go to the floor. The order of those members remaining to ask questions is Senator Casey, Senator Isakson, Senator Brown, and Senator Cantwell.

Senator Casey?

Senator CASEY. Thank you, Senator Isakson.

Both doctors, thank you for being here, and we are grateful for your testimony and for your work on this.

Dr. Conway, I want to start with you. Since the incidence of chronic illness is higher in low-income populations, could you walk us through some of the steps that you are taking, or CMS is taking, to adjust the Medicare readmissions program to better account for the greater degree of difficulty involved in treating these low-income populations? Could you walk us through that?

Dr. CONWAY. Yes. I would be happy to, sir.

Senator CASEY. And I know it may be by way of reiteration.

Dr. CONWAY. Thank you, Senator, for the question. First, in terms of the actual measures, we are working with the National Quality Forum on a pilot project to look at how we could deal at the measure level with socioeconomic factors. I will let Dr. Miller speak to the MedPAC recommendation about whether to put providers in different quartiles or quintiles based on the population they serve in terms of socioeconomic status. So, we are doing that work with the National Quality Forum multistate effort.

Two, from the IMPACT Act, Congress approved funding for the Department to look at socioeconomic factors and work on risk-adjustment issues. We are working with the Office of the Assistant Secretary for Planning and Evaluation on studies looking at appropriate risk adjustment or stratification or other payment adjustments based on socioeconomic factors.

So, we are undertaking that work now and are looking at the readmissions program as part of the work. And I would let Dr. Miller speak to the MedPAC recommendations.

Dr. MILLER. So the key thing is, we would keep the measures of readmissions unadjusted so that you can focus on the disparities and not hide them, and we would tier hospitals based on—and I am going to use income here, because we think that data is most readily available. And to the extent that you can research this issue, we think that is a dominant factor, and it encompasses a lot of other issues.

We would rank the hospitals based on the percentage of patients who are poor and then say there is a criterion, so let us just say the 40th percentile, and then you say the 40th percentile will always be the 40th percentile in each of those categories, but it will be more or less aggressive depending on the proportion of poor folks that you have, and then you are mitigating the impact a bit.

I should point out that there are other things we would change about the penalty that we think make it a lot fairer for hospitals.

We would have a constant multiplier. As I said, we would have this criterion, and the really important point about the criterion is that we would say, when you cross the criterion, there is no penalty.

MedPAC's recommendation is, ideally, there are no penalty dollars. You actually move people to avoid the readmission. The beneficiary and the program benefit from the fact that you do not have a readmission and you do not have to collect the readmissions penalty.

So we would urge also the Congress to think about these other changes that we have recommended, because we think that there is a much better way to design this in its totality.

Senator CASEY. I appreciate both of your answers.

Here is the problem. We have hospitals telling us, and others that are impacted, that they need help now. So I appreciate that this is difficult and you have to consult studies and complete an assessment, but I think what we need to see is some kind of a bridge so they can get some more immediate help, and I urge CMS to consider that.

Yes, Doctor?

Dr. MILLER. I will keep this really brief. This tiering and adjustment on the basis of income is within reach. This is data that people have now and could organize now. You could change things in a relatively short order. Further back, we made recommendations to reorient how the QIO dollars are allocated—those are dollars for quality improvement—that would target them to the providers that have these kinds of issues. Those are two things that could happen relatively quickly while other things are going on.

Dr. CONWAY. We adopted the second recommendation, and the first recommendation, we believe, would require congressional action.

Senator CASEY. Thanks very much. Really just for the record, Dr. Conway, I will submit a question regarding Medicare Advantage and particularly the star rating system and, more particularly, how CMS can better measure the impact of clinical risk factors. So, rather than taking time here, we will make sure we submit that for the record.

Dr. CONWAY. Thank you, Senator.

[The question and answer appear in the appendix on p. 55.]

Senator CASEY. Thanks very much.

Senator ISAKSON. Thank you, Senator Casey.

I will ask my questions very quickly and then go to Senator Brown and then Senator Cantwell.

Experience is a great teacher, and you all can correct me if my memory is bad, because one of my chronic conditions at my age is my memory. But in 1993, my mother passed away. In the 5 years prior to her passing away, my wife and I helped take care of her. She had multiple chronic illnesses. One of them was dementia, which turned into Alzheimer's. We would have to pick her up and take her to physicians for the care, because the fee-for-service system incentivizes that kind of care.

When she fell and broke her hip in the nursing home, Medicare introduced a program called Evercare, where they provided the health care in the nursing home rather than causing us to call an ambulance to take her to the doctor's office. The cost of taking care

of my mother went down, not up, because, instead of calling ambulances, the doctor was coming to the home to treat her, and her quality of life ended up being better in the waning months of her life than it was prior to the time that she fell.

Evercare incentivized the right result because of the fact that she was immobile and not ambulatory, and I think that is the kind of thing we are looking at here. In the fee-for-service system, what you incentivize is what you get. And we incentivize people to go to the doctor, and the doctors incentivize the bill for the reimbursement that Medicare approves, and the more doctor visits, the more health care costs. The absence of coordination ensures you that you may have complications that are unintended, but they generate more fee-for-service visits, going to the doctors.

So my question is this, for both of you to respond to or just comment on. CMS has announced the target of tying 50 percent of Medicare payments to alternative value-based payment models by 2018. That is an admirable goal, but it is worth noting that 30 percent of Medicare beneficiaries are already enrolled in Medicare Advantage, and they receive capitated payments.

I am concerned that CMS policies continue to discourage plans from signing up seniors with multiple chronic conditions who would benefit the most from care coordination. MedPAC has estimated that Medicare's risk-adjustment model already underpays by 29 percent for the sickest beneficiaries, for CMS purposes, resulting in additional costs to Medicare Advantage risk adjustment.

What comment would you have, Dr. Miller?

Dr. MILLER. Well, on your last point with respect to risk adjustment, as I said earlier, there are a couple of recommendations that we have made, technical recommendations, that could be used to adjust the model, that would rebalance the payments. If you take multiple chronic condition patients, your payments go up. If you have healthier patients, your payments go down.

So within the MA system, this would kind of go on, and we have made a couple of recommendations that we think would move in that direction.

Senator ISAKSON. Dr. Conway?

Dr. CONWAY. So we are directly——

Senator ISAKSON. Dr. Conway, excuse me for interrupting. You were nodding when I was talking. Was my recollection of Evercare right?

Dr. CONWAY. Yes, sir, from my knowledge of Evercare.

Dr. MILLER. It was, and I will back that up. And I would also just point out that the Commission made a recommendation to continue the ISNP, the Institutional Special Needs Plans option. That encompasses the Evercare approach to care.

Dr. CONWAY. So, agreed. Let me take the risk-adjustment MA issues and then the payment goals.

On the risk adjustment for Medicare Advantage, we appreciate MedPAC's recommendations on the number of chronic conditions and the fully dual-eligible adjustments. We actually have a group within CMS looking at that, those two issues now, plus the risk-adjustment methodology broadly. And I agree with you, Senator, we want to pay appropriately Medicare Advantage plans that take care of the population with multiple chronic conditions.

Specifically, on the payment goals, it is 30 percent in alternative payment models to providers by 2016 and 50 percent by 2018, so it is important. As we pay Medicare Advantage plans capitated rates—and I work with all those health plan chief medical officers—we also want to make sure that they are paying providers for care coordination as well.

And it is important to note, we launched a health care payment and learning and action network where the majority of major private payers in this country, including those in Medicare Advantage, set tangible goals that are directly aligned with the goals that we set for Medicare. So we think that is going to be very helpful for moving our broader health system forward.

Those alternative payment goals, the point of those, is exactly as you described, that we incentivize providers, health systems, physicians, and clinicians to care for patients in the highest-quality way and the most cost-efficient way, which, by the way, is often in other settings of care, such as in the home-based environment or other settings and not based on a fee-for-service volume-based system.

So, thank you for your comments.

Senator ISAKSON. Well, thank you for your comments. And my time is up, except to acknowledge the fact that I am really looking forward to serving with Senator Warner on this task force on coordinated care. I think, in terms of medical errors, in terms of efficiency, and in terms of quality of care, care coordination is the future of health care reimbursement, in my judgment.

With that said, Senator Brown?

Senator BROWN. Thank you, Senator Isakson. I appreciate your questions too.

I want to talk about community health workers. We have seen in my State—in fact, in my hometown of Mansfield, OH we saw some very creative use of community health workers, a program called CHAP, the Community Health Access Project, that significantly, quantifiably made a huge difference in the number of low-birth-weight babies. That has been patterned in some other communities around the State.

As I think you know from—you are nodding, Dr. Conway; thank you. We were able to get some assistance to help with paying community health workers—generally low-income women with typically high school educations or sometimes GEDs, paid sometimes as little as $9 or $10 or $11 an hour—which was often raised by private funds or through other creative ways, and the impact they have had on preventive care has been pretty phenomenal. And it has also emboldened a number of these young women to move on and become nurses and have opportunities they would not have had otherwise.

So, I have two questions for both of you about community health workers. One, if you would, just talk about the role you see potentially for them, certainly dealing with issues of early care of pregnant women and early care of babies.

Second, has MedPAC or CMS considered any opportunities within Medicare for community health workers, such as authorizing payment for services of some kind so we can see the use of community health workers proliferate a little more than it has?

Dr. CONWAY. I will start on this. First, I am familiar with the program. I was at Cincinnati Children's twice in my career, so I am familiar with Ohio, and it is terrific work.

On community health workers, it is actually part of the Innovation Center portfolio in many places, first, in terms of Strong Start, which is focused on decreasing pre-term birth, and the medical home portion of that. Those entities can use, and many do, health workers to interact with mothers and decrease pre-term birth. So that is one.

Two, in our health-care innovation awards, a number of them are using community health workers—we actually have a whole portfolio we are learning from—and many very effectively in terms of improving quality and lowering cost.

Then the three that Dr. Miller mentioned earlier, and I would cull out, as we have payment models like Comprehensive Primary Care or Pioneer Accountable Care Organizations that are putting per-member per-month, per-beneficiary per-month fees into organizations, many of them take those fees and use them to apply much more of a team-based workforce, everything from certainly nurse practitioners and care managers, but also many of them are employing community health workers as well. Especially, some of our ACOs that serve more safety net populations have seen this as an incredibly powerful tool to improve quality and lower costs for the populations they serve.

Dr. MILLER. I am not familiar with the program, I apologize, but that does cross over into the principles that the Commission has been talking about, to identify population-based payment, per-beneficiary payment, per-episode payment, put the providers at risk, give them the flexibility to use the money in a way that is appropriate. If it is a team-based care and a continuum of skill sets from very low skill to the physician, then that kind of team approach should be allowed, that flexibility should be granted, and that would be a way to support the concept that you are talking about, whether it is these specific workers or other types of aides who get involved in the process.

Senator BROWN. If I could, Mr. Chairman. What Mansfield did—Mansfield, OH, a city of about 50,000—they had two zip codes, one predominantly Appalachian white, one predominantly African-American, where they had very high low-birth-weight baby rates. They hired young women from each area, young black women to serve the African-American community, young white women to serve the white community, and dropped the low-birth-weight baby rate significantly by doing outreach in the community.

They would bring pregnant women in so they could sign up for Medicaid for the doctors when they took them to OB/GYNs or to pediatricians later. But they had no way, except for a local foundation, of paying the actual workers themselves. And quantifiably, it was 50 or 60 babies who were born, if you had looked at demographic trends over a 5-year or 6-year or 7-year period, who were not low-birth-weight who probably would have been if not for the intervention.

So it has tremendous potential at very low cost, with very important human gains and very important financial gains, if we can do

it. So thank you, Dr. Conway, for your knowledge of it and your interest, and, Dr. Miller, for your potential interest in this.

Thank you.

Senator ISAKSON. Thank you, Senator Brown.

Next will be Senator Thune, followed by Senator Cardin, followed by Senator Cantwell.

Senator THUNE. Thank you, Mr. Chairman. This is an important hearing, and particularly as we look at continuing to reform Medicare reimbursement away from paying for volume to rewarding quality. As the witnesses and other members of the committee have highlighted, Medicare beneficiaries with six or more chronic conditions account for a large percentage of Medicare fee-for-service outlays.

My main concern has to do with how new payment models account for rural areas. Over 23 percent of beneficiaries live in rural areas, where the promises of integrated care are left unfulfilled for a lot of seniors largely because of where they live.

So the question has to do with the Medicare Shared Savings Program. It is the only program to date that allows rural communities the opportunity to transform their care delivery. And as you, I am sure, know, rural health systems have a difficult time reaching the beneficiary threshold of 5,000 to participate. But by aggregating together, these systems have created virtual networks that share data and best practices and are improving health outcomes in areas with no availability of care coordination.

So rural beneficiaries deserve integrated care, coordinated care. Current policies do not support that transformation for rural areas, in my opinion. What can we do to help rural facilities on-ramp into providing coordinated care?

Dr. MILLER. I would start my answer in the Accountable Care Organization space, which is where I think you are starting off, and give you at least a conceptual point that the Commission would, I think, make.

You are right. It is an aggregation problem because, if you have very small numbers of beneficiaries, you have very noisy data. You cannot tell whether you have saved money, you cannot tell whether you have improved quality, because you basically just have noise, no signal, and that is the problem that needs to be overcome.

You basically have two tactics here. One is the rural community teams with an urban kind of configuration, so that the ACO encompasses both an urban and rural organization. There you get your numbers and your count that you need. You also may have some reconfiguration of care there that may be a good continuum that you can work through. I can get into that more.

The alternative approach—this one is a little bit more complex—is you knit together rural communities and treat them, in a sense, as an aggregate ACO. Now, there are tradeoffs there. How much integration there is when you are moving from communities that are distant from one another—you are definitely tolerating an average performance: this community is doing well, this community is doing poorly, but on average, this is where things stand.

But conceptually, those are kind of the models, and I do know that we have had a lot of rural ACOs through the office. Those kinds of conversations are occurring.

Senator THUNE. Dr. Conway?

Dr. CONWAY. I would hit on a few points. One, in our proposed regulation, we expanded the attribution model after the statutory sort of physician-based model to include nurse practitioners, physician assistants, et cetera. So the hope is, that will help with some of the attribution issues. In the President's budget, as you know, we suggested Congress consider allowing Federally Qualified Health Centers or rural health clinics to count in the attribution model.

We have looked at some of these aggregation issues as well. In our proposed rule, we actually reached out for input from rural communities, and we meet frequently with rural providers and representatives of rural providers on what is the best financial model here.

And then the last thing I would cull out is, we have provided advanced payment to Accountable Care Organizations to get started on that transformation journey, and we have targeted that advance payment to rural areas and to small physician practice areas. So, we think the support in these areas is critically important as well.

Senator THUNE. Good. Thank you. I appreciate your thoughts on that and look forward to working with you and with this committee to address the rural concerns.

Last Congress, Senator Stabenow and I introduced a bill. It was a bipartisan bill to require a demonstration project for a value-based insurance design, or VBID, in Medicare Advantage based on the principle that we need to remove the cost barriers that prevent people with certain chronic conditions, such as diabetes or heart disease, from accessing the basic medications that can keep them healthy and out of the hospital.

Given the move now toward these alternative payment models, I think it is important that we see benefit designs similarly adjust to remove the cost barriers that discourage Medicare beneficiaries from accessing these same high-value services that help them manage their conditions. I think now is the time to see a demonstration program move forward, and I would like to know if that is something that we can work on together and what else you would need from us to help these Medicare beneficiaries with these chronic conditions better manage them.

Dr. CONWAY. So I will start, and I will make two points. One, we would welcome the opportunity to work with you and others on a potential demonstration program and provide technical assistance.

Two, we put out from the Innovation Center a request for information on health plan innovation and what could CMS test in the health plan/Medicare Advantage space, for example. Value-based insurance design was culled out frequently from the public comments, indicating that this was an area we should think about. So, we are evaluating that now.

Dr. MILLER. If I could just add a couple things. I think this fact is correct. I think the CMS folks did, in their demonstration authority, allow the attribution through the nurse practitioners, but I think in the Medicare Shared Savings Program, still by law—so I would just point out there is a law change that also, I think, would encourage this kind of interaction that the two of you just discussed.

The only other thing I would say is the Commission—again, this opens a different issue, so I will be really quick. We made recommendations on redesigning the traditional fee-for-service benefit and, as part of that, said there should be authority for the Secretary to use VBID-types of evidence to adjust copayments if they think that there is a high-value service, but also a low-value service.

And so we have put that into the debate, and, if you and your staff want to talk in more detail about that, I would be happy to do that.

Senator THUNE. That would be good. I think flexibility is important. Thank you.

Thank you, Mr. Chairman.

Senator ISAKSON. Thank you, Senator Thune.

Senator Cardin, followed by Senator Cantwell.

Senator CARDIN. Thank you, Mr. Chairman, and thank you for this hearing. Improving care for Medicare patients with chronic conditions is a matter that I think we are all very interested in.

Let me just share this with you. Last week I was at the ribbon-cutting for Mosaic, which is a community-based mental health services clinic in Baltimore, set up in conjunction with Sheppard Pratt in order to provide community care in an integrated setting for individuals with mental health and addictive disorders. It has made arrangements with qualified health centers so that they are doing primary care, as well as mental health.

I have been working on the adoption of a collaborative care model—and I know, Senator Cantwell, that in your State they have used the collaborative care model successfully—in which you provide help to primary care physicians to deal with common mental disorders, providing them with care managers and designated psychiatric consultants. This model has been tested in 80 randomized, controlled research settings. The largest one to date is the IMPACT study which showed major progress in quality, plus showed a six-to-one savings in dollars.

I am sorry that the court stenographer cannot see Dr. Conway nodding his head in a positive way as I have been making these comments. I would like that to be part of the record. And of course, there is also the CMMI's COMPASS initiative, where you did a study, a model on depression, to more effectively treat patients with diabetes and cardiovascular disease, and we saw tremendous progress there.

So my question is, what steps are we taking or can we take in order to encourage more of these integrated and collaborative care models that will save us dollars but have faced challenges under the current system, in order to implement them in a more widespread way?

Dr. CONWAY. So, thank you, Senator, for your question. This is a critically important topic and important to me, both on a professional and personal level. I was actually at a meeting hosted by the Kennedy Forum last week on this issue. I will name a couple of possibilities in this arena and things we are doing.

One, with the collaborative care model, we are trying to embed those concepts throughout our learning environments and our ACOs and our Comprehensive Primary Care initiatives and these

alternative payment models. In our Comprehensive Primary Care initiative, they are focused very strongly on collaborative care and integrating behavioral health with the physical health delivery system.

Two, in the health care innovation awards—you mentioned COMPASS, which is one of the largest ones—we are testing the model very directly using the Innovation Center authority. You mentioned the evidence-based effort, so I will not repeat it, but you are correct. There is a strong evidence base over time.

Three, recently we have gotten some comments asking us, in our fee-for-service system, do we have the authority to somehow think about care coordination codes or other codes in this arena?

So, I think we are trying to tackle it through population-based payments, where, as you said, when we incentivize quality and lower cost, these type of models will deliver that to the patients that they serve. We are also trying to address it directly through some of our innovation awards and testing the model very directly.

Then lastly, in the fee-for-service environment, we are always thinking about what we can take that we are learning from the Innovation Center and these new models and the evidence base out there, and are there ways to integrate that into our core payment program.

Senator CARDIN. That is encouraging. I would just point out that, with mental health needs, a large percentage go untreated and then become a more difficult problem and we see them in the emergency rooms, and they become very costly.

We have seen historic neglect in dealing with mental health needs compared to other physical illnesses. So I think for all those reasons, there is a great return here in doing the right thing as far as care is concerned, as well as saving dollars.

There are reimbursement challenges today in the system that we need to correct. So I just urge us to work together as to how we can—different coding might work, but we have to eliminate the disincentives that are in the current system, where an integrated or collaborative care model is not financially rewarded for saving money.

Dr. Miller, any comments?

Dr. MILLER. I think a lot of them were encompassed by Dr. Conway's comments. I think that the payment system has to be structured so you are allowed to approach the beneficiary through an episode-type of approach. So we are talking about bundled or population-types of approaches, which I believe Dr. Conway mentioned.

Quality metrics have to point people in that direction, which I believe he mentioned. And the only thing I would add is that your risk-adjustment mechanism has to back in behind that. So, if you take those very complicated populations—and again, I am happy to hear about the success here, but I also know, around the country, approaches for behavioral health have also had huge problems in trying to just identify the people who would benefit from them and bring them into a coordinated care-type of model.

So I think there are unique challenges here and that risk-adjustment models have to reach to those.

Senator CARDIN. Build on the successful models. We have a lot of successful models out there that have been done. Let us build on those to provide the services that are needed that are not being provided today and, by the way, save money in our health care system.

Thank you, Mr. Chairman.

Senator Cantwell [presiding]. Thank you, Senator Cardin. And thanks for mentioning the University of Washington and the Washington, Wyoming, Alaska, Montana, and Idaho (WWAMI) system on this particular effort of collaborative care. I think bringing mental health services into the primary care setting in the region has really been key. So thank you for mentioning that.

Dr. Conway, Dr. Miller, now that I have, so to speak, the gavel, I could stay here for a long time until the Pacific Northwest reimbursement rate issues were solved, but I think instead I will just ask you some basic questions and hopefully we can move this discussion forward. First, do you agree that the high-performing providers of Medicare Advantage plans help us improve chronic care management in the Medicare population? Dr. Conway?

Dr. CONWAY. Yes. I agree we have Medicare Advantage plans that are high-performing and improve chronic condition management.

Senator CANTWELL. So how does Medicare currently incent providers who take on risk by being paid the capitated rate by Medicare Advantage plans?

Dr. MILLER. If I am following the line of questions, the payment system incents a plan to take those kinds of populations in two or three ways: number one, a risk-adjustment system that actually increases their payments when they take more complex patients; number two, quality metrics, to the extent that they are aimed at the kinds of outcomes that would occur with these patients, increase the benchmark and, therefore, the possible reimbursement that that plan can get; and three, through greater flexibility to kind of reorganize how they approach and try different strategies for managing the population.

Senator CANTWELL. Well, I guess I am saying, how could you better incent Medicare Advantage to—we have this reimbursement rate way lower than the rest of the country because we are more efficient. In some ways, we have better outcomes because of it. So I guess we can be grateful for that.

Where we practice, we have better outcomes. But we also have people who do not want to practice there because of a lower reimbursement rate. So we want the rest of the Nation to be more efficient, but we obviously want the ACO model, which is determined on historic numbers.

So you are going to take these ACOs, they are going to use historic numbers, so we are already going to get less right there. And then, with the way we wrote the SGR language, Medicare Advantage is also not as incentivized. We have language in there saying, let us study and work on it.

So I guess I am asking you today, this morning, what are your ideas to make sure that they are properly incented so that these ACOs basically get off the fee-for-service, on that historic rate, and get onto something that really incents that?

We have seen phenomenal success here. I always think of the Everett Clinic, because they had to manage the sickest population at Boeing and they did a phenomenal job—phenomenal job—in reducing those costs.

It is kind of basic. People kind of overlook it, but it really works. We do not want those people who are already moving forward to be shackled or basically slowed down because of these historic rates, and we want to figure out a way to enable them within the Medicare Advantage program.

So I want to hear your thoughts on that.

Dr. MILLER. I will start off, and Dr. Conway, I am sure, will have things to say. But sticking to managed care for a second, first off, we made the recommendation—I went through this before you got into the room—in which we said there should be new flexibilities in the regular order managed care plans that allow them to construct targeted programs around chronic conditions or combinations of chronic conditions and allow them flexibility to say, these particular sets of services are for people who have these kinds of issues. Right now, they do not have that flexibility. It is too simplistic, but they kind of have to give everything to everyone, and we want to give them greater ability to target.

The second thing is to pay for higher quality when the managed care plan's performance is greater than the ambient fee-for-service. So, again, I understand your payment issue, but to the extent that the MA outperforms the ambient fee-for-service, payment should be increased in the managed care environment.

To quickly jump to the ACO environment—and I believe CMS has taken action in some of its demonstrations on this—we said that in the ACOs, if you are in a market that is below average and you are in an ACO that is performing below that average, then when you adjust your utilization downward, your benchmark should not follow it. So, in other words, we do not penalize the fact that you are starting from a lower historical level and then take it down from that point. And I believe in the new generation, CMS is trying to take that idea on.

Senator CANTWELL. Well, how will some of these Washington providers achieve those goals if they are already starting at great efficiencies?

Dr. MILLER. I think the point with the Washington providers is that, at their current reimbursements, as you have said, there is some evidence that the quality does perform well there, and if, under ACOs, the benchmark does not come down in those kinds of environments, then it should help Washington in that instance. Over the longer haul—this is a longer conversation—there has been this discussion of moving off of the historical benchmarks for ACOs, and we have outlined some of this and the need to move to a different benchmark to address some of the issues that we are talking about here.

I have to say, there is a complexity that is going to be very hard to overcome in Washington in the sense that, if a managed care model——

Senator CANTWELL. In which Washington?

Dr. MILLER. I am sorry; in the Northwest of the United States, there is sort of a practice pattern where, if fee-for-service is low uti-

lization, a managed care plan or an ACO cannot outperform that. There are going to be sets of issues that are going to be difficult to overcome, because the response in many parts is to say, well, let us increase what we pay. Then the savings begin to evaporate, and I think that is the issue that needs to be——

Senator CANTWELL. No, no, no. We just want to be—listen, we are not happy that we are so efficient and produce better outcomes, and the rest of the—whatever you want to call it—political spectrum wants to now reward bad providers with worse outcomes with very tiny incentives and, in the meantime, continue to shackle us with complexity when we can drive even more innovation and even more savings.

So we are not happy. It is a start. What we did in the SGR is a start. We would be more aggressive, and we would reward good performance. So I guess my point is, instead of the way you described it—listen, we want to get off the fee-for-service for sure. We want to reward outcomes. I think the question is, how can you use that ACO model and Medicare Advantage plans to get those savings? Instead of penalizing them, reward them.

We are not saying we want higher reimbursement rates just for higher reimbursement rates. We want the United States of America to have an aggressive policy towards these very successful lower-cost, better-outcome models and incent people.

But the incentive is still driven now towards the very expensive providers and trying to tease them into doing good things. We wish that we would be way more aggressive than we currently are.

Dr. MILLER. And I see your point. I am sorry that I came across differently. We have made specific comments on the ACOs, and in the managed care environment, that I think do try to address some of the issues you are getting at.

Senator CANTWELL. Well, we will look forward to seeing those details.

So, Dr. Conway, do you agree that we need to do something here to make sure that ACOs and Medicare Advantage are more harmonized toward achieving, again, not just more fee-for-service rates, but actually cost savings that then can be turned into other things?

Dr. CONWAY. Yes. I would mention three things, briefly. One is that we are looking at the Medicare Advantage risk-adjustment payment methodology.

Two, with the Medicare Shared Savings Program, we are looking at some of the benchmarking issues and recommendations from MedPAC and others, and input from—thank you for your leadership in this area.

Then, three, with the next-generation ACO model, which we recently announced and have a robust interest in, we set the benchmarking very differently so there is greater opportunity for traditionally low-cost providers to be rewarded if they achieve that attainment of quality and cost, and they are awarded that financially in the model.

Senator CANTWELL. Having been involved in many discussions as we led up to the SGR repeal, the immediate response was, oh well, Medicare Advantage, no, no, they already have some incentives, so we should exclude them, and that is really not the point.

The point is, you want to deal with this chronic population, and they are part of dealing with that chronic population, and you want them to be in an ACO. So if people can achieve more savings, if people can achieve better outcomes and reduce the utilization and better target what the patients really need, we should figure out how to incent that, not basically penalize certain sectors.

So, again, I get that this is almost a cultural issue between where we are in the Northwest and where some other parts of the country are, but this is about, in very specific terms, better outcomes, and what we want to achieve for all our health care delivery systems is better outcomes.

But when we can show that you can get better outcomes at lower cost, it is a win-win situation for everyone. So hopefully we can get this issue resolved as it relates to Medicare Advantage and ACOs.

So with that, I am going to say that the record is going to remain open until the 21st, and we hope members who have any other comments or input can submit those by then.

Otherwise, the hearing is adjourned, and I thank our witnesses.

[Whereupon, at 11:53 a.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

PREPARED STATEMENT OF PATRICK CONWAY, M.D., M.SC., ACTING PRINCIPAL DEPUTY ADMINISTRATOR, DEPUTY ADMINISTRATOR FOR INNOVATION AND QUALITY, AND CHIEF MEDICAL OFFICER, CENTERS FOR MEDICARE AND MEDICAID SERVICES, DEPARTMENT OF HEALTH AND HUMAN SERVICES

Chairman Hatch, Ranking Member Wyden, and members of the Committee, thank you for inviting me to discuss the Centers for Medicare and Medicaid Services' (CMS) work to improve care for beneficiaries with chronic disease. CMS is working hard to ensure that all Americans receive better care; that we spend our health care dollars more wisely; and that we have healthier communities, a healthier economy, and ultimately, a healthier country.

Medicare beneficiaries have serious chronic care needs. In 2010, more than two-thirds, or 21.4 million fee-for-service beneficiaries, had at least two or more chronic conditions.[1] In the same year, almost 60 percent of beneficiaries had heart disease, another 45 percent had high cholesterol and roughly 30 percent had diabetes.[2] Although chronic disease affects Medicare subpopulations differently—for example, depression is more common among beneficiaries with disabilities—all beneficiaries are at risk.[3]

The high prevalence of chronic disease has both social and economic costs. Medicare beneficiaries with multiple chronic conditions are the heaviest users of health care services. As the number of chronic conditions increases so does the utilization of health care services and health care costs. In 2010, among the 14 percent of Medicare beneficiaries with six or more chronic conditions, over 60 percent were hospitalized, which accounted for 55 percent of total Medicare spending on hospitalizations. Beneficiaries with six or more chronic conditions also had hospital readmission rates that were 30 percent higher than the national average.[4] Caring for the chronically ill can be complicated and requires effective communication and collaboration of various providers across health care settings. Fee-for-service payment systems do not always support effective care management for persons with chronic disease. CMS is working to improvecare for Medicare beneficiaries with chronic conditions by encouraging better chronic care management in both fee-for-service and Medicare Advantage, while testing innovative models to help identify better ways to provide health care.

ESTABLISHING THE PAYMENT FRAMEWORK FOR SUCCESS

Earlier this year, Health and Human Services Secretary Burwell announced measurable goals and a timeline to move the Medicare program, and the health care system at large, toward paying providers based on the quality, rather than the quantity of care they give patients. This initiative will ultimately create a payment environment that appropriately promotes and rewards better care management for persons with chronic illness.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Account-

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[1] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.*
[2] Id.
[3] Id.
[4] Id.

able Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018, through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

To achieve better care, smarter spending and healthier people, we are focused on three key areas: (1) improving the way providers are paid, (2) improving and innovating in care delivery, and (3) sharing information more broadly to providers, consumers, and others to support better decisions while maintaining privacy.

Payment Incentives: When it comes to improving the way providers are paid, we want to reward value and care coordination—rather than volume and care duplication. Many providers today receive a payment for each individual service, such as a physician visit, surgery, or blood test, and it does not matter whether these services help (or harm) the patient. Conversely, providers are generally not paid to keep their patients healthy before chronic diseases like diabetes develop or worsen. In other words, providers are paid based on the volume of care provided rather than the value of care provided. We want to pay providers for what works—whether it is something as complex as preventing or treating disease or something as straightforward as making sure a patient has time to ask questions.

Care Delivery: To improve care delivery, we are supporting providers to find new ways to coordinate and integrate care. And we are also focused on improving the health of our communities—with a priority on prevention and wellness to help prevent chronic disease in the future. When a patient is admitted to the hospital or referred to a specialist without effective coordination between providers, it can lead to duplicative X-rays or lab tests that mean wasted time and money to the patient. With more emphasis on coordinated care, patients are more likely to get the right tests and medications rather than taking tests twice or getting procedures they do not need. Better care coordination can also mean giving patients more quality time with their doctor; expanding the ways patients are able communicate with the team of clinicians taking care of them; or engaging patients and families more deeply in decision-making. For example, if a patient is discharged from the hospital without clear instructions on how to take care of themselves at home, when they should take their medicines, or when to check back in with the doctor, it can lead to an unnecessary readmission back into the hospital for easily preventable harms. This is especially true of individuals who have complex illnesses or diseases that may be more difficult to manage. We are supporting care improvement through a variety of channels, including facilitating hospitals and community groups teaming up to share best practices.

Information Sharing: As we look to improve the way information is distributed, we are working to create more transparency on the cost and quality of care, to use electronic health information to inform care, and to bring the most recent scientific evidence to the point of care so we can bolster clinical decision-making. While we have made great strides in encouraging and supporting the adoption of electronic health records, there are many areas where important information is missing. For example, many providers in the health system such as nursing homes do not have electronic health records to be able to store and share health information electronically with their patients or other providers, and some providers find that their electronic health records do not share information (*i.e.,* are not "interoperable") with other systems as easily as they would have hoped.

When information is available to the treating physician across all settings of care, patients can rest assured that all their relevant information is being tracked accurately and they are not asked to repeat information from recent hospitalizations or laboratory tests. Doctors can get electronic alerts from a hospital letting them know that their patient has been discharged and can proactively follow up with special care transition management tools. CMS is bringing together partners in the private, public and non-profit sector in pursuit of these goals. HHS has established the Health Care Payment Learning and Action Network, which will serve as a forum where payers, providers, employers, purchasers, states, consumer groups, individual consumers, and others can discuss, track, and share best practices on how to transition towards alternative payment models that emphasize value. The Network will be supported by an independent contractor that will act as a convener and facilitator.

SUPPORTING CARE MANAGEMENT IN FEE-FOR-SERVICE MEDICARE

CMS will continue to make improvements to Medicare fee-for-service payment systems as value-based payment models are developed. Recent improvements that promote more effective chronic care management include enhancing the Medicare Shared Savings Program, paying for care transitions and chronic care management services in the Medicare physician fee schedule, and emphasizing communication and care coordination through quality measurement.

Care Coordination through the Medicare Shared-Savings Program (Shared Savings Program): Shared Savings Program participants, also known as Accountable Care Organizations (ACOs), are groups of doctors, hospitals, and other health care providers that work together to give Medicare beneficiaries in Original Medicare (fee-for-service) high quality, coordinated care. ACOs can potentially share in savings they generate for Medicare, if they meet specified quality and financial targets. In December 2014, CMS announced that 89 new ACOs would join the Shared Savings Program on January 1, 2015. With the addition of those new participants CMS now has a total of 404 ACOs participating in the Shared Savings Program, serving more than 7.2 million beneficiaries. When combined with the 19 ACOs participating in the Pioneer ACO models—discussed in more detail below—we have a total of 423 ACOs serving over 7.8 million beneficiaries.

CMS is seeing promising results from the Shared Savings Program. In fall 2014, we released results from the ACOs who started the program in 2012. Shared Savings Program ACOs improved on 30 of the 33 quality measures in the first two years, including patients' ratings of clinicians' communication, beneficiaries' rating of their doctors, and screening for high blood pressure. They also outperformed group practices reporting quality on 17 out of 22 measures. We are also seeing promising results on cost savings with combined total program savings of $417 million for the Shared Savings Program and the Pioneer ACO Model.

While we are encouraged by what we have seen so far, we also understand there are opportunities to improve the program to make it stronger. In late 2014, we published a proposed rule to update the requirements for the program. We are reviewing comments from ACOs, beneficiaries, and their advocates, providers, and other interested stakeholders.

New Codes for Care Transitions and Chronic Care Management: For 2013, CMS adopted a policy to pay separately for care management involving the transition of a beneficiary from care furnished by a treating physician during a hospital stay to care furnished by the beneficiary's primary physician in the community. This policy pays providers for activities that are critical for smoothing transitions back into the community and for preventing hospital readmissions. These activities include: reviewing discharge instructions and ensuring beneficiaries understand them, collaborating with outpatient providers that will be assuming care of the patient, making referrals to community resources and assisting with scheduling appointments with community-based providers.

CMS built on this work by adopting a policy in Calendar Year 2015 to pay separately for non-face-to-face care management services furnished to beneficiaries with two or more chronic conditions. This policy responds to the physician community, which has told us that the care coordination included in many of the evaluation and management services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved with these types of beneficiaries. Providers will now be paid for expanding access to both in-person care and alternative (*e.g.,* over-the-phone) appointments, developing care plans, and coordinating care with other providers. Chronic care management can help to avoid adverse events like unnecessary hospitalizations, improve beneficiary outcomes, and avoid a financial burden on the health care system. Successful efforts to improve chronic care management could improve the quality of care while simultaneously decreasing costs. Taken together, these policies signal CMS's commitment to improving care management for the chronically ill and better supporting primary care providers, which are frequently on the front lines delivering these services.

Emphasizing Communication and Care Coordination through Measurement: CMS operates several quality measurement programs that help providers improve their performance and support the agency's goal of paying for value. Programs like the Physician Quality Reporting System (PQRS) and Hospital Readmission Reductions Program also include measures that promote effective care coordination and care management.

PQRS: PQRS is a pay-for-reporting program that promotes reporting of quality information by eligible professionals. Most providers are required to report nine measures of their choice from a comprehensive list, giving them flexibility and options in achieving program expectations. Over time, CMS has updated the measures list with several that emphasize the delivery of well-coordinated effective care across health care settings. These measures evaluate if care is coordinated with specialists ("closing the referral loop"), if patients are seen following a mental health hospitalization ("follow up after hospitalization for mental illness"), and if a patient's medication is reconciled following a discharge from a hospital ("medication reconciliation").

Hospital Readmissions Reduction Program: This program continues CMS's progress towards creating a payment landscape that supports integrated and high-quality care. When patients are consistently readmitted to hospitals, it can be a symptom of dysfunctional and poorly coordinated health systems. Under the Readmission Reduction Program, hospitals have a strong incentive to work collaboratively with other health care providers to manage care transitions and smooth beneficiaries' path back to the home. Beneficiaries with chronic illness, because of their vulnerability, are particularly at risk for admissions and readmissions.[5] By reducing Medicare payments to hospitals with excess readmissions, this program creates incentives to better coordinate care and reduce readmissions for Medicare beneficiaries, including those with multiple chronic conditions. In Fiscal Year (FY) 2015, the maximum reduction in payments under the Hospital Readmissions Reduction Program increased from two percent to three percent of base discharge amounts, as required by law. For FY 2016, CMS will assess hospitals' excess readmission rates and calculate penalties using five readmissions measures endorsed by the National Quality Forum.

MEDICARE ADVANTAGE

Unlike "traditional Medicare" which is fee-for-service based, Medicare Advantage plans are offered by private companies that contract with CMS to provide Medicare Part A and B benefits. Most Medicare Advantage Plans also offer prescription drug coverage. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans. Beneficiaries enrolled in a Medicare Advantage plan, have their Medicare services covered and paid through the plan. Medicare Advantage plans are expected to leverage their provider networks to coordinate high-quality care for beneficiaries, including those with chronic conditions. As a part of their required Quality Improvement program, all Medicare Advantage organizations must conduct a Quality Improvement Project and a Chronic Care Improvement Program; these initiatives focus on reducing hospital readmissions and reducing the incidence and severity of cardiovascular diseases, respectively. Both aim to improve health outcomes and beneficiary satisfaction through increased quality of care, especially for those with chronic conditions. Each CMS-approved program is tailored to a Medicare Advantage organization's particular population and includes elements of shared decision-making and care coordination.

Rewards and Incentives Programs in Medicare Advantage Plans: In 2014, CMS added new regulations that allow Medicare Advantage organizations to offer beneficiaries rewards and incentives for participating in activities that focus on promoting improved health, preventing injuries and illness, and promoting efficient use of health care resources. The goal of Rewards and Incentives Programs is to encourage enrollees to be actively engaged in their health care and, ultimately, improve and sustain their overall health and well-being. Medicare Advantage organizations may use these programs to target beneficiaries with chronic conditions and to encourage behaviors that aid in disease management and/or prevention.

Improving Quality in Medicare Advantage Plans: The Affordable Care Act ties payment to private Medicare Advantage plans to the quality ratings of the coverage they offer. A Medicare Advantage plan that receives a four- or five-star rating receives a bonus payment. As care coordination is one measurement used to determine a plan's star rating, plans are encouraged to deliver high-quality, coordinated care. Since those payment changes have been in effect, more beneficiaries are able to choose from a broader range of higher-quality Medicare Advantage plans, and more seniors have enrolled in these higher-quality plans as well.

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[5] *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.*

In recent years, the Medicare Advantage program has continued to grow, quality of participating plans has continued to increase, and premiums have remained stable. Medicare Advantage enrollment has increased by 42 percent since enactment of the Affordable Care Act in 2010 to an all-time high of more than 16 million beneficiaries, with nearly 30 percent of Medicare beneficiaries enrolled in MA plans. In 2015, 60 percent of MA enrollees will be enrolled in four- or five-star plans,[6] compared to an estimated 17 percent back in 2009. Average premiums today are lower than before the Affordable Care Act went into effect, dropping six percent between 2010 and 2015.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) established a Medicare Advantage coordinated care plan (MA CCP) that was specifically designed to provide targeted care to individuals with special needs.[7] MA CCPs that are set up to provide services to these special needs individuals are called "Specialized MA plans for Special Needs Individuals," or Special Needs Plans (SNPs). SNPs offer the opportunity to improve care for Medicare beneficiaries with special needs, primarily through improved coordination and continuity of care. SNPs may be any type of MA CCP, including a health maintenance organization, or a local or regional preferred provider organization plan.

Chronic Condition Special Needs Plans (C–SNPs) restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C–SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries move from high risk to lower risk on the care continuum. CMS has approved 15 SNP-specific chronic conditions for which C–SNPs can target enrollment.[8] C–SNPs are expected to have specially designed Plan Benefit Packages that offer benefits and services that go beyond the provision of basic Medicare Parts A and B services and care coordination required of all CCPs.

Health plans increasingly have responded to market developments and fiscal pressures with innovations in care delivery, plan design, beneficiary and provider incentives, and network design. Though evidence suggests that these innovations may reduce cost, improve quality, and enhance beneficiary satisfaction, adoption of some of these innovations has been limited in stand-alone Medicare Prescription Drug Plans, Medicare Advantage and Medicare Advantage Prescription Drug plans, Medicaid managed care plans, Medigap plans, and Retiree Supplemental health plans.

Last year, the CMS sought input on initiatives to test innovations in plan design, including but not limited to value-based insurance design; care delivery; beneficiary and provider incentives and engagement; and/or network design in Medicare health plans and Medigap and Retiree Supplemental health plans. Many of these approaches have potential to improve the quality and efficiency of care provided to individuals with serious, chronic illness.[9]

DELIVERY SYSTEM REFORM DEMONSTRATIONS

The Affordable Care Act created the CMS Center for Medicare and Medicaid Innovation ("Innovation Center") for the purpose of testing "innovative payment and service delivery models to reduce program expenditures . . . while preserving or enhancing the quality of care" for those individuals who receive Medicare, Medicaid, or Children's Health Insurance Program benefits. The Innovation Center is testing new payment and service delivery models focused on improving quality, reducing spending and enhancing care management and care coordination. The results of this work will help to inform efforts to improve care for individuals with multiple chronic conditions across the health care system. Examples of this work includes:

Pioneer Accountable Care Organization Model: Nineteen ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Results from the second independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of $384 million in the Model's first two years. Pioneer ACOs generated Medicare savings of $279.7

[6] CMS calculates star ratings from one to five (with five being the best) based on quality and performance for Medicare health and drug plans to help beneficiaries, their families, and caregivers compare plans.

[7] The MMA defines "special needs individuals" as: (1) institutionalized beneficiaries; (2) dual eligibles; and/or (3) individuals with severe or disabling chronic conditions as specified by CMS.

[8] For the full list of SNP-specific chronic conditions, please visit:
https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/Chronic-Condition-Special-Need-Plans-C-SNP.html#s1.

[9] *http://innovation.cms.gov/files/x/hpi-rfi.pdf.*

million in their first year and $104.5 million in 2013.[10] Medicare beneficiaries who are in Pioneer ACOs, on average, report more timely care and better communication with their providers, use inpatient hospital services less, have fewer tests and procedures and have more follow-up visits from their providers after hospital discharge. Earlier this month, the CMS Office of the Actuary certified that the Pioneer ACO Model meets the stringent criteria for expansion under the Innovation Center Authority. The Actuary's certification that expansion of Pioneer ACOs would reduce net Medicare spending, coupled with Secretary Burwell's determination that expansion would maintain or improve patient care without limiting coverage or benefits, means that we will consider ways to scale the Pioneer ACO Model into other Medicare programs.

Building on this success, the Innovation Center recently launched a new ACO model called the Next Generation ACO Model, which further enables innovation by providers to improve care for patients. The Next Generation ACO Model offers a new opportunity in accountable care—one that sets more predictable financial targets, enables providers and beneficiaries greater opportunities to coordinate care, and aims to attain the highest quality of care. ACOs in the Next Generation ACO Model will take on greater financial risk than those in current Medicare ACO initiatives, while also potentially sharing in a greater portion of savings. Next Generation ACOs will have a number of tools available to enhance the management of care for their beneficiaries. These include additional coverage of telehealth and post-discharge home services, coverage of skilled nursing care without prior hospitalization, and reward payments to beneficiaries for receiving care from ACOs.

Bundled Payments for Care Improvement Initiative: The Innovation Center is testing how bundling payments for episodes of care can result in more coordinated care for Medicare beneficiaries and lower costs for Medicare. Bundling payment for services that patients receive across a single episode of care, such as heart bypass surgery or a hip replacement, is one way to encourage doctors, hospitals and other health care providers to work together to better coordinate care for patients, both when they are in the hospital and after they are discharged. The initiative currently has 181 Awardees in Phase 2 (risk-bearing), including 55 conveners of health care organizations, representing 512 Medicare organizational providers. Additionally within Phase 1 (preparatory) of the initiative are 607 participants, including 87 conveners of health care organizations, representing 5,479 Medicare organizational providers.

Comprehensive Primary Care Initiative: The Innovation Center is currently testing the Comprehensive Primary Care initiative (CPC), which is a multi-payer partnership between Medicare, Medicaid, private health care payers, and primary care practices in four states[11] and three regions.[12] This initiative includes providing care management for those at greatest risk; improving health care access; tracking patient experience; coordinating care with hospitals and specialists; and using health information technology to support population health. Practices receive non-visit based care management fees from the participating payers, and the opportunity to share in savings. Results from the first year suggest that CPC has generated nearly enough savings in Medicare health expenditures to offset care management fees paid by CMS, with hospital admissions decreasing by two percent and emergency department visits by three percent. Results should be interpreted cautiously as effects are emerging earlier than anticipated, and additional research is needed to assess how the initiative affects cost and quality of care beyond the first year.

Multi-Payer Advanced Primary Care Initiative: The Innovation Center is currently supporting the Multi-Payer Advanced Primary Care Practice (MAPCP), which is a multi-payer initiative in which Medicare is participating with Medicaid and private health care payers in eight advanced primary care initiatives in Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. The demonstration completed its original three-year performance period at the end of 2014 but was extended for an additional 2 years in five of the states.[13] Under this demonstration, participating practices and other auxiliary supports (*e.g.,* community health teams) receive monthly care management fees from the participating payers and additional support (*e.g.,* data feedback, learning collaboratives, practice coaching). More than 3,800 providers, 700 practices, and 400,000 Medicare bene-

[10] See *http://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf.*
[11] Arkansas, Colorado, New Jersey, and Oregon.
[12] New York's Capital District and Hudson Valley, Ohio and Kentucky's Cincinnati-Dayton region, and Oklahoma's Greater Tulsa region.
[13] The five states are New York, Vermont, Maine, Rhode Island, and Michigan.

ficiaries participated in the first year. Unlike CPC, the eight states participating in MAPCP convene the participants and administer the initiatives rather than CMS. During the first year, the demonstration produced an estimated $4.2 million in savings. Also, the rate of growth in Medicare fee-for-service health care expenditures was reduced in Vermont and Michigan, driven largely by reduced growth in inpatient expenditures.

Providing states with additional flexibility and resources to enhance care: The State Innovation Models Initiative aims to help states deliver high-quality health care, lower costs, and improve their health system performance. Together with awards released in early 2013, over half of states (34 states and 3 territories and the District of Columbia), representing nearly two-thirds of the population are participating in efforts to support comprehensive state-based innovation in health system transformation aimed at finding new and innovative ways to improve quality and lower costs. Seventeen states are currently implementing comprehensive statewide health transformation plans.[14]

Integrating care for individuals enrolled in Medicare and Medicaid: Many of the ten million Medicare-Medicaid enrollees suffer from multiple or severe chronic conditions. Total annual spending for their care is approximately $300 billion. Twelve states have entered into agreements with CMS to integrate care for Medicare-Medicaid enrollees.[15] Enrollees participating in the Financial Alignment Initiative have access to coordinated services and, in some states, services that were not available outside of this demonstration, like dental, vision, and community-based behavioral health services. These demonstrations are designed to provide enrollees with person-centered, integrated care that provides a more easily navigable and seamless path to accessing and using services covered by Medicare and Medicaid.

Independence at Home: Created by the Affordable Care Act, the Independence at Home demonstration uses home-based primary care teams designed to improve health outcomes and reduce expenditures for Medicare beneficiaries with multiple chronic conditions. Under the demonstration, fourteen primary care practices and three consortia of physician practices are providing home-based primary care to targeted chronically ill beneficiaries for a three-year period. The care is tailored to an individual patient's needs and preferences with the goal of keeping them from being hospitalized.

Transforming Clinical Practice Initiative: Through this initiative, CMS will invest in the creation of evidence-based, peer-led collaboratives and practice transformation networks to support clinicians and their practices as they move towards and navigate a value-based health care system that rewards value and high quality care.

The initiative leverages the preliminary success of existing programs and models that have proven effective in achieving transformation, specifically in quality improvement, health care collaborative networks, and financial and program alignment. It identifies existing successful healthcare delivery models and works to rapidly spread these models to other health care providers and clinicians. We believe many of these clinician-driven quality improvement strategies and interventions could promote more effective communication and better coordinated care for individuals with multiple chronic conditions.

CONCLUSION

Providing coordinated care to individuals with multiple chronic conditions can be complex, and requires significant coordination that may not always occur in our fragmented health care delivery system. CMS is committed to improving care for Medicare beneficiaries with chronic disease while increasingly transitioning our payment systems to reward the value of care delivered—not volume. We believe these actions will create a payment environment that supports improved chronic care delivery. At the same time, the agency is testing new models of care delivery and pursuing improvements in traditional Medicare and Medicare Advantage that aim to improve quality, enhance patient satisfaction and lower costs. CMS hopes that this work in the Medicare program will not only improve care of our beneficiaries, but will help to inform efforts to improve coordination across other payers. We look for-

[14] Arkansas, Colorado, Connecticut, Delaware, Idaho, Iowa, Maine, Massachusetts, Michigan, Minnesota, New York, Ohio, Oregon, Rhode Island, Tennessee, Vermont, and Washington.

[15] California, Colorado, Illinois, Massachusetts, Michigan, Minnesota, New York, Ohio, South Carolina, Texas, Virginia, and Washington.

ward to working with you and other stakeholders to continue to improve the Medicare program to better care for its most vulnerable beneficiaries.

QUESTIONS SUBMITTED FOR THE RECORD TO PATRICK CONWAY

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. Dr. Conway, Medicare now offers a per-beneficiary monthly payment to certain physicians who provide care management services to patients with two or more chronic conditions. CMS implemented this new billing code in the standard budget-neutral manner, but I am curious how much money CMS expects to spend on this particular code? Additionally, does CMS have an estimate of how many beneficiaries may be helped under this code? Finally, is there any concern that creation of this new code may cause an increase in fraud and abuse should physicians classify patients as having two or more chronic conditions when they actually don't?

Answer. Chronic care management (CCM) is a Medicare service that can be billed, under certain conditions, by a physician or non-physician practitioner for managing a patient's care for a month. It is only paid if a minimum level of service is provided. As you note, these payments are designed to support care management activities for beneficiaries with two or more chronic conditions. In 2012, HHS research found that more than two-thirds, or 21.4 million fee-for-service (FFS) beneficiaries, had at least two or more chronic conditions.[1] We believe that these vulnerable Medicare beneficiaries can benefit from care management and want to make this service available to all such beneficiaries. Because the payment was implemented as part of the 2015 Physician Fee Schedule, with payments beginning January 1, 2015, we do not yet have any data on how much Medicare is spending on CCM. Once we have data, we will evaluate the utilization of this service to determine what types of beneficiaries elect to receive the service, what types of practitioners are reporting it, and consider any changes in payment that may be warranted in the coming years. If a physician classified a patient as having two or more chronic conditions when they did not in order to qualify for a CCM payment, the claim would be inappropriate and the physician potentially would be subject to penalties related fraud or abuse. Like we do for all other services, we will review and investigate patterns of utilization that suggest inappropriate behavior.

Question. Dr. Conway, private health plans like PPOs and HMOs can create preferred networks of providers where beneficiaries are charged lower cost-sharing if they seek medical services in network. ACOs and other alternative fee-for-service Medicare payment models do not operate the same way. Given this restriction in Medicare fee-for-service, it appears our options to strengthen care coordination services are somewhat limited to, for example, changing the provider payment structure. Because ACOs are not allowed to navigate their patients to specific providers, how effective do you believe ACOs will ultimately be at coordinating care and lowering costs?

Answer. Although the Accountable Care Organization (ACO) model is relatively new, we have preliminary results demonstrating that it is possible for Medicare-enrolled providers and suppliers to improve care coordination and quality for FFS beneficiaries while also creating cost efficiencies. For example, results from the second independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of $384 million in the Model's first two years. In addition, Medicare beneficiaries who are aligned to Pioneer ACOs, on average, report more timely care and better communication with their providers, use inpatient hospital services less, have fewer tests and procedures and have more follow-up visits from their providers after hospital discharge. In fact, the independent CMS Office of the Actuary recently certified that expansion of the Pioneer ACO Model, as tested in the first two years of the Model, would reduce net program spending under Medicare. In the first year of the Medicare Shared Savings Program, 58 ACOs held spending $705 million below their targets and earned performance payments of more than $315 million as their share of savings. Together, ACOs in the Pioneer ACO Model and Medicare Shared Shavings Program generated over $417 million in savings for Medicare. An additional 60 ACOs reduced health costs compared to their benchmark but not sufficiently enough to qualify for savings. Shared Savings Program ACOs also improved on 30 of 33 quality measures.

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[1] See *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf.*

Because ACOs are assessed on the total cost of care the beneficiary receives, not just the care provided by the ACO, program incentives encourage coordination of care and referrals to high quality and lower cost providers and suppliers, regardless of whether that provider or supplier is part of the ACO. Even if a beneficiary sees a doctor outside of the ACO—it is still in the ACO's best interest to work with that doctor to help coordinate and improve care for the beneficiary. ACOs can also be successful without restricting beneficiary access by educating beneficiaries about providers who collaborate with the ACO to improve care.

In addition, the Center for Medicare and Medicaid Innovation (CMMI) is soliciting applications for ACOs interested in participating in the Next Generation ACO Model, which includes a model design element to test whether financial rewards for beneficiaries who use providers that the ACO has identified as high value providers improve health outcomes and reduce spending for those beneficiaries. This is an alternative to designing a preferred network, and aims to improve beneficiary care without restricting access.

Question. Dr. Conway, how many ACOs do you think will really be willing to take on two-sided risk and actually write checks to the government when they exceed their spending target?

Answer. In 2011, Medicare made almost no payments to providers participating in CMMI models or ACOs promoting delivery system reform, but today such payments represent approximately 20 percent of Medicare payments. Earlier this year, the Secretary announced the goal of tying 30 percent of Medicare FFS payments to alternative payment models, such as the Shared Savings Program, by 2016 and 50 percent by 2018.

It is our desire to encourage ACOs to progressively take on more performance-based risk to drive quality improvement and efficiency in care delivery. For this reason, we established both a shared savings only (one-sided) model and a shared savings/losses (two-sided) model. This structure provides a pathway for organizations to increasingly take on performance-based risk. In the recently published Shared Savings Program final rule, we build on these principles and have finalized a set of policies we believe aligns with and advances the Secretary's goals. We believe the refinements to our existing two-sided risk model and the addition of our new Track 3 model, which provides greater rewards for taking on greater risk and includes greater flexibilities to coordinate care and improve quality will encourage organizations to take on performance-based risk. In addition, refinements to the requirements for a repayment mechanism reduce burden on ACOs and continue to ensure payment of losses to Medicare.

ACOs positioned to manage the total cost of care and population health will be interested in two-sided risk models because they offer the highest reward. We continue to believe that accountability for losses is an important motivator for providers to change their behavior and to maximize reductions in unnecessary expenditures, and that the prospect of accountability for losses will ensure that the program attracts participants that take seriously their commitment to achieving the program's goals. While there are ACOs that may not be ready for that level of risk now, these ACOs could become ready over time. CMS has many initiatives designed to help support providers as they integrate care including the Health Care Payment Learning and Action Network, the State Innovation Model Initiative and the Transforming Clinical Practice Initiative. We continue to hear support from stakeholders for offering a spectrum of ACO models with varying levels of risk, accountability, and reward.

Question. Dr. Conway, you mentioned Secretary Burwell's goal of tying at least 50 percent of traditional, fee-for-service Medicare payments to the use of alternative payment models by 2018. This is an aggressive target. While recent ACO demonstrations have shown some promise, these payment initiatives are still relatively new. There is no definitive data to prove if ACOs will improve quality and significantly reduce Medicare spending long-term. Ultimately, is it your intention to have as many ACOs as possible, with as many Medicare beneficiaries placed in them as possible, to meet this goal—even if all the ACOs are not effective? How will CMS quantify success? Will you act to streamline alternative payment models that fail and promote the ones that are most successful?

Answer. CMS offers bundled payment initiatives, advanced primary care models, and other payment models (along with ACOs) that support the Department's payment reform goals. Organizations and providers are free to choose the delivery system reform path and model that is right for them. Based on formal evaluations and

operational experience, we have a robust process in place for periodically assessing the effectiveness of various models and to expand, adjust or discontinue models based on those assessments. The law also requires that models tested by the Innovation Center shall be modified or terminated, unless the Secretary determines (and the CMS Chief Actuary certifies, with respect to spending) that the model is expected to improve the quality of care without increasing spending, reduce spending without reducing the quality of care, or improve the quality of care and reduce spending. The Innovation Center, working in concert with the Office of the Actuary, continuously monitors progress and results in order to identify successful and unsuccessful models and take necessary action.

One example of data that proves ACOs are improving quality and would reduce Medicare spending in the long-term is the Secretary's determination that the Pioneer ACO Model, as tested in the first two years of the Model, met the Affordable Care Act's criteria for expansion of a model. The independent evaluation report for CMS found that the Pioneer ACO Model generated over $384 million in savings to Medicare over its first 2 years—an average of approximately $300 per participating beneficiary per year—while continuing to deliver high-quality patient care. The Actuary's certification that expansion of the Pioneer ACO Model would reduce net Medicare spending, coupled with the Secretary's determination that expansion would maintain or improve patient care without limiting coverage or benefits, means that HHS will consider ways to scale the Pioneer ACO Model into other Medicare programs.

This summer CMS will again assess the financial and quality performance of Medicare ACOs participating in both the Shared Savings Program and the Pioneer ACO Model—providing an additional set of data points that the Agency can use to assess the effect of ACOs on quality and cost of care. Rapid growth in Medicare ACO participation rates has certainly signaled increasing interest among the provider community and while the Agency is pleased with the preliminary health, quality and cost outcomes of ACOs, it will continue to assess and evolve the program/models to promote their success and continued program participation. The initial quality and financial performance results are promising in that we're seeing improvements in beneficiary experience of care and health outcomes, as well as reductions in the growth of per capita Medicare spending. To ensure long-term success and the continued promotion of accountability for the health and cost outcomes of Medicare beneficiaries, we plan to adopt successful elements of models currently being tested in our national valued-based payment programs.

Question. Dr. Conway, your testimony indicates all ACOs produced a total Medicare savings of $417 million. I assume that ACOs achieve greater savings in parts of the country that have the highest fee-for-service Medicare utilization. Can you please give me more details as to how, exactly, this saving was generated?

Answer. CMS is pleased with the quality and financial results so far and recognizes that it takes time for providers to invest in and diffuse care redesign practices that lead to higher quality and better care. Early results have shown that ACOs with diverse organizational structures and located in diverse geographies have shared savings and/or lowered growth in spending.

ACOs have generated savings in diverse regions of the country, in areas of both higher and lower Medicare costs and utilization. Recent evaluations indicate ACO savings were achieved through reducing inpatient hospital utilization and skilled nursing care, as well as decreasing some types of diagnostic procedures and physician services.

ACOs have implemented a variety of strategies designed to improve care coordination for beneficiaries and lower the rate of growth in expenditures. Above and beyond the early quality data generated by participating organizations, we have anecdotal evidence that illustrates the importance of encouraging beneficiary participation in the Shared Savings Program. For example, ACO providers/suppliers report very meaningful changes in patient engagement through beneficiary participation in the governing body of the ACO and on patient advisory committees. In response to beneficiary input, clinical practices are offering extended office hours, including weekend hours, and ensuring timely appointments and access to clinical staff. Using the data shared by CMS, ACOs are able to identify high risk beneficiaries that require additional clinical attention, assign case managers, and actively work to improve care for these beneficiaries. One ACO reported that it has implemented a process for performing in home medication reconciliation and review of care plans as a follow up to hospital discharge and for one third of those patients, discovered an intervention that avoided an unnecessary hospital readmission. Active identifica-

tion and management of patients also has uncovered previously unaddressed issues that factored into patient inability to adhere to treatment plans. For example, one ACO reported that it has uncovered several psycho social issues that were resulting in avoidable readmissions, such as the inability to self-medicate. In that instance, the ACO addressed the concern by arranging for home health services for those beneficiaries.

Question. Dr. Conway, your testimony notes that the CMS Office of the Actuary certified that expansion of the Pioneer ACO model will reduce net Medicare spending. CMS reports that Pioneer ACOs generated gross savings of $384 million during the program's first 2 years—$279.7 million in 2012 and $104.5 million in 2013. That is a drop of $175.2 million between the program's first year results compared to its second year. Now, I understand that if Medicare spending remains flat, but beneficiary health outcomes increase, we may be heading in the right direction. But objectively, I want to know what this drop signals to you in terms of long term savings projections? Has the CMS Actuary looked into this?

Answer. While we expect some volatility in spending and savings from year to year, the decrease in savings between the first and second performance year parallels broader spending trends in the Medicare program. Since the spending of FFS beneficiaries aligned with Pioneer ACOs is compared against the spending of their FFS peers, if those peers have a lower growth in spending, it would be more difficult for Pioneer ACOs to demonstrate savings in their aligned beneficiary populations.

Spending results for both performance years varied across all 32 Pioneer ACOs. In 2012—the first year of the model—19 organizations had statistically significant savings compared to their near market. The estimated savings and losses compared to the near market for the remaining 13 ACOs were not statistically significant in 2012.

In 2013, 11 Pioneers had significant savings. Of those, all but one, Allina Health, already had achieved significant savings in 2012. Among the remaining 21 ACOs, 19 had spending that was not significantly different from their near markets. Two Pioneer ACOs—Partners Healthcare and Monarch—had significantly higher spending than their near-market comparison populations in 2013 totaling $41.7 million, offsetting some of the savings accrued by the 11 Pioneers with significant savings in that year. Fewer Pioneer ACOs having statistically significant savings in the second performance year and two Pioneer ACOs having higher spending that offset savings from other ACOs in that year are two causes for the lower overall gross savings figure in the second performance year.

Additionally, the CMS Office of the Actuary's examination of the specific markets utilized in the evaluation report confirms that a majority of chosen comparison populations were significantly affected by the formation of new Medicare Shared Savings Program ACOs in mid-2012 and, to a greater extent, in 2013 and beyond. This outcome is potentially related to the lower average savings estimated by the evaluation for the second performance year under both near- and far-market comparisons.

CMS believes that the certification by the independent CMS Office of the Chief Actuary that expansion of the Pioneer ACO Model, as tested in the first 2 years of the Model, would reduce net spending in the Medicare program lends further support to the potential for long-term savings from Medicare ACOs.

Question. Dr. Conway, ACOs are likely to be geographically limited in areas where there are enough willing providers and beneficiaries to form them. Assuming ACOs work in the long run, what do patients do who live in areas of the country with little to no ACO penetration?

Answer. We share your interest in making sure that Medicare beneficiaries and providers can participate in innovative care models, such as ACOs, no matter where they live. We also recognize that communities have different health care challenges. Some geographic areas may feature multiple organizations engaging in delivery system reform while others may face barriers to developing and implementing models aimed at achieving delivery system reform.

Already, many beneficiaries can access CMMI payment and service delivery models and Medicare Shared Savings Program (MSSP) ACOs aimed at promoting delivery-system reform efforts. Although payment- and delivery-transformation work is happening across the country, there are some areas that have comparatively less penetration of alternative payment models. Further, beneficiaries that live in rural areas are on average less likely to have access to Innovation Center payment and service delivery models or MSSP ACOs than those living in urban areas.

Because of these differences CMS has targeted initiatives to expand delivery-system reform efforts to more rural and underserved areas. These initiatives include:

- The Advance Payment ACO Model, which was designed to help entities such as smaller practices and rural providers with less access to capital participate in the MSSP.
- The ACO Investment Model, a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and also to support existing ACOs.
- The Transforming Clinical Practice Initiative, which will invest in the creation of support and alignment networks and practice transformation networks. These networks will serve as important resources for clinicians in rural areas as they navigate the new value-based health care system.
- The State Innovation Model Initiative, in which participating states are testing and evaluating multi-payer health system transformation models. States like Idaho, Utah, Michigan, and Texas have received grants to develop their payment and delivery system reform plans. Other states like Maine, Oregon, Colorado, Minnesota Tennessee, and Arkansas have received testing grants to implement their plans.
- Finally, under the Health Care Innovation Awards initiative, awards have been made to organizations that are implementing the most compelling new ideas to improve care and overall health while lowering costs to people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program, particularly those with the highest health care needs. There have been 50 awards in Round One and 12 awards in Round Two testing interventions in rural areas. These have included projects in 37 states and a combined total funding for projects that include rural interventions in the Health Care Innovation Award portfolio at almost $554 million.

QUESTIONS SUBMITTED BY HON. RON WYDEN

REIMBURSEMENT FOR COMMUNITY HEALTH WORKERS

Question. Community health workers have become an increasingly important part of our health system post-ACA. They are an integral part of care teams, particularly for vulnerable populations with complex and chronic health needs However, even in states like Oregon that are leading the way in care coordination, there is a need for more patient education and follow-up services like medication management. These are areas where community health workers can make a big difference.

Fortunately, the ACA and subsequent CMS regulations/guidance took steps to increase the role of community health workers in Medicaid. In 2013, CMS changed Medicaid regulations to clarify that states can reimburse for preventive services "recommended" by a physician or licensed practitioner, even if the service is ultimately provided by a community health worker or other health professional that falls outside the state's licensing scheme. Previously, such services were only reimbursed if they were provided by a physician or licensed practitioner. Beginning January 2014, CMS also allowed Medicaid agencies to reimburse for preventive services ordered by a physician but provided by a community health worker. However, no such reimbursement exists for the Medicare program, which also has vulnerable, high-risk populations.

How have states been using new Medicaid options to reimburse community health workers and other health professionals that fall outside state licensing schemes?

Answer. As you note, CMS revised our regulations to conform to the current statutory definition of preventive services, requiring that a physician or other licensed practitioner recommend these services rather than specifically providing them. We agree that making the conforming changes to our regulations to implement the statutory requirements broadened the availability of these important preventive services in keeping with statutory intent. As commenters noted, increasing the pool of providers could result in greater access to care and treatment for Medicaid and CHIP beneficiaries.

Given the importance of this issue, we noted in a February 2013 State Medicaid Director Letter that we had proposed the change to our regulations and that with

the finalization of this change, states would be able to claim the one-percentage-point FMAP increase for services delivered by practitioners other than physicians or other licensed providers.

Beyond the guidance we provided in February 2013, we have described the opportunity for states to include additional practitioners in the delivery of these services through the use of webinars and regular communication with the states. As states continue to consider this new flexibility, we remain available to work with those states that are interested in updating their state plans accordingly.

Question. How can we better utilize community health workers in Medicare? Are there beneficiary sub-populations where community health workers could make a particularly big difference?

Answer. CMS recognizes that community health workers can be an important part of our work to improve health care delivery and is building evidence about how to best use them, specifically in the Innovation Center. A number of Health Care Innovation Awards recipients have utilized community health workers as part of their efforts to provide higher quality care at lower costs.

Accountable Care Organizations (ACOs) and the Comprehensive Primary Care initiative (CPC) are two additional ways CMS is working to ensure better health care, better health, and lower growth in expenditures with the help of community health workers. Participants in both the Pioneer ACO model and the CPC are employing a team-based workforce that can include community workers to improve beneficiaries' quality of care, while lowering cost.

Question. Has CMS explored potential reimbursement options for community health workers in Medicare?

Answer. We have a number of Health Care Innovation Award awardees employing Community Health Workers or other types of lay-health workers to improve patient and caregiver engagement, care coordination, and many other crucial aspects of health care delivery. Our evaluation of these awards is looking closely at the various ways these workers have been deployed and the related barriers and facilitators to their use. While we have some preliminary findings related to implementation, we do not yet have data across these awardees to suggest either success or failure in improving patient outcomes. We hope to have these data in the near future, as our evaluators continue to analyze the awardees. We will carefully review these results with the intention of informing future models and CMS policy more generally.

Currently, community health workers are not eligible to enroll in Medicare to receive payment for services provided to Medicare beneficiaries. CMS routinely evaluates its provider enrollment policies, and has implemented new safeguards as a result of provisions in the Affordable Care Act. In considering potential enrollment of Community Health Workers in Medicare, CMS will need to ensure that necessary program integrity safeguards are in place.

Question. Does CMS need anything from Congress, legislative or otherwise, in order to expand the role of community health workers in Medicare?

Answer. CMS is committed to using all tools available to provide comprehensive, high-quality health care coverage to Medicare beneficiaries with chronic conditions. CMS is constantly looking for ways to improve beneficiary care and outcomes while reducing beneficiary and taxpayer costs. We are happy to provide technical assistance on any legislation that the Committee considers.

ALTERNATIVE PAYMENT MODELS IN AREAS WITH HIGH PREVALENCE OF CHRONIC DISEASE AND LITTLE CARE COORDINATION

Question. Many areas of the country have a high prevalence of chronic disease with corresponding high health care costs. The current fee-or-service system lacks care coordination which is a necessity for those living with chronic illness. Increased care coordination can cut down on duplicative costs, which Medicare has no way of avoiding in the fee-for-service system. Addressing these areas with different payment incentives may be helpful.

Are there areas with a high prevalence of chronic disease that also have little enrollment in Medicare Advantage or alternative payment models?

Why haven't these areas of the country moved towards alternative payment models?

Answer. We share your interest in ensuring that all Medicare beneficiaries with chronic disease can have access to integrated and coordinated care. Already, many beneficiaries can access a Center for Medicare and Medicaid Innovation (CMMI) payment and service delivery model or Medicare Shared Savings Program (MSSP) ACO. In addition, ninety-nine percent of Medicare enrollees have access to at least one Medicare Advantage plan and over half of Medicare Advantage enrollees are now in high-quality plans with 4 or more stars.

We also recognize that communities face different challenges as they work to transform the way they deliver health care. Some geographic areas may have a long history of mature managed care where others do not. Other areas feature multiple organizations engaging in delivery system reform while others may face barriers to developing and implementing alternative payment models. There are scattered areas, including some in the Southeast and Midwest, where beneficiaries have both high incidence of chronic disease but less robust access to Innovation Center payment and service delivery models or MSSP ACOs than beneficiaries in other parts of the country. In response to concerns and available research suggesting that some providers lack adequate access to the capital needed to invest in infrastructure necessary to successfully implement population care management, and to encourage new ACOs to form in rural and underserved areas, CMMI developed the ACO Investment Model initiative. The ACO Investment Model structures its payments to address both the fixed and variable costs associated with forming an ACO for new ACOs and with making ongoing investments to improve care coordination for existing ACOs.

Question. What can Congress do to encourage alternative payment models in these areas? Are there unique circumstances in these areas that require a different type of model?

Answer. CMS has several targeted initiatives to expand alternative payment models to more rural and underserved areas, including areas that have both fewer CMMI payment and service delivery models or MSSP ACOs and high burdens of chronic disease. These initiatives include:

- The Advance Payment ACO Model, which was designed to help entities such as smaller practices and rural providers with less access to capital participate in the MSSP.
- The ACO Investment Model, a new model of pre-paid shared savings that builds on the experience with the Advance Payment Model to encourage new ACOs to form in rural and underserved areas and also to support existing ACOs.
- The Transforming Clinical Practice Initiative, which will invest in the creation of support and alignment networks and practice transformation networks. These networks will serve as important resources for clinicians in rural areas as they navigate the new value-based health care system.
- The State Innovation Model Initiative, in which participating states are testing and evaluating multi-payer health system transformation models. States like Idaho, Utah, Michigan, and Texas have received grants to develop their payment and delivery system reform plans. Other states like Maine, Oregon, Colorado, Minnesota, Tennessee, and Arkansas have received testing grants to implement their plans.
- Finally, under the Health Care Innovation Awards initiative, awards have been made to organizations that are implementing the most compelling new ideas to improve care and overall health while lowering costs to people enrolled in Medicare, Medicaid, and the Children's Health Insurance Program, particularly those with the highest health care needs.

We appreciate the Committee's interest in this important issue and we look forward to working with the Chronic Care Workgroup to further enhance beneficiary access to high-quality, cost-effective care.

TARGETING THE CHRONICALLY ILL

Question. Chronic diseases are the most costly conditions to treat in the healthcare system, accounting for almost all of Medicare spending—93%. In the 2014 physician fee schedule, CMS added a new code for non-face-to-face chronic care management (CCM) services. The beneficiary, however, must have at least 2 chronic conditions to be eligible to receive the CCM services. While the implementation of this code is a start, more than two-thirds of Medicare beneficiaries are living with mul-

tiple chronic conditions; those with more than the average of 2 conditions require more treatment and care coordination and how that is targeted must be addressed.

As the committee begins the undertaking of chronic care reform, what is the best way to identify and target Medicare beneficiaries who need help the most?

Answer. CMS looks forward to working with you and the Committee as you examine options for chronic care reform. We know that advanced primary care practices, ACOs and Medicare Advantage plans use a variety of administrative and clinical data sources to stratify their patients based on level of severity and number of chronic conditions. This information enables providers to strategically deliver the appropriate level of services to beneficiaries depending on their health status and individual needs. For example, providers can use this information to both make intensive care management services available to beneficiaries with multiple chronic conditions and identify lower-risk beneficiaries in need of important preventive care. One of our goals through developing and increasing the availability of alternative payment models is to give more organizations this type of flexibility to identify and provide appropriate care and coordination for beneficiaries based on their individual needs.

Question. How do we identify beneficiaries in which we know better care coordination will decrease spending and improve the quality of care they receive?

Answer. Improved care coordination and care management can be important for all Medicare beneficiaries. For those with multiple chronic conditions, better-organized care can lower costs by reducing duplicative tests and procedures and reducing inpatient and emergency room use. Better and consistent preventive care for those without (or with few) chronic conditions may help catch and prevent the onset of disease. Currently, providers are generally not incentivized to keep their patients healthy before diseases like diabetes develop or worsen. In other words, providers are paid based on the volume of care provided rather than the value of care provided. We want to pay providers for what works—whether it is something as complex as preventing or treating disease or something as straightforward as making sure a patient has time to ask questions.

Question. Do we define the number of conditions like the chronic care management codes do? If so, what is the right number of conditions?

Should we focus on specific diseases? If so which ones?

Answer. All beneficiaries, regardless of the number of chronic conditions they have, may benefit from the care coordination afforded by an APM, while other more intensive and focused interventions may be more appropriate for beneficiaries with multiple serious conditions. Strategies for identifying patients for chronic care management services—whether by Medicare fee-for-service (FFS) costs, the number of chronic conditions, the types of conditions or the severity of those conditions—may depend on the particular policies or interventions the Committee considers for reforms.

As you noted, CMS added a code to the 2015 Physician Fee Schedule to pay separately for non-face-to-face care management services. Prior to establishing this code, CMS learned from stakeholders that payments for Evaluation and Management services, which bundle together both face-to-face and non-face-to-face care management activities, did not adequately make payment for non-face-to-face services for complex beneficiaries. CMS adopted the separate payment for beneficiaries with multiple chronic conditions to address payment accuracy for resource costs. In other initiatives, including the Medicare Shared Savings Program (MSSP) and the Comprehensive Primary Care initiative, all FFS Medicare beneficiaries are attributed to participating providers based on where they seek care. Providers in these initiatives are encouraged to risk-stratify their patients to focus their chronic care interventions.

In regards to focusing on specific diseases, the CMS has several initiatives targeted at improving quality and lowering costs for beneficiaries with select chronic conditions. These initiatives include the Million Hearts initiative, which focuses on cardiovascular disease, and the Every Diabetic Counts initiative, which hopes to reach and improve health outcomes in 18,000 Medicare beneficiaries with diabetes. The Innovation Center's Oncology Care Model focuses on Medicare beneficiaries with certain types of cancer, while the Comprehensive End Stage Renal Disease (ESRD) Care initiative concentrates on Medicare beneficiaries with ESRD. Finally, many condition-specific initiatives are also being tested through the Innovation Cen-

ter's Health Care Innovation Awards and we would be happy to discuss these further with the Committee.

UNDERSTANDING THE ROLES OF ACCOUNTABLE CARE ORGANIZATIONS (ACOS) AND OTHER ALTERNATIVE PAYMENT MODELS IN CHRONIC CARE

Question. The Affordable Care Act (ACA) created the Medicare Shared Savings Program (MSSP), a voluntary program in which the participants are ACOs—groups of doctors, hospitals or other providers that work together to provide high quality, coordinated care. ACOs can potentially share in the savings they generate for Medicare if they also meet quality standards.

Is there more that Medicare can do to incentivize ACOs to focus on chronically ill individuals?

Answer. The Shared Savings Program incentives present in the program have motivated many ACOs to focus their efforts on improving care for chronically ill individuals. ACOs have created methods to identify Medicare FFS beneficiaries with multiple chronic conditions because these are often high-risk individuals who benefit most from proactive care coordination. CMS provides Medicare data to ACOs to help them identify beneficiaries at greatest need for care coordination. In addition, CMS continues to engage ACOs in robust shared learning where organizations at the forefront of transforming care can rapidly share their experiences—both successes and failures—with peers.

Additionally, the Chronic Care Management and Transitional Care Management codes now provide additional care coordination payments for all FFS physicians and practitioners, including those belonging to an ACO. Due to the structure of the Shared Savings Program, participating organizations welcome high-risk chronic condition patients because that is where the greatest opportunity for care improvement and cost savings exist. We also have aligned our physician quality reporting and performance based incentive programs, such as the Physician Quality Reporting System and the Physician Value Modifier with the ACO quality reporting structure, which places emphasis on evidence based chronic disease measures and patient experience of care.

Question. Should there be ACOs that are specifically focused on the chronically ill?

Answer. ACOs, by nature of their mission to manage total cost of care for a population, pay attention to the needs of chronically ill patients. We believe that care for FFS beneficiaries is improved by encouraging ACOs to focus on care process improvement for all patients, rather than by encouraging focus on a particular type of patient or type of provider. Additionally, ACOs have the flexibility to identify care needs that are specific for their unique populations. We believe giving ACOs the flexibility to redesign care to meet the needs of their unique populations and communities ultimately supports healthcare process transformation that improves care for all patients.

CMS has developed one ACO model, the Comprehensive End Stage Renal Disease (ESRD) Care initiative, focusing on one specific chronic illness (end-stage renal disease), reflecting the unique nature of payment for dialysis services and ESRD beneficiaries' high burden of disease.

Question. What other payment models could help further care coordination for these fragile patients?

Answer. The Oncology Care Model (OCM) is another model in which care coordination will be emphasized for a patient population with complex health care needs. The goal of OCM is to improve care coordination, appropriateness of care, and access to care for Medicare beneficiaries with cancer. To that end, the model will use aligned financial incentives, including performance-based payments and monthly care management payments, aimed at encouraging oncology practices to provide comprehensive, patient-centered, and coordinated care.

Additionally, the Comprehensive Primary Care initiative, a multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care, has a strong focus on care coordination for the chronically ill. This initiative includes providing care management for those with multiple chronic conditions; improving health care access; tracking patient experience; and coordinating care with hospitals and specialists.

INTEGRATING DRUG SPENDING INTO DELIVERY SYSTEM REFORM

Question. Currently, CMS is implementing a number of alternative payment models such as ACOs and bundled payments that are attempting to coordinate care for a beneficiary in traditional fee-for-service Medicare. While these efforts are focusing on the medical side of the patient's care, like hospital, physician and nursing home services, drug spending is not involved. Under Medicare Advantage, some plans have integrated the Medicare drug benefit into the general MA benefit. This allows for one organization to coordinate all health under "one roof."

Can we do more to integrate the proper use of prescription drugs into efforts to better coordinate care for those beneficiaries with chronic diseases who are enrolled into traditional Medicare?

Answer. CMS has worked to improve care for high-risk fee-for-service beneficiaries under the stand-alone Part D program. The Part D Medication Therapy Management (MTM) Program is specifically designed to improve outcomes for Medicare beneficiaries. MTM programs are designed to ensure optimum therapeutic outcomes for targeted beneficiaries through improved medication use and are coordinated with any care management plan established for those individuals under a chronic care improvement program. Targeted beneficiaries for a Part D plan's MTM program, in general, are enrollees who meet all of the following criteria: have multiple chronic diseases, are taking multiple Part D drugs, and are likely to incur annual Part D drug costs that meet or exceed a certain threshold ($3,138 for 2015).

Another specific area where the Part D program is working to better coordinate care is with beneficiaries who are at high risk for an adverse drug event due to their use of opioids and for whom focused case management may be appropriate. As part of this case management approach, Part D sponsors work with prescribers to identify a medically appropriate dose and, in some cases, identify a primary prescriber to better manage the beneficiary's care. Part D sponsors may adapt this approach to other drugs or classes of drugs, including HIV drugs, as long as they use the same level of diligence and documentation that CMS expects with respect to opioids.

Question. Can CMS integrate more of Part D into these new payment models similar to how Medicare Advantage has done?

Answer. CMS shares the goal of finding mechanisms for alternative payment models to include accountability for drug spending and utilization. For example, the Oncology Care Model will give providers some accountability for beneficiaries undergoing chemotherapy.

The design of the Medicare Part D program, in which CMS contracts with private entities (stand-alone prescription drug plan (PDP) sponsors, MA organizations and other types of Medicare health organizations) who then act as the payers and insurers for prescription drug benefits, may pose challenges to full accountability for Part D expenditures for entities like ACOs. However, CMS believes it is important to find strategies for including Part D accountability into ACO initiatives and is exploring options for facilitating partnerships between Part D Plans and ACOs in the Next Generation ACO Model. The earliest CMS would be able to implement such Part D interaction for the Next Generation ACO Model would be Performance Year 2 (2017). Any Part D interaction would be subject to appropriate safeguards and conditions to protect against fraud and abuse.

CMS continues to work to integrate Part D into payment models. The Medicare Part D program pays a capitated amount to private insurers to manage the prescription drugs of Medicare FFS beneficiaries. Under this structure, savings in prescription drug spending within the capitated amount result in savings to the Part D plans rather than savings to Medicare. Incorporating drug costs under Medicare Advantage, on the other hand, works because it allows a single private insurer to manage all of the risks for a single patient to work to earn a profit.

Some conditions such as cancer, however, have prescription drug spending that is high enough to require direct payments from the Medicare Trust Funds, such as during the catastrophic phase of the Part D benefit. These costs can be tied directly to Medicare spending for FFS beneficiaries, as opposed to the capitated payments made to their Part D plans. Because the Oncology Care Model will hold participating practices accountable for certain Part D costs, the model is expected to incent the use of high-value Part D drugs.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

COMMUNITY HEALTH WORKERS

Question. Poor care coordination can lead to worse health outcomes, increased hospital admissions, and higher cost. Community Health Workers (CHWs) play an integral role in public health, prevention, cost containment, and care coordination.

In Ohio, we have seen how CHWs help patients—including high cost patients—understand and navigate our nation's complex health care system, teach healthy behaviors that can prevent disease before it starts, and help patients manage chronic disease by coordinating their care among many providers and reminding them to take their medicine, do their exercises, and stay on track with their other self-treatment tasks.

The Affordable Care Act (ACA) has helped expand opportunities for CHWs to contribute to increased value and care coordination; however the health reform law offered no direct new funding for the employment of CHWs within the dominant fee-for-service (FFS) delivery system.

Dr. Conway—to follow up on the question I asked during the hearing, can you both talk about the role of CHWs in care coordination and the value of integrating CHWs with other health care professionals into care teams?

Answer. With more emphasis on coordinated care, patients are more likely to get the right tests and medications rather than taking tests twice or getting procedures they do not need. Better care coordination can also mean giving patients more quality time with their doctor; expanding the ways patients are able communicate with the team of clinicians taking care of them; or engaging patients and families more deeply in decision-making. We are supporting care improvement through a variety of channels, including facilitating hospitals and community groups teaming up to share best practices.

CMS recognizes that community health workers can be an important part of our work to improve health care delivery and is building evidence about how best to use them, specifically in the Innovation Center. A number of Health Care Innovation Awards recipients have utilized community health workers as part of their efforts to provide higher quality care at lower costs.

Accountable Care Organizations (ACOs) and the Comprehensive Primary Care initiative (CPC) are two additional ways CMS is working to ensure better health care, better health, and lower growth in expenditures with the help of community health workers. Participants in both the Pioneer ACO model and the CPC are employing a team-based workforce that may include community workers to improve beneficiaries' quality of care, while lowering cost.

CMS is committed to improving care for Medicare beneficiaries with chronic disease while increasingly transitioning our payment systems to reward the value of care delivered—not volume. We believe these actions will create a payment environment that supports improved chronic care delivery.

Question. Dr. Conway—you mentioned that many of the innovation grants coming out of the Center for Medicare and Medicaid Services' (CMS) Center for Medicare and Medicaid Innovation (Innovation Center, or CMMI), incorporate CHWs. Has CMS collected enough data to comment on the results of these demonstrations that involve CHWs? If so, can you elaborate on what the data tells us? Has CMS considered any opportunities for CHWs within the Medicare program, such as the authorization of payment for services for CHWs? If not, is this an area where a specific charge from Congress might be helpful?

Answer. We have a number of Health Care Innovation Award awardees employing Community Health Workers or other types of lay-health workers to improve patient and caregiver engagement, care coordination, and many other crucial aspects of health care delivery. Our evaluation of these awards is looking closely at the various ways these workers have been deployed and the related barriers and facilitators to their use. While we have some preliminary findings related to implementation, we do not yet have data across these awardees to suggest either success or failure in improving patient outcomes. We hope to have these data in the near future, as our evaluators continue to analyze the awardees. We will carefully review these results with the intention of informing future models and CMS policy more generally.

INNOVATION AND PREVENTION

Question. Dr. Conway, your testimony highlights how CMS's Innovation Center is testing new ways to deliver care that will improve quality, reduce spending, and enhance care management and coordination. The Innovation Center seems to represent one of our best opportunities to rethink and test how we deliver health care services.

I am especially interested in how we can do more to promote health and prevention, which means investing in prevention to keep populations healthy and out of the hospital instead of waiting for some members of a population to become patients with one or more chronic diseases.

We already know that a major portion of health outcomes is not driven by care delivery, but by other factors that drive either poor or positive health outcomes.

Dr. Conway—you've spoken publicly about the potential for an Innovation Center funding opportunity to pilot and test a model you've referred to as "Accountable Health Communities." It is my understanding that this would be an investment at the community level to bring public health and the social determinants of health infrastructure together with the health care delivery system. What more can you tell us about this concept? Does CMS have a timeline for this Funding Opportunity Announcement?

Answer. CMS is considering an Accountable Health Communities model, which has not yet been finalized. CMS is happy to update you and the Committee on any related Funding Opportunity Announcements.

PREVENTION AND POPULATION HEALTH

Question. For a lot of the most important delivery system reform work, states are in the driver's seat. A great example of this is the State Innovation Model (SIM) grant program being administered through the Innovation Center.

Ohio is one of 17 states that is currently implementing a comprehensive, statewide health transformation plan through the SIM Initiative. Ohio is using the SIM grant to develop a plan to develop and expand the utilization of patient-centered medical homes (PCMH) to the majority of Ohioans covered under Medicaid, Medicare, and commercial health plans. These PCMHs are designed to integrate physical health with behavioral health and improve care coordination, thereby lowering costs.

Dr. Conway, can you tell us what tools and resources are being provided to states who are interested in promoting both clinical and community prevention as part of their SIM initiatives?

Answer. The purpose of SIM is to accelerate transformation of state delivery and payment systems for the preponderance of a state population. Through SIM, the Innovation Center works with other components of CMS, as well as other Federal partners including CDC and ONC, to help states design and implement clinical and prevention transformation activities in delivery and payment models.

SIM is collaborating with other payers to ensure that basic clinical preventive service delivery is reflected in any delivery and payment reforms implemented in a state.

The Innovation Center has developed a robust learning system that catalogs and disseminates common evidence based interventions across all SIM states. CMS's Center for Medicaid and CHIP Services participates with SIM states through assisting the states to develop State Plan Amendments and waivers that can accelerate the implementation of alternative payment models such as PCMH and ACOs that can help promote prevention and population health. ONC is working with the SIM states to ensure that community health services providers receive and use clinical and claims data to drive improvement.

CMS has also worked with additional Federal partners to assist states to take advantage of Behavior Health and Primary Care integration programs through SAMHSA and Community Health Worker curricula through HRSA.

RISK ADJUSTMENT

Question. MedPAC research shows that the Medicare Advantage HCC risk-adjustment model—which is used for Dual Eligible Special Needs Plans (D–SNPs) and the Medicare-Medicaid Plans (MMPs) in financial alignment demonstrations—

often underpays for high-cost beneficiaries, and does not always accurately pay the cost of full-benefit duals. Some D–SNPs and MMPs—including those in Ohio, exclusively enroll high-cost duals because they are integrating these individual's Medicare and Medicaid benefits as Congress intended. Yet CMS's risk-adjustment model undermines the sustainability of these programs.

Dr. Conway—when will CMS fix the risk-adjustment model, either by adopting MedPAC's recommendations or making other changes so as to not undermine Congress' and the administrations' integrated care programs for duals?

Answer. CMS takes very seriously the concerns raised by commenters that the model may disproportionately affect specific populations, particularly dual eligibles. We are evaluating the impact of the model on these populations (including exploring ideas raised by MedPAC and others such as whether partial duals and full duals should be treated differently).

CMS is evaluating the impact of the Medicare Advantage risk-adjustment model to ascertain whether it underpays plans that serve a large share of dual eligibles. Once the analysis is complete, as appropriate and consistent with the data, we could make changes to the risk-adjustment model. This work could inform risk-adjustment payment policies in 2017.

In addition, in 2014 and 2015, CMS has undertaken a public process to investigate how the share of enrollees in a plan who are dually eligible affects a contract's star quality ratings (and thereby its quality bonus payment and rebate share) under the Medicare Advantage Stars Rating Program. CMS received and reviewed 65 submissions to a Request for Information on this topic. We are committed to continuing to study this issue and would propose, where appropriate, alternate payment adjustments in this fall's request for comment on 2017 star quality ratings.

We will share our analysis with stakeholders and, if appropriate, propose modifications to the model to improve predictive accuracy in a future year's process.

CANCER AS A CHRONIC CONDITION

Question. For many Medicare beneficiaries, cancer is not a one-time disease, but can be a reoccurring condition and even a chronic disease that never entirely goes away. The occurrence of cancer, like many other chronic conditions, becomes more common with age. By doing more to detect, prevent, and treat cancer, we can help control costs and prevent some chronic conditions from occurring.

Colorectal cancer is a great example. Despite being the second leading cause of cancer death in the United States, colorectal cancer is largely preventable. Providers have the tools to both prevent colorectal cancer and detect it during early stages, when treatment is most successful. The most effective preventive action for this disease is a screening colonoscopy, which allows for the early detection and removal of tissue that could become cancerous.

Under current law, seniors covered by Medicare are eligible for colorectal cancer screenings without cost sharing. However, if a physician takes a further preventive action—like removing a polyp—during the screening, the procedure is billed as a "treatment" rather than a "screening," and the cost is passed on to the patient. Because it is impossible to know in advance if a polyp will be removed during a screening colonoscopy, Medicare beneficiaries do not know whether or not their screening will be fully covered until the procedure is over. The financial barrier that coinsurance creates (approximately $100–300 depending on site of service) may lead to Medicare beneficiaries not choosing this highly effective method of colorectal cancer prevention.

Medicare-aged individuals account for two-thirds of colorectal cancer diagnoses. The current co-pay policy seems to be counter to the intent of the law and a poor way of preventing a chronic condition from occurring.

Dr. Conway—do you agree that the current co-pay under Medicare is a disincentive to getting people screened?

Ultimately, it seems that we are actually creating new costs for the program if folks aren't getting screened because of the potential out-of-pocket charge. If we decrease the disincentives for screenings, we can improve health outcomes and save money for both seniors and taxpayers.

Dr. Conway—the Removing Barriers to Colorectal Cancer Screening Act (S. 624) would fix this discrepancy by waiving Medicare's cost-sharing requirement for preventive colonoscopies, even if a polyp or tissue is removed. Do you support elimi-

nating this barrier to care? By increasing access to these screenings, is it possible to help prevent the occurrence of colorectal cancer and the associated costs to the Medicare program?

What other regulatory or legislative fixes would help ensure seniors have access to cancer screening services and high-quality treatment options before their diseases become chronic?

Further, I understand that there is a similar problem with the much cheaper stool-based screening tools. For instance, if a Medicare beneficiary gets a fecal immunochemical test (FIT) and it comes back positive, it is recommended that the beneficiary then go in for a colonoscopy as a continuation of the screening process. However, if the beneficiary goes in for that additional screening, they are charged a co-pay. Faced with the cost, it seems to me that they may skip the follow-up colonoscopy altogether and potentially limit the potential to stop cancer before it starts.

Dr. Conway—what is the logic behind the refusal to cover (without a co-pay) the follow-up colonoscopy to a positive FIT test?

Answer. Medicare covers a broad range of cancer screening procedures to detect cancer early when it's most treatable. We also cover high-quality treatment options and have transparent, evidence-based processes in place to consider coverage of new treatments and technology as they become available. A colonoscopy furnished under the circumstance you described in subpart d. of the question would be considered a diagnostic colonoscopy, not a screening colonoscopy, for which cost-sharing is not waived under current law.

I am aware of the dilemma faced by Medicare beneficiaries who find out, after the fact, that their colonoscopy has been coded as a non-preventive service due to discovery and removal of a polyp, and unexpected cost-sharing may apply. This results from two sections of current law: one (enacted in Section 4104 of the Affordable Care Act) that waives application of the Part B deductible in this circumstance but does not waive coinsurance, and one (titled "Special Rule for Detected Lesions" at Section 1834(d)(3)(D) of the Social Security Act) that requires that a colonoscopy in which a lesion or growth is biopsied or removed must be classified and paid as a "colonoscopy with such biopsy or removal," not as a screening colonoscopy. Amending these provisions would require a legislative change.

We would be glad to provide technical assistance on any legislation the Committee considers on this issue.

QUESTIONS SUBMITTED BY HON. ROBERT P. CASEY, JR.

FACTORS TO CONSIDER IN THE MEDICARE ADVANTAGE STAR RATING PROGRAM

Question. The National Quality Forum (NQF) and other peer reviewed journals, have concluded that the current star rating system for Medicare Advantage should include measures related to social determinants of health, such as socioeconomic status, education or ethnicity because many of the quality performance criteria measured by the star rating program (*i.e.,* medication adherence rates) are directly correlated to member socioeconomic characteristics. So in the ongoing effort to drive high standards and high quality care for all MA beneficiaries, including dual eligible and some of the more vulnerable beneficiaries, how can CMS better measure the impact of clinical risk factors, low-income status and other sociodemographic factors in the star rating program?

Answer. Multiple MA organizations and PDP Sponsors believe that plans with a high percentage of dual-eligible and/or Low-Income Subsidy (LIS) enrollees are disadvantaged in the current Star Ratings Program. Further, NQF has recommended that each performance measure should be assessed individually to determine the appropriateness of adjustments for socioeconomic status. Thus, CMS is examining whether performance on Star Ratings clinical measures is sensitive to the percentage of dual-eligible/LIS enrollees in the plan. Extensive internal and contract-supported research has been commissioned and continues to date.

CMS issued a Request for Information (RFI) that provided the opportunity for the public and plans to submit their analyses and research regarding any relationship between dual-eligible status and lower MA and Part D quality-measure scores. In the RFI, we also solicited examples of any research that demonstrated high-quality

performance in MA or Part D plans can be achieved in plans serving dual-eligible beneficiaries.[2]

CMS's research has found some differences in measure-level performance for dual-eligible/LIS beneficiaries, although for the majority of measures the differences are small. However, evidence of an association between higher dual-eligible/LIS enrollment and lower Star Ratings does not prove causality.

CMS believes additional research into what is driving the differential performance on a subset of measures is necessary before seeking stakeholder comment on any proposed changes to the Star Ratings system. It is the goal of the research to provide the evidence as to whether sponsors that enroll a disproportionate number of Dual/LIS beneficiaries are systematically disadvantaged by the Star Ratings. In addressing any disparities in performance, we need to ensure that any changes to the Star Ratings system do not mask true differences in quality.

The IMPACT Act (Pub. L. 113–185) instructs the Assistant Secretary for Planning and Evaluation (ASPE) to conduct a study that examines the effect of individuals' socioeconomic status on quality measures and resource use and other measures for individuals under the Medicare program. All CMS components are in the process of coordinating their research with ASPE. The Star Ratings team will continue to work collaboratively with ASPE to examine the issue and its impact on the Star Ratings.

Upon completion of additional research, any adjustments for the 2017 Star Ratings would be proposed in the fall Request for Comments.

QUESTION SUBMITTED BY HON. CHUCK GRASSLEY

Question. In his February 2014 letter to then-CMS Administrator Tavenner, MedPAC Chairman Hackbarth noted the challenges that Medicare continues to face in achieving better medication management quality and outcomes. He suggested that ". . . better medication management might be achieved through programs offered by ACO's, medical homes and other team-based delivery models." He further noted that "Providers working within these care models have more incentive to improve their patients' medication regimens" and that . . . "patients, encouraged by their physicians and pharmacists . . . may be more likely to participate in [such] programs and follow the advice they receive." Is CMS actively pursuing policy changes and payment structures that would more effectively support a team-based approach to comprehensive medication management programs throughout the Medicare program?

Answer. We agree that better medication management could potentially improve beneficiary outcomes and lower program costs. When appropriately applied, medication management has the potential to reduce adverse drug events, reduce unnecessary hospital and emergency room utilization, and improve medication adherence. Accordingly, CMS has made it a priority to integrate the proper use of prescription drugs into new payment and service-delivery models in an effort to better coordinate care for beneficiaries. For example, the Million Hearts®: Cardiovascular Disease Risk Reduction Model test is a randomized-controlled trial designed to identify and test models of care delivery that reduce cardiovascular risk. Each participating practice must develop an Individual Risk Modification Plan, which includes medication reconciliation with a review of beneficiary adherence and potential interactions as well as medication compliance and self-management.

QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON

Question. Earlier this year, CMS announced a target of tying 50 percent of Medicare payments to alternative, value-based payment models by 2018. That's an admirable goal, but I think it's worth noting that 30 percent of Medicare beneficiaries are already enrolled in Medicare Advantage plans that receive capitated payments. I'm concerned that CMS policies continue to discourage plans from signing up seniors with multiple chronic conditions who would benefit the most from care coordination. MedPAC has estimated that Medicare's risk-adjustment model already un-

[2] The research conducted and information collected related to dual-eligible/LIS status and Star Ratings measures is publically available at *http://go.cms.gov/partcanddstarratings.*

derpays by 29 percent for the sickest beneficiaries, yet CMS proposes additional cuts to Medicare Advantage risk adjustment.

It's been nearly 3 years since MedPAC discussed the need to improve risk adjustment for Medicare Advantage enrollees with multiple chronic conditions. But instead of increasing incentives for plans to enroll the sickest patients, CMS has been cutting back these incentives. Do you agree that Medicare beneficiaries with multiple chronic conditions have the most to gain from the care coordination services provided by the best Medicare Advantage plans? Why hasn't CMS implemented MedPAC's recommendations?

Answer. We agree that beneficiaries with chronic conditions benefit from care coordination. Published research, as well as our own findings related to the Medicare Advantage plans with the highest star ratings, indicates that care coordination activities are key to reducing hospitalizations and ER use, slowing disease progression, and preventing development of complications and comorbidities.

The CMS Hierarchical Condition Category risk-adjustment model is an additive model, meaning that we add together the factors for each condition a beneficiary has. When we measure model performance, we find that our model predicts well for beneficiaries across risk categories. That is, for the 10 percent of beneficiaries with the highest predicted costs, our model predicts almost exactly. For the sickest group of beneficiaries, *i.e.,* the one percent of beneficiaries with the highest predicted costs, our model predicts 94 percent of their costs.[3]

Question. The chronically ill comprise 15% of Medicare beneficiaries—yet they account for 75% of costs. More than two decades ago, CareMore began to address this disparity with a new model of care based on three key pillars: chronic care management, acute care management, and predictive modeling and early intervention. These plans diagnose conditions early by providing beneficiaries access to disease management and care coordination programs that are demonstrating improvements in quality compared to FFS Medicare with 67% fewer hospitals days and 50% fewer admissions. What strategies should be employed to encourage MA plan programs that focus on prevention and early detection of health conditions?

Answer. All Medicare Advantage (MA) plans have both a Chronic Care Improvement Program (CCIP) and Quality Improvement Project (QIP), as required by regulation. Both CCIPs and QIPs in MA organizations consist of a comprehensive, well-organized, and logical plan that is expected to improve health outcomes and enrollee satisfaction. This often includes disease prevention and early detection. Since 2012, all CCIPs have focused on reducing cardiovascular disease through disease management. Beginning in 2015, all QIPs will focus on population specific chronic conditions and incorporate aspects of care coordination that will facilitate the use of disease management strategies to manage current chronic conditions, promote healthier lifestyles and utilize routine/preventive care to achieve optimal health outcomes.

Additionally, CMS recently adopted a rule permitting rewards and incentives in the final rule published in May 2014. MA programs may now provide enrollees with rewards/incentives in exchange for participating in health related activities. We believe MA plans may use such programs to encourage enrollees to participate in health screenings and other disease management services.

Finally, MA special needs plans (SNPs) are required to complete a comprehensive Health Risk Assessment (HRA) and Model of Care (MOC) for each individual enrollee. The HRA is a key step in evaluating each beneficiary in order to create an appropriate MOC complete with a care coordination team and disease management plan. While completion of HRAs is not a requirement for non-SNP MA plans, all MA plans are strongly encouraged to complete HRAs within 90-days of enrollment.

Question. In January, we saw the implantation of the new payment code for managing Medicare patients with multiple chronic conditions. This is a great step towards complex care management and improving transitions of care. As part of the code's utilization requirement, I am pleased to see the requirement of creating a patient-centered care plan and providing a copy of the plan to the patient. Although the code is just in the beginning stages of implementation, has CMS seen any positive results from providers in improving patients' care while they navigate the health care system?

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[3] For more information, see the model's evaluation report at *http://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Evaluation_Risk_Adj_Model_2011.pdf.*

Answer. Because the payment was implemented as part of the 2015 Physician Fee Schedule, with payments beginning January 1, 2015, we do not yet have any results on the impact from this code. We will evaluate the utilization of this service to evaluate what types of beneficiaries receive the service and what types of practitioners are reporting it, and consider any changes in payment that may be warranted in the coming years.

QUESTIONS SUBMITTED BY HON. TIM SCOTT

Question. Given that we know that beneficiaries with four or more chronic conditions account for more than 70% of all Medicare spending in a given year, I think we are in need of serious solutions that prevent seniors from even getting to that point. Fortunately, Medicare Advantage plans are doing just that by identifying high risk beneficiaries in order to improve their health, instead of manage the decline. More importantly, we know these plans are specifically designed to provide a full spectrum of care, and the outcomes have been great. Unfortunately for seniors on traditional Medicare, their plans are not designed with this same focus on coordination. Dr. Conway, given the successes of Medicare Advantage plans in mind and as we move forward with legislative solutions, what does Congress need to do to ensure that all Medicare beneficiaries have access to benefits that keep them well, as opposed to simply treating people once they get sick?

Answer. CMS agrees that all beneficiaries, regardless of whether they are enrolled in traditional Medicare or Medicare Advantage, should receive high-quality care designed to prevent chronic illness. All Medicare beneficiaries have access to preventive care because the Affordable Care Act eliminated coinsurance and the Part B deductible for recommended preventive services covered by Medicare, including many cancer screenings and other important benefits.[4] By making certain preventive services available with no cost sharing, and by removing barriers to prevention, Americans and health care professionals can better prevent illness, detect problems early when treatment works best, and monitor health conditions. In 2014, nearly 39 million Medicare beneficiaries received at least one free preventive service.[5]

CMS also added a code to the 2015 Physician Fee Schedule to pay separately for non-face-to-face chronic care management (CCM) services. The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. Prior to establishing this code, CMS learned from stakeholders that payments for Evaluation and Management services, which bundle together both face-to-face and non-face-to-face care management activities, did not adequately make payment for non-face-to-face services for complex beneficiaries. CMS adopted the separate payment for beneficiaries with multiple chronic conditions to address payment accuracy for resource costs.

With more emphasis on coordinated care, patients are more likely to get the right tests and medications rather than taking tests twice or getting procedures they do not need. Better care coordination can also mean giving patients more quality time with their doctor; expanding the ways patients are able communicate with the team of clinicians taking care of them; or engaging patients and families more deeply in decision-making. We are supporting care improvement through a variety of channels, including facilitating hospitals and community groups teaming up to share best practices.

Additionally, CMS is committed to improving care for Medicare beneficiaries with chronic disease while increasingly transitioning our payment systems to reward the value of care delivered—not volume. We believe the actions outlined below will create a payment environment that supports improved chronic-care delivery and prevention.

HHS has set a goal of tying 30 percent of traditional, or fee-for-service (FFS), Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements, by the end of 2016, and tying 50 percent of payments to these models by the end of

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[4] For a full list of free preventive services available, see *http://www.cms.gov/Medicare/Prevention/PrevntionGenInfo/index.html.*

[5] *http://downloads.cms.gov/files/Beneificiaries-Utilizing-Free-Preventive-Services-by-State-YTD-2014.pdf.*

2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018, through programs such as Hospital Value Based Purchasing and Hospital Readmissions Reduction.

CMS is already making progress towards these goals, developing and testing different payment models. For example, Medicare Shared Savings Program participants, also known as ACOs, are groups of doctors, hospitals, and other health care providers that work together to give Medicare FFS beneficiaries high quality, coordinated care. ACOs can potentially share in savings they generate for Medicare, if they meet specified quality and financial targets. In December 2014, CMS announced that 89 new ACOs would join the Shared Savings Program on January 1, 2015. With the addition of those new participants CMS now has a total of 404 ACOs participating in the Shared Savings Program, serving more than 7.2 million beneficiaries.

An additional 19 ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Medicare beneficiaries who are in Pioneer ACOs, on average, report more timely care and better communication with their providers, use inpatient hospital services less, have fewer tests and procedures and have more follow-up visits from their providers after hospital discharge.

Question. It has been brought to my attention that there is anomaly in current CMS policy and local Medical Advisory Committees (MACs) coverage decisions regarding patient access to technology and innovation. CMS grants, under specific circumstances subsequent to a rigorous application process, a "New Technology DRG Add-On Payment" (NTAP) for new innovative medical technology that demonstrates a substantial clinical improvement over existing therapy. When CMS makes this determination, the intent is clear that a technology receiving NTAP designation should be made available to Medicare beneficiaries. Despite NTAP designation, a MAC may make a separate non-coverage determination, thereby denying beneficiary access to innovative technology that has undergone an extensive review by CMS, which has already determined substantial clinical improvement over existing therapies based upon the evidence. Can you comment on this incongruity between CMS determinations of NTAP and local MACs establishing contrary coverage decisions?

Answer. Before payment is made, an item must be covered by Medicare. Decisions regarding Medicare coverage are generally made by Medicare contractors that administer the program in their local areas. Independently, CMS makes national decisions on whether a new technology is a "substantial clinical improvement" and meets other criteria for an additional payment beyond our normal fee schedule payment amounts. On a few rare occasions, the local Contractor Medical Director may come to a different conclusion on whether a given technology is reasonable and necessary for the treatment of illness or injury (Medicare's coverage criteria) than physicians in CMS's Central Office regarding whether a technology is a substantial clinical improvement (a Medicare payment criterion for NTAP).

The Medicare Administrative Contractors (MACs) have authority to make reasonable and necessary determinations within their respective jurisdictions. Local coverage determinations (LCDs), like national coverage determinations, are based on a thorough review of published scientific evidence. The NTAP and LCD process are both grounded upon evidence, and carried forth through separate authorities, which infrequently may lead to varying decisions depending upon circumstances such as when the evidence reviews and analyses were conducted.

QUESTIONS SUBMITTED BY HON. DEBBIE STABENOW

Question. Dr. Conway, I recently reintroduced my bipartisan HOPE for Alzheimer's Act, which would provide Medicare reimbursement for a care-planning session for newly diagnosed Alzheimer's patients and their caregivers in order to educate families about the disease, their loved one's needs, community supports, clinical trials, and the like. Nearly 10 percent of Medicare beneficiaries have Alzheimer's disease and 1 in 5 Medicare dollars is going to treat these patients. We're hard pressed to talk about protecting the Medicare program for future generations and addressing Medicare spending without addressing the serious financial toll this disease is taking on the program. We need to find a cure, but we also need to help families right now. Dr. Conway, could the new chronic care management code be used in some way to address this issue? What other things are CMS and CMMI

working on to give Alzheimer's patients and caregivers access to the services and information they need? What role do you see a care-planning session like the one described in the HOPE for Alzheimer's Act could plan in combating Alzheimer's and reducing federal health care spending?

Answer. Care planning and care coordination can play an important role in effectively managing chronic conditions, including Alzheimer's disease. Chronic Care Management (CCM) payments are designed to support care management activities for beneficiaries with two or more chronic conditions. Medicare began making separate payment for non-face-to-face CCM services under the physician fee schedule beginning on January 1, 2015. The CCM service is extensive, including structured recording of patient health information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice. If a beneficiary has two or more chronic conditions, which may often be the case for many Medicare beneficiaries with Alzheimer's disease, the beneficiary would qualify to receive CCM services.

The Innovation Center is testing several projects within its Health Care Innovation Awards initiative on different aspects of dementia-care support. For example, in 2012, the Trustees of Indiana University received an award to test The Aging Brain Care program, a care coordination program for 2,000 Medicare and Medicaid beneficiaries living with dementia and/or depression and their caregivers. In this program, care coordinators conduct extensive person-centered planning and care-coordinator assistants go into the home and check medications, fall risks, changes in cognitive functioning, and medical needs. They ascertain the social networks and resources available to these beneficiaries and offer referrals for senior-center services, day programs, or other available services, such as transportation, counseling services, or home-based supports. Caregivers get supports as well, including peer-support groups and respite services.

The Aging Brain Care program surpassed their goal of enrolling 2,000 beneficiaries and the local health system has agreed to continue to fund the program after the close of the Health Care Innovation Award period and funding. While our findings are not yet final for this and the other dementia-related projects, our preliminary data suggest that person-centered, coordinated care planning is important for persons newly diagnosed and living with Alzheimer's disease, and for their caregivers. Many of the Innovation Center models include care coordination as a central aspect of delivery system and payment reform. The learning around care planning from the Health Care Innovation Awards will be used in the design and execution of current and future models.

Question. Dr. Conway, I am happy that CMS is now reimbursing providers for non-face-to-face chronic care management. We know that the work health care professionals can do behind the scenes—coordination between providers, medication reconciliation, and patient monitoring—reduces costs and improves the health of patients with the most complex, chronic conditions. Far too many seniors were left without access to these services and this new reimbursement is a great step forward. However, I am concerned that the co-pay associated with this new benefit—about $8 per month—could be restricting access. Just last week, a group of family physicians from across Michigan told my staff that many seniors who were initially excited about receiving the services asked to withdraw after receiving the first bill. A senior not being able to afford an $8 co-pay should not be a barrier to an improved care delivery system that can ultimately save Medicare thousands of dollars. Please discuss the utilization rates of this benefit and what role the $8 copay could have on enrollment. Please also discuss why there may be a need for this copay, as well as ways we can work together to reduce or eliminate it.

Answer. The Medicare statute only waives deductible and coinsurance for preventive and screening services. As chronic care management is not a screening or preventive service, the Medicare statute requires that coinsurance be charged.

Question. Dr. Conway, several members on the committee, including myself, are looking into how poverty impacts delivery system reform efforts such as reducing the rate of hospital readmissions. We know that the incidence of chronic illness is higher in low-income populations, which is why I am happy CMS and others are looking at how to account for socioeconomic status in health reform efforts. Unfortunately, hospitals are facing financial penalties today. To ensure that our policies are truly improving hospital outcomes and not merely penalizing hospitals that act as community safety-nets for our most vulnerable constituents, can you discuss what

steps you believe the administration could take right now to offer temporary relief for hospitals in this situation?

Answer. CMS notes there are differing opinions regarding whether measures should be risk adjusted for socioeconomic status. While some stakeholders argue in favor of making socioeconomic status risk adjustments, others believe such adjustments may mask the potential disparities of care provided by hospitals and could potentially result in lower-quality care for vulnerable populations, including Medicare beneficiaries.

CMS applies a risk-adjustment methodology to our outcomes measures to account for comorbidities and other factors, including age, sex, and markers of severity (such as cardio-pulmonary arrest) to ensure hospitals are not penalized for serving populations that are sicker or have higher incidences of chronic disease.[6] In addition, CMS monitors the impact of socioeconomic status on hospitals' results as it continuously refines the measures used in its quality reporting and payment programs.

In order to specifically address the issue of risk adjustment for socioeconomic status, the Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting research on this issue as directed by the IMPACT Act (Pub. L. 113–185), and will issue a report to the Congress by October 2016. CMS will closely examine the recommendations issued by ASPE and consider how they apply to CMS quality programs.

CMS remains committed to working with the Committee and other stakeholders to reform the delivery system while addressing any unintended consequences.

QUESTION SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Medicare beneficiaries with multiple chronic conditions are the largest users of health care services. For example, the 14 percent of beneficiaries with six or more chronic conditions, such as chronic kidney disease, heart failure, and chronic obstructive pulmonary disorder (COPD), accounted for 55% of total Medicare spending on hospitalizations. What models, including coordinated care models, currently exist that could be translated to improve quality and reduce Medicare costs for those with ESRD and/or multiple chronic conditions?

Answer. The Comprehensive ESRD Care (CEC) initiative focuses on Medicare beneficiaries with ESRD. Currently, the ESRD Prospective Payment System bundles the cost of dialysis into a single fee for dialysis care, but does not provide care coordination outside the dialysis center. The new CEC initiative is designed to further align incentives inside and outside the dialysis center through the creation of ESRD Seamless Care Organizations (ESCO). ESCOs are groups of healthcare providers and suppliers who work together to provide Medicare beneficiaries with ESRD with more patient-centered coordinated care across the spectrum of their services, from physician offices to hospitals to dialysis centers.

This type of coordinated care can be found in many models at CMS. Models stressing improved care coordination include the Oncology Care Model, the Comprehensive Primary Care initiative, the Pioneer ACO Model, and the Next Generation ACO Model. Providers in these models have deployed improved care coordination to manage their highest risk patients.

QUESTIONS SUBMITTED BY HON. MARK R. WARNER

Question. As CMS continues to reimburse for care transitions and begins reimbursement for care coordination, how do you plan to ensure that adequate quality measures are developed, and that providers are actually coordinating care in a manner that is beneficial to the patient?

Answer. The scope of service requirements for transitional care management (TCM) and chronic care management services (CCM) is aimed at ensuring a patient's care is coordinated in a manner that is the most beneficial for him or her. For example, the CCM service is extensive, and requires at least 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month. These services include structured recording of patient health

[6] Readmission measure methodology reports available at: *https://www.qualitynet.org/dcs/ContentServer?cid=1219069855841&pagename=QnetPublic%2FPage%2FQnetTier4&c=Page.*

information, an electronic care plan addressing all health issues, access to care management services, managing care transitions, and coordinating and sharing patient information with practitioners and providers outside the practice.

In addition to the payment requirements, CMS is also ensuring adequate development of quality measures. CMS has added a care transition measure to our hospital patient experience of care survey to incorporate patient assessments of their care-coordination services. The three-question Care Transition Measure was adopted in the Hospital Inpatient Quality Reporting Program starting in 2013, and initial measure data were posted on *Hospital Compare* in December 2014. The Hospital VBP Program has proposed to adopt this measure to pay on hospital performance beginning with 2016 discharges.

CMS also encourages providers to coordinate care by measuring outcomes where care coordination is critical to success, such as reducing hospital readmissions. CMS includes hospital readmission measures in both the Hospital Inpatient Quality Reporting Program and the Hospital Readmissions Reduction Program. Through public reporting and payment incentive programs, and other initiatives such as Partnership for Patients, national rates of readmissions for Medicare beneficiaries have been trending down for several years.

This care transition measure provides insight to CMS to further determine progress towards meeting the goals of the CMS Quality Strategy. One of the basic aims of CMS focuses on strengthening person and family engagement as partners in their healthcare in addition to promoting effective communication and coordination of care. CMS has committed to incorporating an emphasis on improving these essential elements as part of the quality improvement activities being implemented in communities across the Nation. This commitment further aligns with efforts to make care safer, more effective, and more affordable for all.

Initiatives have been designed to ensure the transitions across settings are person-centered and maximize an individual's ability to remain in the community. Attention towards the individual and their complex needs support the movement towards creating a high quality healthcare experience. The QIN–QIOs, Hospital Engagement Networks and Community-Based Care Transitions Program, and others, focus their work on understanding the suitability of the community infrastructure through the development of community collaborations. In an effort to ensure care is coordinated effectively and proactively, providers are implementing tools to help patients and caregivers prepare for post-acute care needs, such as Discharge Planning Checklists, upon admission, and in some cases prior to scheduled admissions. Many facilities are tracking the implementation and use of these tools and, when an unsuccessful care transition occurs, examining the contributing factors in order to identify opportunities for improvement. CMS has also engaged patients and families in its learning and actions networks to improve transitions of care. Continuing assessment provides feedback as to the success of these efforts and serves to direct future initiatives and continuous quality improvement.

Question. When does CMS plan to begin reimbursement for the advanced care planning CPT codes? Are the codes sufficient to providing patients and caregivers with the information needed to make informed decisions? What steps is CMS taking to ensure new and innovative advanced care models are properly studied and scaled?

Answer. In the 2015 Physician Fee Schedule Final Rule, CMS indicated that we will consider whether to pay for the new CPT codes for advance care planning after there is an opportunity for public comment. We are considering this issue as we develop the CY 2016 Physician Fee Schedule proposed rule.

Question. How important is it to integrate non-medical services that support activities of daily living into the care regularly provided for patients with chronic conditions? How does CMS plan to bring proven high-touch, care coordination models to beneficiaries in the Medicare Fee-For-Service program? Are there any entities leading the way in this regard?

Answer. The integration of non-medical services that support activities of daily living can have an important role in ensuring quality care for patients with chronic conditions. The Independence at Home Demonstration tests home-based primary care for Medicare fee-for-service (FFS) beneficiaries with multiple chronic illnesses. Participating practices make in-home visits tailored to an individual patient's needs and coordinate their care. Treating people at home may allow practitioners to provide more holistic care by observing how patients actually function in their day-to-

day environment and identifying unmet needs for services that can help their patient remain independent.

PREPARED STATEMENT OF HON. ORRIN G. HATCH,
A U.S. SENATOR FROM UTAH

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R–Utah) today delivered the following opening statement at a committee hearing examining how Congress can address the challenges Medicare patients with chronic conditions face:

Today's hearing signals the Finance Committee's first step in a bipartisan process that will continue over the next 6 months. Ranking Member Wyden, myself, and other members of the committee have expressed strong interest in understanding the impact chronic care coordination programs have on Medicare.

Chronically ill patients account for a large percentage of Medicare spending. In 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, while 14 percent had six or more. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending. In fact, fee-for-service Medicare spent an average of more than $32,000 per beneficiary with six or more chronic conditions compared to an average of around $9,000 for all other patients.

Left unresolved, this situation will only get worse.

Researchers at the Centers for Disease Control and Prevention found an increasing number of adults between 45 and 64 years old—members of the Baby Boom generation—living with multiple chronic conditions, signaling even higher future spending for the Medicare program.

We have to find ways to provide high quality care at greater value and lower cost—all without adding to the deficit.

The good news is that the successful Medicare Advantage program gives beneficiaries the option to receive covered benefits from private plans that are incentivized to manage care across all settings. That explains why 15.7 million beneficiaries—or 30 percent of Medicare participants—chose a Medicare Advantage plan in 2014. I am concerned that ongoing payment cuts and changes to the risk adjustment and quality measurements may be putting these plans at a disadvantage.

Traditional fee-for-service Medicare still fails to properly incentivize providers who engage in labor and time intensive patient care coordination. While disease management and chronic care coordination have been widely used by private sector health insurers, their application in fee-for-service Medicare has been largely restricted to demonstration programs.

Since Obamacare became law, there has been an increased focus on programs like Accountable Care Organizations and medical homes. But for more than a decade, the Centers for Medicare and Medicaid Services, or CMS, has piloted numerous demonstration programs to find out what does and does not work to improve health outcomes for patients with chronic diseases.

These demonstration programs have shown, at best, mixed results.

According to one Congressional Budget Office report, CMS paid 34 programs in six major demonstrations to provide disease management or care coordination services in traditional Medicare. On average, these 34 programs had little to no effect on hospital admissions or Medicare spending.

Now I know that the Obama Administration is actively pursuing new care coordination programs through the Center for Medicare and Medicaid Innovation. My hope is that this research will yield long-term results. By identifying cost-effective, data-driven ways to improve patient health, policymakers can better target scarce federal resources to get more value for the dollars spent.

But developing and implementing new policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a daunting challenge. The lack of success in past demonstration programs underscores the inherent limitations of traditional Medicare's fee-for-service payment system—one that rewards providers for delivering increased volume of services, but doesn't incentivize them to coordinate medical care.

Additionally, programs that try to improve outcomes for patients with chronic conditions struggle to identify successful interventions that motivate individuals to

alter their health habits. Beneficiaries often have physical and cognitive challenges that limit their ability to effectively communicate with multiple providers.

So, I think this committee understands that we have a very difficult task in front of us. There are no easy answers. That is why I am looking forward to hearing from our panel of expert witnesses. I want to thank Dr. Conway and Dr. Miller for appearing before us today. They will help us understand which care coordination efforts are most effective, which policies have failed, and explain why.

But the committee is not stopping there. After this hearing, we plan to take two additional steps to address these important issues.

First, today I want to announce that Ranking Member Wyden and I have appointed Senators Johnny Isakson and Mark Warner to form a full Finance Committee chronic care reform working group. We have tasked this bipartisan group with studying these complex issues and producing an in-depth analysis of potential legislative solutions. These recommendations will serve as a foundation to develop bipartisan chronic care legislation.

Second, in the coming days, Senators Isakson and Warner, along with Ranking Member Wyden and I, will issue a formal invitation requesting all interested public and private sector stakeholders submit their ideas on ways to improve outcomes for Medicare patients with chronic conditions. Stakeholder input is critical for this committee to work toward the goal of producing bipartisan legislation that can be introduced and marked up in the Finance Committee later this year.

So, as you can see, today's hearing is just the first step in our efforts to address these issues. But, it is an important step. I look forward to an informative discussion.

PREPARED STATEMENT OF MARK E. MILLER, PH.D., EXECUTIVE DIRECTOR, MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC)

Chairman Hatch, Ranking Member Wyden, distinguished Committee members, I am Mark Miller, executive director of the Medicare Payment Advisory Commission (MedPAC). The Commission appreciates the opportunity to discuss improving care for Medicare beneficiaries with chronic conditions.

MedPAC is a congressional support agency that provides independent, nonpartisan policy and technical advice to the Congress on issues affecting the Medicare program. The Commission's goal is a Medicare program that ensures beneficiary access to high-quality care, pays health care providers and plans fairly by rewarding efficiency and quality, and spends tax dollars responsibly.

Although traditional fee-for-service (FFS) presents the greatest obstacles to successful chronic care management, the Commission believes that improving care coordination for beneficiaries with chronic conditions will require policy improvements in each of Medicare's three current payment models: FFS, Medicare Advantage (MA), and Accountable Care Organizations (ACOs).

The Commission has been concerned for many years that FFS Medicare does not incentivize or facilitate comprehensive care coordination. The resulting lack of coordination can fail beneficiaries, particularly those with multiple chronic conditions who would benefit most from effective care management. The Commission has identified a number of policies to encourage FFS providers to coordinate care and take greater responsibility for beneficiaries' outcomes rather than focusing on individual services or settings. These policies would reward and facilitate better care for beneficiaries with chronic conditions in FFS.

In the longer run, the Commission maintains that Medicare must move away from a siloed and disjointed FFS approach to care and toward integrated payment and delivery systems that are focused on meeting patients' needs, coordinating care, and ensuring positive outcomes. Payment models that incentivize plans and providers to take responsibility for the full spectrum of a beneficiary's care, such as ACOs and MA plans, may offer better incentives and tools for care coordination and chronic care management. However, there is also room for improvement within these models. The Commission has discussed policies to increase the incentives for ACOs and MA plans to care for the sickest patients and to give these organizations greater tools and flexibility to deliver high-quality, coordinated care.

In the following testimony, I will review the obstacles to chronic care management in FFS, outline the Commission's recommendations for promoting care coordination

in FFS, and discuss improvements to MA and ACO policy that would increase their willingness and ability to care for beneficiaries with chronic conditions.

BACKGROUND

Coordinating care for Medicare beneficiaries with multiple chronic conditions is a substantial task. More than two-thirds of beneficiaries have two or more chronic conditions, and 14 percent of beneficiaries have six or more (Centers for Medicare and Medicaid Services 2012). The most common chronic conditions among Medicare beneficiaries include high blood pressure, high cholesterol, ischemic heart disease, arthritis, and diabetes. Certain chronic conditions are highly comorbid, meaning they are likely to be accompanied by other chronic conditions. For example, about 55 percent of beneficiaries with stroke or heart failure have five or more additional chronic conditions.

Beneficiaries with multiple chronic conditions account for a large share of both Medicare service use and Medicare spending. Beneficiaries with zero or one chronic conditions account for 32 percent of the Medicare FFS population but only 7 percent of Medicare FFS spending, whereas beneficiaries with six or more chronic conditions account for 14 percent of the Medicare FFS population but 46 percent of total Medicare FFS spending (Centers for Medicare and Medicaid Services 2012). The more chronic conditions beneficiaries have, the more likely they are to have high service use and account for high program spending. For example, among the 32 percent of FFS beneficiaries in 2010 with zero or one chronic conditions, only 4 percent had a hospitalization. By contrast, of the 14 percent of FFS beneficiaries with six or more chronic conditions, more than 60 percent had a hospitalization, accounting for 55 percent of total Medicare FFS spending on hospitalizations. Beneficiaries with many chronic conditions are also disproportionate users of post-acute care (PAC) and physician services. Particularly problematic for care coordination, beneficiaries with multiple chronic conditions are more likely to visit many different physicians. Beneficiaries with zero to two chronic conditions visited a median of three physicians in a year, including one primary care provider and two specialists, in contrast with beneficiaries with seven or more chronic conditions, who visited a median of 11 physicians in a year, including three primary care providers and eight specialists (Pham et al. 2007).

Coordinating care is challenging even in a single health event. The challenge increases significantly for beneficiaries who have multiple events in a year, requiring interactions with a wide variety of providers who have little incentive or ability to coordinate their care. Without effective care coordination, beneficiaries may have to repeat medical histories and tests, receive inconsistent medical instructions or information, experience poor transitions between sites of care, and use higher intensity settings when it is not necessary. Beneficiaries with multiple chronic conditions also have high rates of rehospitalization, which can result when hospitals do not coordinate with a patient's physician or post-acute care provider after the original hospitalization. In 2010, the 69 percent of FFS beneficiaries with two or more chronic conditions accounted for 98 percent of all Medicare FFS hospital readmissions (Centers for Medicare and Medicaid Services 2012).

Improving care coordination for beneficiaries with chronic conditions may represent an opportunity to simultaneously raise quality and lower costs. Fewer repeated and unnecessary medical tests, physician instructions that are clear and consistent, care delivery in lower intensity settings, and fewer readmissions can all result in better care that may also cost less for the beneficiary and the Medicare program. However, the incentives in FFS Medicare to increase volume often work at cross-purposes with efforts to coordinate care and improve care delivery.

Reasons for Poor Care Coordination in FFS

Health care under traditional FFS Medicare can be poorly coordinated for several reasons. First, FFS payment generally does not specifically pay for non-face-to-face care activities, which include providers communicating with each other to coordinate a beneficiary's care. Second, there is no financial incentive to avoid duplicative services. Third, no easy way exists to collaborate across providers and settings. And finally, no one entity is accountable for care coordination.

Medicare's FFS system, which generally pays for discrete episodes or services within siloed settings for face-to-face encounters, gives little incentive to providers to spend time coordinating care. Services provided by a physician or other health care professional that do not involve a face-to-face encounter are not billable under Medicare's fee schedule (there are a few exceptions to this general rule). Instead,

care coordination activities are largely subsumed in the fee schedule's evaluation and management codes, which pay for in-person visits.

FFS, which contains financial incentives for providers to increase volume, does not discourage duplicative services. If a physician performs a diagnostic test for a beneficiary, and that beneficiary visits a second physician who replicates the test, both physicians are paid the same rate. Thus, providers have little incentive to avoid duplicating services—for example, by requesting a patient's test results from a different provider rather than simply repeating the test themselves.

Even if a provider sought to request information or collaborate on a plan of care with a beneficiary's other providers, there are limited mechanisms for communication and collaboration across settings and services in FFS. In fact, there is significant evidence that communication across providers and settings is poor. Important instructions are often not received before patients have their first visit with the provider. For example, a community-based physician may treat a patient who has been discharged from the hospital before the physician received the hospital's discharge summary (Callen et al. 2011, Kripalani et al. 2007). One study found that only a quarter of hospital discharge summaries mentioned that there were test results outstanding, even though all patients had results outstanding and their discharge summaries should have included such information (Were et al. 2009).

Similar incompleteness was found in transfers between primary care and specialty physicians and between community-based physicians and hospital-based physicians (McMillan et al. 2013, Pham et al. 2008, Schoen et al. 2005). Even providers with robust information technology systems are often unable to use them to communicate easily with other providers because their systems are not interoperable (Elhauge 2010). Obstacles to communication make it difficult for multiple providers in different practices and settings to work together on developing and managing a coherent plan of care for a beneficiary.

Care coordination in FFS might occur more consistently if there were a single entity responsible for overseeing a patient's care across multiple healthcare providers and settings. However, there is no such entity in FFS. This function is most nearly replicated by the patient's primary care provider. The Commission believes that primary care is an essential part of comprehensive, holistic, and ongoing care for patients, including facilitating the transitions between settings and handoffs between providers during which patients with chronic conditions are particularly vulnerable. Therefore, the Commission is concerned about the current state of support for primary care. Primary care is essential for creating a coordinated health care delivery system, but the Medicare fee schedule undervalues it relative to specialty care. Even though the relative payment for primary care services under the fee schedule has increased over the last decade, compensation for primary care practitioners is still substantially less than that of other specialties. Disparities in compensation could deter medical students from choosing primary care practice, deter current practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided.

POLICIES TO ENCOURAGE CARE COORDINATION IN FFS

While the Commission believes that integrated payment and delivery systems are more promising models for fostering care coordination, FFS is likely to remain a viable Medicare payment model for the foreseeable future. Therefore, it is necessary to take intermediate steps to improve care coordination and provide explicit payments for the related activities that are not currently paid for under the FFS system. Policy options could include adding codes or modifying existing codes in the fee schedule that allow practitioners to bill for care coordination activities, creating a per-beneficiary payment, or using payment policy to reward or penalize outcomes resulting from coordinated or fragmented care.

Adding or Modifying Fee Schedule Codes

One path to bolster Medicare's support of beneficiaries with chronic conditions requiring ongoing and episodic management is to add additional codes to the fee schedule for physicians and other health professionals for a bundle of care coordination services. CMS has taken steps along these lines. In 2013, CMS established and began paying for a Transitional Care Management (TCM) code that covers 30 days of transitional care provided to beneficiaries recently discharged from a hospital or skilled nursing facility (SNF). The TCM payment is designed to cover both an in-person visit with the patient as well as non-face-to-face activities supporting the beneficiary's transition home. In addition, starting in 2015, CMS will pay for a Chronic Care Management code, which is designed to support the ongoing, non-face-

to-face management of patients with chronic conditions. The code does not require an in-person visit with the beneficiary.

Expanding the current fee schedule codes to more fully capture care coordination activities could be designed to be budget-neutral within the fee schedule, and codes could be inserted within the current fee schedule structure through the standard notice and comment process.

However, there are potential disadvantages. Unless new codes are carefully defined, including which beneficiaries are eligible, who can bill, and what services are provided, these proposals may generate more spending without commensurate improvement in the quality of care for beneficiaries with chronic illness. Beneficiaries would also be required to pay standard Part B cost sharing for new codes.

More broadly, it is the Commission's view that only practitioners who provide comprehensive, ongoing care to a beneficiary over a sustained period of time should be eligible to receive care coordination payments. Furthermore, the fee schedule itself, which comprises 7,000 discrete services, cannot be depended on to result in the comprehensive management of a patient's ongoing illness.

Per-Beneficiary Payment for Primary Care

In response to its concern about the current state of primary care, the Commission made a recommendation in 2008 to create a budget-neutral primary care bonus funded from non-primary care services. The Patient Protection and Affordable Care Act of 2010 (PPACA) created a primary care bonus program called the Primary Care Incentive Payment program (PCIP). PCIP provides a 10 percent bonus payment on fee schedule payments for primary care services provided by eligible primary care practitioners. It expires at the end of this year.

The Commission recommends that the additional payments to primary care practitioners continue after the PCIP expires; however, they should be in the form of a per-beneficiary payment as a step away from a per-visit payment approach and toward a beneficiary-centered payment that supports care coordination. The Commission recommends funding the per-beneficiary payment by reducing fees for all services in the fee schedule other than primary care services. (Fees for primary care services would not be reduced, even if those services were provided by a non-primary care practitioner). Beneficiaries would not pay cost sharing, just as beneficiaries do not pay cost sharing to fund the PCIP. This method of funding would be budget-neutral and would help rebalance the fee schedule to achieve greater equity of payments between primary care and other services. At least as an initial starting point, the Commission supports funding the per-beneficiary payment at the same level as the PCIP. At that funding amount, and given an average patient panel size, eligible practitioners would receive about $3,900 in additional Medicare revenue per year.

Readmissions Penalties

Hospital readmissions are a prime example of bad outcomes that can result from poor care coordination. The Commission recommended in 2008 that hospitals be penalized for relatively high risk-adjusted readmission rates. As of October 2012, a readmission policy now penalizes hospitals with high readmission rates for certain conditions, and readmission rates have started to decline.

Expanding readmission policies to PAC settings could help reduce unnecessary rehospitalizations and better align hospital and PAC incentives. If hospitals and PAC providers were similarly at financial risk for rehospitalizations, they would have an incentive to better coordinate care between settings. Aligned readmission policies would hold PAC providers and hospitals jointly responsible for the care they furnish. In addition, the policies would discourage providers from discharging patients prematurely or without adequate patient and family education. Aligned policies would emphasize the need for providers to manage care during transitions between settings, coordinate care, and partner with providers to improve quality.

The Commission has recommended payments be reduced to both SNFs and home health agencies with relatively high risk-adjusted readmission rates (Congress subsequently enacted a SNF readmissions penalty in the Protecting Access to Medicare Act of 2014). The proposed readmissions reduction policies would be based on providers' performance relative to a target rate. Providers with rates above the target would be subject to a reduction in their base payment rate, while providers below would not. Such an approach could encourage a significant number of providers to improve. The proposed policies also seek to establish incentives for all providers to improve, without penalizing providers that serve a significant share of low-income

patients. To do so, providers' performance would be compared with other providers that serve a similar share of low-income patients.

MEDICARE ADVANTAGE AND BENEFICIARIES WITH CHRONIC CONDITIONS

Currently, nearly one third of Medicare beneficiaries are enrolled in private Medicare Advantage (MA) plans that are responsible for providing the full range of Medicare-covered services to their enrollees. For beneficiaries with chronic conditions, the siloed nature of FFS could potentially be remedied in a managed care setting.

MA Payment Reform

The Commission has long supported a private plan option in Medicare. Private plans have greater incentives to innovate and use care-management techniques that fill potential gaps in care delivery. However, until recently, Medicare payments to private plans were set at levels that strongly encouraged plan entry, and the most rapidly growing plan—the private FFS option—did not coordinate care but merely mimicked the FFS system. This option flourished because MA benchmarks, which are the basis of MA plan payments, were set at levels far above FFS expenditures. These high benchmarks resulted in MA program growth, but at a high cost to taxpayers and all Medicare beneficiaries, who faced higher Part B premiums as a result of the program's higher overall Part B expenditures. Observing these trends, the Commission recommended that MA benchmarks be reduced in order to align them more closely with FFS expenditures. The Commission's objective was to create incentives for plans to be less costly than FFS, while quality incentives would incentivize plans to exceed FFS outcomes. Enacted legislation addressed the Commission's concerns with the PFFS option and reduced MA benchmarks, leading to greater efficiency in the MA program.

Plans Are Becoming More Efficient; Both the Medicare Program and Beneficiaries Benefit

The changes in payment policy that have brought MA benchmarks closer to FFS expenditures have increased the financial pressure on MA plans, and they have become more efficient, as we can judge from the trend that we see in MA plan bids. The MA plan bid is a plan's statement of the revenue needed to provide the Medicare Part A and B benefit. In 2015, MA plan bids averaged 94 percent of FFS, a 10-percentage-point decline from 2010, when they averaged 104 percent. Thus, in 2015, MA plans on average are able to provide the Medicare benefit at a cost that is lower than the Medicare FFS program, although there are a significant number of plans that do not bid below FFS.

When MA plans can provide the Medicare benefit at a lower cost than the MA benchmark, a portion of the difference is paid back to plans. Although plan bids for the Medicare benefit average 94 percent of FFS in 2015, actual plan payments average 102 percent of FFS because while plans are bidding below their benchmarks, the benchmarks are still higher than FFS on average. When bids are below benchmarks, MA plans are required to use the additional revenue to provide extra benefits to their Medicare enrollees. The extra benefits can be reduced premiums, lower cost sharing, or the provision of additional benefits that Medicare does not cover. These types of benefits make MA an attractive option for Medicare beneficiaries, and in particular for Medicare beneficiaries who have high health care expenditures because of their chronic conditions. In addition, MA plans are required to have out-of-pocket maximum liability amounts. That is, unlike FFS Medicare, there is a cap on the amount of out-of-pocket expenditures a beneficiary can incur in a given year. Beneficiaries with chronic conditions perhaps derive the greatest benefit from the out-of-pocket cap requirement.

Special Needs Plans Are Available, but all Plans Should Be Able To Manage Chronic Conditions

One feature of the MA program is that plans can choose to specialize in the care of beneficiaries with chronic conditions by offering special needs plans (SNPs). The chronic condition SNPs (C–SNPs) offer tailored benefit packages to an enrolled population consisting exclusively of beneficiaries with specific chronic conditions. As of April 2015, there were 52 MA contracts that included C–SNP offerings, enrolling just over 300,000 beneficiaries (or about 2 percent of total MA enrollment). The most common condition covered by C–SNPs is diabetes: 90 percent of the enrollment in C–SNPs is in plans for beneficiaries with diabetes (often in combination with other conditions). By having a plan that includes only beneficiaries with a specific chronic condition, a C–SNP offers a set of benefits that address the needs of that population. For example, C–SNPs for diabetics offer medical transportation as an extra benefit

to ensure that diabetics have good access to health care professionals who will monitor the management of their disease. This kind of benefit is offered in a C–SNP in lieu of benefits that might appeal to a more general population, such as gym memberships or a foreign travel benefit.

Diabetes is a common condition in the Medicare population: 28 percent of beneficiaries in FFS Medicare have been diagnosed as diabetics. Among MA enrollees, there is a similar proportion with a diagnosis of diabetes. This means that the vast majority of MA beneficiaries with diabetes (and other chronic diseases) are being cared for in general MA plans, not in specialized C–SNPs. It is also noteworthy that all of the current C–SNP plans for diabetics are plans within a larger general MA contract (non-SNP) offered by the same organization in the same service area as the C–SNP.

Because certain chronic conditions are so prevalent among Medicare beneficiaries, the view of the Commission is that all MA plans should be able to offer programs and benefits that can be tailored to the needs of beneficiaries with chronic conditions. MA plans do have a certain amount of flexibility in designing benefit packages, but the current requirement that a plan must offer a uniform benefit package to all its enrollees prevents a non-SNP plan from having a benefit package that is available only to beneficiaries with a specific illness. The Commission has recommended that all plans be allowed to modify their benefit structure to permit variation in the benefits offered, depending on their enrollees' health care needs. In other words, the C–SNP concept of having a benefit package designed for beneficiaries with certain chronic conditions should be folded into the general MA structure, given how many beneficiaries have chronic conditions, and given that an enrollee of a plan may be relatively healthy on first enrolling in a plan but is likely to develop chronic conditions as he or she ages.

Certain Categories of Beneficiaries May Continue To Need SNPs

The Commission's recommendations on C–SNPs are based on the belief that all plans should be equipped to manage Medicare beneficiaries with chronic conditions that are prevalent among Medicare beneficiaries. At the same time, the Commission recognizes that for certain beneficiaries with specific diseases that are less prevalent, the C–SNP option should continue to be available. The Commission has recommended that C–SNPs continue to serve beneficiaries with diseases such as end-stage renal disease (ESRD) and HIV–AIDS. In the case of ESRD, the C–SNP option exists in part because the Medicare law prohibits Medicare beneficiaries with ESRD from enrolling as new enrollees of an MA plan. The Commission has recommended removing this prohibition.

The Commission also made recommendations regarding the two additional types of SNPs. The Commission recommended the continuation of the SNP option for plans specializing in the care of institutionalized beneficiaries (I–SNPs), which perform well on a number of quality measures, particularly hospital readmission rates. Reducing hospital readmissions for beneficiaries in nursing homes suggests that I–SNPs provide a more integrated and coordinated delivery system than beneficiaries could receive in traditional FFS. For plans specializing in Medicare beneficiaries who are dually eligible for Medicare and Medicaid (D–SNPs), the Commission recommended continuing this option only for plans that fully integrate Medicare and Medicaid coverage.

The Risk Adjustment System Can Be Refined To Improve Payment for Chronic Conditions

Appropriate risk adjustment is an important part of paying MA plans fairly and equitably for the care of patients with different clinical needs. The Medicare program makes risk-adjusted payments to MA plans, using health status as one of the bases of risk adjustment. With risk adjustment, payments to plans increase in relation to the expected costs of providing medical care to each enrollee. Plans are paid more for beneficiaries with chronic conditions, and the relative level of payment for each condition is determined on the basis of treatment costs in FFS Medicare. The objective is to ensure that plans are willing to enroll patients with chronic conditions, and that they are paid fairly to manage these patients.

However, the Commission has found that the current risk-adjustment system overpays for beneficiaries who have very low costs and underpays for beneficiaries who have very high costs. This inequity could encourage plans to avoid high-cost beneficiaries, who are more likely to be the chronically ill. The Commission has suggested three refinements to the risk-adjustment system that would likely lead to more accurate payments to MA plans caring for beneficiaries with chronic condi-

tions: using 2 years of diagnosis data to determine a person's risk profile, using the number of conditions a person has as a risk-adjustment factor, and introducing a distinction in the risk-adjustment system between "full" and "partial" Medicare and Medicaid dually eligible beneficiaries. Beneficiaries with full Medicaid coverage ("full duals") have higher expenditures than "partial duals." To the extent that the higher expenditures found among "full duals" is due to the greater prevalence of chronic conditions in this population, the suggested change may have the effect of increasing plan payments for a subset of beneficiaries with chronic conditions.

Quality Bonus Payments Give Plans an Incentive To Improve Care

Another impetus for plans to provide good care to enrollees with chronic conditions is the quality bonus program (QBP). As of 2012, MA plans receive bonus payments based on their ranking in a 5-star rating system. Under the statutory provisions that introduced the bonus program, plans with a star rating of 4 or higher get an increase in their benchmarks. As a result, plans at the bonus level have additional revenue to provide extra benefits to their enrollees.

A plan's star rating is based on its performance on a set of up to 46 measures of quality, patient satisfaction, and contract performance. The quality measures have the greatest weight in determining the star rating. Outcome measures make up about 40 percent of the weighting in the star rating calculation; patient experience measures make up about 19 percent; clinical process measures make up another 20 percent of the weight; and two measures of overall improvement have a weight of 12 percent. Thus, these categories of measures comprise over 90 percent of the weight of the star rating.

The individual quality measures that feed into the star ratings are often measures that track care provided to beneficiaries with chronic conditions. Seven of the 46 measures (with a weight of nearly 20 percent) are specific measures related to the treatment of diabetics. Other measures, such as hospital readmission rates and whether plans improved their enrollees' physical health, would also reflect how a plan performs with respect to the care rendered to enrollees with chronic conditions. It is therefore in the best interest of plans to perform well in providing care to beneficiaries with chronic conditions.

There Are Issues With the Star Rating System

Special needs plans serving Medicare–Medicaid dually eligible beneficiaries have raised concerns with the star rating system, and there is evidence showing an association between poorer star ratings and a higher proportion of dually eligible, or low-income, enrollees. CMS acknowledges this situation and has found that for certain quality measures in the star rating system there may be a bias affecting such plans. CMS has been considering ways to identify and address any bias in the star rating system. The Commission's work has found that a factor that also needs to be examined is the proportion of enrollees in a plan who are under the age of 65—beneficiaries entitled to Medicare on the basis of disability or end-stage renal disease. The Commission's March 2015 report showed that plans with a high proportion of under-65 enrollees tend to have far lower overall star ratings and lower ratings on certain measures that are components of the star rating system.

ACCOUNTABLE CARE ORGANIZATIONS (ACOS) AND CHRONIC CARE

In 2012, Medicare introduced a new payment model, the ACO, which pays for care on a FFS basis but includes incentives for providers to reduce unnecessary care while improving quality. The ability of ACOs to manage patients with multiple chronic conditions will be crucial to their success. Under the ACO model, a group of providers is accountable for the spending and quality of care for a group of beneficiaries attributed to them. The goal of the ACO program is to give groups of FFS providers incentives to reduce Medicare spending and improve quality, similar to the incentives for MA plans. Because beneficiaries with multiple chronic conditions have historically accounted for a large share of Medicare spending and ACOs' spending targets are based on historical spending for their beneficiaries, controlling the growth in spending for those beneficiaries will be essential for ACOs to meet their spending targets. There is much less opportunity to achieve savings for relatively healthy beneficiaries with low historic spending.

As the ACO programs have unfolded, the Commission has spoken to representatives from many ACOs and conducted structured interviews and case studies with Pioneer ACOs. Based on these discussions, as well as the Commission's own analysis of data on ACO performance, the Commission has commented on three issues for ACOs that are particularly important in regard to beneficiaries with multiple

chronic conditions: fully prospective attribution and financial targets, regulatory relief for ACOs at two-sided risk,[1] and reduced beneficiary copays to increase beneficiary identification with the ACO.

The first issue is fully prospective attribution of beneficiaries and setting of financial targets. Under current policy, ACOs are an attribution model, not an enrollment model. Beneficiaries do not choose to be in an ACO; instead they are attributed to the ACO based on their claims history. However, under current policy most ACOs do not know with certainty in advance which beneficiaries they will be accountable for. Although there is preliminary attribution at the beginning of the year, final attribution and financial calculations are retrospective. According to data from ACOs, both the beneficiaries who are included in an ACO's population and its financial targets have often changed significantly over the course of a year.

Moving from retrospective to prospective attribution is important for the program because it will enable ACOs to know which beneficiaries they are accountable for at the beginning of the year. With this certainty, ACOs can focus their care coordination efforts on those beneficiaries with the knowledge that they will share in the returns from those efforts; this should increase their willingness to make the investment to improve care coordination. This is particularly important for beneficiaries with multiple chronic conditions who have the most to benefit from care coordination.

Second, if its beneficiaries are known with certainty and the ACO is in a two-sided risk model, CMS could grant regulatory relief to those ACOs to pursue more innovative care management. For example, an ACO could allow beneficiaries to be discharged to SNFs without meeting the current 3-day inpatient stay requirement or allow ACOs to waive certain cost sharing. Other waivers could include allowing billing and payment for broader telehealth services and eliminating the homebound requirement for the home health benefit. Fully prospective assignment is necessary because CMS must know in advance to which beneficiaries the relief applies in order to process claims appropriately. The ACO must be at two-sided risk because the regulations that are being waived were intended to prevent unnecessary use of health care services, and only ACOs at two-sided risk have enough of an incentive to offset the FFS tendency to increase use of services. It follows, therefore, that for the waiver to apply, the beneficiary must be prospectively attributed and the provider involved (*e.g.,* the physician ordering direct admission to an SNF) must be a participant in an ACO at two-sided risk.

A related issue is allowing ACOs to waive some or all cost sharing for visits with ACO practitioners. A challenge for ACOs is that because beneficiaries are not enrolled, ACOs cannot require beneficiaries to seek care from ACO providers. Beneficiaries can go outside of the ACO for care, and the ACO is still responsible for any Medicare spending they incur. Reduced cost sharing is one way of increasing beneficiary identification with the ACO. We have considered in particular eliminating or reducing cost sharing for ACO beneficiaries' visits to primary care providers who are in the ACO. This would give the beneficiaries a reason to want to be attributed to the ACO and encourage beneficiaries to stay within the ACO network of providers—allowing more effective care management. The cost sharing reduction would be absorbed by the ACO and would not change Medicare program payments. This waiver would be limited to ACOs at two-sided risk for the same reasons as above. The greater patient engagement with ACO providers could contribute to improved care management and make attribution more meaningful.

Although ACOs have the potential to improve care for beneficiaries with multiple chronic conditions, that potential will not be realized unless Medicare policies support real change. The goal should be to create conditions that will reward efficient ACOs that can create real value for the Medicare program, its beneficiaries, and the taxpayers—not to maximize the number of ACOs or to ensure that every provider can join an ACO. In particular, we do not endorse the approach of weakening ACO performance standards and accountability simply to create more ACOs.

A strategy to encourage movement from traditional FFS to ACOs that is more consistent with the goals we discuss here would reward ACO providers both with shared savings from reduced utilization and with quality bonus payments when their quality of care exceeds traditional FFS in the relevant market. The first meth-

[1] Two-sided risk means that an ACO is liable for losses in relation to its financial target as well as being able to share in savings. Many ACOs are now in one-sided models under which they can share savings but are not at risk for losses. Incentives are much stronger in a two-sided model.

od of reward is already incorporated in the ACO model. The second method, not currently in the ACO model, is to reward providers organized into ACOs that can achieve *population* health outcomes that are better than those produced by traditional FFS in their market. This is being done in some manner in the MA program now; a redesigned approach could apply to both MA plans and ACOs. To be clear, providers who are not in an entity such as an ACO or MA plan that can take responsibility for a population of Medicare beneficiaries would not be eligible to receive such a bonus. The availability of a population quality bonus could make the ACO program more attractive to providers relative to traditional FFS without weakening performance standards or accountability. Beneficiaries may also migrate to ACO providers because of lower cost sharing and higher quality, both features that would be of particular interest to beneficiaries with multiple chronic conditions. This movement of beneficiaries might also further encourage providers to join an ACO

CONCLUSION

Improving care for beneficiaries with chronic conditions will require policies to improve provider incentives and care coordination tools across the three current Medicare payment models. In FFS in particular, the incentives to coordinate care and achieve high-quality outcomes are lacking. Policies to add or modify fee schedule codes for non-face-to-face care activities, establish a per-beneficiary payment for primary care practitioners, and expand readmissions policies to the post-acute care sector all hold promise for addressing some of the shortcomings of the FFS model. However, the Commission believes that in the longer run, Medicare must move away from FFS and toward models that require plans and providers to take financial responsibility for achieving high-quality outcomes while coordinating a beneficiary's full spectrum of care. MA plans and ACOs both have potential in this regard, although the Commission believes that both could benefit from policies to improve their willingness and ability to care for the sickest beneficiaries. The Commission looks forward to working with the Committee to achieve the goal of better care at lower cost for Medicare beneficiaries with chronic conditions.

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QUESTIONS SUBMITTED FOR THE RECORD TO MARK E. MILLER

QUESTIONS SUBMITTED BY HON. ORRIN G. HATCH

Question. Dr. Miller, you recommend the creation of a budget-neutral per-beneficiary payment for primary care physicians. You estimate this payment would result in $3,900 a year in new revenue for eligible practitioners. This is an interesting idea, but I am hoping you can give us some context to understand your policy intent. Can you quantify, in percentage terms, how much of a decrease in Medicare physician specialty spending this would be, and how much of an increase in spending for primary care physicians? I think this is important because if a primary care doctor, for example, made $10,000 per year, then a $3,900 payment increase would be a big help. But if the same doctor made $200,000 per year, then perhaps a $3,900 payment increase may not incentivize him to increase care coordination services?

Answer. The Commission supports funding the per-beneficiary payment at the same level as the current Primary Care Incentive Payment (PCIP), with eligible primary care practitioners and primary care services defined as they are in the PCIP. In order to fund a budget-neutral per-beneficiary payment, the Commission would reduce fees for services that are not defined as primary care services under the current PCIP program. A per-beneficiary payment funded at the same level as the PCIP would require fee reductions of 1.4 percent for non-PCIP services.

For providers receiving the per-beneficiary payment, the increase on average would equal the PCIP's increase in program payments for primary care services, which in percentage terms is 10 percent.

The Commission's goal in recommending a per-beneficiary payment for primary care is to help rebalance the fee schedule in favor of primary care, and send a signal that primary care is valued by the Medicare program. The Commission acknowledges that a per-beneficiary payment in itself will not guarantee an increase in care coordination activities. Nonetheless, the Commission believes a per-beneficiary payment for primary care is needed until new and better payment and delivery system reforms are established.

Question. Dr. Miller, you have seen the January 2012 CBO report showing, at best, mixed results in previous CMS chronic care demonstration program designs. Why do you think the previous demonstrations did not work as well as hoped, and what future policy changes do you think Congress or CMS could initiate that might produce better results to improve outcomes and lower costs?

Answer. The reasons that previous demonstrations have failed to produce significantly improved outcomes or lower costs are not clear. That said, at least with respect to ACOs, the Commission believes that three principles should be used to guide the development of new models going forward. First, providers should be at two-sided risk, meaning they have the potential to share in both savings and losses. Two-sided risk creates a much stronger incentive for providers to reduce spending than one-sided risk. Second, providers should know which beneficiaries they are responsible for and what their spending targets are at the beginning of the year. With this certainty, providers can focus their care coordination efforts on beneficiaries with the knowledge that they will share in the returns from those efforts; this should increase their willingness to make the investment to improve care coordination. Third, if providers are in a two-sided risk model and know their attributed beneficiaries with certainty, CMS could grant them regulatory relief to pursue more innovative care management. For example, providers could be allowed to waive the current 3-day inpatient stay eligibility requirement for skilled nursing care or waive certain beneficiary cost sharing. Providers must be at two-sided risk because the regulations that are being waived were intended to prevent unnecessary use of health care services, and only those at two-sided risk have enough of an incentive to offset the FFS tendency to increase use of services.

Question. Dr. Miller, how concerned are you about potential fraud and abuse of the new chronic care management code in the Medicare physician fee schedule?

Answer. It is important to monitor billing patterns for new codes. Any time a new code is added to the fee schedule there is a risk of spending increases. However, the chronic care management code does have some restraints on volume—only one physician may bill the code per beneficiary, and the code can only billed once a month.

Question. Dr. Miller, how would site of service payment neutrality impact how providers deliver care to Medicare patients with chronic conditions?

Answer. When payment rates for treating similar patients differ across settings, there is a financial incentive to provide care in the setting with the higher payment rate. A resulting shift in services from a lower cost setting to a higher cost setting can raise costs for the beneficiary and the Medicare program. For example, hospitals have been purchasing physician offices and converting them into hospital outpatient departments. Services that were previously billed under the physician fee schedule are then billed under the hospital outpatient payment system, which typically has higher payment rates, even though care has not changed significantly. Beneficiaries, who pay coinsurance equal to a percentage of Medicare's payment rates, will also experience higher cost sharing. For beneficiaries with multiple chronic conditions, who use health care services at higher rates than beneficiaries without chronic conditions, these cost sharing differences can add up, particularly in FFS, which does not have a catastrophic cap. The goal of the Commission's site-neutral payment recommendations is to ensure that beneficiaries have access to high quality care in an appropriate setting, at the lowest possible cost to the beneficiary and the taxpayer.

QUESTIONS SUBMITTED BY HON. RON WYDEN

ALTERNATIVE PAYMENT MODELS IN AREAS WITH HIGH PREVALENCE OF CHRONIC DISEASE AND LITTLE CARE COORDINATION

Question. Many areas of the country have a high prevalence of chronic disease with corresponding high health care costs. The current fee-or-service system lacks care coordination which is a necessity for those living with chronic illness. Increased care coordination can cut down on duplicative costs, which Medicare has no way of avoiding in the fee-for-service system. Addressing these areas with different payment incentives may be helpful.

Are there areas with a high prevalence of chronic disease that also have little enrollment in Medicare Advantage or alternative payment models?

Why haven't these areas of the country moved towards alternative payment models?

What can Congress do to encourage alternative payment models in these areas? Are there unique circumstances in these areas that require a different type of model?

Answer. There are areas of the country with high chronic disease burdens and limited enrollment in MA or alternative payment models (though there are also areas with high rates of chronic conditions that have high MA enrollment and/or ACO participation). Such areas may exist for numerous reasons. They may not have a strong culture of managed care or care coordination, or they may lack entities with the capacity or expertise to engage in care management. They may also be areas where traditional FFS spending is low, making it difficult for a new model to find further efficiencies in care delivery. In its June 2014 report, the Commission observed that no one payment model (FFS, ACO, or MA) delivers the highest value in every market nationwide. Rather than attempting to promote one payment model across markets, the Commission discussed creating a payment system that allows the highest quality, lowest cost model in each market to flourish. Creating such a system requires developing consistent payment rules, quality metrics, and risk-adjustment methods to create a level playing field for all payment models. The Commission's discussion about how to synchronize policies across payment models is ongoing.

TARGETING THE CHRONICALLY ILL

Question. Chronic diseases are the most costly conditions to treat in the health-care system, accounting for almost all of Medicare spending—93%. In the 2014 physician fee schedule, CMS added a new code for non-face-to-face chronic care management (CCM) services. The beneficiary, however, must have at least 2 chronic conditions to be eligible to receive the CCM services. While the implementation of this code is a start, more than two-thirds of Medicare beneficiaries are living with multiple chronic conditions; those with more than the average of 2 conditions require more treatment and care coordination and how that is targeted must be addressed.

As the committee begins the undertaking of chronic care reform, what is the best way to identify and target Medicare beneficiaries who need help the most?

How do we identify beneficiaries in which we know better care coordination will decrease spending and improve the quality of care they receive?

Do we define the number of conditions like the chronic care management codes do? If so, what is the right number of conditions?

Should we focus on specific diseases? If so which ones?

Answer. Rather than requiring the Medicare program to define populations who would benefit from care management efforts, the Commission supports designing payment systems that give providers incentives and flexibility to identify such patients and tailor care coordination efforts to their needs. Under payment models that require providers to take risk and incorporate accurate quality measurement and risk-adjustment methods, providers have a strong incentive to manage care for high cost patients. For example, in order to share in savings, ACOs must keep annual spending for their attributed populations below a fixed financial benchmark. In response to this incentive, many ACOs have focused care management efforts on individuals with high Medicare spending, many of whom have multiple chronic conditions.

Given its siloed nature, traditional FFS will likely always entail some degree of coordination failure. However, implementing coordination measures (*e.g.,* readmissions measures) that hold providers accountable for the outcomes of poor coordination could incentivize providers to focus care coordination efforts on high-risk beneficiaries as well.

UNDERSTANDING THE ROLES OF ACCOUNTABLE CARE ORGANIZATIONS (ACOS) AND OTHER ALTERNATIVE PAYMENT MODELS IN CHRONIC CARE

Question. The Affordable Care Act (ACA) created the Medicare Shared Savings Program (MSSP), a voluntary program in which the participants are ACOs—groups of doctors, hospitals or other providers that work together to provide high-quality, coordinated care. ACOs can potentially share in the savings they generate for Medicare if they also meet quality standards.

Is there more that Medicare can do to incentivize ACOs to focus on chronically ill individuals?

Should there be ACOs that are specifically focused on the chronically ill?

What other payment models could help further care coordination for these fragile patients?

Answer. Many ACOs are already concentrating their efforts on individuals with high Medicare spending; frequently those individuals have multiple chronic conditions. In comment letters to CMS in June 2014 and February 2015, the Commission provided guidance on how ACOs' effectiveness could be increased by increasing the power of their incentives and care management tools. First, ACOs should be at two-sided risk, meaning they have the potential to share in both savings and losses. Two-sided risk creates a much stronger incentive for providers to reduce spending than one-sided risk. Second, ACOs should know which beneficiaries they are responsible for and what their spending targets are at the beginning of the year (*i.e.,* prospective attribution and prospective benchmarks). With this certainty, providers can focus their care coordination efforts on beneficiaries with the knowledge that they will share in the returns from those efforts; this should increase their willingness to make the investment to improve care coordination. Third, if providers are in a two-sided risk model and know their attributed beneficiaries with certainty, in some instances CMS could grant them regulatory relief to pursue more innovative care management. For example, providers could be allowed to waive the current 3-day inpatient stay eligibility requirement for skilled nursing care or waive certain beneficiary cost sharing. Finally, beneficiaries should be able to be directly attributed to ACOs if they receive care from non-physician providers, including nurse practitioners and physician assistants. This change would require Congressional action.

FLEXIBILITY FOR MEDICARE ADVANTAGE PLANS

Question. Under current law, a Medicare Advantage plan must offer one set benefit package and be available to any eligible beneficiary in the plan's service area. Chronic Disease Special Needs Plans (C–SNPs) are a subset of MA plans that have special authority provided by Congress to target only beneficiaries with chronic diseases. MedPAC has recommended that Congress limit the types of chronic disease C–SNPs can target to only the most serious (HIV, ESRD, serious mental health) but allow general MA plans to vary their benefit packages to tailor to specific beneficiaries with specific chronic conditions. Some argue this will allow for better care coordination while others will argue that this will allow some MA plans a better ability to avoid costly, complicated patients to limit the plan's overall risk.

What types of flexibility did the Commission have in mind and how would that translate into better coordinated care?

Answer. Under the C–SNP option, plans have the flexibility to design a benefit package targeted to beneficiaries with a specific chronic condition, such as diabetes. Plans can provide a set of benefits and a cost-sharing structure that differs from what is offered to enrollees of a general MA plan. The Commission recommended granting general MA plans this flexibility in its March 2013 report.

In a general MA plan, plans are not allowed to offer certain benefits to only some enrollees. For example, plans are not currently allowed to provide a non-emergency transportation benefit only to beneficiaries with diabetes—to encourage physician visits to monitor the patient's condition—or reduced cost sharing on hypertension medication only for diabetics, to encourage the appropriate treatment regimen for diabetes. While each of these benefits promotes coordinated care for a subpopulation in which the benefits can be very important, current rules would require that a non-emergency transportation benefit be provided to any patient, and reduced cost sharing would have to be provided to anyone taking hypertension medication—not just diabetics. It can be argued that such benefits promote coordinated care for any patient; however, patients with chronic conditions such as diabetes must have more frequent medical visits and generally take multiple medications. Thus, they face higher total out-of-pocket costs than the general MA population (or enrollees whose only condition is hypertension), and these condition-specific higher out-of-pocket costs can lead to a beneficiary's skimping on medication or avoiding necessary medical visits. Better coordinated care is achieved with a more tailored or targeted benefit package.

Question. Is the Commission worried about potential bad actors who would use this new flexibility to establish a benefit package aimed at avoiding sick and costly beneficiaries? What protections could be put in place to prevent this type of gaming?

Answer. The Commission does have some concern that this flexibility could be abused. However, there is a process in place for CMS to monitor MA bids for potential gaming and abuse. A key provision of the statute governing the review of MA bids and proposed benefit packages is the anti-discrimination provision of section 1852(b)(1)(A) of the Social Security Act. This is the authority for the Centers for Medicare and Medicaid Services to review and approve benefit packages as outlined in the agency's yearly call letters. For example, when plans propose value-based insurance design packages that are currently permissible—such as differential cost sharing to encourage the use of specific providers in a network—CMS will review such proposals to ensure that they are not discriminatory. A C–SNP-like option for general MA plans, if it were to be authorized, should be subject to a similar approval process.

INTEGRATING DRUG SPENDING INTO DELIVERY SYSTEM REFORM

Question. Currently, CMS is implementing a number of alternative payment models such as ACOs and bundled payments that are attempting to coordinate care for a beneficiary in traditional fee-for-service Medicare. While these efforts are focusing on the medical side of the patient's care, like hospital, physician and nursing home services, drug spending is not involved. Under Medicare Advantage, some plans have integrated the Medicare drug benefit into the general MA benefit. This allows for one organization to coordinate all health under "one roof."

Can we do more to integrate the proper use of prescription drugs into efforts to better coordinate care for those beneficiaries with chronic diseases who are enrolled into traditional Medicare?

Can CMS integrate more of Part D into these new payment models similar to how Medicare Advantage has done?

Answer. Given its siloed nature, traditional FFS will likely always entail some degree of coordination failure. Implementing measures of care coordination, such as readmissions measures, into FFS could encourage some improvement in care coordination. However, to achieve true coordination and care management, Medicare will need to move to population-based models such as MA and ACOs where an entity has responsibility for a beneficiary's full spectrum of care. MA plans that incorporate the Part D benefit could serve as a model for incorporating a prescription drug benefit into new payment models.

QUESTIONS SUBMITTED BY HON. SHERROD BROWN

COMMUNITY HEALTH WORKERS

Question. Poor care coordination can lead to worse health outcomes, increased hospital admissions, and higher cost. Community Health Workers (CHWs) play an integral role in public health, prevention, cost containment, and care coordination.

In Ohio, we have seen how CHWs help patients—including high-cost patients—understand and navigate our nation's complex health care system, teach healthy behaviors that can prevent disease before it starts, and help patients manage chronic disease by coordinating their care among many providers and reminding them to take their medicine, do their exercises, and stay on track with their other self-treatment tasks.

The Affordable Care Act (ACA) has helped expand opportunities for CHWs to contribute to increased value and care coordination, however the health reform law offered no direct new funding for the employment of CHWs within the dominant fee-for-service (FFS) delivery system.

Dr. Miller—to follow up on the question I asked during the hearing, can you both talk about the role of CHWs in care coordination and the value of integrating CHWs with other health care professionals into care teams?

Dr. Miller—would MedPAC be willing to look into the role of CHWs as it relates to Medicare care coordination? Has the Commission done any relatable research on carecoordinators that could be helpful in determining the potential success of CHWs on care teams?

Answer. In its June 2012 report, the Commission examined team-based primary care models, in which a care coordinator works with a team of medical and social service providers involved in the beneficiary's care. In some of the models, the structure of the team is explicitly prescribed. In others, the team is more fluid and centers on a care manager who coordinates with medical professionals, social service providers, patient coaches, nutritionists, pharmacists, home care workers, and other parties as needed. These team-based models can include elements such as palliative care and social service supports. One example of a team-based model is the patient-centered medical home. To date, the outcomes from medical home demonstrations have been mixed. Some studies have shown reductions in hospitalizations. Others have shown very little change in utilization and spending. And the evidence on medical homes is markedly more positive in integrated delivery systems than it is in traditional FFS.

Rather than developing models that explicitly define appropriate care providers, the Commission supports implementing payment systems that give providers the incentives and flexibility to experiment with new care delivery models. Providers could use this flexibility to develop team-based care models that incorporate community health workers if they find that CHWs improve patient care. For example, the Commission has provided extensive guidance on improving ACOs and increasing flexibility for MA plans (see June 2014 and February 2015 ACO comment letters, March 2013 MA recommendations).

PREVENTION AND POPULATION HEALTH

Question. For a lot of the most important delivery system reform work, states are in the driver's seat. A great example of this is the State Innovation Model (SIM) grant program being administered through the Innovation Center.

Ohio is one of 17 states that is currently implementing a comprehensive, statewide health transformation plan through the SIM Initiative. Ohio is using the SIM grant to develop a plan to develop and expand the utilization of patient-centered medical homes (PCMH) to the majority of Ohioans covered under Medicaid, Medicare, and commercial health plans. These PCMHs are designed to integrate physical health with behavioral health and improve care coordination, thereby lowering costs.

Dr. Miller—has MedPAC given any deliberation or made any recommendations on what can be done within the Medicare program to invest more in population health?

Answer. The Commission has discussed using population-based quality measures and moving to payment models that provide the incentives and flexibility for providers to focus on population health initiatives. In its June 2014 report, the Commission expressed concern that Medicare's current quality measurement programs are becoming overbuilt, burdensome to providers, and too focused on process meas-

ures, which are not well correlated with patient outcomes. The report discussed an alternative quality measurement system based on a small set of population-based outcome measures (*e.g.,* rates of potentially preventable emergency department visits in a given area). Measuring quality at the population level could incentivize providers to develop innovative population health management strategies, without being overly prescriptive about specific activities that providers are required to perform. In contrast, current process-oriented measures may encourage "teaching to the test," with providers focusing their quality improvement efforts solely on activities that are measured, but which may not lead to better outcomes (*e.g.,* measuring rates of flu vaccinations among healthcare providers). A population-based approach could also be useful for comparing quality across FFS, ACOs, and MA, and for making payment adjustments within the MA and ACO models. The Commission notes that a population-based outcomes approach may not be appropriate for adjusting FFS Medicare payments in an area because FFS providers have not explicitly agreed to be responsible for a population of beneficiaries.

The ACO model, and any similar payment model that requires providers to take responsibility for the full spectrum of a beneficiary's care, contain strong incentives to focus on population health. The Commission has made several suggestions for enhancing ACOs' effectiveness, including increasing the power of ACOs' incentives (*e.g.,* higher share of savings, two-sided risk models, not reducing benchmarks for already efficient ACOs) and regulatory relief to increase beneficiary engagement (*e.g.,* waiving copays for primary care visits with ACO providers) for ACOs in two-sided risk arrangements.

PRIMARY CARE AND CARE COORDINATION

Question. Dr. Miller, in your testimony you say that "primary care is an essential part of comprehensive, holistic, and ongoing care for patients" and that "primary care is essential for creating a coordinated health delivery system, but the Medicare fee schedule undervalues it relative to specialty care."

We know that primary care is essential for creating a coordinated health care delivery system. I share the Commission's concern that disparities in compensation could deter future generations of health care professionals from choosing primary care as their area of practice.

The ACA included a primary care bonus program for Medicare providers, which expires at the end of this year. It also included a primary care parity provision for Medicaid providers, which expired at the end of last year.

Dr. Miller—can you talk a little bit about how these programs helped increase access to care and improve care coordination among the Medicaid and Medicare populations?

Answer. There is currently little data to show whether the Primary Care Incentive Payment program increased access or improved care coordination for the Medicare population. Moreover, because it is a temporary program, any impact it could have had on the physician pipeline would be dampened. The Commission's rationale for recommending a per-beneficiary payment for primary care was not necessarily to increase care coordination, which may not be realistic at the current Medicare bonus funding levels. Rather, the Commission's goal is to correct the undervaluation of primary care services in the physician fee schedule. A per-beneficiary payment could also be a first step in moving Medicare's payment for primary care from a service-oriented fee-for-service payment approach and toward a beneficiary-centered payment approach.

Question. What are your suggestions for ensuring the future of primary care as Congress works to develop and implement policies to streamline care coordination, improve quality, and reduce costs?

Answer. First, the Primary Care Incentive Payment program expires this year. The Commission recommends that the Congress work quickly to replace it with a per-beneficiary payment.

Second, the Medicare fee schedule for physicians and other health professionals undervalues primary care relative to procedurally based care. To rebalance the fee schedule, the Commission has proposed identifying overpriced services and pricing them appropriately.

Third, our nation's system of graduate medical education (GME) is not aligned with the delivery system reforms essential for increasing the value of health care in the United States. To address this inadequacy, the Commission has proposed re-

forming Medicare's funding of GME to support education and training in skills needed for improving the value of our health care delivery system—including evidence-based medicine, team-based care, care coordination, and shared decision-making.

RISK ADJUSTMENT

Question. MedPAC research shows that the Medicare Advantage HCC risk-adjustment model—which is used for Dual Eligible Special Needs Plans (D–SNPs) and the Medicare-Medicaid Plans (MMPs) in financial alignment demonstrations—often underpays for high-cost beneficiaries, and does not always accurately pay the cost of full-benefit duals. Some D–SNPs and MMPs—including those in Ohio, exclusively enroll high-cost duals because they are integrating these individual's Medicare and Medicaid benefits as Congress intended. Yet CMS's risk-adjustment model undermines the sustainability of these programs. Dr. Miller—what are the solutions MedPAC has identified to improve the risk-adjustment model for duals and other high-cost beneficiaries?

Answer. The Commission has found that the current risk-adjustment system overpays for beneficiaries who have very low costs and underpays for beneficiaries who have very high costs. This inequity could encourage plans to avoid high-cost beneficiaries, who are more likely to be the chronically ill. The Commission has suggested three refinements to the risk-adjustment system that would likely lead to more accurate payments to MA plans caring for beneficiaries with chronic conditions: using 2 years of diagnosis data to determine a person's risk profile, using the number of conditions a person has as a risk-adjustment factor, and introducing a distinction in the risk-adjustment system between "full" and "partial" Medicare and Medicaid dually eligible beneficiaries (June 2012 report, March 2015 report). Beneficiaries with full Medicaid coverage ("full duals") have higher expenditures than "partial duals." To the extent that the higher expenditures found among "full duals" is due to the greater prevalence of chronic conditions in this population, the suggested change may have the effect of increasing plan payments for a subset of beneficiaries with chronic conditions.

CANCER AS A CHRONIC CONDITION

Question. For many Medicare beneficiaries, cancer is not a one-time disease, but can be a reoccurring condition and even a chronic disease that never entirely goes away. The occurrence of cancer, like many other chronic conditions, becomes more common with age. By doing more to detect, prevent, and treat cancer, we can help control costs and prevent some chronic conditions from occurring.

Colorectal cancer is a great example. Despite being the second leading cause of cancer death in the United States, colorectal cancer is largely preventable. Providers have the tools to both prevent colorectal cancer and detect it during early stages, when treatment is most successful. The most effective preventive action for this disease is a screening colonoscopy, which allows for the early detection and removal of tissue that could become cancerous.

Under current law, seniors covered by Medicare are eligible for colorectal cancer screenings without cost sharing. However, if a physician takes a further preventive action—like removing a polyp—during the screening, the procedure is billed as a "treatment" rather than a "screening," and the cost is passed on to the patient. Because it is impossible to know in advance if a polyp will be removed during a screening colonoscopy, Medicare beneficiaries do not know whether or not their screening will be fully covered until the procedure is over. The financial barrier that coinsurance creates (approximately $100–300 depending on site of service) may lead to Medicare beneficiaries not choosing this highly effective method of colorectal cancer prevention.

Medicare-aged individuals account for two-thirds of colorectal cancer diagnoses. The current co-pay policy seems to be counter to the intent of the law and a poor way of preventing a chronic condition from occurring.

Ultimately, it seems that we are actually creating new costs for the program if folks aren't getting screened because of the potential out-of-pocket charge. If we decrease the disincentives for screenings, we can improve health outcomes and save money for both seniors and taxpayers.

Dr. Miller—the Removing Barriers to Colorectal Cancer Screening Act (S. 624) would fix this discrepancy by waiving Medicare's cost-sharing requirement for preventive colonoscopies, even if a polyp or tissue is removed. Do you support elimi-

nating this barrier to care? By increasing access to these screenings, is it possible to help prevent the occurrence of colorectal cancer and the associated costs to the Medicare program?

What other regulatory or legislative fixes would help ensure seniors have access to cancer screening services and high-quality treatment options before their diseases become chronic?

Answer. The Commission has not specifically looked into this issue, and does not take positions on draft legislation. In general, preventive services are an important piece of the care continuum, and the effective delivery of preventive care can lead to better outcomes for beneficiaries and lower costs for the Medicare program. A strong primary care system is crucial for preventive care, as many preventive services are often delivered by a primary care provider. The Commission has made recommendations to support primary care, as described in question #2 about prevention and population health.

QUESTION SUBMITTED BY HON. ROBERT P. CASEY, JR.

FACTORS TO CONSIDER IN THE MEDICARE ADVANTAGE STAR RATING PROGRAM

Question. The National Quality Forum (NQF) and other peer-reviewed journals, have concluded that the current star rating system for Medicare Advantage should include measures related to social determinants of health, such as socioeconomic status, education or ethnicity because many of the quality performance criteria measured by the star rating program (*i.e.,* medication adherence rates) are directly correlated to member socioeconomic characteristics. So in the ongoing effort to drive high standards and high quality care for all MA beneficiaries, including dual eligible and some of the more vulnerable beneficiaries, how can CMS better measure the impact of clinical risk factors, low-income status and other sociodemographic factors in the star rating program?

Answer. The Centers for Medicare and Medicaid Services acknowledges an association between low-income status and performance in the quality measures that determine a plan's star rating, and thus the plan's eligibility for a quality bonus payment. The agency's initial proposal to address the concern (by reducing the weighting of certain measures) was not implemented, and the agency continues to examine the issue. The Commission has found an association between disability status and performance on quality measures in that plans with a high share of Medicare beneficiaries under the age of 65 tend to have lower star ratings.

The issue of how to adjust for such differences is something the Commission has addressed in looking at Medicare's hospital readmission penalties. Hospitals with higher shares of low-income patients are more likely to have penalties because of their higher readmission rates. The Commission has suggested using an approach whereby hospitals are grouped into categories (deciles) by their share of low-income patients. The target performance will be determined for each category, with penalties applied when a hospital does not meet the target for its category of hospitals (*e.g.,* a grouping consisting of hospitals with over 50 percent of patients being low income). Though penalties will be adjusted for hospitals with high shares of low-income patients, the reported readmission rate will not be adjusted, because the Commission is concerned that reporting an adjusted rate could mask care disparities for low-income beneficiaries. A similar approach could be used for determining the bonus status of MA plans. However, the mechanics of how that would work are more complicated in that many measures, not just a single measure, are used to determine the overall star rating of a plan, and not all measures show a low-income or disability effect.

Plans are concerned about risk adjustment in the star rating system in part because of the financial impact of failing to qualify for quality bonus payments. Related to this issue, the Commission's suggestions for improving risk adjustment are intended to pay plans that care for certain Medicare-Medicaid dually eligible beneficiaries and enrollees with multiple chronic conditions more fairly. The Commission has suggested using 2 years of diagnosis data to determine a person's risk profile, using the number of conditions a person has as a risk-adjustment factor, and introducing a distinction in the risk-adjustment system between "full" and "partial" Medicare and Medicaid dually eligible beneficiaries.

QUESTIONS SUBMITTED BY HON. JOHNNY ISAKSON

Question. Earlier this year, CMS announced a target of tying 50 percent of Medicare payments to alternative, value-based payment models by 2018. That's an admirable goal, but I think it's worth noting that 30 percent of Medicare beneficiaries are already enrolled in Medicare Advantage plans that receive capitated payments. I'm concerned that CMS policies continue to discourage plans from signing up seniors with multiple chronic conditions who would benefit the most from care coordination. MedPAC has estimated that Medicare's risk-adjustment model already underpays by 29 percent for the sickest beneficiaries, yet CMS proposes additional cuts to Medicare Advantage risk adjustment.

Could you elaborate further on the recommendations MedPAC has made to improve the risk-adjustment model in Medicare Advantage, particularly the recommendation to pay more to care for beneficiaries based on the number of chronic conditions they have? What feedback has MedPAC received since making this recommendation?

Answer. The Commission has discussed three refinements to the risk-adjustment system that would likely lead to more accurate payments to MA plans caring for beneficiaries with chronic conditions: using 2 years of diagnosis data to determine a person's risk profile, using the number of conditions a person has as a risk-adjustment factor, and introducing a distinction in the risk-adjustment system between "full" and "partial" Medicare and Medicaid dually eligible beneficiaries. Beneficiaries with full Medicaid coverage ("full duals") have higher expenditures than "partial duals."

To evaluate whether adding a chronic condition count to the risk-adjustment model would improve accuracy, we calibrated two versions of CMS's current risk-adjustment model. One version was the standard model that CMS uses in the MA program. The other is the conditions model, which adds six indicators for how many conditions each beneficiary has to the standard model: zero, one, two, three, four, and five or more conditions. We found that the standard model underpredicts for beneficiaries who have zero conditions, five or more conditions, and eight or more conditions and overpredicts for one, two, three, and four conditions. In contrast, the conditions model predicts quite accurately for each of those groups. Because the conditions model predicts accurately for the sickest beneficiaries (those who have many conditions), it may be beneficial for plans that care for these beneficiaries.

CMS stated at the May 14th hearing that it was investigating MedPAC's risk-adjustment ideas, including adding a chronic condition count to the risk-adjustment model. Certain plans who serve large shares of low-income beneficiaries have also expressed support for this policy.

Question. The chronically ill comprise 15% of Medicare beneficiaries—yet they account for 75% of costs. More than two decades ago, CareMore began to address this disparity with a new model of care based on three key pillars: chronic care management, acute care management, and predictive modeling and early intervention. These plans diagnose conditions early by providing beneficiaries access to disease management and care coordination programs that are demonstrating improvements in quality compared to FFS Medicare with 67% fewer hospitals days and 50% fewer admissions. What strategies should be employed to encourage MA plan programs that focus on prevention and early detection of health conditions?

Answer. The Commission has a long history of supporting managed care options in Medicare because the financial incentives of the capitated MA payment system encourage plans to innovate and use approaches, such as care management techniques, that are not possible in traditional fee-for-service Medicare. In other words, the design of the MA program is intended to give plans strong incentives to focus on prevention and early detection. How each plan responds to these incentives is up to the plan, but the kinds of activities cited in the question can be viewed as an example of "best practices" that can result in improved health while also promoting the efficient delivery of care, as high-cost care is avoided through prevention and early detection.

Question. In January, we saw the implantation of the new payment code for managing Medicare patients with multiple chronic conditions. This is a great step towards complex care management and improving transitions of care. As part of the code's utilization requirement, I am pleased to see the requirement of creating a patient-centered care plan and providing a copy of the plan to the patient. Although the code is just in the beginning stages of implementation, has CMS seen any posi-

tive results from providers in improving patients' care while they navigate the health care system?

Answer. It is too soon to assess whether the new code has had any effect on improving patients' care, although billing of the code in the first quarter of 2015 does appear to be quite low.

QUESTION SUBMITTED BY HON. TIM SCOTT

Question. One of the reasons I've fought so hard to preserve choice for our seniors through the preservation of strong Medicare Advantage plans is the simple fact that we know these plans work. We know they work, especially in the area of care coordination. These plans are incentivized and rewarded for making and keeping people healthy and, more importantly, seniors are happy with their plans. Unfortunately, each year Medicare Advantage plans face cuts by CMS. My biggest concern is for the low income beneficiaries who often benefit the most from these plans. Dr. Miller, can you discuss the impact of continued Medicare Advantage cuts on rural, low income beneficiaries? In particular, the impact of the loss of focused care coordination?

Answer. The Commission has long supported payment neutrality between FFS and MA. Changes in payment policy have brought MA benchmarks closer to FFS expenditures and have increased the financial pressure on MA plans. As a result, plans have become more efficient, as we can judge from the trend that we see in MA plan bids. In 2015, MA plans on average are able to provide the Medicare benefit at a cost that is lower than the Medicare FFS program, although there are a significant number of plans that do not bid below FFS. The average value of extra benefits offered through non-specialized plans actually increased slightly between 2014 and 2015 (to $75 per person per month from $74). MA enrollment has also continued to grow. Between November 2013 and November 2014, enrollment in MA plans grew by about 9 percent—or 1.3 million enrollees—to 15.8 million enrollees (compared with growth of about 3 percent in the same period for the total Medicare population). About 30 percent of all Medicare beneficiaries were enrolled in MA plans in 2014, up from 28 percent in 2013.

With regard to rural areas, the share of beneficiaries living in rural areas who are enrolled in MA is below that of urban areas, but that share grew from 18 percent in 2013 to 20 percent in 2014. MA enrollment is growing more quickly in rural areas than in urban areas.

QUESTIONS SUBMITTED BY HON. PATRICK J. TOOMEY

Question. Medicare beneficiaries with multiple chronic conditions are the largest users of health care services. For example, the 14 percent of beneficiaries with six or more chronic conditions, such as chronic kidney disease, heart failure, and chronic obstructive pulmonary disorder (COPD), accounted for 55% of total Medicare spending on hospitalizations. What models, including coordinated care models, currently exist that could be translated to improve quality and reduce Medicare costs for those with ESRD and/or multiple chronic conditions?

Answer. MA plans and ACOs could both be effective care models for beneficiaries with ESRD and/or multiple chronic conditions. The Commission has recommended allowing beneficiaries with ESRD to enroll in MA plans (they cannot currently join MA). To allow general MA plans to better care for beneficiaries with common chronic conditions, the Commission has recommended allowing plans the flexibility to tailor benefits for enrollees with specific chronic conditions or sets of conditions (March 2013 report). For example, under the Commission's recommendation, plans would be allowed to provide non-emergency transport services exclusively for beneficiaries with ESRD, or any other population that the plan deems likely to benefit from these services.

The ACO program incentivizes providers to focus care coordination efforts on patients with high Medicare spending, who are likely to suffer from multiple chronic conditions. MedPAC's interviews with ACOs suggest that they are already concentrating on this population. The Commission has made several suggestions for enhancing ACOs' effectiveness, including increasing the power of ACOs' incentives (*e.g.,* higher share of savings, two-sided risk models, not reducing benchmarks for already efficient ACOs) and regulatory relief to increase beneficiary engagement

(*e.g.,* waiving copays for primary care visits with ACO providers) for ACOs in two-sided risk arrangements (June 2014 and February 2015 comment letters).

Question. Some estimates show that one in five Medicare dollars are currently spent on an individual diagnosed with dementia, and are on pace to grow to one in three dollars by 2050 unless there is the development of a new meaningful therapy or treatment. Has MedPAC considered ways CMS might address the currently high spending attributable to beneficiaries with Alzheimer's disease and other dementias?

Answer. MedPAC has not directly considered ways to address high spending attributable to beneficiaries with Alzheimer's disease and other forms of dementia. However, the Commission's recommendation to allow general MA plans the flexibility to tailor benefits to specific beneficiary populations would allow MA plans to design benefit packages for beneficiaries with dementia.

PREPARED STATEMENT OF HON. RON WYDEN,
A U.S. SENATOR FROM OREGON

I would first like to thank Chairman Hatch for his leadership on this critical issue. Ten months ago, the Finance Committee came together to discuss one of the premier challenges of our time—addressing the chronic illnesses that dominate America's flagship health program, Medicare. Chronic illnesses—heart disease, diabetes, and cancer, among others—now account for almost 93% of Medicare spending.

That certainly wasn't the case when the program began in 1965. Back when Medicare first started, its primary purpose was to help people with catastrophic health events that put them in the hospital. That picture has turned upside down. Though it's hard to get the numbers from that era, we know this much: in 1970, according to the Centers for Medicare and Medicaid Services, 64 percent of total Medicare spending was devoted to care provided to patients in the hospital. By 2010, that number dropped to 26 percent.

Today, the vast majority of Medicare dollars are spent caring for patients living with multiple persistent, chronic health conditions that require a variety of services. Although it's a good thing that care is being provided outside the hospital, but this care is—more often than not—uncoordinated and costly.With a trend this clear, it's time for both parties to tackle this issue head on, and I commend Chairman Hatch for making it a priority for the Committee.

I also want to point out that last month, Congress took the important step of ending the broken Sustainable Growth Rate formula. Throwing SGR in the junk bin accomplished two big things. First, it engraved in stone the principle of rewarding medical care that provides quality care over quantity. And second, it cleared the legislative logjam that has blocked Congress from taking a close look at how Medicare can be tuned to work better for patients and encourage providers to improve the care they are delivering. So it is going to be critical to build off that progress as the Finance Committee moves forward to address the challenge of treating chronic illnesses.

Since our hearing last July, I've held a number of roundtables in Oregon to hear what the Committee can do to make Medicare work better when it comes to chronic care. I received a lot of crucial insights along the way and I'm going to take some time to offer what, in my view, are several key principles that should be a part of any attempt to more effectively care for patients with multiple chronic conditions.

First, Medicare needs to encourage teams of providers to coordinate care for their patients with chronic conditions. People dealing with multiple chronic illnesses often have half a dozen doctors, but those doctors may not communicate to provide the most efficient care. This situation needs to be turned on its head in favor of a holistic approach that encourages providers to work together to make our patients healthy.

Working with multiple doctors is especially challenging for people living in rural communities. Treating multiple chronic conditions is hard to do anywhere, but it's even more difficult when doctors and specialists are eighty miles apart. Families that face chronic health issues shouldn't have to add a whistle-stop tour of doctor's offices to their list of challenges.

Second, Congress needs to make life easier for providers who want to coordinate care, whether that's more information about patients, improved access to innovative

technology, or other measures that promote flexibility. At the same time, accountability is critical to ensure providers are successfully treating patients while also producing savings from coordinating care. And if something doesn't work, health innovators should explore other options.

I've been passionate about this issue for a while now, but with the input and efforts of the whole Finance Committee I am confident we can craft a solution that really gets at the heart of the challenges posed by chronic illnesses, and do so in a way that brings members together on a bipartisan basis.

I'm especially pleased to be teaming up with Chairman Hatch on a plan that begins with a working group and ends with legislation passing out of this committee. This working group will develop policy options to address how Medicare can work better for Americans with chronic illnesses, and it will be co-chaired by Senators Isakson and Warner.

Senator Isakson has been as dogged as anyone on this issue, and I had the privilege of working with him last year to propose some of our own ideas. Senator Warner will also be a chair, and since joining the committee last year he has already demonstrated an unshakeable commitment to seeking workable solutions on big, important issues, and doing so in a bipartisan way. I look forward to seeing the results from this working group, especially given the interest of Members like Senator Bennet and others, who have demonstrated an eagerness to dig into this issue and come up with real, meaningful reforms.

The Committee has already received some vital feedback from patients, providers and others, including a woman named Stephanie Dempsey, who was a witness at our hearing last July. Ms. Dempsey was dealing with heart disease, lupus, arthritis and a seizure disorder, and I'm sorry to say she passed away in December due to those conditions. At the hearing she said to us: "I am confident that you will not forget me and countless other people when you develop policies that will help all of us. Our goals are all the same: to live long, healthy, and productive lives."

Her death should clearly signal the seriousness of chronic illness and the urgency needed by this Committee to adopt a lasting, robust solution to address how Medicare treats it. It's critical for us to keep in mind who we're working to help.

COMMUNICATIONS

STATEMENT OF THE AMERICAN COLLEGE OF CLINICAL PHARMACY (ACCP) AND THE COLLEGE OF PSYCHIATRIC AND NEUROLOGIC PHARMACISTS (CPNP)

"A PATHWAY TO IMPROVING CARE FOR MEDICARE PATIENTS WITH CHRONIC CONDITIONS"

May 14, 2015

The American College of Clinical Pharmacy (ACCP) and the College of Psychiatric and Neurologic Pharmacists (CPNP) appreciate the opportunity to provide the following statement for the Senate Finance Committee related to the May 14, 2015, hearing entitled "A Pathway to Improving Care for Medicare Patients with Chronic Conditions."

ACCP is a professional and scientific society that provides leadership, education, advocacy, and resources enabling clinical pharmacists to achieve excellence in patient care practice and research. ACCP's membership is composed of over 16,000 clinical pharmacists, residents, fellows, students, scientists, educators and others who are committed to excellence in clinical pharmacy practice and evidence-based pharmacotherapy.

The College of Psychiatric and Neurologic Pharmacists is an association of specialty pharmacists who work to improve the minds and lives of those affected by psychiatric and neurologic disorders. These professionals apply their clinical knowledge in a variety of healthcare settings and positions ranging from education to research with the goal to apply evidence-based, cost efficient best practices in achieving patient recovery and improving quality of life.

Currently, millions of complex, chronically ill Medicare beneficiaries receive care in a delivery system that is fragmented and insufficiently focused on quality and outcomes. We applaud the leadership of the Committee in holding this hearing to examine a program deficiency that not only fails to adequately meet patient needs but threatens the long-term structural and financial viability of the Medicare program.

The burden of chronic physical and mental health conditions has far reaching implications for the Medicare program. Over 68% of Medicare beneficiaries have two or more chronic conditions and over 36% have four or more chronic conditions. In terms of Medicare spending, beneficiaries with two or more chronic conditions account for 93% of Medicare spending, and those with four or more chronic conditions account for almost 75% of Medicare spending.[1]

Irresistible demographic trends in the U.S. mean that the number of Americans who depend on the Medicare program for their health care will increase significantly in the corning decades. Some estimates suggest that Medicare, in its current form, will become insolvent by as early as 2027. It is clear that in order to protect the integrity of the program for today's seniors and ensure its sustainability for future generations the structure of Medicare's current benefit design must be improved and modernized.

As the committee continues its effort to examine ways to improve how care for chronically ill Medicare beneficiaries is delivered and paid for, ACCP and CPNP urge you to focus on models that promote and incentivize a truly patient-centered and inter professional approach to medication related clinical care and medication safety. Medications are the fundamental treatment intervention in each of the eight

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[1] CDC Report—Prevalence of Multiple Chronic Conditions Among Medicare Beneficiaries, United States, 2010. Available at: *http://www.cdc.gov/pcd/issues/2013/12_0137.htm*. Accessed May 11, 2015.

most prevalent chronic conditions in Medicare patients based on the most recent data from the Centers for Medicare and Medicaid Services (CMS). The typical Medicare beneficiary sees two primary care providers and five medical specialists in any given year. Four of every five medical encounters result in a prescription order (new or refill); 60% of seniors are taking 3 or more discrete prescription or non-prescription medications at any point in time.

More specifically, we urge you to include reforms to the Medicare Part B program that provide for coverage of comprehensive medication management (CMM) services provided by qualified clinical pharmacists as members of the patient's health care team. This team-based service of CMM is supported by the Patient Centered Primary Care Collaborative, (PCPCC), in which ACCP as well as the major primary care medical organizations are actively involved. CMM helps ensure that seniors' medication use is effectively coordinated, and in doing so enhances seniors' health care outcomes, contributing directly to Medicare's goals for quality and affordability. CMM can "get the medications right" as part of an overall effort to improve the quality and affordability of the services provided to Medicare beneficiaries.

In "getting the medications right," CMM also contributes to enhanced productivity for the entire health care team, allowing other team members to be more efficient in their own particular patient care responsibilities. Physicians and other team members are freed up to practice at the highest level of their own scopes of practice by fully utilizing the qualified clinical pharmacist's skills and training to coordinate the medication useprocess as a full team member.

In order to enhance access to high-quality care and to ensure the sustainability of the Medicare program as a whole, it is essential that progressive payment and delivery system improvements that have emerged and are being actively utilized in both public and private-sector integrated care delivery systems be facilitated and aggressively promoted—especially those that measure and pay for quality and value, not simply volume of services, and that fully incentivize care that is patient centered and team based.

ACCP and CPNP are dedicated to advancing a quality-focused, patient-centered, team-based approach to health care delivery that helps assure the safety of medication use by patients and that achieves medication-related outcomes that are aligned with patients' overall care plans and goals of therapy through the provision of CMM. Clinical pharmacists, working collaboratively with physicians and other members of the patient's health care team, utilize a consistent process of direct patient care that enhances quality and safety, improves clinical outcomes and lowers overall health care costs.

In summary, as part of the process of reforming the Medicare payment system, Congress should enact reforms to the Medicare Part B program that provide for coverage of CMM services provided by qualified clinical pharmacists as members of the patient's health care team within its broader payment reform efforts. We would welcome the opportunity to provide further information, data, and connections with successful practices that provide CMM services to help further inform the committee about this service in the context of Medicare payment and delivery system improvements that will modernize and sustain the program for the future.

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John Lovelace, Chairman • Margaret A. Murray, Chief Executive Officer

Statement of the Association for Community Affiliated Plans

For the Hearing in the Senate Finance Committee

"A Pathway to Improving Care for Medicare Patients with Chronic Conditions"

May 14, 2015

The Honorable Orrin Hatch, Chairman
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

The Honorable Ron Wyden, Ranking Member
U.S. Senate Committee on Finance
United States Senate
Washington, DC 20510

Chairman Hatch, Ranking Member Wyden, and Members of the Committee:

Thank you for holding your hearing on May 14th entitled, "A Pathway to Improving Care for Medicare Patients with Chronic Conditions." ACAP represents not-for-profit, community-based, safety-net health plans (SNHPs): 17 of our 59 SNHP members operate Special Needs Plans (SNPs) and 14 operate Medicare-Medicaid Plans (MMPs) in the Financial Alignment Demonstration. ACAP's 14 MMPs collectively enroll over 30 percent of all beneficiaries in the Financial Alignment Demonstration. SNHPs understand the challenges of managing and improving care for chronically ill Medicare beneficiaries:

- Sixty-four percent of ACAP's D–SNP enrollees are age 65 and older, and 36 percent are under age 65 and disabled; 48 percent of ACAP's MMP enrollees are age 65 and older and 52 percent are under age 65 and disabled.
- Twenty-seven percent of ACAP's D–SNP enrollees and 28 percent of ACAP's MMP enrollees receive community-based long-term care services and supports (LTSS).
- Eight percent of ACAP's D–SNP enrollees and 13 percent of ACAP's MMP enrollees utilize institutional LTSS.
- Thirty percent of ACAP's D–SNP enrollees and 44 percent of ACAP's MMP enrollees have a mental health condition.

To help you better understand the challenges of caring for a population with complex chronic illnesses, we wanted to offer you some examples of how our member plans address these challenges. Below is an example of how one SNHP improves care coordination for Medicare beneficiaries:

> ***CareSource.*** CareSource enrolls nearly 16,000 dual-eligible beneficiaries in Ohio's Financial Alignment Demonstration. CareSource has developed a Trans-Disciplinary Care Team (TDCT) to provide members with an integrated, comprehensive approach to care. The TDCT includes the member, care manager, the member's primary physician and other health care providers, as well as the member's family and caregivers. An assigned care manager visits in person to monitor the care needs of the member and the TDCT, and ensures ongoing communication between the member and all health care providers to chart a course of action when necessary. Led by the care manager, the TDCT can be instrumental in aiding members returning to their homes after long stays in nursing facilities. A Community Waiver Care Manager, who aids with that transition, meets with the TDCT to ensure effective care management of the home and that community-based services are available to the member.

Specifically, upon returning to his home after a stay at a long-term care facility, a CareSource member received a check-in phone call from his care manager. On the call, the CareSource manager learned that the member's wife and primary caregiver had fallen and sustained a hip fracture and was recovering in a local rehabilitation facility. His daughter had moved back into the house to care for her father, but the care manager still decided to reach out to his wife and visit her in the rehabilitation facility, even though she was not a CareSource member. The member's wife, feeling understandably overwhelmed by her own injury and caretaking responsibilities for her husband, admitted that she was struggling to understand the mountains of documents and bills piling up in her mailbox. She produced a freezer bag stuffed with mail, some of which was relevant to her injury and some for her husband's ongoing recovery. The Caresource care manager went through each and every item in the bag, writing explanatory notes on each and highlighting those which required immediate attention. The member's wife was relieved to have the stress of interpreting and following up on the paperwork lifted. She asked the care manager to help take her picture to email to her husband, to assure him that her recovery was progressing well.

SNHPs also understand the complexities of managing care for low-income elderly and disabled beneficiaries whose health status and access to care is challenged by socio-economic barriers. The majority of ACAP's D–SNP enrollees have incomes low enough to quality for full Medicaid benefits.[1] Many of ACAP's D–SNP enrollees were first Medicaid beneficiaries before gaining Medicare eligibility. Not-for-profit SNHPs are well positioned to draw on their strong community relationships to integrate physical, mental, and behavioral health services for their members and to provide Medicare beneficiaries with necessary services that they may not receive through traditional Medicare.

Amida Care. Amida Care is a Medicaid and special needs health plan based in New York City focused on serving HIV-positive beneficiaries. Amida Care believes that employment can play a major role in strengthening the physical and behavioral health status of its enrollee population. To this end, Amida Care has hired, trained and employed more than 250 of its enrollees to serve in a variety of community-support roles. This does not preclude the individual from seeking/obtaining full-time employment and private health coverage, but rather affords experience that can lead to attainment of full-time employment.

Commonwealth Care Alliance (CCA). CCA enrolls more than 10,000 dual-eligible beneficiaries in the Massachusetts Financial Alignment Demonstration. CCA opened regional care centers staffed with primary care physicians and nurse practitioners for members that lacked a regular or meaningful relationship with a primary care physician before they were enrolled in the demonstration. This capacity was necessary to accommodate subsets of the dual eligible population who were poorly served in Medicare fee-for-service. An increased commitment to coordinated care has made a significant difference for many high-cost individuals, who are newly engaged in the health care system after years of experiencing fragmented health care in an uncoordinated system.

We hope these examples of how SNHPs provide enhanced care management and benefits to chronically ill Medicare beneficiaries are useful to the Committee as it works to identify ways to improve care for chronically ill Medicare beneficiaries. We have documented additional examples of how SNHPs provide enhanced care coordination and benefits to dual-eligible beneficiaries enrolled in the Financial Alignment Demonstration in a fact sheet titled, "ACAP Plans and the Duals Demonstration: Early Progress, Innovations, and Challenges."

ACAP is prepared to assist with additional information, if needed. If you have any additional questions please do not hesitate to contact Christine Aguiar at (202) 204–7519 or caguiar@communityplans.net.

Sincerely,

Margaret A. Murray
Chief Executive Officer

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[1] Only full-benefit dual eligibles can enroll in the financial alignment demonstration, therefore all of ACAP's MMP enrollees are also eligible for full-Medicaid benefits.

Cc: The Honorable Sherrod Brown
The Honorable Rob Portman
The Honorable Charles Schumer
Members, Senate Finance Committee

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National Kidney Foundation Statement for the Record

"A Pathway to Improving Care for Medicare Patients with Chronic Conditions"

May 14, 2015

The National Kidney Foundation (NKF) commends the Senate Finance Committee for developing a new working group to consider policy options for lowering healthcare costs and improving chronic care in the Medicare program. This initiative is desperately needed and NKF looks forward to working with the committee on this endeavor.

NKF is America's largest and long-established health organization dedicated to the awareness, prevention, and treatment of kidney disease for hundreds of thousands of healthcare professionals, millions of patients and their families, and tens of millions of people at risk. In addition, NKF has provided evidence-based clinical practice guidelines for all stages of chronic kidney disease (CKD), including transplantation since 1997 through the NKF Kidney Disease Outcomes Quality Initiative (NKF KDOQI).

As you know, Medicare spends $87 billion annually to care for patients with kidney disease, including nearly $29 billion for most of the 636,000 individuals with ESRD.[1] As CKD advances from stage 1–4, costs nearly double from one stage to the next.[2] Over 26 million people are living with CKD, yet only 10% are aware they have it[3] and another 73 million are at risk. Risk factors for kidney disease include diabetes, hypertension, age over 60, and a family history of kidney failure. A recent study published by researchers leading the Centers for Disease Control and Prevention's (CDC) CKD surveillance program show that the burden of CKD is increasing and that over half of U.S. adults age 30–64 are likely to develop CKD.[4] Minority populations, particularly African Americans, are disproportionately affected. African Americans are three times more likely than whites to progress to ESRD and start dialysis at a younger age, thus spending more of their lifetime on dialysis.[5] Mortality in earlier stage CKD among African Americans under age 65 is also higher compared to European Americans.[6] Additionally, CKD is a disease multiplier that leads to cardiovascular disease, bone disease and other chronic conditions. Intervention at the earliest stage is vital to improving outcomes, lowering health care costs, and improving patient experience.

Earlier this year, NKF submitted a letter to the Committee expressing our concern that changes in the Medicare Advantage (MA) risk-adjustment model removed the only incentive in the Medicare program to detect and manage CKD in its earliest stages. Unfortunately, the Centers for Medicare and Medicaid Services (CMS) proceeded with the new risk-adjustment model. NKF has continued to recommend and

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[1] United States Renal Data System, 2014 Annual Data Report: Epidemiology of Kidney Disease in the United States. National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD, 2014.

[2] Honeycutt AA, Segel JE, Zhuo XH, Hoerger TJ, Imai K, Williams D: Medical Costs of CKD in the Medicare Population. J Am Soc Nephrol 2013. 24.

[3] Tuot DS, Plantinga LC, Hsu CY, et al. Chronic kidney disease awareness among individuals with clinical markers of kidney dysfunction. Clin J Am Soc Nephrol. Aug 2011;6(8):1838–1844.

[4] Hoeger, Thomas, et al. The Future Burden of CKD in the United States: A Simulation Model for the CDC CKD Initiative, Am J Kidney Dis. 2015;65(3):403–411.

[5] Centers for Disease Control and Prevention, National Chronic Kidney Disease Fact Sheet 2014, *http://www.cdc.gov/diabetes/pubs/pdf/kidney_Factsheet.pdf.*

[6] Mehrotra, Rajnish et al., Racial Differences in Mortality Among Those with CKD, J Am Soc Nephrol. 2008 Jul; 19(7): 1403–1410.

advocate for improved strategies to incentivize earlier detection and care coordination for CKD in the Medicare program, which could save lives, kidneys and lower costs. NKF has even established its own national initiative, CKD Intercept, to improve early detect ion and management in those with and at risk for kidney disease. However, our efforts alone will not be enough to move this country in the direction of treating of CKD early, before it ends in death or kidney failure. Therefore, we request the Committee's support in making CKD detect ion and management a national priority.

In a recent clinical study, only 12% of primary care practitioners (PCPs) were properly diagnosing CKD in their patients with diabetes who are at the highest risk of kidney disease. In addition, the study found that PCPs conducted a urine albumin to creatinine ratio and a serum creatinine to estimate kidney function (two simple tests) in only about half of their diabetic patients.[7] Earlier detection allows the introduction of patient education and medical management that can slow the progression of the kidney disease and reduce the associated co-morbidities, such as cardiovascular events, and drug toxicity for many individuals. PCPs acknowledge that kidney disease is under recognized and that patient outcomes could be improved with increased recognition, earlier treatment of CKD, and improved collaboration with nephrologists,[8] however, the gap in appropriate diagnosis remains.

Diagnosis of CKD is associated with patient awareness (of CKD) leading to improved opportunities for patient engagement[9]—a key component of the National Quality Strategy and Healthy People 2020. In addition, conversations and surveys of patients with kidney disease have shown that those with kidney failure would have welcomed the opportunity to modify their lifestyle had they understood they had kidney disease and known its risks prior. I can also personally attest to this. I am a kidney transplant recipient. Through my personal experience, I know firsthand how early detection and preventative actions can actually slow (and in many cases) prevent the progression of kidney disease. My CKD was caught early and as a result I was able to postpone the need for dialysis and transplantation for almost 4 years.

It is critical to provide education and other "motivators" to promote appropriate guideline driven care in those identified with CKD.[10] Given the widespread underdiagnosis of CKD, the lack of both practitioner and patient awareness, and the absence of appropriate quality measures there is a critical need for improvement in CKD care. The KDIGO clinical practice guidelines provide practitioners with a road map on detection and diagnosis of CKD. Given this, early stage CKD is particularly well positioned for alternative care and payment models. CMS has created an alternate payment model for ESRD, which has the potential to improve care for those Medicare beneficiaries, but we desperately need for Medicare to also begin looking upstream to improve care for the many millions who have earlier stage CKD. We look forward to further details about the working group and to partnering with the Committee as it considers policy options for lowering healthcare costs and improving care for those living with chronic disease.

Please contact Tonya Saffer, Senior Health Policy Director at 202–244–7900 extension 717 or by email at tonya.saffer@kidney.org with any questions.

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[7] Szczech LA, et al. Primary Care Detection of Chronic Kidney Disease in Adults with Type-2 Diabetes: The ADD–CKD Study (Awareness, Detection and Drug Therapy in Type 2 Diabetes and Chronic Kidney Disease), PLOS One November 26, 2014.

[8] Allen AS, Forman JP, Orav EJ, Bates DW, Denker BM , Sequist TD. Primary care management of chronic kidney disease. J Gen Intern Med. Apr 2011;26(4):386–392.

[9] Szczech LA, et al. Primary Care Detection of Chronic Kidney Disease in Adults with Type-2 Diabetes: The ADD–CKD Study (Awareness, Detection and Drug Therapy in Type 2 Diabetes and Chronic Kidney Disease), PLOS One November 26, 2014.

[10] Tuot OS, Plantinga LC, Hsu CY, Powe NR. Is awareness of chronic kidney disease associated with evidence-based guideline-concordant outcomes? Am J Nephrol. 2012;35(2):191–197.

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PRESIDENT AND CEO

May 15, 2015

Senate Committee on Finance
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Attn. Editorial and Document Section **COMMENTS ON CHRONIC CARE HEARING**

Dear Members of the Committee:

Because Pub. L. 114–10 requires half of Medicare beneficiaries to be served in care coordination networks by 2018, the Congress must explore new models of care coordination in various settings. Senior living communities offer one of the easiest opportunities to provide care coordination because of the proximity of providers to patients, and the frequency of their interaction.

We urge the Committee to move quickly to test promising new models of care coordination, including those in a senior living community (known as Continuing Care Retirement Communities, or CCRCs) where seniors have the ability to "age in place." **For the vast majority of seniors, residential care coordination *could reduce the cost of Medicare by 30% and Medicaid by 20%, promote personal responsibility and provide lifetime health and housing security.***

As you know, CCRCs are an extremely popular housing solution for seniors, with more than 2,000 operating around the country. While seniors normally enter the CCRC in the independent setting, the CCRC model provides assisted living, skilled nursing, and memory care services for residents on an "as needed" basis at no additional cost. The ability to offer needed care in a residential setting (without the expense of providing "room and board") makes CCRCs the optimal setting for patients, providers and payers.

Because of outmoded geographic restrictions on Medicare Advantage plans; currently these senior communities are unable to offer a coordinated, comprehensive medical home model for their Medicare residents. **Instead of requiring each CCRC resident to manage and navigate their own health care issues, CCRCs should be allowed to provide on-site primary care in a payment system that reduces cost and improves outcomes by assisting Medicare beneficiaries to get the right care, rather than the most care.**

The SHIFT model would provide primary and non-acute services onsite, and coordinate and pay for acute and specialist care offsite as needed—promoting care coordination and disease management services to avoid hospitalizations and lower the total cost of care for seniors. Recent studies show that a residential care setting such as a CCRC is the ideal setting to integrate all of these cost containment strategies for Medicare seniors because of the near-constant interaction between staff and residents. This model offers the best chance of actually delivering comprehensive and coordinated healthcare.

Operationally, the SHIFT community would bear the risk and responsibility for providing comprehensive senior health and housing services to its residents in exchange for a reasonable entrance fee and a moderate monthly fee—affordable to the vast majority of America's seniors. The SHIFT community would utilize an interdisciplinary health care team led by salaried primary care physicians and advanced practice nurses to administer and coordinate comprehensive health care services for all SHIFT residents under a capitated, risk-adjusted Medicare payment.

The attached actual Medicare cost data show that Medicare would save more than 30% for every SHIFT resident. The reason is simple: the costs of primary care, skilled nursing care, long term care hospitals, home health, rehabilitation, medical transport and hospice represent about 30% of Medicare expenses for eligible seniors in a CCRC. The attached chart demonstrates that these silos of Medicare costs are *already paid for in the underlying CCRC cost structure of the SHIFT campus.* Although further savings are also likely to come from better health

and better healthcare—these are not included in the 30% savings claimed. **Additionally, a 2009 study by Avalere Health showed that the SHIFT plan could result in Medicaid savings of 20%.** Medicaid payments for SHIFT residents who "spend down" into Medicaid would be much less than current nursing care costs, and residents will be able to stay in their CCRC home, and reducing state's burgeoning Medicaid expenses for custodial nursing care.

A growing body of clinical evidence suggests that these savings forecasts are not only achievable, but are likely understated. Recent data from the U.S. Agency for Health Research and Quality shows that 60% of hospital admissions from all U.S. nursing homes are "potentially avoidable," and should be managed by a doctor on-site—as proposed in SHIFT. Additionally, multiple studies point to various care-coordination practices resulting in savings to Medicare and Medicaid. Also, recent Commonwealth Fund reports point to care coordination savings in "low-value health care practices" and "overutilization of technology" which could be implemented quickly and easily in the residential care setting:

- *http://www.commonwealthfund.org/publications/in-brief/2015/mar/too-much-technology*
- *http://www.commonwealthfund.org/publications/in-brief/2013/jan/over-150-potentially-low-value-health-care-practices*

Congress should move to provide seniors with better care at lower cost by demonstrating such reform models as soon as possible. S. 395/H.R. 837 gives CMS explicit authority to test up to 5 different state projects for care coordination in a residential care setting, and immediately reduces Medicare payments by 10% for the providers who serve Medicare patients who volunteer for the demonstrations.

We look forward to working with you to achieve the goals of Pub. L. 144–10. Thanks for your interest in improving and sustaining our system of senior care.

Sincerely,

Jeff A. Petty
President

Residential Care Coordination Program

The Secretary shall create a **Residential Care Coordination Program (RCCP) coordinating Medicare and Medicaid payment** to foster development of on-site primary care medical homes providing comprehensive, care-coordination in congregate residential care settings (such as continuing care retirement communities). The RCCP shall:

A. Provide and/or coordinate all covered Medicare items and services, as well as provide any other non-covered services (such as care coordination and disease management) necessary to optimize the well-being of the enrolled beneficiaries.

1. **Negotiated Agreement:** As part of an application process, CMS shall negotiate appropriate terms of participation (including outcomes measurements to ensure high quality) with providers and states to assume full risk for the full cost of all items and services furnished to beneficiaries under the program in exchange for a capitated payment.
2. **10% Cost Reduction:** The risk-adjusted capitated payment amount derived by the Secretary constitutes a 10% reduction from expected risk-adjusted fee-for-service Medicare costs for enrolled beneficiaries.
3. **No Net Cost to Government Accounts:** In no event will the Medicare costs of the RCCP exceed the expected risk-adjusted cost of providing all necessary items and services to beneficiaries under Medicare Fee-For-Service.
4. **Freedom of Choice:** Allows individuals to disenroll from the RCCP and return to Fee For-Service Medicare while continuing to live in the residential care facility if they choose.

B. Coordinate Medicaid assistance for those individuals who become financially eligible for Medicaid while participating in the RCCP:

1. **Negotiated Agreement:** As part of the negotiated agreement with states and approved providers described above, CMS shall allow every individual in the RCCP who financially qualifies for Medicaid to remain in their residential care home if they so choose while continuing to receive all health care services under the capitated arrangement described above.

2. **Cost Reduction:** Caps Medicaid payments for RCCP enrolled beneficiaries at an amount equal to the portion of the enrolled beneficiary's monthly residential care living costs (up to $2000/month) which they can no longer afford to pay.
3. **No Net Cost to Government Accounts:** In no event will the Medicaid costs of the RCCP exceed one-half of the expected costs of providing all necessary nursing care services for participating individuals who qualify for Medicaid.

SHIFT

Potential Savings based on 2011 Medicare Data
National
http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Medicare-Geographic-Variation/GV_PUF.html

	Current FFS Medicare Spending			Minimum Savings Potential		
Category of Service	2011 Avg payment/ user	# Users per 1,000 beneficiaries	Total $ for 1,000 beneficiaries	Rationale	%	$
Hospital Inpatient	$ 16,635	190	$ 3,158,941	Save 19% - Dobson/Davanzo estimate[1] from care coordination	19%	$ 600,199
Inpatient Rehab/LTCH	24,863	13	333,161	Save 100% - provided by existing SHIFT employees [2]	100%	333,161
Home Health	5,362	103	552,301	Save 100% - provided by existing SHIFT employees [2]	100%	552,301
SNF	16,314	59	959,257	Save 100% - provided by existing SHIFT employees [2]	100%	959,257
Hospital Outpatient	1,642	632	1,037,416	No savings claimed from improved outcomes	0%	-
FQHC/RHC	377	73	27,631	No savings claimed	0%	-
Ambulatory Surgical	807	105	84,780	No savings claimed from improved outcomes	0%	-
Evaluation & Management	1,001	896	896,415	60% of visits are primary care[3] - save 2/3 No savings claimed for 40% of visits to specialists	40%	358,566
Procedures	1,007	639	643,930	No savings claimed from improved outcomes or elimination of duplication in testing	0%	-
DME	710	290	206,177	No savings claimed	0%	-
Testing	332	798	264,985	No savings claimed from improved outcomes	0%	-
Imaging	371	705	261,257	No savings claimed from improved outcomes	0%	-
Other	1,111	361	400,512	No savings claimed	0%	-
Hospice	11,308	30	343,761	Save 100% - provided by existing SHIFT employees [2]	100%	343,761
Part B Drugs	556	548	304,489	No savings claimed	0%	-
Total			$ 9,475,014			$ 3,147,246
% savings						33%

[1] 19% savings based on experience of Veterans Administration which reduced bed days by 25%, also 17% reduction in hospital admissions due to care coordination found by Piekes et al at Mercy Hospital System.

[2] Existing staff of SHIFT can provide these services, not requiring additional providers or expense.

[3] MEPS, 2008

The Medicare Residential Care Coordination Act of 2015

Directs the Secretary of Health and Human Services to establish and implement a demonstration project under titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act to evaluate the use of capitated payments made to eligible continuing care retirement communities for residential care coordination programs in up to 5 states. Fully at-risk capitated payment is 90% of expected Medicare fee for service cost of beneficiaries enrolled in the program.

S. 395 introduced 2/5/2015

Original Cosponsors:
Senator Chuck Grassley [R–IA]
Senator Robert Casey [D–PA]
Senator Bill Cassidy, M.D. [R–LA]

H.R. 837 introduced 2/10/2015

Original Cosponsors:
Rep. Mike Fitzpatrick [R–PA–8]
Rep. Jenkins, Lynn [R–KS–2]
Rep. Barton, Joe [R–TX–6]
Rep. Buchanan, Vern [R–FL–16]
Rep. Kelly, Mike [R–PA–3]
Rep. Cartwright, Matt [D–PA–17]
Rep. Rothfus, Keith J. [R–PA–12]
Rep. Boyle, Brendan F. [D–PA–13]
Rep. Doyle, Michael F. [D–PA–14]
Rep. Brady, Robert A. [D–PA–1]
Rep. Fattah, Chaka [D–PA–2]

Cosponsors:
Rep. Meehan, Patrick [R–PA–7]
Rep. Scott Tipton [R–CO–3]

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