

**STRENGTHENING MEDICARE FOR TODAY
AND THE FUTURE**

HEARING
BEFORE THE
SPECIAL COMMITTEE ON AGING
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WEDNESDAY, FEBRUARY 27, 2013

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 3:02 p.m., in Room 106, Dirksen Senate Office Building, Hon. Bill Nelson, Chairman of the Committee, presiding.

Present: Senators Nelson, Whitehouse, Blumenthal, Baldwin, Donnelly, Warren, Collins, Flake, and Ayotte.

OPENING STATEMENT OF SENATOR BILL NELSON, CHAIRMAN

The CHAIRMAN. Good afternoon. A long time ago, this committee was formed when our Nation was facing a crisis of our uninsured elderly. At that time, the panel played a key role in the expiration of health insurance coverage for older Americans. Ultimately, what happened in 1965 was the enactment of Medicare. This committee has an incredible legacy and it is certainly a privilege for Senator Collins and me to lead this committee at this particular time.

Last week, during the recess, I went to an elderly research facility called the Institute of Aging at the University of Florida in Gainesville, and then I went on to the Claude Pepper Center in Tallahassee at Florida State University in preparation for this hearing and I listened to some of our State's foremost experts on matters involving the elderly.

And so now we are literally at the point of facing another budget crisis, much of which focuses on the debate about the exploding health care cost, and therefore, by inference, the Medicare program, and it is front and center.

Now, there is a bit of good news and that came from the Congressional Budget Office. Federal spending, in their recalculations, Federal spending on Medicare has actually been lower than what they predicted three years ago. Medicare spending in fiscal year 2012 grew by three percent to \$551 billion—that is according to CBO—and that represents the slowest growth since 2000. And while that is progress, we know that there are many financial challenges ahead. More of the baby boomers are retiring. Health care costs continue to rise. There is still a lack of efficiency in the use of the system. And Medicare could end up reaching a spending of \$1 trillion by 2023.

So although we have seen some progress, we can do better, and that is what the two of us believe that this committee has a role to play in discussing the options that will strengthen Medicare, try

to reduce the cost, and to improve upon the care that seniors receive without reducing benefits or shifting all of the cost to consumers.

For example, care coordination has more to do than just saving in dollars. It means hours of time and a Medicare beneficiary's life. Reducing hospital readmissions will not only save the Medicare program billions, it will save beneficiaries from potential infection and further out-of-pocket expense.

And with that in mind, I look forward to hearing from the panel today on how we can better reimburse providers for prevention, engage consumers through price transparency, which is a hearing I just came from that Senator Rockefeller is having in the Commerce Committee, and in the various drugs, devices, and medical services, how we can better deliver that to our seniors, and, of course, to simplify administrative burdens.

I am delighted that Senator Collins is a co-leader of this committee and I welcome the opportunity to lead this committee with you and would ask for your opening comments.

OPENING STATEMENT OF SENATOR SUSAN M. COLLINS

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

Let me first say that I am absolutely delighted to be working with you. We have worked together in the past, but this will give us an opportunity for a whole new level of collaboration and cooperation and I look forward to your leadership of this committee and being your partner.

Florida has the highest percentage of Americans age 65 or older, but it is actually the State of Maine that is the oldest State in the Nation if you measure by median age. A lot of people are surprised to learn that. But I think that the combination of those two facts makes it entirely appropriate that the two of us are leading this committee.

I also want to welcome all of our committee members. There are a few of them who have joined us. I am sure others are on their way.

Throughout its history, this committee has spurred Congress to action through hearings, investigations, and reports. I look forward to forging a strong partnership as we work together to shine a spotlight on issues of vital importance to older Americans, such as health care, retirement security, long-term care, elder fraud and abuse, and research on diseases like Alzheimer's and diabetes that take a devastating toll on Americans and their families as well as on the Federal budget.

I would point out that it has been since the 1990s that a Mainer had a leadership role on this committee, but my predecessor and good friend, Senator Bill Cohen, served as the Ranking Member and as Chairman of this committee back in the 1990s. So I look forward to following in his formidable footsteps.

Mr. Chairman, as you pointed out, Medicare is a critically important program that provides essential health coverage for more than 50 million of our Nation's seniors and disabled citizens. It is, therefore, appropriate that our very first hearing in the 113th Congress will focus on ways to strengthen and sustain Medicare into the future.

Medicare has made an invaluable contribution to the lives of more than 130 million older Americans and individuals with disabilities since its creation in 1965. As the Chairman has pointed out in his opening statement, prior to Medicare, more than half of all Americans over age 65 were uninsured and nearly a third lived in poverty. Today, virtually all seniors have access to health care coverage through Medicare, and the official poverty rate among seniors is less than nine percent. Medicare has provided both health and economic security to our Nation's seniors for almost 50 years, and by any measure, the program has been a great success.

It is, however, time for our country to have a serious debate about how to secure the future of Medicare. This is particularly true in light of the most recent Medicare Trustees Report that projected that the Part A Trust Fund will be exhausted in just 11 years and unable to pay benefits in full or on time.

Rapid increases in health care spending, coupled with the demographics associated with an aging baby boom population, pose serious challenges to Medicare in the 21st century. The number of people eligible for Medicare is projected to soar from a little more than 50 million today to nearly 90 million in 2040, and the retirement of the baby boom generation not only means millions of more Americans on Medicare, but also fewer workers paying into Medicare. This is the combination of the perfect storm. We, therefore, face a major challenge as we look for ways to slow Medicare spending growth while continuing to provide quality health care for an aging population.

I am also mindful of the mounting deficits and towering National debt our country has accumulated and its impact on our seniors and, indeed, on all Americans, including future generations. Today, Medicare accounts for about 15 percent of total Federal spending, a percentage that is certain to increase. It is inevitable that the program will be part of the ongoing discussions over how to reduce Federal deficits and the National debt.

The importance of Medicare and the magnitude of the fiscal challenges we face as a Nation underscore how important it is that we reach a bipartisan consensus on the way forward. I have opposed past efforts to restructure Medicare in ways that I believe could be harmful to the 50 million American seniors and disabled individuals who rely on the program. I believe, however, that there are changes that could be made without jeopardizing access to affordable quality health care for our Nation's seniors.

The real key to getting Medicare costs under control is to get health care costs under control. Today, the United States spends 18 percent of its Gross Domestic Product on health care, more than any other industrialized nation, yet we lag behind many other nations on many measures of quality. In health care, quantity does not always equal quality, and clearly, there is more that we can do to reward value rather than volume, quality rather than quantity.

So today's hearing will discuss some of the options for delivery system reforms that have the potential not just to slow the growth in health care spending, but also to improve health care quality.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

While I am blessed to have 20/15 vision, I can hardly see you all down there——

[Laughter.]

And so on future hearings, I want to invite you not to spread out like this, regardless of seniority.

But we need to take care of some business before I turn to you all for your statements.

[Whereupon, at 3:15 p.m., the committee proceeded to Executive Session and reconvened at 3:16 p.m.]

The CHAIRMAN. And so let me turn to Senator Warren for your statement, please.

OPENING STATEMENT OF SENATOR ELIZABETH WARREN

Senator WARREN. Thank you very much, Mr. Chairman, and thank you, Ranking Member Collins. As the newest member, I am delighted to be here and hope to learn from you and eager to work under your leadership.

I think we all agree that we need to find the way to cut the rate of increase in health care costs, and there are two very different visions for how to do that. We hear a lot of talk about the best way to do that is to cut Medicare benefits so that fewer people receive assistance. But the way I see that, people will still get sick, however you design Medicare benefits. People will still have heart attacks. They will still have strokes. They will still have diabetes. And they will still need care. And many of them will still go for care, only they will go to emergency rooms and be unfunded patients. We will find other ways to give care that is more expensive and less expensive and I just think that is the wrong approach to think about.

The alternative is that we describe this problem, I think, very much as Senator Collins does, and I am very much in agreement with her. The problem we have, I would describe much less as a Medicare problem and much more as a problem of health care overall and that our goal has to be how to deliver better outcomes at lower costs. And I believe that a big part of that means funding the research to figure out how to do that. Sometimes it is about funding health care research directly, how we get better treatment of diabetes, how we get better treatment of strokes that helps bring down costs and at the same time increases the quality of life of our patients.

I think this is the approach that we should be using. I hope this is part of what we will be talking about here. And I look forward to learning from our panelists today, and again, thank you for your leadership on this, Senator Collins and Senator Nelson.

The CHAIRMAN. Senator Ayotte.

OPENING STATEMENT OF SENATOR KELLY AYOTTE

Senator AYOTTE. I want to thank the Chairman and the Ranking Member. I look forward to being part of this committee, as well.

I also want to welcome all the panelists, particularly Dr. Goodman, and I appreciate the excellent work being done at the Dartmouth Atlas program. I had the chance to visit Dartmouth in 2011 and hear about the important work that you are doing there and

so I am very honored that you are here talking about that work before this important committee today, so thank you.

The CHAIRMAN. Senator Blumenthal.

OPENING STATEMENT OF SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thank you for having this hearing on this very, very important topic. Thank you to all of our witnesses for being here today.

I have to disclose in the interests of full disclosure, Mr. Chairman, that David Blumenthal is my brother. I always knew he was a Nationally recognized expert, I just did not know in what.

[Laughter.]

And I am going to spare him the withering, relentless cross-examination that I spent last night preparing.

[Laughter.]

But I want to say how strongly I agree with you and Senator Collins, Senator Warren, that this kind of inquiry provides a profoundly significant and historic opportunity, not only to examine improving the Medicare program, but really the entire health care delivery system for our country, which is desperately in need of reform and re-engineering and, in fact, can produce better outcomes by making them less expensive, in other words, reducing the kinds of readmission that Dr. Goodman so aptly describes, following some of the examples that are set forth in Dr. Blumenthal's testimony from elsewhere in the country, and supporting the efforts of the Center for Medicare and Medicaid Innovation, which right now is undertaking initiatives that offer great promise for reaching our common goal, which is better outcomes at less cost. The two are not only compatible, they are mutually supportive.

So I want to thank, also, particularly Senator Whitehouse, who has spoken about this issue, as I have, for some time. And my hope is that health care reductions in cost will be re-engineered around the system and can be measured and scored so that we can include them in deficit reduction, because they are real means of reducing the deficit. They ought to be counted and scored. And Senator Whitehouse and I have been talking about this issue for some time.

Thank you all for being here today. This testimony is profoundly important and valuable to us.

The CHAIRMAN. Senator Flake.

OPENING STATEMENT OF SENATOR JEFF FLAKE

Senator FLAKE. I am just glad to be here. Thanks. I look forward to the witnesses.

The CHAIRMAN. Senator Baldwin.

OPENING STATEMENT OF SENATOR TAMMY BALDWIN

Senator BALDWIN. Thank you, Mr. Chairman and Ranking Member Collins.

I am really excited to join this committee and I wanted to start out by recognizing the person I have succeeded to the Senate and the person you have succeeded to the Chair of the Aging Committee, Herb Kohl, who chaired this committee for six years and spent his entire career in the United States Senate as an incredible champion for Wisconsin's seniors and, in fact, all seniors in Amer-

ica. So I was thrilled to find out that I could become a member of the Aging Committee.

And I am delighted with the topic of this first hearing. Aging issues and Medicare, in particular, are also important to me, near and dear to my heart, especially because I was raised by my grandparents, my maternal grandparents, and got a chance as a much younger person than most to become more familiar with the issues that affect people as they age and the Medicare program, in particular. My grandmother was 56 when I was born, so it was in my teens and early 20s that I had my first exposure to Medicare.

My grandparents were my heroes for what they did for me. No matter what happened, they were there for me as I was growing up. So when my grandmother became older and more frail, it was my deep honor to be able to return the favor and make sure that she received quality health care. Medicare was there for her. And, I would say, because Medicare was there for her and I could depend on the fact that she was getting affordable, quality, competent care, in a way, as her caregiver, Medicare was also there for me. I did not have to worry that a medical emergency would exhaust all of her resources or all of mine. And Medicare allowed me to remain as a caregiver, also focused on building a new career as an attorney at first and public servant after that.

Medicare has served my family and millions of others very well for decades, and it is why hearings like this are so important. I am delighted to have this panel of witnesses here today to help us talk about how we can make sure that Medicare remains strong for decades and generations to come and I appreciate the fact that you are taking the time with us.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator Whitehouse.

OPENING STATEMENT OF SENATOR SHELDON WHITEHOUSE

Senator WHITEHOUSE. Thank you, Chairman Nelson.

I am delighted that for the first hearing of the Aging Committee under your chairmanship, we are focusing on this issue. I think that for all the public attention that is being devoted to the sequester and the row that we are having over the sequester here in Washington, the most important hearing going on is this one, because our health care expense is an enormous fiscal, even National security, problem for our country.

And I think our Ranking Member, Senator Collins, said it exactly right when she said the way to address Medicare costs is to address health care costs and we have such an opportunity, whether you look at the 18 percent of GDP we burn compared to the least efficient of our international industrialized competitors only using 12 percent of their GDP to actually provide better health care results for the population, or whether you look at very well established and well regarded organizations like the President's Council on Economic Advisors, the Institutes of Medicine, the New England Health Care Institute, the Lewin Group, former Bush Treasury Secretary O'Neill, who put the savings out of our health care system between \$700 billion and \$1 trillion a year, all by making the system work better for patients and provide better outcomes.

This is not a zero sum game in which you have to take something away in order to make the system more efficient. This is one of those happy win-wins where better care produces lower costs.

And so I think you are in exactly the right spot, and I think the more this incredibly valuable and relied on essential Medicare program is pushed into the spotlight of benefit reductions, or out of the gunsight, I should say, of benefit reductions, the more we have to remind everybody that that is the wrong way to go about the business of solving this problem.

I will close by reminiscing about the former CEO of Kaiser Health, George Halvorson. Kaiser is a pretty darn big health care operator in this country and CEO Halvorson was no fool. I can remember him at one point saying to a group—he was introducing me to a group that I was about to speak to, and he said, “This business of going after health care savings with cuts and rationing is the wrong way to go at the health care problem.” He said, “It is so wrong, it is criminal.” He went on to say, “It is an inept way of thinking about our health care problem.” But those ideas keep popping up, even if they are so wrong as to be nearly criminal, even though they are inept.

And you could not have, I do not think, much of a better panel to point us out the right path and to show us that not only is this the right path in principle, but that out in the real world, in virtually every single one of our States, CEOs who run health care companies are actually doing this and actually showing the improved outcomes and the savings. This is not hypothetical any longer. It is actually starting to result in real savings and real improvements.

So I am very grateful to you, Mr. Chairman, that you have chosen this as your opening salvo and I look forward to being a loyal ally to you and to your Ranking Member as you continue to press this issue forward.

The CHAIRMAN. And soon, Senator Collins and I are anticipating that we will have a hearing on some of the scams that are being perpetrated against seniors. So that is coming down the line very soon.

Senator Donnelly.

OPENING STATEMENT OF SENATOR JOE DONNELLY

Senator DONNELLY. Thank you, Mr. Chairman. I want to thank you and Ranking Member Collins for the opportunity to be on this committee.

This work is critically important. It is to preserve the health and dignity of our seniors, to enable them to get quality medical care while still meeting the financial challenges that our Nation faces. So we will continue to work to get it right. We will work to change the financial trajectory for our country and also still deliver extraordinary medical care for our seniors.

It is an honor to be here. Thank you.

The CHAIRMAN. Thank you, Senators, and thank you to our panel.

First, we are going to hear from Dr. Juliette Cubanski from the Kaiser Family Foundation, and we want her to put our conversation in the context of the Medicare senior. Dr. Cubanski is the As-

sociate Director for the Program on Medicare Policy with the Foundation here in Washington. She focuses on Medicare options among seniors and has been heavily involved in the Foundation's efforts to monitor the implementation of Medicare provisions in the health care reform bill and also assessing the implications of that bill.

Let me just introduce each of you and then we will go down the line so we know all that are on this very renowned panel.

Next, we will have Dr. Ken Thorpe, the Chair of the Department of Health Policy and Management at Emory. Dr. Thorpe is a renowned expert on the measurement of cost savings through care coordination and disease management, maximizing both the cost and the quality value of an intervention. Dr. Thorpe also leads the Partnership to Fight Chronic Disease, working with a coalition of patients, providers, and organizations to reform care to patients affected by multiple serious maladies.

Dr. David Goodman is a Professor of Pediatrics and of Health Policy, Director of the Center for Health Policy Research, and a Co-Principal Investigator of the Dartmouth Atlas of Health Care. Many of you have seen Dr. Goodman's report on unnecessary hospital readmissions. Dr. Goodman will be presenting his latest reports and the lessons to be learned from the study.

And Dr. David Blumenthal, the much younger brother of the Senator—

[Laughter.]

A nationally renowned health care delivery system reform expert and President of The Commonwealth Fund. Dr. Blumenthal will explain The Commonwealth Fund's newest proposals aimed at stabilizing American health care spending while producing lower cost and better value, not just Medicare. This proposal has the potential to save, Senator Collins, \$2 trillion over ten years.

So I will introduce you, but in the reverse order, with you after Dr. Cubanski.

Dr. Cubanski.

STATEMENT OF JULIETTE CUBANSKI, PH.D., ASSOCIATE DIRECTOR, MEDICARE POLICY PROJECT, HENRY J. KAISER FAMILY FOUNDATION

Ms. CUBANSKI. Thank you. Good afternoon, Chairman Nelson, Ranking Member Collins, and distinguished members of the committee. I am Juliette Cubanski, Associate Director of the Program on Medicare Policy at the Henry J. Kaiser Family Foundation. I appreciate the opportunity to be with you here today to discuss Medicare and the Foundation's recent polling on proposed Medicare program changes.

Medicare was established in 1965 to provide health insurance to people ages 65 and older and was expanded in 1972 to cover younger people with permanent disabilities. Medicare provides the same set of benefits to everyone who is covered, regardless of their income or medical history. Today, Medicare covers one in six Americans, or 50 million people.

The vast majority of seniors say Medicare is working well for them, and various surveys indicate that beneficiaries generally have reliable access to physicians, hospitals, and other providers.

People with Medicare tend to have significant health needs and modest financial resources. Four in ten beneficiaries have three or more chronic conditions, and half of beneficiaries have annual incomes less than \$22,500, which is about 200 percent of poverty for a single person.

Benefits covered by Medicare include hospitalizations, physician visits, preventive services, post-acute care, and prescription drugs. Under the traditional Medicare program, benefits are divided into three parts, A, B, and D. Part A benefits include hospital and skilled nursing facility stays, home health care, and hospice care. Part B benefits include physician visits, outpatient services, lab work, and preventive services. Part D is a voluntary prescription drug benefit delivered either through stand-alone prescription drug plans to supplement traditional Medicare or through Medicare Advantage plans.

Medicare Advantage, or Part C, is an alternative to traditional Medicare where beneficiaries can enroll in a private health plan for all Medicare covered benefits most often including prescription drugs. Today, more than a quarter of all beneficiaries are enrolled in Medicare Advantage plans.

Most Medicare beneficiaries report using one or more Medicare covered services each year. In 2009, 77 percent of people with Medicare had at least one physician visit, and nearly one in five was admitted to a hospital. While most beneficiaries use some medical care in any given year, a majority of Medicare spending is concentrated among a small share of beneficiaries with significant medical needs.

While Medicare helps pay for many important medical benefits, it does not cover all the costs of care. Medicare coverage requires premiums, deductibles, and cost sharing. For example, beneficiaries are subject to a deductible of nearly \$1,200 this year when they are hospitalized, and most beneficiaries pay a monthly premium for Part B services of about \$105 this year, while those with higher incomes pay a higher monthly premium. Medicare Advantage and Part D plans also have premiums and cost sharing for this coverage and these costs vary widely across plans.

And unlike most private health insurance policies, Medicare does not limit beneficiaries' annual out-of-pocket spending. And Medicare does not cover some services that the Medicare population is likely to need, most notably long-term services and supports and dental and vision services.

Most beneficiaries have some form of additional insurance to help pay their medical expenses, such as retiree health benefits, Medigap policies, or Medicaid for those with low incomes. Nevertheless, many beneficiaries face considerable and growing out-of-pocket costs to meet their medical and long-term care needs.

Looking to the future, Medicare is expected to face financing challenges due to rising health care costs and an aging population, and as you are all well aware, Medicare also is playing a major role in discussions about reducing the Federal budget deficit. Yet, the Foundation's recent polling shows that a majority of the public believes that deficit reduction can occur without major reductions in Medicare spending.

When asked about specific proposals to reduce Medicare spending, a majority of Americans support requiring drug companies to give Medicare a better deal on medications for low-income beneficiaries and requiring high-income seniors to pay higher Medicare premiums. Other proposals, however, are opposed by a majority of the public, including requiring all seniors to pay higher Medicare premiums, increasing the Medicare payroll tax, reducing Medicare payments to hospitals and other providers, and raising the age of Medicare eligibility.

While Medicare faces long-term financial challenges, it is important to remember that Medicare is a vital source of economic and health security for 50 million people today and millions more in the future. Moving forward, it will be important to assess the implications of proposed changes to the Medicare program for current and future beneficiaries, including effects on costs, quality, and access.

Again, thank you for this opportunity to testify and I look forward to your questions.

[The prepared statement of Ms. Cubanski follows:]



**AN OVERVIEW OF THE MEDICARE PROGRAM AND
MEDICARE BENEFICIARIES' COSTS AND SERVICE USE**

Statement of

Juliette Cubanski, Ph.D.

Associate Director, Program on Medicare Policy
The Henry J. Kaiser Family Foundation

Before the
Special Committee on Aging
U.S. Senate

"Strengthening Medicare for Today and the Future"

February 27, 2013

Good afternoon, Chairman Nelson, Ranking Member Collins, and distinguished members of the committee. I am Juliette Cubanski, Associate Director of the Program on Medicare Policy at The Henry J. Kaiser Family Foundation in Washington, D.C. The Kaiser Family Foundation is an independent, non-profit private operating foundation that is focused on health policy analysis, communications, and journalism. I appreciate the opportunity to be with you here this afternoon to provide an overview of the Medicare program and the beneficiary experience in Medicare today, as part of your hearing on strengthening Medicare for today and the future.

Medicare's Role in Providing Financial and Health Security to Elderly and Disabled Americans

Health insurance coverage is important to people of all ages, but is especially important for seniors and adults with disabilities who are significantly more likely than others to need costly medical care. Since its establishment nearly 50 years ago, Medicare has made a significant contribution to the lives of older Americans and people with disabilities by bolstering their economic and health security and relieving millions of older Americans from relying on charity care or having to bear the full burden of their health expenses. Prior to Medicare, more than half of all Americans over age 65 were uninsured (De Lew 2000) and nearly a third of seniors were in poverty; today virtually all seniors have Medicare coverage and the official poverty rate among those ages 65 and older is just under 9 percent (U.S. Bureau of the Census 2012). For younger people living with disabilities, Medicare has provided life-saving and life-sustaining access to care and treatment that would otherwise be out of reach for many and has allowed millions to stay in their homes rather than be institutionalized.

Today, the vast majority of seniors (80 percent) say that Medicare is working well for them (**Exhibit 1**). Beneficiaries generally have reliable access to physicians, hospitals, and other providers, and report relatively low rates of problems across a number of access measures. According to a recent survey by the Medicare Payment Advisory Commission (MedPAC), Medicare beneficiaries are about as likely as privately insured individuals to report problems finding a doctor who would see them, and this problem does not appear to be widespread (MedPAC 2012). Among the Medicare population at large, only 2 percent of Medicare beneficiaries looked for a new primary care physician in 2011 and reported a problem finding one. And a relatively small share of Medicare beneficiaries report experiencing problems accessing needed medical care. For example, according to the

Foundation's analysis of the Medicare Current Beneficiary Survey, only 5 percent of all beneficiaries reported trouble getting health care in 2010, while 9 percent said they delayed seeking medical care due to cost, and 9 percent said they had a serious medical problem for which they should have seen a doctor but did not.

An Overview of Medicare and Who Is Covered

Medicare was established in 1965 to provide health insurance coverage to people ages 65 and older, and was expanded in 1972 to cover younger people with permanent disabilities. Today, one in six Americans—50 million people—are covered by Medicare, including 41 million seniors and 9 million non-elderly adults living with permanent disabilities. Medicare covers people without regard to their income or medical history and provides the same set of benefits to everyone who is entitled to Medicare coverage. These benefits include hospitalizations, physician visits, preventive services, post-acute care, and a prescription drug benefit delivered through private plans, which have been playing an increasingly larger role in delivering all Medicare benefits in recent years.

Medicare covers a population that on the whole tends to have significant health needs and modest financial resources (**Exhibit 2**). Four in 10 Medicare beneficiaries have three or more chronic conditions, and nearly one fourth have a cognitive or mental impairment. The oldest beneficiaries, those ages 85 and older, are 13 percent of all people on Medicare, while the youngest, those under age 65 with disabilities, are 17 percent.

Many people with Medicare live on modest incomes primarily derived from Social Security. Half of beneficiaries had annual incomes less than \$22,500 in 2012—around 200 percent of the federal poverty level for a single person—and one-fourth of beneficiaries had incomes below \$14,000, while only a small share had relatively high incomes (**Exhibit 3**).

Medicare Benefits

Under the traditional Medicare program, benefits for hospital services, physician services, and prescription drugs are divided into three parts: Part A, Part B, and Part D, respectively. Under Medicare Advantage (Part C), private health plans offer integrated coverage of all benefits covered under Part A and Part B, and typically also Part D. Today, the majority of people with Medicare (73 percent) receive benefits through the traditional Medicare program, while 27 percent of beneficiaries are enrolled in a Medicare Advantage plan.

- **Part A** is the Hospital Insurance program, which helps pay for hospital visits and skilled nursing facility stays, post-acute home health care, and hospice care. Most people become entitled to Part A after paying payroll taxes for 10 years and enrollment is automatic upon reaching age 65.
- **Part B** is the Supplementary Medical Insurance program, which helps pay for physician visits, outpatient hospital services, lab work, and preventive services such as mammograms and flu shots. Enrollment in Part B is voluntary, but the majority of people who are entitled to Part A also enroll in Part B.
- **Part D**, which started in 2006, is a voluntary, outpatient prescription drug benefit, delivered either through private stand-alone prescription drug plans to supplement traditional Medicare or through Medicare Advantage plans. Part D plans are required to provide a “standard” drug benefit, but plans can vary the design of the benefit as long as it is at least equal in value to the standard benefit, and in fact most plans offer an alternative benefit design. In 2013, beneficiaries who want to enroll in Part D have more than 20 stand-alone prescription drug plans to choose from in each state, along with many Medicare Advantage plans. Today, about 90 percent of people in Medicare have drug coverage, a majority of whom (32 million beneficiaries) are enrolled in a Part D plan.
- **Part C**, known as Medicare Advantage, offers an alternative to traditional Medicare, where beneficiaries can enroll in a private plan, such as a health maintenance organization or preferred provider organization. These plans receive payments from the government to provide enrollees with all Medicare-covered benefits, most often including the Part D drug benefit, and, often, extra benefits that Medicare does not cover such as vision and dental services. Today about 13 million Medicare beneficiaries, more than a quarter of all people with Medicare, are enrolled in Medicare Advantage plans **(Exhibit 4)**.

Despite the important benefits that Medicare covers, there are gaps in Medicare's benefit package. Medicare does not pay for many relatively expensive services and supplies that are often needed by the elderly and younger beneficiaries with disabilities. Notably, Medicare does not pay for most custodial long-term services and supports, such as extended nursing home stays. Traditional Medicare also does not cover vision exams or eyeglasses, dental services, or hearing aids.

Beneficiaries' Use of Medicare-Covered Services

A majority of Medicare beneficiaries enrolled in traditional Medicare reported using one or more Medicare-covered services in 2009 (**Exhibit 5**). Nearly eight in ten beneficiaries (77 percent) visited a physician in 2009, with a median number of 4 visits per patient. Nearly one in five (19 percent) reported at least one inpatient hospital stay, and 20 percent of those who were hospitalized in the year were readmitted within 30 days of at least one of their initial hospital discharges. Among the 9 percent of beneficiaries who reported using home health services, the median number of visits was 17. Nearly three in ten beneficiaries (28 percent) had at least one visit to an emergency department in 2009; 12 percent had two or more visits. Five percent had a skilled nursing facility stay in 2009, and 2 percent had a hospice stay.

While most people with Medicare use some amount of medical care in any given year, a majority of spending is concentrated among the relatively small share of beneficiaries with significant needs and medical expenses. In 2009, 10 percent of beneficiaries in traditional Medicare accounted for nearly 60 percent of Medicare spending (**Exhibit 6**).

How Much Do Beneficiaries Pay for Medicare?

While Medicare covers a wide array of medical services, Medicare coverage is not free to beneficiaries. In addition to paying into Medicare during their working years through payroll taxes, people with Medicare face premiums, deductibles, and cost-sharing amounts for Medicare coverage. Unlike typical private insurance plans, traditional Medicare does not place a limit on how much beneficiaries have to spend out of pocket for inpatient and outpatient services each year.

- **Part A:** Most beneficiaries do not pay a monthly premium for Part A services, but are subject to a deductible before Medicare Part A coverage begins. In 2013, the Part A deductible for each "spell of illness" is \$1,184 for an inpatient hospital stay. Beneficiaries are generally subject to coinsurance for benefits covered under Part A, including extended stays in a hospital (\$296 per day for days 61-90 and \$592 for days 91-150 in 2013) or skilled nursing facility (\$148 per day for days 21-100 in 2013). There is no copayment for home health visits.
- **Part B:** Beneficiaries enrolled in Part B are generally required to pay a monthly premium (\$104.90 in 2013). Beneficiaries with annual incomes greater than \$85,000

for an individual or \$170,000 for a couple pay a higher, income-related monthly Part B premium, ranging from \$146.90 to \$335.70 in 2013. Approximately 5 percent of all Medicare beneficiaries are required to pay the Part B income-related premium in 2013, but because the income thresholds are frozen at their current levels through 2019, a larger share of beneficiaries will be required to pay the income-related Part B premium over the next several years. Part B benefits are subject to an annual deductible (\$147 in 2013), and most Part B services are subject to coinsurance of 20 percent. No coinsurance and deductibles are charged for preventive services that are rated A or B by the U.S. Preventive Services Task Force.

- **Part C:** Medicare Advantage plan premiums and cost sharing vary widely across plans. Medicare Advantage enrollees generally pay the monthly Part B premium and often pay an additional premium directly to their plan. In 2013, the average monthly premium for Medicare Advantage drug plans (weighted by 2012 enrollment) is \$39; premiums vary by plan type and are lower for HMOs (\$30 per month) than for PPOs (\$64 per month) (Gold et al. 2012). Medicare Advantage plans are required to limit beneficiaries' total out-of-pocket spending each year (the maximum is \$6,700 in 2013), but cost-sharing requirements vary widely across plans in 2013.
- **Part D:** In general, individuals who sign up for a Part D plan pay a monthly premium, along with cost-sharing amounts for each prescription. These amounts vary by plan. In 2013, the average monthly premium for stand-alone prescription drug plans is \$40 (weighted by 2012 enrollment) (Hoadley et al. 2012). Higher-income Part D enrollees are required to pay an income-related premium surcharge in addition to their monthly Part D premium, ranging from \$11.60 to \$66.60 in 2013. The standard Part D benefit in 2013 requires enrollees to pay a deductible of \$325 and 25 percent coinsurance for prescriptions, up to an initial coverage limit of \$2,970 in total drug costs, followed by a coverage gap, where enrollees pay 47.5 percent of the cost of brand-name drugs and 79 percent of the cost of generic drugs until they have spent \$4,750 out of pocket (excluding premiums) (**Exhibit 7**).

Taken altogether, Medicare's fairly high cost-sharing requirements could be a burden for beneficiaries with fixed incomes or extensive medical needs, while the absence of an annual out-of-pocket spending limit places beneficiaries at risk of having potentially catastrophic medical expenses. As a result, a majority of beneficiaries in traditional Medicare have some form of additional insurance to help with out-of-pocket costs and provide benefits that

Medicare does not cover **(Exhibit 8)**. Sources of supplemental coverage include: employer-sponsored retiree health benefits (41 percent); private insurance policies known as Medigap, which cover some or all of Medicare's deductibles and coinsurance (21 percent); and Medicaid, which pays Medicare premiums and cost sharing and provides additional benefits, such as long-term services and supports and dental services, for most of the nine million low-income Medicare beneficiaries who are currently also covered by Medicaid. Beneficiaries with both Medicare and Medicaid are referred to as "dual eligibles."

Beneficiaries who have some type of private supplemental insurance (i.e., retiree health benefits or Medigap) to help cover their Medicare-related expenses typically pay premiums for this coverage. The 17 percent of beneficiaries in traditional Medicare who have no supplemental coverage do not face these premium costs, but they are responsible for paying the full amount of their Medicare cost-sharing obligations out of their own pockets.

As a result, many beneficiaries face significant out-of-pocket costs for both premiums and non-premium expenses to meet their medical and long-term care needs. Spending on Part B and Part D premiums and cost sharing as a share of annual average Social Security benefit payments has increased from 6 percent in 1970 to 26 percent in 2010 **(Exhibit 9)**. Overall, beneficiaries' out-of-pocket health spending has risen faster than their incomes in recent years, from around 12 percent in 1997 to more than 15 percent in 2009, and Medicare households spend three times as much of their household budgets on health care compared with non-Medicare households (15 percent versus 5 percent) **(Exhibit 10)**. Altogether, these facts could warrant focusing greater attention on the adequacy of Medicare coverage and on ways to improve the Medicare program and the financial protection it provides to beneficiaries.

Future Outlook

Looking to the future, Medicare is expected to face significant financing challenges due to rising health care costs, the aging of the U.S. population, and the declining ratio of workers to beneficiaries. Medicare also is playing a major role in policy discussions about reducing the federal budget deficit. As part of these discussions, a number of Medicare proposals have been made, including: restructuring Medicare benefits and cost sharing; eliminating "first-dollar" Medigap coverage; increasing Medicare premiums for all beneficiaries or those with relatively high incomes; raising the Medicare eligibility age; changing Medicare

from its current defined benefit structure to a “premium support” system; and accelerating the implementation of delivery system reforms (Kaiser Family Foundation 2013a).

While policymakers weigh potential Medicare savings options to reduce the deficit, the public does not perceive a need for significant cuts. The Foundation’s recent polling shows that a majority of the public (75 percent) believes that deficit reduction can occur without major reductions in Medicare spending (Kaiser Family Foundation 2013b). In fact, 58 percent of Americans say they would not be willing to see any reductions to Medicare as part of deficit reduction discussions. When asked about specific proposals to reduce Medicare spending in the context of deficit reduction, a majority of Americans expressed support for two proposals: 1) requiring drug companies to give the federal government a better deal on medications for low-income people on Medicare; and 2) requiring high-income seniors to pay higher Medicare premiums; these proposals were supported by 85 percent and 59 percent of Americans, respectively (**Exhibit 11**). Notably, the survey also shows that relatively few Americans (roughly two in ten) are aware that wealthier Medicare beneficiaries already pay higher premiums for their Medicare coverage.

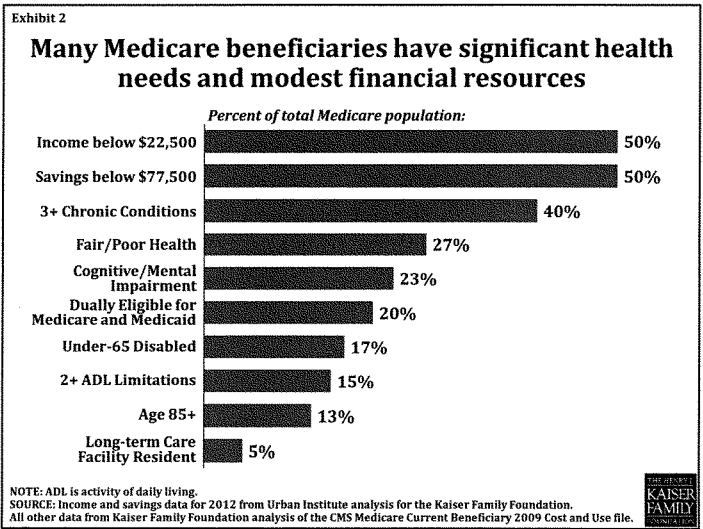
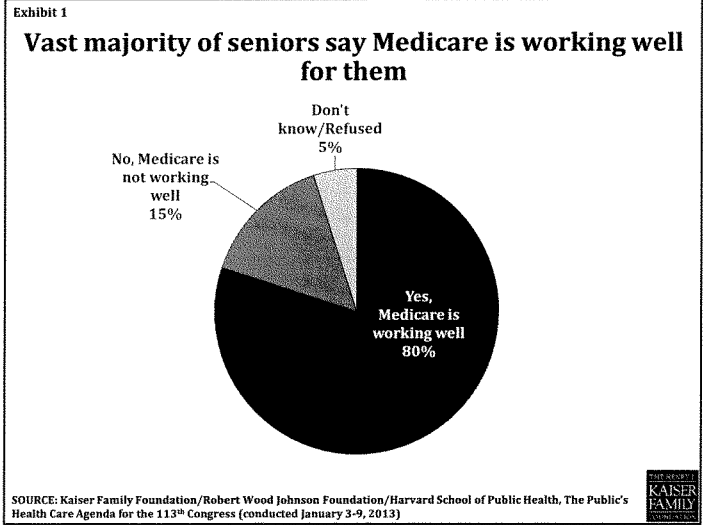
Other proposals are opposed by a majority of Americans, including: 1) requiring all seniors to pay higher Medicare premiums; 2) increasing the payroll taxes workers and employers pay to help fund Medicare; 3) reducing payments to hospitals and other health care providers for treating people covered by Medicare; and 4) gradually raising the age of Medicare eligibility from 65 to 67 for future retirees. These proposals were opposed by 85 percent, 55 percent, 51 percent, and 51 percent of Americans, respectively.

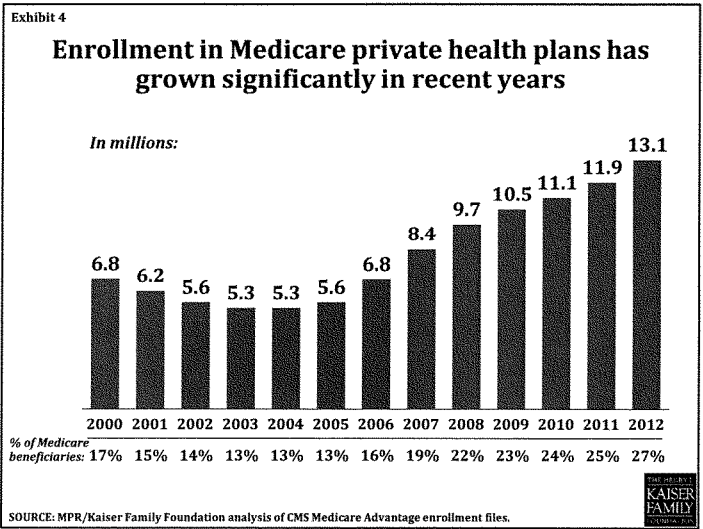
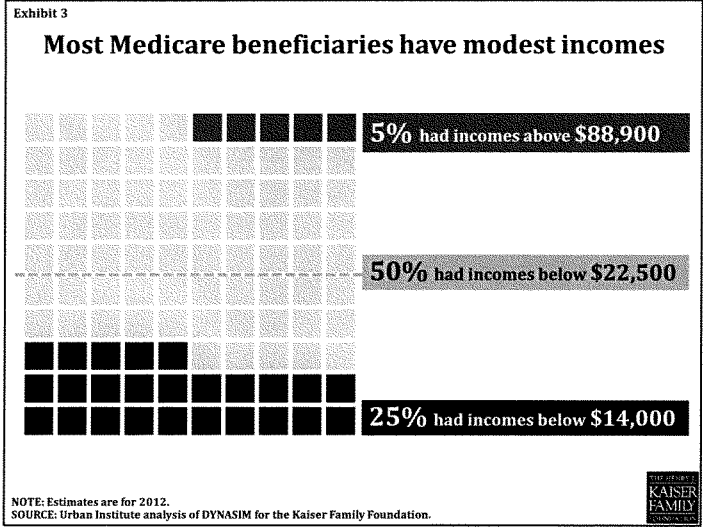
A challenge facing policymakers is finding ways to control Medicare spending growth and sustain Medicare for future generations, while setting fair payments to providers and plans, and without negatively affecting patient care, imposing an undue financial burden on seniors and people with disabilities in Medicare, or shifting costs onto other payers. While Medicare faces long-term financial challenges, it is also important to remember that Medicare is a vital source of financial and health security for 50 million people today, and the vast majority of seniors say that Medicare is working well for them. Therefore, moving forward it will be important to assess the implications of proposed changes to the Medicare program for current and future beneficiaries.

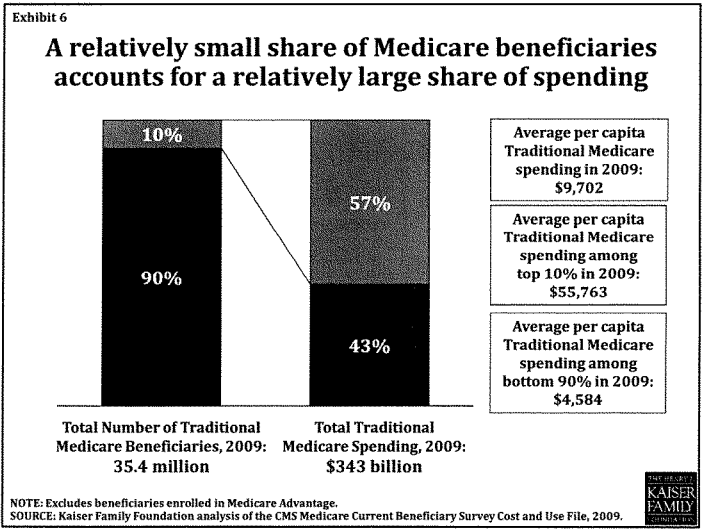
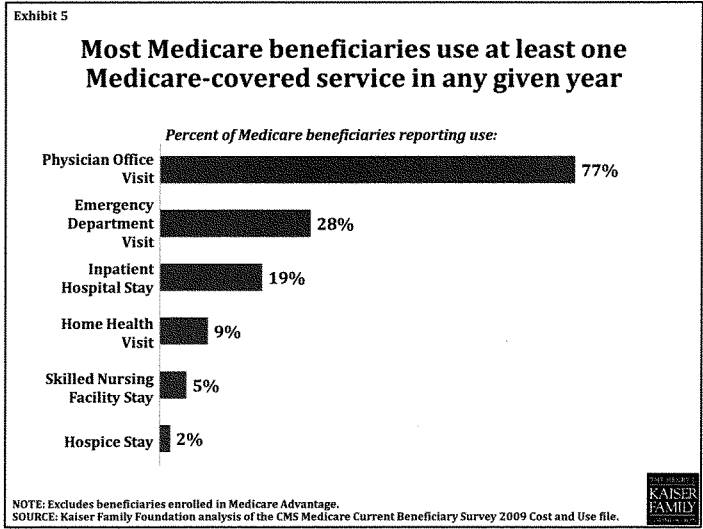
Again, I appreciate this opportunity to testify, and I will be happy to take your questions.

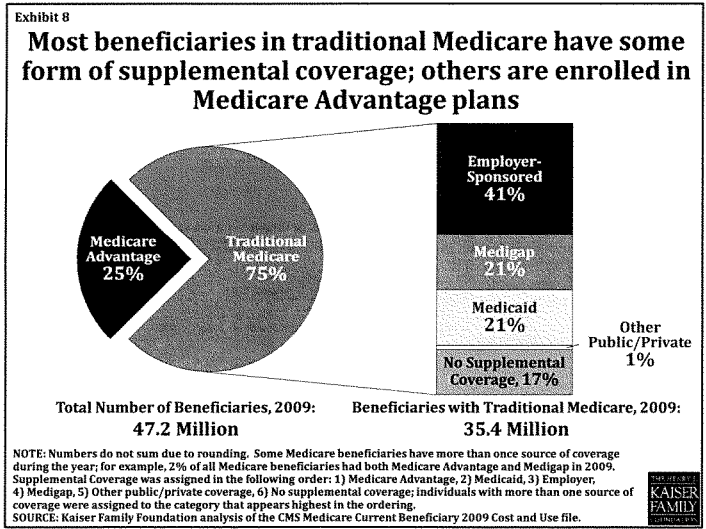
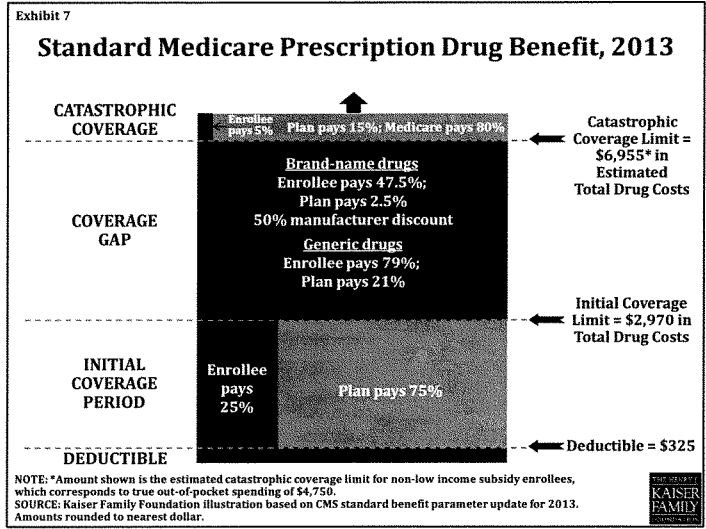
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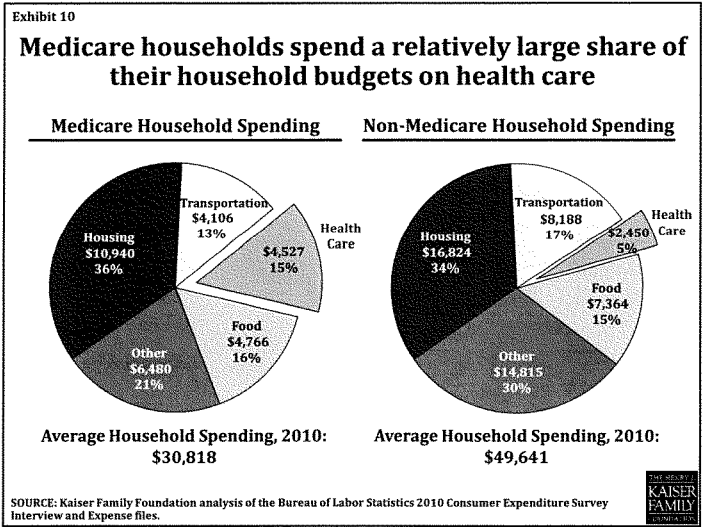
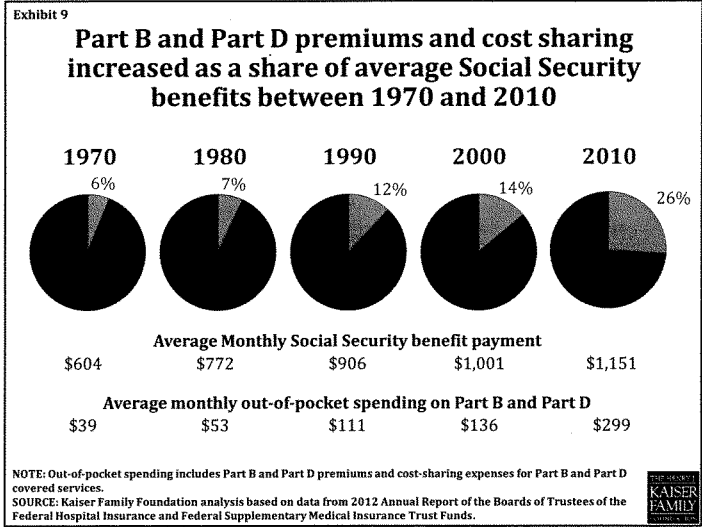
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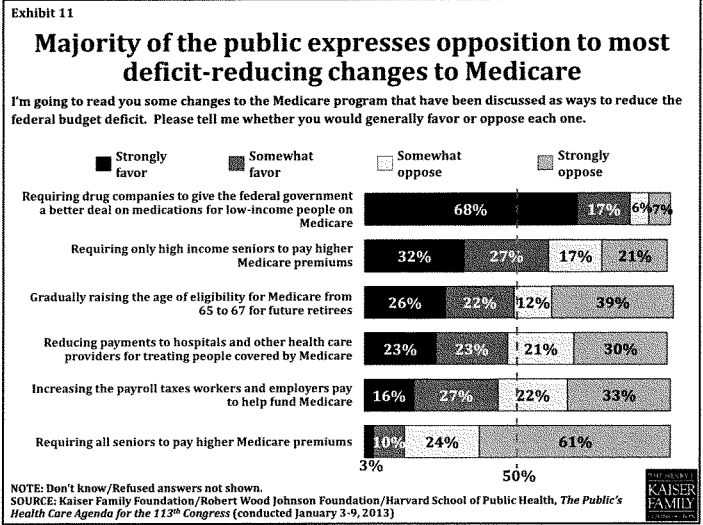












The CHAIRMAN. Thank you, Dr. Cubanski.

We are going to go right down the line and then I am going to defer asking questions so that you all can get your questions in, and then I will just do clean-up toward the end.

Dr. Goodman.

STATEMENT OF DAVID GOODMAN, M.D., DIRECTOR, DARTMOUTH INSTITUTE FOR HEALTH POLICY AND CLINICAL PRACTICE AND CO-PRINCIPAL INVESTIGATOR, DARTMOUTH ATLAS OF HEALTH CARE

Dr. GOODMAN. Thank you, Mr. Chairman, for the invitation to testify about hospital readmissions.

Readmissions are a case study of what is right and what is wrong in health care improvement efforts. At Dartmouth, we have studied variation in the care of Medicare beneficiaries and unnecessary readmissions stand out as a \$15 billion a year problem. Readmissions, however, should not be viewed as a discrete problem in quality, but connected to larger structural deficits in care delivery and financing.

No Medicare patient should have to be readmitted to the hospital because of poor quality of care during the initial hospitalization, inadequate discharge planning, or lack of care coordination with community providers. What is often ignored in the focus on improving coordination in the care of patients after they leave the hospital is that patients often experience similar problems in fragmented care before they are initially admitted.

Interest in readmissions has been longstanding, but has increased recently because rates are now publicly reported, and many sections of the ACA are concerned with reducing rehospitalization. The ACA also mandates penalties, as much as one percent of a total hospital's base operating DRG payments.

Through funding from the Robert Wood Johnson Foundation, the Dartmouth Atlas released a report this month, the Revolving Door Report on U.S. Hospital Readmissions. For common causes of medical hospitalization, such as congestive heart failure, almost one in five Medicare patients is rehospitalized in 30 days. Despite the high rates of readmissions Nationally, there is marked variation across hospitals. Patient factors explain only about ten percent of these differences.

While some hospitals have high rates, there are many with relatively low rates. For example, while the National rate for 30-day readmissions for medical discharges was 15.9 percent in 2010, the NCH Health System in Naples, Florida, had a rate of 14.2 percent and the three largest hospitals in Maine had rates below the National average, including only 13.9 percent of patients readmitted at Maine General in Augusta. And New Hampshire did very well, as well.

Overall readmission rates were virtually unchanged, however, from 2004 to 2010, although some hospitals again demonstrated notable reductions.

Our failure to address high rates of rehospitalizations Nationally is rooted in improvement efforts that are too narrowly focused and are unconnected with the larger problems in Medicare. Efforts to reduce unnecessary rehospitalizations are concentrated on care im-

provements around the time of discharge, again with little attention to the care of the patients before the first hospitalization or after the 30th day.

The chances that patients are readmitted to the hospital in a given location are closely linked to the chances that they are initially hospitalized. We have known for almost 40 years that hospitalization rates vary markedly across areas, even after controlling for patient differences. This dramatic variation in the care of patients is strongly affected by long-embedded practice styles coupled with financial incentives to fill hospital beds.

What can we do about it? First is to pay for good care, not more care. Incentives to improve community-based care that keep patients healthy and out of the hospital whenever possible need to replace fee-for-service payments that reward higher volumes of care. The specific penalty for excessive readmissions ignores the pervasive incentives in the Medicare program for the initial hospitalization. Accountable Care Organizations and other forms of shared savings and population-based payments are promising innovations in the way that we pay and organize health care. The incentives in these models encourage integrated delivery systems that tie together the fragmented set of providers found in many communities. These and other new payment models need to be coupled with an expanded set of indicators that guide providers and patients in their search for quality.

Second is this issue of indicators. Readmission rate is an indicator, but the focus on 30-day readmission rate is useful only when accompanied by a full set of indicators that track the actual experiences of Medicare patients, particularly those with chronic illness. At present, ACOs are monitored on 33 quality metrics, or will be monitored on 33 quality metrics, but this is a list that everyone agrees needs to evolve as there is better understanding of the short list, of the most important measures. These need to be in the direction of patient reported outcomes, like health status, not just readmission rates. If we do not continue to expand the breadth and depth of quality indicators, but not the number, we will not recognize the most important opportunities to improve care and save needless expenditures. The coupling of robust health care measures with broad population-based payment models will help ensure that the quality of care every day is as good as the care 30 days after hospital discharge.

[The prepared statement of Dr. Goodman follows:]

Beyond Reducing Hospital Readmissions:

The Thirty-First Day

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Invited Testimony

The United States Senate Special Committee on Aging
Hearing on "Strengthening Medicare for Today and the Future"

February 27, 2013

Executive Summary

Thank you, Mr. Chairman, for the invitation to testify about hospital readmissions and the opportunity for improving care for Medicare patients.

At Dartmouth we have studied variation in the care of Medicare beneficiaries, and unnecessary readmissions stands out as a \$15 billion problem. Readmissions, however, should not be viewed as a discrete problem in quality, but connected to larger structural deficits in care delivery and financing.

UNNECESSARY HOSPITAL READMISSIONS ARE A KNOWN, COSTLY, AND LARGELY PREVENTABLE PROBLEM.

No Medicare patient should have to be readmitted to the hospital because of poor quality of care during the initial hospitalization, inadequate discharge planning, or a lack of care coordination with community providers.

What is often ignored in the focus on improving coordination in the care of patients after they leave the hospital is that patients often experience similar problems in fragmented care before they are initially admitted.

HOSPITAL READMISSIONS: WHY IS THIS IMPORTANT TODAY?

Interest in readmissions has been longstanding but has increased recently because rates are now publicly reported and many sections of The Patient Protection and Affordable Care Act (PL111-48) are concerned reducing rehospitalization. The ACA also mandates penalties, as much as 1% of a hospital's total base operating DRG payments.

WHAT IS KNOWN ABOUT UNNECESSARY READMISSIONS IN MEDICARE PATIENTS?

Through funding from the Robert Wood Johnson Foundation, the Dartmouth Atlas released a report this month, "*The Revolving Door: A Report on U.S. Hospital Readmissions*".

For common causes of medical hospitalization, such as congestive heart failure, almost one in five Medicare patients are rehospitalized in thirty days. Despite the high rates of readmissions nationally, there is marked variation across hospitals. Patient factors explain only about 10% of these differences. While some hospitals have high rates, there are many with relatively low rates. For example, while the national rate for thirty-day readmissions for medical discharges was 15.9% in 2010, the NCH Health System in Naples, FL had a rate of 14.2%, and the three largest hospitals in Maine had rates below the national average, including only 13.9% of patients readmitted at Maine General in Augusta. [The percent of patients rehospitalized at St. Charles Medical Center in Bend, OR was 13.2%, 12.6% at St. Marks Hospital in Salt Lake City, 14.1% at St. Johns Hospital in Springfield, MO, and at Banner Del E. Webb Medical Center in Sun City West, AZ the rate was 14.1%.] Overall readmission rates were virtually unchanged from 2004 to 2010, although some hospitals demonstrated notable reductions.

CONNECTING THE READMISSION PROBLEM TO THE LARGER WEAKNESSES IN MEDICARE.

Our failure to address high rates of rehospitalization is rooted in improvement efforts that are too narrowly focused and are unconnected with the larger problems in Medicare. Efforts to reduce unnecessary rehospitalizations are concentrated on care improvements around the time of discharge with little attention to the care of patients before the first hospitalization or after the thirtieth day.

WE ARE MISSING AN IMPORTANT CAUSE OF READMISSIONS.

The chances that patients are readmitted to the hospital in a given location (i.e. region or hospital) are closely linked to the chances that they are initially hospitalized. We have known for almost forty years that hospitalization rates vary markedly across areas even after controlling for patient differences. This dramatic variation in the care of patients is strongly affected by long embedded practice styles couple with financial incentives to fill hospital beds.

HOW TO IMPROVE THE CARE OF MEDICARE PATIENTS BEFORE, DURING, AND AFTER HOSPITALIZATION.

Pay for good care, not more care.

Incentives to improve community-based care that keeps patients healthy and out of the hospital whenever possible need to replace fee-for-service payments that reward higher volumes of care. The specific penalty for excessive readmissions ignores the pervasive incentives in the Medicare program for the initial hospitalization.

Accountable care organizations (ACOs) and other forms of shared savings and population-based payments are promising innovations in the way that we pay and organize health care. The incentives in these models encourage integrated delivery systems that tie together the fragmented set of providers found in many communities. These and other new payment models need to be coupled with an expanded set of quality indicators that guide providers and patients in their search for quality.

Measure care quality with metrics that are meaningful to patients.

The focus on thirty day readmission rates is useful only when accompanied by a full set of indicators that track the experiences of Medicare patients with chronic illness. At present ACOs are monitored on 33 quality metrics. This list needs to evolve, as there is a better understanding of the short list of the most important measures. If we don't continue to expand the breadth and depth of quality indicators, we will not recognized the most important opportunities to improve care and save needless expenditures.

The coupling of robust health care measures with broad population-based payment models will help ensure that quality care *every day* is as good as the care thirty days after hospital discharge.

Beyond Reducing Hospital Readmissions:**The Thirty-First Day**

Thank you, Mr. Chairman, for the invitation to testify about hospital readmissions and the opportunity to improve care for Medicare patients. I am a physician who has practiced in primary and specialist care in urban, rural, and academic settings. I still provide care for patients. Most importantly for this hearing, for more than twenty years I have studied regional and provider variation in the health care with my collaborators John Wennberg and Elliott Fisher at the Dartmouth Institute for Health Policy and Clinical Practice. I am the Director for the Center for Health Policy Research at the Institute and lead the *Dartmouth Atlas of Health Care*.

In our studies of the variation in medical care among Medicare patients, unnecessary readmissions stand out as a problem. Readmissions should not be viewed as a discrete problem in quality, but connected to larger structural deficits in the delivery and financing of care.

UNNECESSARY HOSPITAL READMISSIONS ARE A KNOWN, COSTLY, AND LARGELY PREVENTABLE PROBLEM.

No Medicare patient should have to be readmitted to the hospital because of poor quality of care during the initial hospitalization, inadequate discharge planning, or a lack of care coordination with community providers. Unfortunately, many patients face diminished prospects of recovery due to the failure of hospital-based clinicians to develop a care plan that is coordinated with the next care providers, those in community clinics and practices. Many patients leave the hospital without a list of medications, or an understanding of when the medications need to be taken. Others have no way to get to a pharmacy for the medications or were not scheduled for follow-up care with a doctor or a nurse.

The failure of good discharge planning and care coordination leads to needless misery for patients. No one wants to become sick again and land back in a hospital bed when it could have been prevented with better care. As the most expensive venue of medical care, unnecessary hospital readmissions cost patients and the public over \$15 billion per year.¹ Improving the care of patients leaving the hospital is a clear win for patients, their families, and the Medicare program.

Patients leaving the hospital have just completed the first step in their treatment. Full convalescence after a major acute illness can take weeks or months, and many patients with chronic illness require life-long coordinated care from primary care and specialist physicians, home health nurses, and other providers. The successful outcome of hospitalized patients requires that hospitals expand their traditional role of inpatient treatment to include a seamless transition with community providers.

The focus on reducing fragmentation in care after hospitalization ignores the uncoordinated care many patients experience before they are initially admitted. The current payment model, with some exceptions, incentivizes hospitals as the site of care, and hinders the effective delivery of the care that can keep patients in the community during an acute illness.

HOSPITAL READMISSIONS: WHY IS THIS IMPORTANT TODAY?

Unnecessary hospital readmissions have long been a concern of clinicians and health policy analysts, but interest has increased recently for two reasons: First, the variation in the performance of hospitals in good care transition has become visible to the public with reporting of thirty day readmission rates by the Dartmouth Atlas and CMS. Second, many sections of The Patient Protection and Affordable Care Act (PL111-148) are concerned with unnecessary readmissions. The implementation of the ACA has begun to bring some hospitals, community providers, and researchers together to address the problem.

¹ Medicare Payment Advisory Commission. 2007. Report to the Congress: Promoting Greater Efficiency in Medicare. Washington, DC: Medicare Payment Advisory Commission, p. 103.

The ACA requires a wide range of reporting and improvement activities to prevent readmissions, specifically “the implementation of activities to prevent hospital readmissions through a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by and appropriate health care professionals.” Most notably, Section 3025 (i.e. Hospital Readmission Reduction Program) requires the penalization of hospitals with excessively high rates through payment cuts as high as 1% of a hospital’s total base operating DRG payments. This penalty can increase to as much as 3% in FY 2015. The attention of the ACA to readmissions is explicit. The remedies for poor and inefficient care that leads to needless hospitalization in many regions is less obvious but is of even greater importance.

Reducing readmission rates is possible through well-tested strategies that have been known for many years. The combination of improved communication between physicians and patients, better patient adherence to care plans including medications, and the consistent application of evidenced-based medical care has been shown to reduce readmissions in clinical trials.¹ The best way to extend these improvement methods broadly to thousands of hospitals is not as clear, and many questions remain about the importance of focusing on readmissions compared to other problems in care delivery and financing of Medicare, such as the unwarranted variation in overall hospitalization rates.

WHAT IS KNOWN ABOUT UNNECESSARY READMISSIONS IN MEDICARE PATIENTS?

Through funding from the Robert Wood Johnson Foundation, the Dartmouth Atlas has extensively studied the care provided to Medicare patients after hospitalization and has issued two reports.² The most recent report, “*The Revolving Door: A Report on U.S. Hospital*

¹ Peikes D, Chen A, Schore J, Brown R. Effects of care coordination on hospitalization, quality of care, and health care expenditures among Medicare beneficiaries: 15 randomized trials. *JAMA* 2009;301(6):603-18.

² Goodman DC, Fisher ES, Chang CH and the Dartmouth Atlas of Health Care. *After Hospitalization: A Dartmouth Atlas Report on Post-Acute Care for Medicare Beneficiaries*. Hanover, NH: Dartmouth College. 2011. and Goodman DC, Fisher ES, Chang CH; and The Dartmouth Atlas of Health Care. *After Hospitalization: A Dartmouth Atlas Report on Readmissions in Medicare Beneficiaries in Robert Wood Johnson Foundation. The*

Readmissions" was issued this month and is available from the Robert Wood Johnson Foundation web site. (<http://www.rwjf.org/en/research-publications/find-rwjf-research/2013/02/the-revolving-door--a-report-on-u-s--hospital-readmissions.html>) The Atlas also provides extensive data on its web site about thirty day readmissions and the use of ambulatory care after discharge (e.g. visits to primary care clinicians, to any clinician, and to emergency rooms). (www.dartmouthatlas.org)

For common causes of medical hospitalization, such as congestive heart failure, almost one in five Medicare patients are rehospitalized in thirty days. The chances of coming back into the hospital depend on where the patient lives and which hospital provides the initial care. Thirty-day readmission rates for medical and surgical discharges varied markedly across Hospital Referral Regions and hospitals in 2010 (Figure 1, Table 2). Patient factors explain only about 10% of these differences according to analyses done at Dartmouth.¹ A much greater proportion of the variation can be explained by a complicated set of factors related to quality of care and health system capacity within the hospital and the community.² These are the same factors that explain the variation in overall hospital use.

Despite the overall high rates of readmissions in the U.S. (Table 1), there are many hospitals that have relatively low readmission rates. Although the national rate for thirty-day readmissions for medical discharges was 15.9% in 2010, there were pockets of improvement and excellence. The NCH Health System in Naples, FL had a rate of 14.2%, and the three largest hospitals in Maine had rates below the national average, including only 13.9% of patients readmitted at Maine General in Augusta. The percent of patients rehospitalized at St. Charles Medical Center in Bend, OR was 13.2%, 12.6% at St. Marks Hospital in Salt Lake City, 14.1% at St. Johns Hospital in Springfield, MO, and at Banner Del E. Webb Medical Center in Sun City West, AZ the rate was 14.1%.

Revolving Door: A Report on U.S. Hospital Readmissions. Princeton, NJ: Robert Wood Johnson Foundation. 2013.

¹ These unpublished analyses were conducted using CMS risk adjustment methods for acute myocardial infarction discharges.

² Epstein AM, Jha AK, Orav EJ. The relationship between hospital admission rates and rehospitalizations. *The New England Journal of Medicine.* Dec 15 2011;365(24):2287-2295.

Although national readmission rates were virtually unchanged from 2004 to 2010, (Table 2) some hospitals demonstrated notable reductions. St Francis Hospital in Hartford, CT had a 8.9% reduction in surgical readmissions, Concord Hospital in NH had a 32% decrease while Mt Sinai in Manhattan had a 16% decline and St. Vincent in Indianapolis, IN had a 7.8% decrease. Brigham and Women's in Boston, MA had an 8.4% decrease in medical readmissions. Improvements in readmission rates also occurred at hospitals in Illinois, South Carolina, Tennessee, Texas, and West Virginia and many other states.

The Dartmouth Atlas also reports other care indicators for Medicare beneficiaries after hospitalization. Fifty seven percent of patients had no primary care visit within 14 days of hospital discharge for a medical condition, and almost 19% had an emergency room visit within thirty days. Just as with readmission rates, there was substantial variation in these rates across regions and hospitals. Little improvement was noted between 2004 and 2010 in primary visits while the percent of patients visiting the emergency room increased nationally by 9%. (www.dartmouthatlas.org)

We have a persistent problem in the care of patients when they leave the hospital. The problem is of tremendous importance to patients, seemingly difficult and expensive to remedy, and is part of a larger problem in health care capacity and financial incentives.

CONNECTING THE READMISSION PROBLEM TO THE LARGER WEAKNESSES IN MEDICARE.

Our failure to address high rates of re-hospitalization is rooted in improvement efforts that are too narrowly focused and are unconnected with the larger problems in Medicare. The hospital payment penalty mandated by the Affordable Care Act is viewed by some as a laudable incentive towards better care transitions. But it may have unintended consequences by overemphasizing a single, albeit an important, dimension of care. Efforts to reduce unnecessary re-hospitalizations are concentrated on care improvements around the time of discharge with little attention to the care of patients before the first hospitalization or after the thirtieth day.

WE ARE MISSING AN IMPORTANT CAUSE OF READMISSIONS.

The chances that patients are readmitted to the hospital in a given location (i.e. region or hospital) are closely linked to the chances that they are initially hospitalized. We have known for almost forty years that hospitalization rates vary markedly across areas, even after controlling for differences in patient health and socio-economic status.¹ For patients with medical conditions, such as congestive heart failure or pneumonia, these dramatic differences in the care of patients are strongly affected by the per capita supply of hospital beds. Well-meaning doctors tend to use whatever beds are available even when there are reasonable community-based treatment options. Hospitals are incentivized to fill beds with fee-for-service payments that reimburse with little regard to the quality of care provided.

The connection of thirty-day readmissions to the more general use of hospitals as a site of care is seen in Figures 2 and 3. Across the 306 Hospital Referral Regions, readmission rates correlate with the overall number of medical discharges per 1,000 beneficiaries. There is a similarly high correlation with the number of days patients with chronic illness spend in the hospital in the last six months of life. Readmissions are connected to the larger problem of excessive hospitalization that occurs in many areas of the country.

HOW TO IMPROVE THE CARE OF MEDICARE PATIENTS BEFORE, DURING, AND AFTER HOSPITALIZATION.**Pay for good care, not more care.**

Much of the attention on reducing readmissions has been in the direction of better transitional care. CMS will begin this year to provide bundled payment to physicians for transitional care services after discharge from a health care facility, such as an acute care hospital. The estimated payments for the first year of these services are \$600 million.²

¹ Wennberg J. *Tracking Medicine: A Researcher's Quest to Understand Health Care*. New York: Oxford University Press; 2010.

² Bindman AB, Blum JD, Kronick R. Medicare's transitional care payment – A step toward the medical home. *New England Journal of Medicine* 2013; 368:692-694.

These types of payment are a step in the right direction, but fail to change the underlying incentives that are permissive of needless hospital-based care.

Incentives to improve community-based care that keep patients healthy and out of the hospital whenever possible need to replace fee-for-service payments that reward higher volumes of care. The specific penalty for excessive readmissions ignores the incentives in the Medicare program for the initial hospitalization. Some of the most effective methods for reducing the *number of rehospitalizations* also reduce the *number of initial hospitalizations*. This improvement can occur *without any change in the readmission rate*, as the number of initial and subsequent hospitalizations decreases proportionately.¹ These are the type of effective community-based interventions that should be incentivized.

Accountable care organizations (ACOs) and other forms of shared savings and population-based payments are promising innovations in the way that we pay and organize health care.² The incentives are strongly in the direction of the care that patients want and need, which means high quality ambulatory care, inpatient care coordinated with community services, and patient-centered shared decision making that keeps the patient at the center of health care decisions. The incentives in these models encourage integrated delivery models that ties together the fragmented set of providers found in many communities. These and other new payment models need to be coupled with an expanded set of quality indicators that guide providers and patients in their search for quality.

Measure care quality with metrics that are meaningful to patients.

The U.S. health care system has traveled a long journey from John Wennberg's 1973 Science³ paper on medical practice variation in Vermont to today's assortment of publicly available measures of health quality and utilization reported by the Dartmouth Atlas, CMS,

¹ 1. Brock J, Mitchell J, Irby K, et al. Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. *JAMA*. 2013;309(4):381-391.

² Fisher ES, Shortell SM, Kreindler SA, Van Citters AD, Larson BK. A framework for evaluating the formation, implementation, and performance of accountable care organizations. *Health affairs (Project Hope)*. Nov 2012;31(11):2368-2378.

³ Wennberg J, Gittelsohn. Small area variations in health care delivery. *Science*. Dec 14 1973;182(117):1102-1108.

and others. Measuring health care has been of extraordinarily high value in identifying what work's well and poorly, and has helped point us to solutions. But, the work on measuring and understanding health care is incomplete.

The focus on thirty day readmission rates is useful only when accompanied by a full set of indicators that track the experiences of Medicare patients with chronic illness. At present ACOs are monitored on 33 quality metrics. Many of these are familiar, such as control of diabetes, others such as functional health status, are less used today, but of central importance to monitoring care. The all-condition readmission rate is one of the measures. This list will need to evolve further, as there is a better understanding of the short list of the most important metrics.

For anyone who is outside of the health care policy "beltway," the follow-up question to learning about thirty day readmission rates is "What about the 31st day?" To this we might add questions about the days before the patient first came into the hospital and their care and outcomes six months after they left. If we don't continue to expand the breadth and depth of quality indicators, we will not recognize the most important opportunities to improve care and save needless expenditures. The coupling of robust health care measures with broad population-based payment models will help ensure that quality care every day is as good as the care thirty days after hospital discharge.

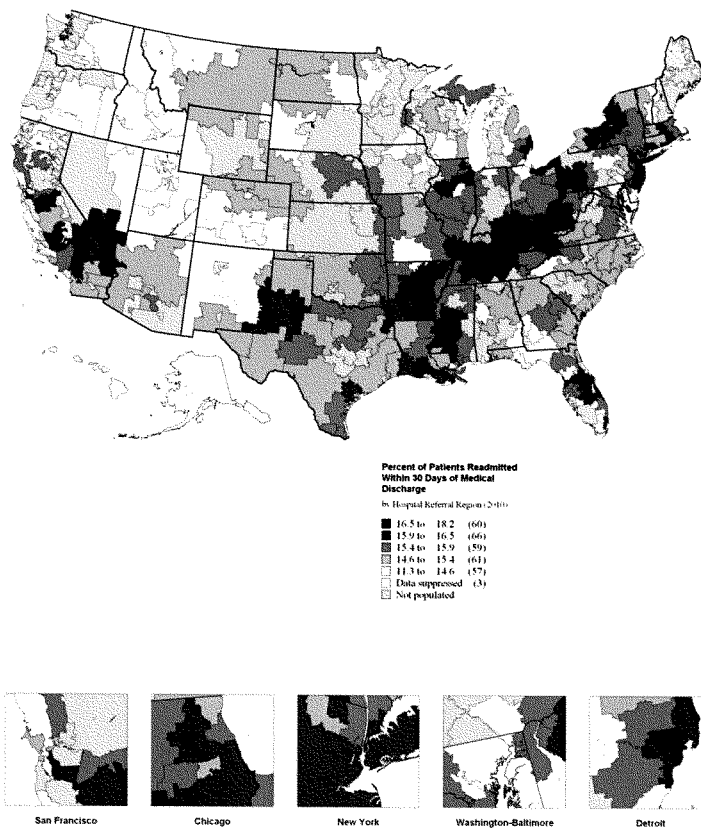


Figure 1. Thirty day readmission rates after medical hospitalization by Hospital Referral Regions, 2010 fee-for-service Medicare beneficiaries > 65 years.

Table 1. United States 30 day readmission rates for Medicare beneficiaries.

Condition	Percent Readmitted	
	2004	2010
Medical	15.9	15.9
CHF	20.9	21.1
AMI	19.4	18.1
Pneumonia	15.1	15.3
Surgical	12.7	12.4

Table 2. Readmission rates for the three largest hospitals (by combined medical and surgical discharges) for selected states. Shaded cells indicate better than average performance in 2010 readmissions or in lowering readmissions from 2004 to 2010.

State	Hospital	City	Medical 30-day readmissions			Surgical 30-day readmissions			Combined cohort size	
			2010	U.S. rank	2010 change	U.S. rank	2010	U.S. rank		2010 change
Arizona	Banner Boswell Medical Center	Sun City	15.3	1,164	7.8%	474	12.3	811	8.9%	4,909
Arizona	Mayo Clinic Hospital	Phoenix	16.8	515	15.6%	164	10.7	1,235	-7.6%	1,081
Arizona	Banner DeLee Webb Medical Center	Sun City West	14.1	1,541	2.6%	799	11.7	962	9.0%	465
Connecticut	Hartford Hospital	Hartford	15.6	1,016	0.9%	920	12.3	835	-5.6%	1,009
Connecticut	St. Francis Hospital and Medical Center	Hartford	16.8	525	11.2%	302	12.2	861	-8.9%	1,124
Connecticut	Yale-New Haven Hospital	New Haven	18.8	79	5.3%	635	15.0	270	3.8%	634
Florida	Florida Hospital Orlando	Orlando	17.3	350	4.5%	679	14.9	288	-3.3%	905
Florida	NCH Downtown Naples Hospital	Naples	14.2	1,517	-2.0%	1,121	8.9	1,599	-24.7%	1,583
Florida	Orlando Regional Medical Center	Orlando	17.1	397	1.3%	888	15.7	201	-0.5%	799
Illinois	North Shore Evanston Hospital	Evanston	15.7	984	9.6%	376	12.3	823	-6.4%	1,041
Illinois	Northwest Community Hospital	Arlington Heights	16.4	656	4.2%	709	13.5	528	10.1%	429
Illinois	Advocate Christ Medical Center	Oak Lawn	17.1	435	-2.8%	1,174	15.9	177	1.5%	723
Indiana	St. Vincent Indianapolis Hospital	Indianapolis	14.9	1,292	-1.3%	1,066	10.6	1,265	-7.8%	1,086
Indiana	Indiana University Health University Hospital	Indianapolis	18.6	102	18.1%	118	17.0	105	23.5%	199
Indiana	Deaconess Hospital	Evansville	15.3	1,156	6.8%	539	13.0	630	27.9%	147
Maine	Maine Medical Center	Portland	14.7	1,365	-0.9%	1,046	12.8	686	-5.0%	982
Maine	Eastern Maine Medical Center	Bangor	15.3	1,160	-12.6%	1,633	13.9	449	-2.7%	870
Maine	Maine General Medical Center-Waterville	Augusta	13.9	1,572	-0.4%	1,013	9.8	1,455	-8.7%	1,120
Massachusetts	Massachusetts General Hospital	Boston	17.3	358	10.5%	329	13.9	456	-3.0%	888
Massachusetts	Southcoast Hospitals Group	Fall River	16.0	872	0.6%	934	11.5	1,012	-13.4%	1,272
Massachusetts	Brigham and Women's Hospital	Boston	18.8	78	-8.4%	1,475	15.7	191	2.4%	691
Missouri	Barnes-Jewish Hospital	St. Louis	19.9	30	-0.6%	1,028	17.3	85	-2.6%	866
Missouri	St. John's Hospital and Health Center	Springfield	14.1	1,543	2.6%	800	10.0	1,414	-13.9%	1,299
Missouri	Missouri Baptist Medical Center	Town and Country	15.5	1,052	-2.6%	1,154	13.0	638	-13.9%	1,296
Nevada	Renown Regional Medical Center	Reno	17.0	469	10.8%	316	11.9	917	5.8%	565
Nevada	Mountain View Hospital	Las Vegas	17.1	427	4.2%	705	13.8	478	18.5%	263
Nevada	Sunrise Hospital and Medical Center	Las Vegas	17.6	265	4.0%	723	16.8	118	31.7%	123
New Hampshire	Dartmouth-Hitchcock Medical Center	Lebanon	14.8	1,335	-1.9%	1,113	12.3	827	4.9%	600
New Hampshire	Concord Hospital	Concord	15.4	1,100	17.0%	132	7.7	1,701	-31.8%	1,670
New Hampshire	Catholic Medical Center	Manchester	15.0	1,260	7.6%	497	11.5	1,011	-13.8%	1,294
New York	New York-Presbyterian Hospital	New York	16.4	702	7.2%	513	15.6	207	16.4%	298
New York	North Shore University Hospital-Manhasset	Manhasset	15.3	1,121	-8.1%	1,463	15.7	197	24.3%	187
New York	Mount Sinai Hospital	New York	17.4	319	-5.4%	1,327	15.0	267	-16.5%	1,395
Oregon	Providence St. Vincent Medical Center	Portland	14.7	1,373	-3.1%	1,195	10.7	1,224	-5.5%	1,001
Oregon	Rogue Valley Medical Center	Medford	14.4	1,457	1.5%	880	9.3	1,533	-14.6%	1,325
Oregon	St. Charles Medical Center	Bend	13.2	1,689	-7.2%	1,424	6.9	1,739	-31.6%	1,666
Pennsylvania	Lehigh Valley Hospital-Allentown	Allentown	16.3	719	12.0%	274	12.9	644	3.5%	646
Pennsylvania	Lancaster General Health	Lancaster	13.0	1,703	-2.8%	1,175	10.4	1,308	0.8%	747
Pennsylvania	St. Luke's Hospital-Bethlehem Campus	Bethlehem	15.9	919	1.6%	868	14.8	294	15.3%	315
Rhode Island	Rhode Island Hospital	Providence	17.6	279	9.9%	358	14.3	374	5.5%	575
Rhode Island	Miriam Hospital	Providence	18.5	107	18.2%	115	14.0	439	15.1%	323
Rhode Island	Kent County Memorial Hospital	Warwick	18.0	178	12.8%	250	13.8	469	14.1%	344
South Carolina	Spartanburg Regional Medical Center	Spartanburg	15.1	1,219	10.3%	338	10.9	1,190	2.7%	678
South Carolina	Greenville Memorial Hospital	Greenville	15.3	1,147	13.2%	232	12.5	767	1.5%	722
South Carolina	McLeod Regional Medical Center	Florence	15.4	1,112	-8.8%	1,491	10.8	1,210	-13.5%	1,279
Tennessee	Methodist Healthcare-Memphis Hospitals	Memphis	15.8	952	9.5%	382	11.7	975	-13.1%	1,262
Tennessee	Memorial Healthcare System	Chattanooga	14.9	1,301	2.4%	821	10.1	1,376	-16.8%	1,401
Tennessee	Baptist Memorial Hospital-Memphis	Memphis	14.7	1,361	0.2%	960	11.6	983	3.9%	630
Texas	Methodist Hospital-San Antonio	San Antonio	16.1	830	4.5%	676	13.4	538	12.3%	385
Texas	Baptist Health System-San Antonio	San Antonio	16.3	708	-3.2%	1,200	12.2	862	-15.3%	1,355
Texas	Memorial Hermann Northwest Hospital	Houston	14.3	1,484	-5.6%	1,336	11.3	1,071	-8.2%	1,102
Utah	Dixie Regional Medical Center	St. George	11.9	1,781	-7.7%	1,449	11.8	949	11.8%	389
Utah	Intermountain Medical Center	Murray	12.1	1,769	1.9%	846	10.5	1,281	-16.4%	1,393
Utah	St. Mark's Hospital	Salt Lake City	12.6	1,743	7.6%	494	10.2	1,366	14.6%	335
West Virginia	Charleston Area Medical Center	Charleston	16.4	688	-3.3%	1,207	14.4	369	-1.7%	829
West Virginia	St. Mary's Medical Center	Huntington	15.8	947	2.3%	827	11.2	1,116	-23.9%	1,563
West Virginia	Camden-Clark Memorial Hospital	Parkersburg	16.9	497	-2.7%	1,172	12.0	888	-21.0%	1,508
Wisconsin	Aurora St. Luke's Medical Center	Milwaukee	16.3	711	1.6%	876	13.1	601	-10.1%	1,164
Wisconsin	Waukesha Memorial Hospital	Waukesha	14.8	1,339	-8.3%	1,471	10.9	1,185	-11.1%	1,200
Wisconsin	University of Wisconsin Hospital and Clinics	Madison	15.5	1,064	-9.2%	1,513	12.6	739	-2.0%	844

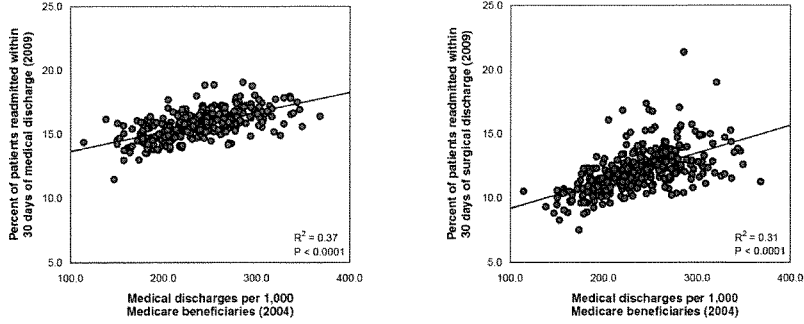


Figure 2. Thirty-day readmission rates are correlated with medical discharge rates, by Hospital Referral Regions.

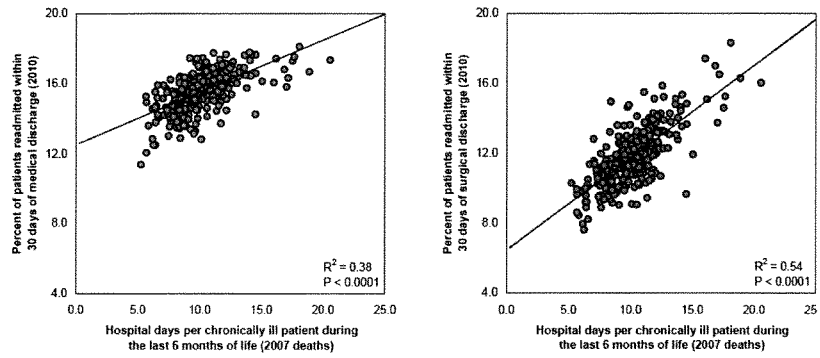


Figure 3. Thirty-day readmission rates are correlated with the number of hospital days of chronically ill patients in the last six months of life, by Hospital Referral Regions.

The CHAIRMAN. Thank you, Dr. Goodman.

Of course, all of your prepared remarks will be inserted as a part of the record, and thank you for your verbal remarks.

Dr. Thorpe.

STATEMENT OF KENNETH E. THORPE, PH.D., ROBERT W. WOODRUFF PROFESSOR AND CHAIR, DEPARTMENT OF HEALTH POLICY AND MANAGEMENT, ROLLINS SCHOOL OF PUBLIC HEALTH, EMORY UNIVERSITY

Mr. THORPE. Thank you, Senator Nelson, Ranking Member Collins, for inviting me here today. I want to focus on some solutions to Medicare that will make it sustainable over the long term and reduce costs in the system, not simply just cutting provider payments and shifting costs around the system.

To do this, though, I think you have to start out by having a clear understanding of where the dollars are spent and what is driving the growth in spending. Let me give you a couple of facts.

In Medicare today, 95 percent of the spending is linked to chronically ill patients.

Second, over half the Medicare population is currently being managed for five or more chronic conditions. It accounts for nearly 80 percent of the costs. Most of the increase in Medicare spending is due to rising rates of largely preventable chronic health care conditions.

And finally, about 27 percent of Medicare patients are diabetics, and about half of them are pre-diabetic.

So if you just think about those statistics in terms of the growth, in terms of incidence, where all the money is in terms of chronic disease, that really should be the focus of our discussion.

Medicare currently provides a personalized health risk assessment to identify at-risk patients, but it does not cover any solutions to actually allow people to act on those. So if you are an overweight pre-diabetic adult or seriously obese, the only treatment option you really have is bariatric surgery. It does not cover intensive lifestyle programs. It does not cover these new class of FDA-approved weight loss drugs, and so on.

In addition, while Medicare started this year to move down the path a little bit to allow physicians a code for transitional care, it does not provide comprehensive care coordination at all, and my concern about this path is that it may continue to promote silo-based and not team-based care.

So in the remaining part of my testimony, I want to outline a three-part reform to Medicare that I think will reduce costs and improve quality.

Point one. We need to continue to transition away from fee-for-service Medicare, fee-for-service payments. It is a system that promotes volume. It runs counter to the incentives that we need to do care coordination. We need to initially start to accelerate the transition towards using bundled payments that really combine and integrate incentives for caring for patients, both in-hospital and post-acute.

Two, we need to make evidence-based programs like the Diabetes Prevention Program a part of the Medicare program. This is a program that we now have a decade of randomized control trial data

that shows that we can have a dramatic reduction in the incidence of diabetes and other chronic conditions in the program if it was a covered benefit. For seniors that are at risk for diabetes, this program reduced the incidence of diabetes by 71 percent. If it was included, it would save Medicare money and improve health care outcomes.

Third, we need to add care coordination into Medicare, original Medicare, now. I think we need to pivot away from a pilot mentality and move much more into an implementation mentality of best practices we already know that work, and let me give you some examples.

One is to focus on team-based care, the provision of care at home by nurses, nurse practitioners, social workers, behavioral health workers, pharmacists, to work in close collaboration with physician practices to manage and engage these patients that have multiple conditions. What functions do they perform? Well, you would have a nurse care coordinator that is basically the quarterback of the team to work with that patient and the family.

You would do comprehensive medication management. We need to broaden our current Part D program to include more patients. The current program is limited to very high-cost Part D patient. Only ten percent of people in Part D participate in this. We need to focus on the total cost, high total cost patients, and broaden what we do in terms of managing very complicated medications. That will save money. We have good data on that.

Transitional care. This is best done by nurses, nurse practitioners, community health workers. We have good established models of how that could work and how that does work. We can cut readmission rates by 25 to 50 percent with similar reductions in hospital costs.

We need to build health coaching and literacy into these teams so that when patients leave the physician's office, they understand the care plan. They understand how to navigate and negotiate the system.

And we need to include measures of quality that are similar to the rest of the program in order to keep these health care teams accountable.

There are some fast ways I think we could do this. I would be happy to discuss that in the Q&A. But I think that in terms of the existing contracting authority that Medicare has, they could contract with health plans, home health agencies, population health managers, to provide team-based care that performs the functions that I just outlined in a very short period of time. Several States are already doing this as part of what they are doing in health care reform and they are expanding use of health teams very quickly. So I think our States and the private sector have already shown us the way.

We always need to do targeted pilots. I guess, in closing, I am just saying that it is time, I think, to pivot and implement program-wide things that we already know that work from experience in the private sector and from what we have seen in the published research data.

Thank you.

[The prepared statement of Mr. Thorpe follows:]

Statement of Kenneth E. Thorpe, PhD

Senate Special Committee on Aging

Hearing On

Strengthening Medicare for Today and the Future

Wednesday, February 27, 2013, 3:00 pm.

Dirksen 106

Statement of Kenneth E. Thorpe, PhD

Senate Select Committee on Aging, February 27, 2013

Good afternoon, Senators. Thank you for inviting me here today to discuss the urgent need to reform health care delivery in the United States and the pivotal role that primary care providers must play in a changed system. I am Ken Thorpe, chairman of the department of health policy and management at Emory University. I also lead the Partnership to Fight Chronic Disease, a national coalition of patients, providers, community organizations, business and labor groups, and health policy experts that is working with state partnerships to prevent chronic illness and reform how we deliver care to patients. In addition, I sit on the board of the Partnership for the Future of Medicare.

Crafting effective solutions to further reductions in the growth in entitlement programs requires a clear understanding of where the dollars are spent, and the factors driving the growth in spending. To date, simply cutting payments to providers and Medicare Advantage plans will achieve budget savings, but they do not reduce costs and over time may ultimately reduce access to care. Virtually all the spending in the Medicare program is associated with chronically ill patients. High and rising prevalence of chronic diseases such as diabetes are a key contributor to the growth in Medicare spending. Yet despite the central role that chronic disease plays in Medicare, the program does not cover lifestyle-related preventive benefits and currently does not provide comprehensive care coordination for most patients. A key direction for reforming Medicare needs to focus on reducing the rise in preventable chronic health care

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conditions, and introducing evidence-based elements of care coordination into traditional Medicare.

Fortunately, we have a substantial body of published research highlighting the impact that key elements of care coordination and prevention have on reducing spending and improving quality. Components of these data are derived from the experience of Medicare Advantage plans, an important part of the Medicare program, as well as other care coordination initiatives in the private sector.¹ Identifying the best practice techniques and adopting them into traditional Medicare should be a key focus of entitlement reform. These key prevention and care coordination initiatives that have proven clinically effective and cost reducing include transitional care, comprehensive medication management, health coaching, and team based, whole person focused, care. In addition to care coordination, making evidence-based programs like the diabetes prevention program, a program with established results that reduce the incidence of diabetes and related chronic conditions among adults (and seniors in particular) should be added to the Medicare program. Introduction of these preventive and care coordination initiatives into traditional Medicare will slow the growth in spending and improve the quality of care provided.

¹ Thorpe, KE, The Medicare Advantage Experience: Lessons for Reform to Original Medicare. manuscript., December 2012. Emory University.

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Virtually all the spending in the Medicare program is associated with patients with multiple largely unmanaged chronic conditions. Recent research examining the growth in spending in the Medicare program found that:

- *About 95 percent of spending in the program is associated with patients with one or more chronic health care conditions;²*
- *Over 53 percent of Medicare patients were treated for five or more chronic conditions during the year. These patients accounted for nearly 78 of total Medicare expenditures.³ (See Appendix 1).*
- *Most of the rise in Medicare spending is traced to rising rates of treated disease prevalence and increased intensity of treatment;*
- *Nearly 85 percent of the growth in Medicare spending since the late 1980s is associated with patients treated for five or more medical conditions; (tabulations from Appendix 1).*
- *Rising rates of obesity among seniors accounts for approximately 10 percent of the increase in spending;⁴*
- *Twenty percent of hospitalized Medicare patients are readmitted to the hospital within a 30 day window. These readmissions are potentially preventable and could account for more than \$500 billion in spending over the next decade.⁵*
- *One-fourth of all adults went to an emergency room for a condition that could have been treated in a more cost-effective non-emergent setting.*

Collectively, these data highlight the need for policy proposals that are designed to reduce the rise in the incidence of preventable chronic disease, more effectively

² <http://www.fightchronicdisease.org/sites/fightchronicdisease.org/files/docs/Thorpe%20-%20Care%20Coord%20Savings%20-%20Final-1.pdf>

³ <http://content.healthaffairs.org/content/25/5/w378.full.pdf+html>

⁴ <http://content.healthaffairs.org/content/28/5/w822.full>

⁵ <http://nyshealthfoundation.org/uploads/general/conversation-with-kenneth-thorpe-diabetes-prevention-program.pdf>

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manage and engage chronically ill patients, and reduce clinically unnecessary use of health care services.

The remaining part of my testimony will focus on three issues. First, what changes has CMS made to start introducing elements of care coordination into the traditional Medicare program. Second, how can we accelerate the adoption of team based care coordination in traditional Medicare? Along these lines, what do the published randomized trials plus the experience with the private sector tell us about the elements of care coordination that improve quality and health outcomes and reduce Medicare spending? Third, how can we replicate and scale these best practices into traditional Medicare over the next couple of years. The Medicare program needs to pivot quickly from a pilot mentality to the implementation of best practices program wide.

Progress to Date

Medicare currently covers several preventive services, including a wide range of clinical preventive services. In addition, the program also covers an initial prevention physical exam, and an annual wellness visit that could include a health risk appraisal and a personalized prevention care plan. However while the program is well suited to identifying at-risk seniors, it does not cover services that would allow seniors to address these risk factors. For instance, Medicare does not cover intensive lifestyle interventions like the diabetes prevention program or FDA approved obesity medications designed to assist obese seniors at risk for a range of chronic conditions. In short, Medicare will

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highlight the need for an action plan and identify at-risk seniors, but provides no coverage that would actually assist seniors in helping meet lifestyle goals personalized care plan. Moreover, Medicare has traditionally not covered any care coordination that would engage seniors with multiple chronic conditions to remain healthy and out of the hospital, ER or clinic.

The Center for Medicare and Medicaid Services (CMS) has started to introduce elements of care coordination, though in a way that may inhibit the ability to allow best practice team based approaches flourish in the program. As part of its 2013 Medicare Physician Fee Schedule, the Centers for Medicare and Medicaid Services (CMS) started to introduce elements of care coordination. The 2013 fee schedule now includes new codes (HCPCS G-code) that will allow physicians to receive a bundled payment (only about \$55 on average) to provide transitional care services to patients discharged from a hospital, nursing home or rehabilitation facility.⁶ While this is certainly an important first start toward introducing care coordination into traditional Medicare, transitional care management is likely best provided by trained nurse practitioner, or nurse coaches using evidence-based models that I will discuss further below. Moreover, using multiple billing codes may make the transition to team based care (nurses, nurse practitioners, mental health workers, pharmacists, social workers and others) that provide a broader range of care coordination functions difficult to achieve.

⁶ Bindman A, Blum J, Kronig R. Medicare's Transitional Care Payment-A Step toward the Medical Home. NEJM 2013; 368(8): 692-694.

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Options for Including Evidence-Based Prevention and Care Coordination into Traditional Medicare

Designing evidenced-based prevention and care coordination approaches for traditional Medicare represents a major policy challenge. One place to start is to examine the experience with Medicare Advantage and see what evidence exists about best practice approaches for reducing costs, improving quality and ensuring patient satisfaction that could be made available to those beneficiaries who account for the largest segment of the Medicare population – those in traditional Medicare. In addition to Medicare Advantage, there is a considerable body of published research that has evaluated core elements of care coordination. Recent publications have demonstrated that innovative Medicare Advantage programs can reduce total Medicare spending and provide the same or better quality of care than traditional Medicare by up to 15 to 20 percent.⁷ How do these plans achieve these savings? They use predictive modeling, target interventions toward high-risk seniors, transitional care, high risk case management, medication therapy, management and adherence, health coaching, and team-based care, among others.⁸ The data also highlight the importance of close interaction and integration of care managers and physician practices. Health teams in Vermont and

⁷ Milstein A, Gilbertson E. American Medical Home Runs, Four real life examples of primary care practices that show a better way to substantial savings. *Health Aff (Millwood)* 2009; 28(3): 1317-1326, and Landon BE et al. Analysis of Medicare Advantage HMOs Compared with Traditional Medicare Shows Lower Use of Many Services During 2003-2009, *Health Aff (Millwood)*. 2012; 31(12): 2609-2617 and Cohen R, et al. Medicare Advantage Special Needs Plans Boosted Primary Care, Reduced Hospital Use among Diabetic Patients. *Health Aff(Millwood)* 2012; 31(1): 100-119.

⁸ <http://content.healthaffairs.org/content/31/6/1156.full>

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North Carolina are good examples of this close interaction between care coordinators and providers practices. Large randomized trials have also evaluated the impact of comprehensive lifestyle modification interventions such as the Diabetes Prevention Program and the Stanford Chronic Disease Management Program.⁹

I have outlined several steps that would be needed to integrate evidence-based prevention and care coordination into the traditional Medicare program. Care coordination could be offered as an opt-out service for all patients in the traditional Medicare program. The services would be offered by health plans, home health agencies, managed care vendors, or others that could provide the range of services outlined below. Care coordinators would be selected through competitive bidding. Another option would be to give seniors of choice of staying in traditional Medicare (with no prevention and care coordination) or selecting a new version of traditional Medicare, “Medicare Plus” that would include the care coordination services.

Transforming traditional Medicare would require the following steps:

1. Transition Away from Fee-for-Service

A key to introducing care coordination into traditional Medicare is to transition away from fee-for-service payments and as a start replace it with more bundled payments. The incentives to increase the volume of services in fee-for-service run completely counter to the incentives to provide clinically effective care coordination. As fee-for-service is

⁹ [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(09\)61457-4/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(09)61457-4/fulltext) and <http://patienteducation.stanford.edu/programs/cdsmg.html>

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phased out over time, it would be replaced by bundled payments for (most) hospital admissions that include all covered post-acute care services 30 days after discharge. There is broad agreement that Medicare's fee-for-service (FFS) payment model is outdated, drives up additional volume of services and must be replaced to improve health care delivery. Our entire health care system is built around FFS and updating our current health care delivery structure will set the stage for an innovative, high-quality health care system. However, transitioning away from FFS will not be easy and will not happen overnight; reforming the Medicare system so that it pays for quality will require significant data collection and monitoring, updates to regulations, and testing and scaling of new and innovative payment models and incentives. Advancing these objectives and facilitating a gradual shift from FFS medicine will take time and will therefore likely occur in stages and lead to a number of new payment model reforms. As an interim step, broader use of bundled payments with quality controls focused on health improvement would provide a useful transitional step. Physician practices that work with health teams to provide care coordination services (outlined below) should receive a bundled payment as part of their collaboration with the health teams.

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2. Add Interventions that Avert Disease Among Overweight and Obese Adults into the Medicare program

Perhaps the best-known lifestyle modification program is the Diabetes Prevention Program (DPP). Randomized trials of other programs such as the Stanford Chronic Disease Management Program produce results similar to the DPP. The original DPP protocol was delivered to overweight, pre-diabetic adults on a one-on-one basis. The large scale randomized trial of the DPP found that lifestyle intervention reduced the prevalence of diabetes by 58 percent relative to placebo. The reduction in diabetes prevalence (as well as hypertension) was traced to a 7 percent reduction in weight among participants. The largest reductions in weight and diabetes prevalence occurred among participants aged 60 and older. Those 60 and older lost an average of 8.2 percent of their starting weight after 12 months compared to 7.5 percent for those aged 45 to 59 and 6.6 percent for adults under age 45.¹⁰ As a result, the prevalence of diabetes was 71 percent lower than placebo for those 60 and older compared to the overall average of 58 percent.¹¹ . In other words, among every 100 overweight or obese adults who completed the intensive lifestyle intervention 19 out of an expected 33 failed to develop Type 2 diabetes. For those 19 individuals, the social and financial costs of a new diabetes diagnosis –for such necessities as additional tests, diabetes education, glucose meters, test strips, and more intensive management of other

¹⁰ <http://www.nejm.org/doi/pdf/10.1056/NEJMoa012512>

¹¹ <http://diabetes.niddk.nih.gov/dm/pubs/preventionprogram/>

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cardiovascular risk factors – were avoided. Moreover, for every 100 adults, 8 avoided the need for blood pressure and cholesterol medications.

Making the DPP a covered benefit under traditional Medicare would save the program money and improve health outcomes. This proposal would build on the foundation of the YMCA community based diabetes prevention programs in place, and currently under expansion. This proposal would allow pre-diabetic or other at risk seniors (based on the results of their wellness plan and as part of the personalized prevention plan developed by their physician) overweight and obese seniors would be eligible to enroll in the program. Depending on participating rates, just enrolling one cohort of overweight, pre-diabetic seniors into the program would generate a net savings to Medicare of about \$2 to \$4 Billion over 10 years and more than \$6 to 15 Billion during the lifetimes of those participating in the program.¹² Similar consideration should be given to including the recently approved FDA weight loss drugs as a covered Medicare benefit in light of the impact they have on weight loss (around 10 to 15 percent reductions).

¹² Thorpe KE and Yang Z. Enrolling people with prediabetes ages 60-64 in a proven weight loss program could save Medicare \$7 Billion or more. *Health Aff (Millwood)* 2011; 30(9): 1673-1679

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3. Contract with health teams to provide care coordination for chronically ill Medicare patients.

Over half of the Medicare population is under treatment for 5 or more chronic health care conditions. These include mental health, behavioral health, and cardiovascular events among others (diabetes). Effective provision of team-based primary care has been shown to improve the quality of care at lower costs¹³. Therefore effective *comprehensive* clinical engagement requires multi-specialty teams of providers with the flexibility to use their resources based on the patient's needs. There is a growing body of evidence that has identified the key functions performed by health plans and successful comprehensive team-based care coordination models in managing chronically ill patients. Health (or chronic care) teams include a clinical leader (nurse, nurse practitioner) coordinating the care plan provided by the physician, nurses, nurse practitioners, pharmacists, social workers, behavioral health specialists and health coaches. These teams would provide the following evidence based functions when coordinating care I. ¹⁴ *Coordination of care for all covered Medicare services utilizing a team-based approach*

- *Approaches that provide a "whole" person focus on preventing disease and managing acute, and mental health services*
- *Medical advice from a care coordinator available 24/7*
- *Assessment of patient risk perhaps and development of an individualized care plan*
- *Comprehensive Medication Management*

¹³ Medicare Payment Advisory Commission. 2008. Report to the Congress: Reforming the delivery system. Washington DC: MedPAC.

¹⁴

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- *Transitional care and health coaching*
- *Regular contact with enrollee*
- *Close integration of the care coordinator nurse and primary care (and specialist) physicians*
- *Evidence-based health coaching to train patient self-management skills and facilitate behavior change.*

These activities provide the foundation for cost savings moving forward and improved health outcomes when coordinating care for chronically ill patients. Each of the major functions outlined above (transitional care, medication adherence, health coaching) have several published randomized trials showing they individually result in improved health outcomes at lower levels of health care spending. Collectively they serve as a powerful, team-based approach to generate substantial proven savings and improved quality of care. A brief summary of some of the randomized trials highlighting the clinical effectiveness and cost savings associated with these care coordination functions is presented below.

Transitional Care.

Two of the best known models of transitional care have been developed by Eric Coleman at the University of Colorado and Mary Naylor at the University of Pennsylvania. The team at Penn defines transitional care as providing "comprehensive in-hospital planning and home follow-up for chronically ill high-risk older adults

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hospitalized for common medical and surgical conditions." The heart of the model is the Transitional Care Nurse (TCN), who follows patients from the hospital into their homes and provides services designed to streamline plans of care, interrupt patterns of frequent acute hospital and emergency department use, and prevent health status decline. While TCN is nurse-led, it is a multidisciplinary model that includes physicians, nurses, social workers, discharge planners, pharmacists, family caregivers, and other members of the health care team in the implementation of tested protocols with a unique focus on increasing patients' and family caregivers' ability to manage their care. For the millions of Americans who suffer from multiple chronic conditions and complex therapeutic regimens, TCM emphasizes coordination and continuity of care, prevention and avoidance of complications, and close clinical treatment and management - all accomplished with the active engagement of patients and their family and informal caregivers and in collaboration with the patient's physicians. More information is available at <http://www.transitionalcare.info/>.

A second model, developed by Eric Coleman uses transition coaches to train patients and family caregivers how to manage their care. Transition coaches are generally not physicians, but are nurse practitioners, nurses, or community health workers. To smooth transitions from hospital to home, the Care Transitions Intervention (CTI) uses coaching and home visits by trained care coordinators. The coach makes one home visit and several phone calls to the patient over a 30 day window. More information on this program is available at www.caretransitions.org.

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According to randomized trials, both programs reduce dramatically hospital readmission rates. Among Medicare patients, the TCI program reduced 30 day readmissions by 30 percent. and at 90 days hospital costs by 25 percent. 15 Randomized trials of the TCN model have demonstrated reductions in readmissions of 56 percent with similar reductions in total Medicare spending after one year. 16

Comprehensive Medication Management

Poor medication management adds substantially to the overall cost of health care , by some estimates adding over \$200 billion per year in additional hospital and other spending. 17 Comprehensive medication management provided as part of an integrated health team has shown to saving \$1.29 in health care spending for every \$1 spent to administer the program. 18 Moreover, a recently summary of the published research literature by the Congressional Budget Office (CBO) found that adherence and persistency in taking medications also reduces spending. Specifically the CBO found

¹⁵ Coleman EA, et al. The Care Transitions Intervention, Results of a Randomized Controlled Trial. *Arch Intern Med.* 2006; 166: 1822-1828

¹⁶ MD Naylor, DA Brooten, RL Campbell, G Maislin, KM McCauley, J.S. Schwartz. Transitional care of older adults hospitalized with heart failure: a randomized, controlled trial. *Journal of the American Geriatrics Society.* May 2004; 52:675-84. See also: MD Naylor, D Brooten, R Jones, et al. Comprehensive discharge planning for the hospitalized elderly. *Annals of Internal Medicine* 1994; 120(June):999-1006. MD Naylor, DA Brooten, R Campbell, et al. Comprehensive discharge planning and home follow-up of hospitalized elders. *Journal of the American Medical Association* 1999; 281:613-20. MD Naylor. Transitional care of older adults. *Annual Review of Nursing Research.* 2003; 20:127-47.

¹⁷ Johnson JA, Bootman JL. Drug-related morbidity and mortality: a cost-of-illness model. *Arch Intern Med.* 1995;155:1949-1956

¹⁸ D. Ramalho de Oliveira, A. Brummel, and D. Miller, "Medication Therapy Management: 10 Years of Experience in a Large Integrated Health Care System," *Journal of Managed Care Pharmacy* 16, no. 3 (April 2010): 185-95.

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that every 1 percent increase in prescriptions filled would reduce Medicare spending by 0.25 percent.¹⁹ Under the Part D program, drug plans must offer medication therapy management program (MTM). However, the criteria for targeting Medicare beneficiaries enrolled in Part D plans are those with multiple chronic conditions (maximum of 3) and with expected annual drug spending for 2013 of \$3,144.20 However, the current MTM program would not include patients with high Part A and B medical costs that may not be appropriately taking medications (non-adherent, etc) and would not hit the \$3,144 spending threshold. Indeed, poor medication management has been linked to 32 percent of all hospitalizations and a key cause of preventable adverse events among Medicare patients.²¹ Recent studies have demonstrated that team based medication management care, as part of an overall care coordination clinical strategy, reduced the growth in spending by 11 percent.²²

As part of the new care coordination services in traditional Medicare, the current MTM program should be broadened and integrated into the overall set of care coordination services provided. A pharmacist working as part of the care coordination team would

¹⁹ Congressional Budget Office, Offsetting Effects of Prescription Drug Use on Medicare's Spending for Medical Services. CBO Washington DC November 2012.

²⁰ <http://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/Downloads/Memo-Contract-Year-2013-Medication-Therapy-Management-MTM-Program-Submission-v041012.pdf>

²¹ at www.oig.hhs.gov/oei/reports/oei-06-09-00090pdf, and Smith M, et al., Why pharmacists belong in the medical home. Health Aff (Millwood) 2010; 29(5): 906-913

²² Isetts B. et al. Managing drug-related morbidity and mortality in the patient centered medical home. Med Care 2012; 50:994-1001

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work with patients that have high prior year **total** Medicare spending (not just those with high Part D spending) to resolve drug therapy issues (drug effectiveness, dosage, compliance and adherence). This broader approach would, as part of the overall care coordination team, link medication management and resolving drug therapy problems to clinical improvements in seniors. Substantial work has already been completed on the design of such a benefit from the Patient-Centered Primary Care Collaborative and the Agency for Healthcare Research and Quality Innovation Exchange Quality Toolkit.

Health Coaching and Patient Literacy

Coaching provides patients with one or more chronic conditions to understand their care plan, participate in shared decision making with their health care providers, and more effectively navigate the health care system. Understand the care plan, and working to consistently execute it is an important approach for reducing unnecessary utilization of health care services. The Health Effective coaching empowers individuals with a wide range of conditions including but not limited to chronic conditions, to participate in medical treatment decisions with their doctors. Coaching would be another key component of care coordination services provided in traditional Medicare. A large randomized trial conducted by Health Dialog and published in the New England Journal of Medicine utilized telephonic health coaching to work with a large population (more than 174,000—7,000 of whom were Medicare patients) of patients.²³ This recent

²³ Wennberg DE et al. A randomized trial of a telephonic care management strategy. NEJM 2010; 313(13): 1245-1255.

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randomized trial showed that total health care spending was 3.6 percent lower in the treatment group (yielding about a 3 percent net savings after accounting for the cost of the intervention). This single component of care coordination alone reduced hospitalizations in the trial by 10 percent and total spending by more than 3 percent.

Conclusion

A considerable body of published research, many from randomized controlled trials, has highlighted the clinical care coordination functions that improve patient quality and reduce costs in the Medicare program. Over time, entitlement reform will have to find quality enhancing approaches that also reduce costs. Adding intensive lifestyle programs like the DPP would conservatively reduce Medicare spending by \$4 billion over the next ten years, and over \$15 billion over the lifetime of overweight prediabetic Medicare patients. Rising rates of preventable chronic illness is a major driver of rising spending in the program, and adding effective programs like the DPP would address these long-term trends.

About 95 percent of total Medicare spending is associated with chronically ill patients. Yet, traditional Medicare does little today to engage these patients to keep them healthy and out of the hospital, emergency rooms and clinics. The team based approach to care coordination outlined above could be scaled and replicated quickly (within 2 years) throughout the Medicare program. This would provide rapid improvements in the quality of care provided to patients with substantial reductions in spending. Based on successful programs like Caremore, XL Health, and group practices like the Marshfield

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Clinic and Geisinger, over the next ten years Medicare could easily save close to \$300 billion over the next decade. These changes to the program really would constitute "health reforms", reforms that reduce the incidence of chronic disease and provide more effective management of patients with multiple chronic conditions.

Thank you again for the opportunity to discuss these vital reforms. I'm happy to take your questions.

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Table 1. Distribution of Health Care Spending Among Medicare Beneficiaries, By Number of Treated Medical Conditions, 1987, 1997, 2002, 2009

Medicare Beneficiaries				
** 2009 dollars **				
1987				
Number of Conditions	Number of Beneficiaries Affected (millions)	Percent of Beneficiaries Affected	Amount of Health Spending (\$ millions)	Percent of Total Health Spending
0	2.8	9.5	653.7	0.4%
1	4.1	14.1	13,389.9	7.4%
2	4.6	16.1	18,284.6	10.1%
3	4.6	15.8	26,326.6	14.5%
4	3.9	13.5	27,895.5	15.4%
5 or more	9.0	31.0	94,408.6	52.2%
Total	29.0	100.0	180,959.0	100.0%
1997				
Number of Conditions	Number of Beneficiaries Affected (millions)	Percent of Beneficiaries Affected	Amount of Health Spending (\$ millions)	Percent of Total Health Spending
0	3.1	8.4	1,461.6	0.5%
1	4.1	11.1	11,691.0	4.4%
2	4.7	12.8	17,110.0	6.4%
3	5.3	14.6	27,074.0	10.1%
4	5.0	13.6	35,569.6	13.3%
5 or more	14.4	39.5	175,190.0	65.3%
Total	36.6	100.0	268,096.1	100.0%
2002				
Number of Conditions	Number of Beneficiaries Affected (millions)	Percent of Beneficiaries Affected	Amount of Health Spending (\$ millions)	Percent of Total Health Spending
0	2.5	6.3	605.1	0.2%
1	3.0	7.5	9,414.7	2.6%
2	4.5	11.5	15,351.5	4.2%
3	4.6	11.8	26,776.0	7.4%
4	5.0	12.7	33,391.3	9.2%
5 or more	19.8	50.2	275,729.5	76.3%
Total	39.4	100.0	361,268.1	100.0%
2009				
Number of Conditions	Number of Beneficiaries Affected (millions)	Percent of Beneficiaries Affected	Amount of Health Spending (\$ millions)	Percent of Total Health Spending
0	2.8	6.4	1,798.3	0.4%
1	3.0	6.7	6,665.2	1.4%
2	4.2	9.5	20,843.2	4.5%
3	4.9	11.0	30,824.0	6.7%
4	5.8	13.2	43,819.5	9.5%
5 or more	23.6	53.3	359,050.0	77.5%
Total	44.3	100.1	463,000.2	100.0%

Source: Author's tabulations based on data from the 1987 National Medical Expenditure Survey (NMES) and the 1997 and 2002 Medical Expenditure Panel Survey (MEPS).

Note: Totals may not add to 100 because of rounding.

The CHAIRMAN. Thank you, Dr. Thorpe.
 You know, a lot of what you all have said is the goal of the Affordable Care Act, and so now the question is making it happen.
 Dr. Blumenthal.

STATEMENT OF DAVID BLUMENTHAL, M.D., PRESIDENT, THE COMMONWEALTH FUND

Dr. BLUMENTHAL. Mr. Chairman, Senator Collins, members of the committee, thank you for having me here today.

I think it is fair to say that the future is upon us. We have been warned for decades about the consequences of relentlessly rising health care costs and now those consequences are coming home to roost. The result is that we face very, very difficult choices.

To echo Senator Whitehouse's remarks, quoting George Halvorson, George Halvorson also talks about having the choice now between rationing and re-engineering our health care system. Rationing involves taking things away, reducing benefits, reducing eligibility, increasing the payments from our senior citizens and others, and reducing payments to providers, all of which will result in a reduction in the quality of benefits and the quality of care ultimately provided to the elderly and violate in some way the contract that was made with them in 1965.

Re-engineering involves fundamental changes to our health care system to make it work better, bending the cost curve down and the quality curve up simultaneously. It requires changes to the entire health care system because you cannot ask a doctor to treat a 64-year-old differently from a 65-year-old. And, as a matter of fact, in many of your States, there are great examples of that kind of re-engineering going on right now, showing the way for innovative, positive health care change.

The Commission on a High Performance Health System, which I chaired and was sponsored by The Commonwealth Fund, put together a comprehensive synergistic set of programs, many of which have been mentioned by other members of this panel or by you in your comments. They involve three pillars, three basic reforms. First of all, changing payment to providers to promote value and quality and release innovation in our health care system at the grassroots.

Secondly, activating consumers by rewarding them with giving them better information and rewarding them for making good choices for themselves and for the health care system by choosing high-performing providers.

And thirdly, reforms in the health care market that would reduce administrative waste, change our broken malpractice system, and set National targets for total health care spending that would not rise faster than GDP.

The savings for this combination of programs, as estimated by the Actuarial Research Corporation, would indeed be \$2 trillion over ten years, with \$761 billion of those dollars accruing to the Medicare program.

Some specific examples of reforms contained in this package. One involves repealing the SGR, freezing current rates of payment at 2013 levels, but providing extra payments for physicians who are members of and deliver care in patient-centered medical homes, Ac-

countable Care Organizations, high-cost control teams of the type that Professor Thorpe has suggested, and also better payments and higher payments for patient-centered medical homes, Accountable Care Organizations, and those high-cost teams.

Secondly, for consumers, providing them much better information about the quality and cost of care that they face and rewarding them for making good health care choices by reducing their copayments for proven, effective care provided in high-value settings. And also giving them the tools that they need, in general, to make better choices.

And thirdly, market reforms that would involve reducing administrative costs, which are a huge burden on a health care system, as I mentioned, changing malpractice, and setting health care cost targets by region that are consistent with our National health care cost aspirations.

We have the knowledge and the means to improve health care, not just to ration it, and history will judge us harshly if we go the route of hollowing out our key Federal programs and our National health care programs without taking advantage of these enormous opportunities to make care more efficient and higher in quality.

Thank you, Mr. Chairman.

[The prepared statement of Dr. Blumenthal follows:]



**STABILIZING AND STRENGTHENING MEDICARE
IN THE CONTEXT OF BROADER HEALTH REFORM**

David Blumenthal, M.D., M.P.P.
President
The Commonwealth Fund

Invited testimony
United States Senate
Special Committee on Aging
Hearing on

Strengthening Medicare for Today and Tomorrow—Controlling Costs and Improving Care
February 27, 2013

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**STABILIZING AND STRENGTHENING MEDICARE
IN THE CONTEXT OF BROADER HEALTH REFORM**

Thank you, Chairman Nelson, Senator Collins, and Members of the Committee, for this invitation to testify on Strengthening Medicare for Today and Tomorrow. I am David Blumenthal, President of the Commonwealth Fund. The Commonwealth Fund is a private foundation that aims to promote a high performing health care system that achieves better access, improved quality, and greater efficiency, particularly for society's most vulnerable, including low-income people, the uninsured, minority Americans, young children, and elderly adults. The Fund carries out this mission by supporting independent research on health care issues and making grants to improve health care practice and policy.

Concerns about federal government spending and the budget deficit have focused discussion on so-called 'entitlement' programs and particularly on Medicare. Although Medicare remains one of the most popular government programs in history, and costs in Medicare are rising more slowly than those in the private sector, it accounts for an increasing share of the federal budget and of our economic resources. With the number of beneficiaries projected to grow rapidly over the next two decades, the tenuous fiscal viability of the program and its effect on government spending have brought calls for changing how the program is structured.

This has brought policy makers to a figurative fork in the road. On one path, policies could be pursued that cut Medicare payments to providers, reduce the benefits available through the program, or restrict program eligibility. These policies could produce program savings, at least in the short run, but they would be both morally and politically difficult, as they shift costs onto elderly Americans, renege on historic promises, and raise the prospect of second class care for a group that is particularly vulnerable. Moreover, these policies generally do not address the underlying causes of the health spending problem, so the payment cuts, reduced benefits, and restricted eligibility would have to become increasingly severe over time.

An alternative—and far preferable—strategy would support comprehensive payment and delivery system changes that produce lower costs and better value not just in Medicare, but across the entire U.S. health system. This path builds on the Affordable Care Act and continues to lead away from our current fee-for-service reimbursement system with a set of initiatives that reward providers, consumers, and payers for choices that improve outcomes and use resources efficiently. We know this approach is viable, as many innovative changes of this type are already beginning to emerge on the health system landscape as the reform law is implemented and both

public and private stakeholders act on the increasing awareness that reengineering health care is preferable to rationing it.

The federal government, largely through the efforts of the new Center for Medicare and Medicaid Innovation (CMMI), is undertaking innovative initiatives not only in Medicare, but also in Medicaid, as well as in partnerships between the two programs and between public and multiple private payers. Just last week, CMMI announced \$300 million in funding for 25 states working to reform their health care delivery systems and contain costs. Arkansas, Maine, Massachusetts, Minnesota, Oregon, and Vermont are at the leading edge of the movement to implement a health care innovation plan that utilizes multi-payer payment reform and innovative service delivery models.

Many other state-level initiatives are underway and already beginning to return real savings to government programs and the patients they serve, including:

- The Missouri Health Home initiative, a program that integrates behavioral health and primary care and has resulted in a 16 percent reduction in per Medicaid beneficiary costs;
- The Illinois Medicaid Medical Home program, which has reduced hospitalizations by 18 percent, lowered emergency room (ER) visits by nine percent, and resulted in \$569 million in cost savings by using primary care case management;
- The Indiana “Right Choices” program, an initiative that focuses on improving care for frequent users of hospital emergency rooms and has reduced emergency department use by 72 percent;
- The care transition model, a program deployed in more than three dozen states, including the Visiting Nurse Service of New York, which has reduced hospital admissions by 54 percent, 30-day hospital readmissions by 24 percent, and ER visits by 27 percent.

Meanwhile, several private sector organizations are also at the forefront of reengineering care to lower costs and improve outcomes, including:

- Geisinger Health System in Pennsylvania, which through its ProvenHealth Navigator medical home model has realized an 18 percent reduction in hospital admissions, a 36 percent reduction in hospital readmissions, and significant improvement on several quality indicators related to chronic care management;
- Appleton Medical Center and Theda Clark Medical Center in northeastern Wisconsin, systems that have redesigned acute care processes using Lean methodologies and achieved cost per case reductions of 15 to 28 percent and lower length-of-stay and readmissions rates;

- Virginia Mason Medical Center in Seattle, Washington, a health care delivery organization that has partnered with health plans and employers to develop standardized approaches to common conditions, decreasing the use of advanced imaging by 23 percent, increasing the availability of same-day appointments, and achieving 91 percent patient satisfaction; and
- Blue Cross Blue Shield of Massachusetts, a payer that has implemented an Alternative Quality Contract in which physician practices are paid a fixed rate, with bonuses for improved quality, leading to three percent savings in the program's first two years.

To build on these initiatives and encourage further progress down a transformative path to a health system that works for all Americans, the Commonwealth Fund's Commission on a High Performance Health System has released a report that recommends an approach to accelerating change across the health system. The three pillars of the Commission's framework involve: using provider payment reform to promote value and accelerate delivery system innovation; engaging consumers with information and positive incentives to choose high-value care and care systems; and undertaking systemwide action to improve how health care markets function.

Policies conforming to this approach could reduce federal government spending by more than \$1 trillion relative to current policy over the next 10 years, and the entire health system more than \$2 trillion—if these policies are enacted now, aggressively implemented, and effectively carried out, with all of the system's stakeholders pulling in the same direction. Based on these projections, net Medicare spending could be \$761 billion lower. The material below elaborates on these points.

MEDICARE, HEALTH SPENDING, AND THE FEDERAL BUDGET

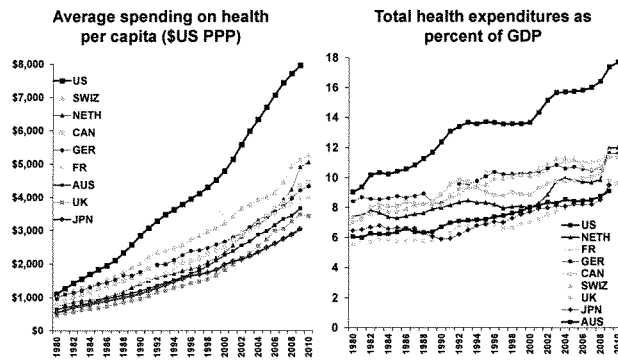
Federal health spending has been a subject of intense concern as the Congress continues to search for ways to reduce the budget deficit. Earlier this month, the Congressional Budget Office estimated that, although it is growing more slowly than previously projected, federal spending on Medicare, Medicaid, and CHIP will reach nearly \$900 billion in 2013, almost 25 percent of the federal budget and more than five percent of the nation's entire economic output (gross domestic product, or GDP).¹ Without fundamental change, federal health spending is projected to reach \$1.8 trillion and consume more than 30 percent of the federal budget by 2023.

Medicare historically has been the dominant component of federal health spending. CBO estimates that the federal government will spend nearly \$600 billion—or about two-thirds of its current health care outlays—on the more than 50 million Medicare beneficiaries in 2013. With the post-World War II baby boom generation beginning to become eligible for Medicare, the

number of beneficiaries is projected to grow to nearly 70 million by 2023, putting increasing pressure on the program's finances and the federal budget.

These concerns about the growth in Medicare spending must, however, be put in the context of three important facts. First, Medicare spending growth is part of a larger trend occurring across the health sector. Health spending nationwide in the United States is the highest in the world, and has been increasing faster than in other developed countries for the past three decades (Exhibit 1). The factors that drive health spending in the public and private sectors, and in different parts of the country, may differ somewhat, but it is clear that it is not just a Medicare problem, or a federal problem, or even a public sector problem alone.

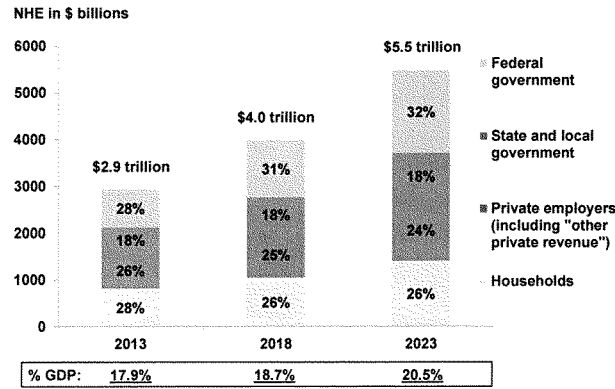
Exhibit 1. International Comparison of Spending on Health, 1980–2010



Notes: PPP = purchasing power parity, GDP = gross domestic product.
Source: Commonwealth Fund, based on OECD Health Data 2012.

Second, our health system is financed about equally by funds from the public (federal and state and local governments) and private (employers and households) sectors, and spending in both those sectors are projected to grow rapidly over the next ten years (Exhibit 2). Consequently, solutions to the larger health spending problem are not likely to be effective if pursued only in one part of the health care system rather than system-wide. For example, drastically cutting reimbursement rates in public programs could shift costs onto private payers and do little to solve the underlying problem.

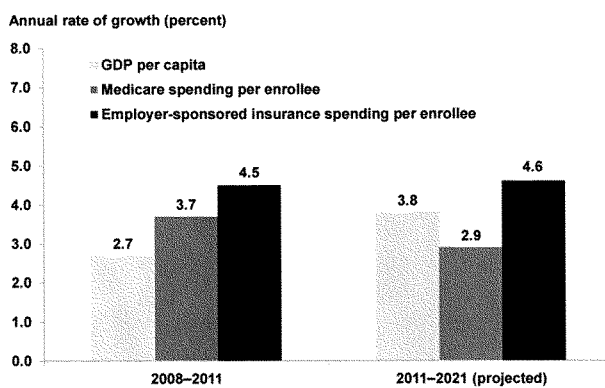
Exhibit 2. Projected U.S. National Health Expenditures (NHE) by Source, 2013–2023



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Third, although the number of Medicare beneficiaries is projected to increase sharply, spending per beneficiary recently has grown more slowly than spending per enrollee in private employer-sponsored plans, and it also is projected to grow more slowly than GDP to the end of this decade (Exhibit 3). Focusing on cuts in Medicare payments, reductions in Medicare benefits, or restrictions in Medicare eligibility without considering systemwide solutions would be ineffective in dealing with the underlying factors that are responsible for health spending growth and also would threaten the program’s continued ability to fulfill its objective: ensuring access to needed care for elderly and disabled Americans.

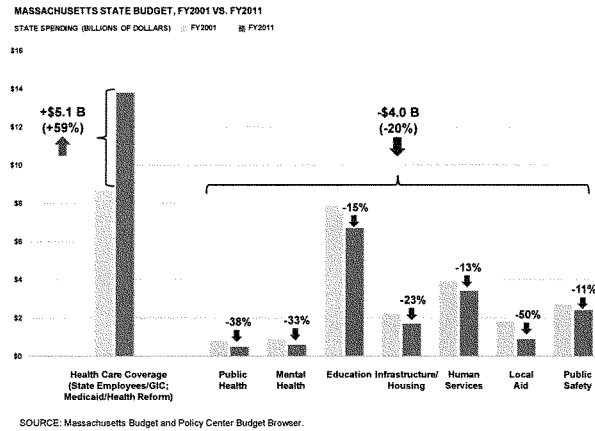
Exhibit 3. Medicare Spending per Enrollee Projected to Increase More Slowly Than Private Insurance Spending per Enrollee and GDP per Capita



Note: GDP = gross domestic product.
Source: CMS Office of the Actuary, National Health Expenditure Projections, 2011-2021, updated June 2012.

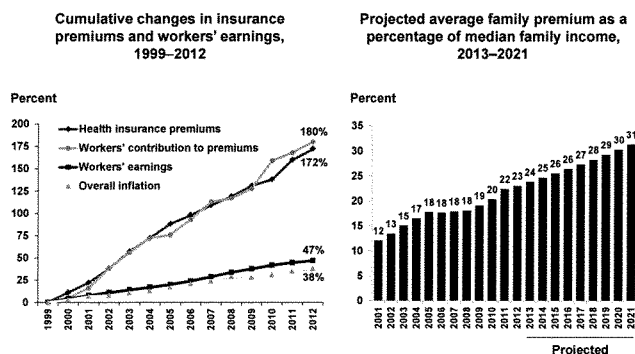
These considerations should not detract from our concern about the health spending problem and its impact on the government budgets. For decades, growth in healthcare spending has outpaced economic growth, consuming resources that might otherwise have been spent on education, infrastructure, and investments necessary to compete in a global economy. Recent analysis of spending in my home state of Massachusetts shows that, since 2001, state spending on health care coverage has increased by \$5.1 billion, or 59 percent, crowding out spending on all other priorities, including education, infrastructure, and public safety (Exhibit 4). As a result, the state's budget for everything other than healthcare coverage has fallen by \$4 billion, or 20 percent, over the last decade.

Exhibit 4. Rising Health Spending Crowds Out Other Priorities



We must remember, though, that the pressure of health spending growth is not limited to the federal or state and local governments. Businesses and families have faced rapid increases in health insurance costs, with average premiums rising almost four times as fast as general inflation and wages since 1999 (Exhibit 5). The full annual cost of health insurance premiums already amounts, on average, to 23 percent of median family income for working-age Americans. If projected trends hold, the average premium for a family plan would exceed \$24,000 by 2021—the equivalent of 31 percent of median family income, intensifying pressure on family budgets.

Exhibit 5. Premiums Rising Faster Than Inflation and Wages



Sources: (left) Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits Annual Surveys, 1999–2012*; (right) authors' estimates based on CPS ASEC 2001–12, Kaiser/HRET 2001–12, CMS OACT 2012–21.

Moreover, across the health system, we are not getting value for our substantial spending. The Institute of Medicine has estimated that thousands of patients die in hospitals each year as a result of medical errors that could have been prevented.² The Medicare Payment Advisory Commission (MedPAC) has calculated that 13.3 percent of hospital readmissions within 30 days of discharge are avoidable.³ Researchers at the RAND Corporation found that patients receive only 55 percent of recommended care for their health conditions.⁴ The Institute of Medicine has estimated that about 30 percent of nationwide health spending in 2009 went for unnecessary services, excessive administrative costs, and other costs that did not produce better patient outcomes.⁵ We can and must do better—and, as the largest payer for health care, Medicare can play a lead role in these efforts.

The primary challenge before us is to build on the foundation established by initiatives in both the public and private sectors and pursue new policies that stabilize the growth not only of federal health spending, but total national health expenditures. These policies must involve all stakeholders, rather than simply shifting costs from one group to another. Most importantly, success will require initiatives that cut across our entire health system, bringing both public and private payers together to accelerate adoption of innovative approaches to organizing, delivering, and paying for health care. This is a significant undertaking, but one that is both possible and urgently needed.

A FORK IN THE ROAD: RATIONING HEALTH CARE OR REENGINEERING THE HEALTH SYSTEM?

We find ourselves at a fork in the road, and we must choose our path carefully. One path, which may be seen as expedient given the pressing demands for immediate and dramatic reductions in federal health spending, would pursue policies that result in instant savings from budgetary scorekeepers. Strategies of this type center on cuts in provider payments, reductions in benefits, and restrictions on eligibility for public programs.

While provider payment cuts would indeed produce needed budgetary savings in 2013, this strategy is problematic given that Medicare payments already are lower than private insurance, and further cuts could undermine providers' willingness to participate in the program. Moreover, as already mentioned, Medicare spending per beneficiary is growing more slowly than both private insurance spending per enrollee and GDP. Targeted reductions in Medicare payments may be warranted, given the prices the government pays for some procedures, devices, and drugs, as has been recommended by MedPAC.⁶ But continued sharp across-the-board reductions in Medicare payment rates will likely hinder access to needed care for Medicare beneficiaries and will not address the underlying factors that drive health spending growth.

Policymakers can also produce immediate budgetary savings by reducing benefits and cutting eligibility for public programs. Examples of this type of strategy include increasing Medicare cost-sharing and raising the age of eligibility for Medicare. But increasing cost-sharing across-the-board does not address the underlying cost of health care—it merely shifts more of those costs to beneficiaries when they use care, increasing the burden on a vulnerable population at a time when they need protection most. Raising the age of Medicare eligibility has been found to have a relatively small net affect on federal costs, shifting costs from Medicare to Medicaid and, beginning in 2014, the federal subsidies available through the new health insurance marketplaces, and having a potential adverse impact on access to care for older adults who do not have access to other affordable coverage.⁷ Targeted policies that include value-based insurance designs with differential cost-sharing for essential versus discretionary care and policies that both provide and encourage better choices by patients can be constructive, but broad reductions in benefits or eligibility would not address the causes of spending growth and would hinder access to needed health care for a vulnerable population.

The preferable—and more effective—strategy for addressing the growth of federal health spending involves addressing costs across the entire health system, primarily by aligning incentives for providers, consumers, and payers to reward choices that lead to better patient

outcomes and use resources wisely. This path leads away from the current fee-for-service reimbursement system that encourages volume rather than value, and instead puts in place policies to reduce unnecessary utilization, increase care coordination, and improve outcomes.

To address federal and broader national concerns about affordability and health care costs, it is imperative to act, but do so in ways that are consistent with the goals of a high performance health system. Incentivizing quality and value, rather than relying on indiscriminate across-the-board payment or eligibility cuts, is key to simultaneously lowering costs, maintaining access, and improving outcomes. This strategy requires that key public and private stakeholders work together, pulling in the same direction to achieve common goals. An effective approach that produces significant savings not just for the federal government, but also for state governments, businesses, and families, must include clear, consistent goals and coordinated incentives for all the key actors in our health system.

THREE PILLARS FOR ACCELERATING SYSTEM IMPROVEMENT: PAYMENT REFORM, ENGAGING CONSUMERS, AND MAKING MARKETS WORK BETTER

With these considerations in the mind, the Commonwealth Fund's Commission on a High Performance Health System has proposed a comprehensive, synergistic set of policies that could generate needed budgetary savings for the federal and state and local governments, provide relief to millions of American businesses and families, and improve value for spending on health care.⁸ The Commission set a goal of holding the growth of nationwide health spending per person to no greater than per capita economic growth, and would accomplish that goal by changing the way health care is paid for, used, and organized.

The three-pronged approach recommended by the Commission would:

- Use provider payment reform to promote value and accelerate delivery system innovation;
- Engage consumers with information and positive incentives to choose high-value care and care systems; and
- Undertake systemwide action to improve how health care markets function.

Under this approach, policies would be enacted that harness both provider and consumer incentives and improve market interactions to produce better care and care experiences at lower cost. These policies would allow flexibility for local innovation and provide better, more transparent information to enable consumers and health system leaders to choose and act wisely.

Using Provider Payment Reform to Promote Value and Accelerate Delivery System Innovation

Payment reform could be used to accelerate the pace of delivery system innovation and care coordination, while increasing accountability for improving outcomes and reducing cost growth over time. To maximize their impact and ensure consistent signals, the policies should be coordinated across public and private programs. The aim of these policies would be to accelerate the move from our current fee-for-service system that ties payment to the provision of individual services to one that rewards efficient care and better patient outcomes. These policies also would strengthen primary care by providing incentives and expanded resources for practices committed to providing coordinated care and helping patients navigate the health care system.

- **Improving Provider Payment.** This policy would repeal and replace the SGR formula (and the reduction it calls for) with a Medicare physician payment policy that provides incentives to improve health outcomes and participate in care system innovation. The Medicare fee schedule would be restructured to reduce payment rates for services meeting specified criteria as overpriced, and institute a system for future increases tied to performance.⁹ To move more quickly to models of coordinated care with accountability for outcomes, the policy would provide future increases in fees only for providers participating in innovative payment or delivery systems such as patient-centered medical homes, bundled payment, and accountable care organizations (ACOs). Fees would otherwise remain at 2013 levels. To use the market to drive down costs, Medicare could institute competitive bidding for medical commodities (drugs, equipment, and supplies).¹⁰ Payment rates for several other types of providers (from among those recommended by MedPAC) would be recalibrated to improve alignment with cost and value.
- **Strengthening patient-centered primary care and supporting care teams for high-cost, complex patients.** Strengthening the primary care foundation of the nation's health system is critical to providing timely access to care, preventive care, and better outcomes for those with chronic disease. Rich evidence from within the U.S. and abroad attests to the potential of redesigned primary care and care teams to improve care and patient experiences—and to lower costs over time by preventing complications and reducing avoidable use of hospitals and more specialized care.¹¹ By enhancing primary care payment for patient-centered medical homes that use teams for managing chronic conditions across sites of care, payment reform would strengthen primary care and care overall. This policy would augment fee-for-service payments with additional payment for care coordination, 24/7 access, and the use of

teams for care delivery. It would include incentives for providers to improve patient outcomes.

In addition to providing core support for medical homes, this policy would invest in the development and more intensive use of teams to manage care and improve care coordination by providing enhanced payment to providers that have the team-based capacity to care for high-cost patients with multiple chronic diseases or disability. Such teams would include nurses and other clinicians working with primary care physicians and would provide and coordinate after-hours or at-home care. Care teams responsible for high-risk, high-cost patients would work interactively with hospitals and specialists to ensure patients make smooth transitions across care settings and receive follow-up care after hospitalizations. Such teams would be held accountable for patients receiving timely, safe, and effective care.

- **Bundling hospital payment to focus on total costs and patient outcomes.** Medicare, Medicaid, and private insurer payments for hospital care typically do not include physician services and do not hold hospitals accountable for readmissions or follow-up care. More inclusive bundled payments in which a single payment is made for all care provided during an episode of care involving a hospital stay—including physician services—would provide incentives for teamwork and accountability for the total costs of care and outcomes associated with hospital episodes of care. Medicare has begun a pilot to test alternative approaches to bundled payment. One model being tested bundles physicians' services and post-acute transition care for selected procedures. Several bundled payment initiatives have been implemented in the private sector as well.¹² Accelerating bundled payment for hospital and post-acute care would support movement toward high performance and provide incentives for hospitals, physicians, and post-acute care providers to make transitions and follow-up care a priority. Greater use of bundled payment for hospital care and post-acute care also would make it easier for patients as well as payers to compare and assess the total costs of care and quality for certain procedures and conditions such as hip replacement surgery, appendectomy, or heart bypass surgery.
- **Adopting payment reforms throughout markets, with public and private payers working in concert.** With federal and state health care programs insuring over 40 percent of the population, the acceleration of payment policy innovations among federal and state public programs would stimulate change across the country, supporting local care system innovation to achieve the triple aim of better care, better health, and lower costs. This effect would be amplified if consistent payment methods and reporting requirements were adopted by private as well as public payers in local markets. This would also reduce complexity for

physicians and strengthen incentives to transform their practices in ways that improve the value of care. More consistent payment approaches among payers could also help counteract the concentration of provider market power, lowering private insurance premium costs for businesses and families.

Examples of promising payment reform initiatives in practice. Many states, private insurers, and health systems have already begun to implement innovative payment arrangements. Missouri and Illinois are just two examples of states that are actively promoting the patient-centered medical home model of payment and delivery system transformation. Early results are promising in both states, with a 16 percent reduction in per Medicaid beneficiary costs in the Missouri Home Health initiatives and 18 percent fewer hospitalizations in the Illinois Medical Home Program. In the private sector, Geisinger Health System, an integrated care system in rural Pennsylvania, Empire Blue Cross Blue Shield of New York, and Group Health Cooperative of Puget Sound are just a few of the payers and health systems already realizing significant savings and better outcomes with the medical home model.¹³

Geisinger's advanced medical home program has been particularly successful at improving quality and increasing value for chronically ill patients in Pennsylvania. Marketed as its "ProvenHealth Navigator," the medical home program features an embedded nurse case manager in practice sites and the use of real-time data to monitor the utilization of services by patients with complex care needs. The reimbursement structure and financial incentives embedded in ProvenHealth include a hybrid of fee-for-service payments, pay for performance bonuses, and infrastructure transformation stipends. Quality targets are set through a collaborative process with providers and health plan teams, and efficiency goals are based on per member per month experiences with each primary care practice. The results are promising—the program experienced an 18 percent reduction in hospital admissions and a 36 percent reduction in readmissions after two years.¹⁴

Blue Cross Blue Shield of Massachusetts continues to realize savings under its innovative Alternative Quality Contract (AQC) program, in which health care providers receive fixed payments for patient care delivered within a defined period.¹⁵ Providers in the AQC are then eligible for bonuses of up to 10 percent if certain quality-related process, outcome, and patient experience measures are met. Early evaluations of the program have been positive—data suggest that the AQC is slowing spending growth by encouraging physicians to refer patients to physician and hospitals that charge lower prices. Researchers have concluded that such changes in referral patterns could pressure more expensive facilities to lower their fees, injecting renewed price competition into the provider markets and leading to additional savings across the state.

At its core, payment reform is the most effective way to drive and reward delivery system innovation. Correctly aligning incentives in the U.S. health system would allow providers and care systems to be rewarded for successfully re-engineering care to lower costs and improve outcomes. There are numerous examples of these transformations in practice, such as Appleton Medical Center and Theda Clark Medical Center in northeastern Wisconsin. These systems have redesigned acute care processes using Lean methodologies and achieved cost per case reductions of 15 to 28 percent and lower length-of-stay and readmissions rates.¹⁶ Further, Virginia Mason Medical Center, a health care delivery organization in Seattle, Washington, has partnered with health plans and employers to develop standardized approaches to common conditions, decreasing the use of advanced imaging by 23 percent, increasing the availability of same-day appointments, and achieving 91 percent patient satisfaction.¹⁷

Estimated budget impact of payment reforms. The Commonwealth Fund contracted with the Actuarial Research Corporation (ARC) to estimate the potential cumulative effects if all recommended payment policies were in place starting in 2013, with first-year impacts in 2014.¹⁸ ARC estimated the incremental and cumulative spending impact over the 10-year period 2014 through 2023, compared with baseline projections under current policies.¹⁹ To estimate the potential of the combined policies, ARC adjusted estimates for each policy to reflect potential overlap.

The payment reform policies described above could produce an estimated \$788 billion in federal savings over the next 10 years, with state and local governments realizing \$163 billion in savings, private employers \$91 billion, and households \$291 billion.²⁰ Based on these projections, net Medicare spending would be an estimated \$587 billion lower than under current policy—more than enough to offset the cost of eliminating the SGR cuts in physician fees. These estimates are contingent also on the synergistic effects of these and other policies, described below, that would improve system performance nationwide.

Engaging Consumers with Information and Positive Incentives to Choose High-Value Care and Care Systems

Currently, patients and consumers have very little information to guide their care decisions or to help them choose care or care systems wisely.²¹ The lack of information about different treatment choices, clinical outcomes, prices, total costs, and quality of care has discouraged efforts to develop insurance benefit designs that provide positive incentives to seek care from high-value care teams or networks. Engaging consumers effectively requires providing better

information on alternative care choices, as well as incentives to choose care systems that provide better patient outcomes and more patient-centered care. A consumer-friendly, patient-centered approach to providing information and positive incentives to choose wisely would complement payment policies that give providers incentives to improve their performance. Positive consumer incentives include reducing cost-sharing or eliminating cost-sharing altogether for essential, highly effective care, and providing patients with comparative cost information for equivalent care choices. To enable such informed choice, there is also a critical need to expand scientific information about the comparative risks and benefits of alternative treatment choices, with assessment of outcomes for existing as well as new medical technologies and practice. These illustrative policies would promote consumer engagement in making informed, high-value choices about providers and treatments.

- **A new “Medicare Essential” plan with more comprehensive benefits and better protection against catastrophic costs, with provider and enrollee incentives to achieve better care, better health, and lower costs.** This proposal would offer Medicare beneficiaries a competitive Medicare Essential plan with integrated benefits and a limit on out-of-pocket costs while providing positive incentives to seek care from high-value care networks and teams. This approach would engage Medicare beneficiaries in making better health choices while protecting access and affordability. These positive incentives would work in tandem with the provider payment policies described above to encourage physician participation in high-performing health care organizations and innovative payment arrangements. Medicare Essential could be designed as self-financing, with beneficiaries paying a premium directly to Medicare. In estimating the potential premium cost for such a plan, we find it would generally be lower than the amount seniors typically pay for current Medicare supplements (Medigap policies), in part because of lower administrative costs.²² This confirms earlier analyses that similarly found that the resulting premium could be less than the current premiums paid by beneficiaries with private Medigap policies that provide supplemental coverage.²³
- **Modifying the payment policy for private Medicare Advantage plans to encourage beneficiaries to enroll in high performing plans.** The benefit package of a Medicare Essential plan would more closely correspond to that provided by private plans in Medicare Advantage and those available through public and private employers. This would provide beneficiaries with real choices among comparable health plan options. Recalibrating payments to Medicare Advantage plans based on the costs of the new Medicare option, with shared savings for lower-cost, high-quality plans and their enrollees, would encourage plans to operate more efficiently and encourage beneficiaries to select the best plan for them. High-

quality plans would be those that perform well (4 or more stars out of the maximum of 5) according to the rating system used by Medicare.²⁴

- **Providing positive incentives for Medicare and Medicaid beneficiaries to seek care from high-value, patient-centered medical homes, high-cost care teams, ACOs, and integrated delivery systems.** To complement provider incentives to strengthen primary care and participate in accountable care networks, both Medicare and Medicaid would offer beneficiaries positive incentives to select care from practices and networks with proven track records of better outcomes. In Medicare, the deductible would be waived for primary care for beneficiaries who register with a practice that is a medical home or for care teams with the capacity to care for high-cost, high-risk patients. Cost-sharing also could be reduced for those patients who agree to receive care from networks that participate in the Medicare Shared Savings Program or the Pioneer ACO initiative. To spread this approach in Medicaid, high-cost and chronically ill patients who elect to receive care provided by teams would be provided with access to enhanced services. Private plans participating in Medicare Advantage, Medicaid, and the health insurance marketplaces would be encouraged to follow a similar approach and to align incentives throughout entire markets to support high-value care teams and care systems. Efforts to align information and provide incentives for all payers within a market would be particularly important to encourage and support networks participating as ACOs with multiple payers. .
- **Enhancing clinical information on outcomes of care and patient experiences to inform choice of care and care systems.** Providing better information on the benefits, safety, and cost of alternative high-cost medical treatments or technologies would inform decisions by patients and providers. As use of electronic medical records spreads, with enhanced capacity to exchange information across providers, the nation has the potential to reap benefits from its investment in smarter information systems and clinical support. Meaningful use of such systems, however, will require a concerted effort across care systems to pool information on outcomes to track and assess patient experience. The potential to learn from experience would be further enhanced with registries that track experience with medical devices or other high-tech procedures, such as the registry for total joint replacement maintained by Kaiser Permanente.²⁵ Developing a national approach, rather than relying on private systems, would provide more complete and accurate information about the safety of devices and other technologies as well as their comparative benefits for patients and doctors. Having all-payer information on prices, quality, patient experiences, and outcomes of care, at both the state and community levels, would inform consumer choice and efforts by providers to improve

care. This information would also would enable payers (both public and private) to develop more value-based insurance benefit designs.

Examples of promising consumer engagement initiatives in practice. Many examples exist of efforts to improve the availability of information. The most advanced involve all-payer claims databases to allow for a more meaningful understanding of costs, quality, and patterns of care across Medicaid, Medicare, and private payers.²⁶ Maine, Massachusetts, New Hampshire, Tennessee, and Utah are early leaders in the all-payer claims database effort. Oregon and New York also are implementing all-payer claims databases.

Value-based insurance design is one consumer engagement strategy that links evidence-based information and patient incentives in an effort to lower costs and improve outcomes. Pitney Bowes, a multi-national U.S. corporation that provides customer communications technologies, introduced a value-based insurance program in January 2007. The initiative eliminated copayments for cholesterol-lowering drugs known as statins for all employees with diabetes or vascular disease and lowered copayments for all employees prescribed the clot-inhibiting drug clopidogrel. A Commonwealth Fund supported evaluation of the program found an increase in patient adherence to both care regimens, suggesting that when coupled with evidence-based research and guidelines, value-based insurance design could lead to better care outcomes and slow the growth in healthcare spending.²⁷ Several of our international peers are already successfully utilizing such strategies on a broad scale.²⁸

Estimated budget impact of consumer engagement policies. The 10-year impact of the consumer engagement policies described above—if enacted now and implemented quickly, aggressively, and effectively—on federal spending overall was estimated at \$71 billion relative to the current policy baseline over 10 years. State and local governments would realize an estimated \$16 billion in savings, private employers \$51 billion, and households \$51 billion.²⁹ The potential impact on net Medicare spending is an estimated \$70 billion. Although these estimates are small relative to the payment reform policies described above, providing and encouraging improved consumer choices is crucial to the achievement of the savings attributed to those payment reforms and to the attainment of a high performance health system.

Undertaking Systemwide Action to Improve How Health Care Markets Function

Currently, health care markets do not function well. Fragmented payment policies and reporting requirements have given rise to an incoherent and inconsistent pricing and added layers of

administrative costs for providers and health plans. At the same time, current malpractice liability laws provide incentives to do more testing while failing to address safety concerns.

Within local markets, consolidation of providers that may result in higher-quality and more-integrated care also has the potential to increase prices, irrespective of value, if a relative imbalance of market power results from the consolidation. In recent years, increasing concentration has been an important factor in driving up costs for care systems and for health insurance. Indeed, increases in prices paid for care by private insurers for “must have” providers or dominant systems have accounted for much of the rise in private insurance premiums as insurers pass on those higher costs, taking the path of least resistance.³⁰ This dynamic creates a growing discrepancy between private and public payment rates and impedes efforts to slow cost growth.

As described above, transparency about health care prices, quality, and outcomes would inform consumer choice as well as providers’ efforts to improve. However, transparency alone will do little to address rising prices. Indeed, there is the potential for lower-cost providers to aim for the high end of the range once this is made public. And in communities where markets are concentrated, with few alternative sources of care, consolidated market power could overwhelm and undermine any incentives for consumers to compare costs.

Given the reality of the current health insurance and delivery system market dynamics, systemwide efforts will be needed to complement payment reforms and changed incentives for consumers. This includes efforts to lower the administrative costs that result from having multiple payers and failure to coordinate or standardize insurers’ policies. To support payment reforms and incentives for consumers to choose wisely, the following policies would seek to further improve the functioning of health care markets by reducing excessive administrative costs, reforming malpractice to promote safety and fair compensation, and enabling multipayer approaches.

- **Simplifying administrative policies and procedures across public and private plans to reduce administrative costs and complexity.** Policies that simplify and require more uniform administrative policies and procedures across public and private plans would reduce an expensive layer of paperwork and make it easier for providers to focus on furnishing more effective, coordinated, and efficient care. Integrating administrative records systems, electronic submission of claims, shared provider enrollment and credentialing systems, and common quality reporting would reduce redundancy and complexity that add time and staffing costs for practices and hospitals. The reduced administrative cost burden would

largely accrue to physicians and hospitals. Streamlined enrollment processes for Medicaid and new insurance marketplaces would also reduce health plan and insurance system administrative costs and promote more continuous enrollment.³¹ Such efforts would build on beginning steps for administrative simplification embedded in the Affordable Care Act³²

- **Reforming medical malpractice policy.** Malpractice reforms should be linked to payment reforms and should provide fair compensation for injury while promoting patient safety and adoption of best practices. Like administrative burdens, high premiums for professional liability insurance add to practice costs, especially for some specialties. Yet, despite its expense, the current malpractice system fails to create effective incentives to provide safe or evidence-based care, or to encourage admissions of mistakes or errors to inform corrective action. Reforming the malpractice system to include provisions for fair compensation for injury and medical costs, policies to encourage disclosure of errors, and protection for those adopting evidence-based practice could curb incentives to provide excessive or inappropriate care. Creating an environment that encourages the medical profession to police itself—such as sharing information about physician records across state borders for licensure—would further protect patients. Such an approach would also promote patient safety and evidence-based practice, and coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives that could lead to or be cited as the reason for excessive care.
- **Establishing spending targets.** Establishing a spending target, and adjusting policies as needed if the target is exceeded, would focus attention on identifying the sources of excessive cost increases. For example, certain geographic regions, more consolidated markets, or specific service areas may be the heart of the problem. Data would be collected to enable state or local communities to establish baselines, set targets, and adjust policies as needed. A spending target would also guide any multipayer negotiations with providers of payment methods and rates. A policy that includes provisions for adjustment of policies over time and allows for focusing on specific geographic areas or services if trends exceed the target would provide impetus to act and collaborate. A well-designed policy could enable targeted action at the geographic or service area or within local markets, with flexibility to refocus over time as needed.

Examples of promising initiatives to improve how health care markets function in practice.

The creation of state-based health insurance exchanges as required under the Affordable Care Act provides a key mechanism through which policymakers can simplify administrative policies and procedures across public and private plans. States like Utah and Massachusetts already had

functional exchanges in place before the enactment of the new law, and can continue to be leaders in developing new initiatives that reduce redundancy and complexity in claims and credentialing

Massachusetts also has enacted a statewide spending target that is intended to provide an impetus to control health spending growth in the state.³³ The target is tied to growth in the state's economy, and includes provisions to improve transparency and accountability for health care providers with regard to quality and cost, and to improve clarity for consumers about the out-of-pocket costs they face. The act creates a Health Policy Commission to implement the new law and a Center for Health Information and Analysis to collect and analyze data on health care costs and quality.

Texas began medical malpractice reform in 2003, placing an upper bound on non-economic damages for plaintiffs in cases against individual physicians. This policy has led to a reduction in medical malpractice premiums for providers, but additional steps could be taken to promote patient safety and adoption of best practices by granting a degree of protection for providers who can demonstrate that they used evidence-based practices. Coupling such malpractice reform with Medicare payment reform would further focus incentives on value, and avoid liability incentives that could lead to or be cited as the reason for excessive care.

Estimated budget impact of policies to improve how markets function. The 10-year impact of these policies to improve market functioning on overall federal spending is an estimated saving of \$177 billion, with state and local governments realizing \$62 billion in savings, private employers \$48 billion, and households \$194 billion.³⁴ Based on these estimates, net Medicare spending would be reduced by \$104 billion relative to projections under current policy. In addition to producing direct system savings, administrative simplification and other suggested policies would reinforce the effect of improved financial incentives, enable better choices that would improve care, enhance the efficient use of health care resources, and reduce costs for providers as well as patients and insurers.

OVERALL IMPACT AND IMPLICATIONS OF A COMPREHENSIVE APPROACH TO HEALTH REFORM

The combined policies proposed by the Commission on a High Performance Health System have the potential to reduce projected national health spending by a cumulative \$2.0 trillion from 2014 through 2023. This assumes that all these initiatives are enacted together as part of a unified, synergistic strategy (Exhibit 6). Of that amount, federal savings would total \$1.0 trillion

over 10 years. Net Medicare spending would be \$761 billion lower than projected under current policy.

Exhibit 6. Cumulative Impact of Comprehensive Strategy on Health Spending, 2013-2023: Medicare, Federal, and NHE

Net impact in billions

	Net Medicare Spending^a	Federal	NHE
Provider payment reforms	-\$587	-\$788	-\$1,333
Provide and support high-value choices by consumers	-\$70	-\$71	-\$189
Make markets work better	-\$104	-\$177	-\$481
Cumulative impact	-\$761	-\$1,036	-\$2,004

^a Estimate derived from estimates of spending by payer developed by the Actuarial Research Corporation.
 Note: NHE = National Health Expenditures. Components may not add to total because of rounding.
 Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

Looking at potential savings by major payer category, there would be substantial potential savings for both public and private payers compared with baseline projections as policies spread across markets (Exhibit 7). In addition to federal government savings, households would save an estimated \$537 billion as a result of lower premium and out-of-pocket costs for medical care. State and local governments would save \$242 billion, primarily as a result of slower growth in their share of Medicaid costs, but also because of slower growth in public employee health care costs. And private employers would save an estimated \$189 billion as a result of lower costs per person for their employees and retirees.

Exhibit 7. Cumulative Impact of Comprehensive Strategy on Health Spending, 2013-2023: By Sponsor

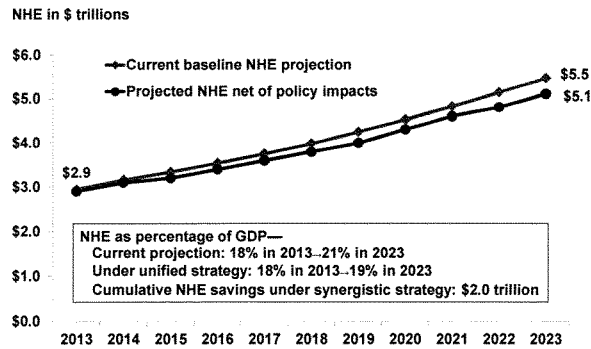
Net impact in billions

	Total NHE	Federal govt.	State and local govt.	Private employers	Households
2013-2023	-\$2,004	-\$1,036	-\$242	-\$189	-\$537

Note: NHE = National Health Expenditures. Components may not add to total because of rounding.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund.

These estimates suggest that it is within our capability to hold spending growth to no more than GDP growth per capita for most of the decade. Specifically, the Commission’s recommendation would hold health spending to an estimated 19 percent of GDP by 2023, compared with the current projection of 21 percent (Exhibit 8).

Exhibit 8. Projected National Health Expenditures (NHE), 2013–2023: Potential Impact of Synergistic Strategy



Note: GDP = gross domestic product.
Source: Estimates by Actuarial Research Corporation for The Commonwealth Fund. Current baseline projection assumes that the cuts to Medicare physician fees under the sustainable growth rate (SGR) formula are repealed and basic physician fees are instead increased by 1% in 2013 and held constant from 2014 through 2023.

Notably, although private spending per insured enrollee would slow, it would continue to exceed GDP annual growth and Medicare per beneficiary growth throughout the decade as it has in recent years. The analysis described here does not examine what could happen to private payer trends if dominant private payers were better able to leverage their purchasing power by paying for value or through multipayer initiatives.

It is important to note that despite the substantial savings produced by these policies over 10 years, the health sector would still grow—with adequate resources to adopt innovations in care delivery, introduce new medical breakthroughs, and ensure care for an aging population. Even under these policies, health spending is projected to increase from \$2.9 trillion in 2013 to \$5.1 trillion in 2023—an increase of more than 75 percent over the decade. Spending on both hospitals' and physicians' services would continue to grow, with the potential for net revenue growth as administrative costs decline.

This substantial—but somewhat slower, more stable, and better targeted—growth in health spending would continue to allow for expansion of services to those who are now uninsured and underinsured, the ongoing adoption of information technology, the introduction of new prescription drugs and medical breakthroughs, and an increase in compassionate care for the most vulnerable, including low-income individuals, the elderly, and the disabled. It also provides for jobs in the health sector, stable incomes for health care professionals, and fiscal viability for efficient hospitals providing essential services.

CONCLUSIONS

In summary, it should be possible to stabilize health care spending growth for both public and private payers while also improving the performance of the health system overall and both quality and efficiency of care. Through a combination of reforming provider payment, engaging consumers to make high-value choices, and improving the way health care markets function, with all stakeholders involved and pulling together, we can achieve this goal.

In combination, these policies would lead to wiser and more efficient expenditures of health care dollars, while also enhancing the benefits of health care. These policies not only would strengthen Medicare for today and tomorrow but also make our health care system as a whole more viable. The resulting savings could be redirected to other essential uses, both in the public and private sectors. In the end, reduced health spending by federal, state, and local governments

and private employers would accrue to households, which ultimately bear the burden of rising health spending through higher taxes, reduced wages, or direct out-of-pocket costs.

Moving from concept to action, however, will require that national policy leaders reach consensus that health care cost growth is a vital national concern, not just a federal budget concern. The need for action applies not only to the federal government, but also to state and local governments, businesses, and households, all of which are under increasing financial pressure as a result of the growth in health spending. Ideally, all of these stakeholders would work together toward the same goals: simplifying the health system; reducing administrative waste; changing the way we pay for care to hold care systems accountable for population health while providing flexibility to innovate; and leveraging the impact of policy changes across payers. By pulling together to stabilize health spending, we have the opportunity to reduce the federal deficit, free up resources for state and local governments, and make care and high-value health insurance more affordable for families and employers.

NOTES

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- ³ Medicare Payment Advisory Commission *Report to the Congress: Promoting Greater Efficiency in Medicare* (Washington, DC: Medicare Payment Advisory Commission, June 2007).
- ⁴ E.A. McGlynn, S.M. Asch, J. Adams, J. Keeseey, J. Hicks, A. DeCristofaro, and E. Kerr, "The Quality of Health Care Delivered to Adults in the United States," *New England Journal of Medicine* June 26, 2003 348(26):2635-2645..
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- ⁹ Specific criteria to identify overpriced services could include: services with unusually large increases in volume, services that are ordered and provided by the same practitioner, and services provided together routinely in the course of the same treatment.
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- ¹⁹ The 'current policy' baseline used to develop these estimates assumed that Congress would continue to defer the Medicare physician fee reductions under the SGR formula, instead increasing fees by one percent in 2013 and then holding them constant from 2014 through 2023.
- ²⁰ These estimates also include the impact of the malpractice reform policy described below, which adds only about \$30 billion over 10 years to the estimate of nationwide savings.
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- ²² K. Davis, C. Schoen, and S. Guterman, "Medicare Essential: Enhancing Value in Medicare by Providing Better Protection and Encouraging Better Choices," draft submitted for journal review, October 2012.
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- ²⁴ Currently, the benchmarks used to set Medicare Advantage plan payments are set well above projected costs under traditional Medicare, and plans alone receive an extra payment if their costs are below that benchmark level.
- ²⁵ E. W. Paxton, M. Inacio, T. Slipchenko et al., "The Kaiser Permanente National Total Joint Replacement Registry," *The Permanente Journal*, Summer 2008 12(3):12-16.
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²⁹ These estimates also include the impact of a policy that would raise the required medical loss ratio in the individual and small group markets, which adds only about \$15 billion over 10 years to the estimate of nationwide savings.

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³² These include: electronic submission standards and streamlined rules for consistent format and data content to comply with HIPAA. Examples include eligibility verification and electronic funds transfers. The adoption of standards are expected to save providers billions over the next 10 years. Since most of the benefits accrue to providers rather than plans, however, these may be difficult to enforce without further action. The Affordable Care Act also limits the administrative overhead for health insurance plans with provisions for thresholds for medical loss ratios, requiring plans to rebate excess overhead charges. The thresholds have provided strong incentives for plans to reduce overhead costs to ensure profit margins.

³³ See R. Steinbrook, "Controlling Health Care Costs in Massachusetts with a Global Spending Target," *Journal of the American Medical Association* September 26, 2012 308(12):1215-1216.

³⁴ The potential impact of a spending target was not included in these estimates.

The CHAIRMAN. Thank you, Dr. Blumenthal.
Senator Collins.

Senator COLLINS. Thank you very much, Mr. Chairman. I have to say that I cannot think of another Chairman who would be so gracious as to allow other members of the committee to question first, so you get high marks from all of us for your graciousness.

I want to start my questions with Dr. Thorpe because I am the Chair and the founder of the Senate Diabetes Caucus, and I am well aware of the fact that, I think the figure is, that we spend more than one out of every four Medicare dollars treating people who have diabetes. I am an original cosponsor of the Medicare Diabetes Prevention Act that we will be reintroducing shortly that would require Medicare to provide coverage for community-based intervention that is offered through hospitals such as the YMCA to help pre-diabetic adults avoid becoming full-fledged, having full-fledged diabetes.

Now, there are some private health care plans like United Health that cover these kinds of services, but Medicare does not, and yet we know that research has proven that these kinds of lifestyle programs can reduce a pre-diabetic patient's risk of getting diabetes by 58 percent overall and 71 percent in adults over age 60. In the process, we would literally save billions of dollars in addition to improving the quality of life.

Why do you think it is so difficult to get changes in the Medicare program that seem to me to be no-brainers in terms of improving quality and saving literally billions of dollars?

Mr. THORPE. Senator, thank you for that question, and certainly, thanks for your leadership in the Diabetes Caucus.

I think you hit the nail on the head. Unless we tackle this issue of the rising rates of things we can prevent, these chronic diseases like diabetes, high blood pressure, bad cholesterol, all of which are related, we will not really be able to ever get at this issue of slowing the growth in spending. So if you think about these proposals I put on the table, we have to think about how does it affect the patients in the Medicare program and what can we do to clinically intervene.

We can make an enormous difference in improving health care outcomes of seniors and save Medicare money. I think, conservatively, even low participation rates, you would save over the next decade \$7 billion by having the Diabetes Prevention Program included as a part of the Medicare benefit. If you think about it, we have a "Welcome to Medicare" physical. We tell you you are at risk. We give you a personalized care plan. And then we send you home. But we do not have anything that is covered that would actually allow a physician to refer a patient to something that would make a difference.

This program would make an enormous difference, and you are right, the private sector has seen the value in it. Some Blue Cross plans, United Health Group are including it in partnership with the YMCAs and other community-based organizations to run it. So that was my second recommendation, is that we should just include this as a covered benefit. It would make an enormous difference in slowing the incidence and prevalence of diabetes in the program,

which has doubled in the last 20 years. We could have made a difference had we had this program built into Medicare a decade ago.

Senator COLLINS. I also think this is another example of the flaws in the reimbursement system that you alluded to. If an individual with diabetes has these terrible consequences of diabetes that is not well controlled and, for example, needs to have a leg amputated, Medicare is going to pay for that. But Medicare will not pay for a nurse practitioner to call that individual three times a week and check on what the blood sugar levels are, whether they are following their nutritional plan, whether they are exercising.

It seems to me we are not paying for the right things, which is not to say that we should not pay for the person who gets in trouble. But if we change the fee-for-service program so that there was more of an emphasis on helping to monitor a person with chronic disease between appointments, do you believe that that, too, would realize savings?

Mr. THORPE. Oh, without question. Again, if you look at where the growth in the spending is in the program, in 1987, half of the spending was linked to patients with five or more chronic conditions. Today, it is almost 80 percent. That is where all of the growth is happening. And we do not provide any type of prevention or care coordination at all for those patients.

So if we did have a system that focused much more proactively on preventing disease, engaging patients with multiple chronic health care conditions, rather than a reactive system that just pays after the fact, that is where we could make an enormous difference in quality.

So I think that we should just build both this prevention initiative, and we know enough about care coordination with respect to what works. We have decades of randomized trials and experience from Medicare Advantage programs that are really best practice and what goes on in the private sector about how to construct really clinically effective care coordination. We could just do that and build that into the original Medicare and have that as a focus over the next couple of years.

Senator COLLINS. Thank you.

To Dr. Goodman, before I yield to my colleagues, I want to particularly welcome you here. I have been fascinated by the work that the Dartmouth Medical Atlas has done over the years. I am very familiar with it because one of your colleagues, or former colleagues, Jack Wennberg, did a project in the State of Maine with Dr. Bob Keller and the Maine Medical Assessment Foundation where they identified outliers among physicians who were performing hysterectomies, and by going to the outlier with data, they were able to change his practice patterns. And it just showed to me how a peer review system backed by good data could make a real difference.

And as you discussed in your opening statement, Maine has very good quality care at a low cost. In fact, my physicians and hospitals are constantly complaining about the low costs because they do not get rewarded for that high-quality medical care in many cases.

I am also very interested in your study on readmissions. As part of the Affordable Care Act, Senator Jeanne Shaheen, who was very familiar with your work, as well, and I joined together to put in

some of the readmissions language with the penalties and try to have a transitional care manager, usually a nurse, a home health visit for the first 30 days.

But you made a really interesting point and that is the problem is not just the fragmentation of care after hospitalization. It is the fragmentation of care before hospitalization, as well.

In the State of Maine, increasingly, physician practices and home health agencies are being purchased by our hospitals or are joining our hospitals, and I am interested in your assessment of whether that is going to help to reduce the fragmentation of care or do you see that as a less desirable development?

Dr. GOODMAN. Well, thank you for your comments, and let me say that when I was preparing this testimony, I had a chat with Jack Wennberg, whose office is a couple doors down from mine, and once again, he reminded me of what he learned, what we all learned from the work that was done in Maine, truly a fascinating story. It is also a story about examining the experience of the total population, because, as you know, he was not focused exclusively on the Medicare population.

And what started up in Maine was systematic collection of data, of all-payer data, and now has the finest system in the country of all-payer data that includes commercial data, Medicaid data, and, of course, Medicare data is available, as well, that has allowed everybody from the business community to the providers and patients to see what is actually going on in health care systems.

What you are referring to is, I think, the grand partly hidden experiment that is occurring in health care, which is an aggregation of providers occurring both between—of hospitals aggregating, but also, of course, of physicians joining with hospitals and forming de facto, although not in all dimensions, integrated delivery systems. And the question is, will that, in fact, drive quality? Does it have the potential of reducing competition or increasing provider power, which then strengthen the hands of the providers in the negotiations, particularly in commercial markets, less so in Medicare, of course.

And we do not know the answer to that, but we do know that both in that sort of organic growth as well as the more systematic fostered integration that will occur under Accountable Care Organizations, that the public protection, if you will, is through robust publicly reported measures that are relevant to patients, so not just process measures about what percentage of patients had Hemoglobin A1c level, but functional health status measures, patient satisfaction measures, so that it is very clear the experience and the outcomes of patients across these delivery systems.

That is our—it is the information for the providers that helps guide their improvement. It is the check on what is a natural behavior of organizations, which is to strengthen themselves first and foremost, to be robust. And so I think that there is increasing attention to taking a close reexamination about what are the most important measures of health care, and this will allow, I think, good public monitoring on what occurs in places like Maine as well as Los Angeles, as well as Boston.

Senator COLLINS. Thank you.

Let me just close by saying that my uncle, Doug Collins, was one of the first Directors of the Maine Dartmouth Family Residency Program in the State of Maine. He has since passed on. But it was a wonderful collaboration and still is.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Collins.

It is Senator Warren.

Senator WARREN. Thank you very much, Mr. Chairman, and I want to join Ranking Member Collins in saying it is very gracious and very generous of you to permit others to take on the questioning first, and to say I feel much safer asking my questions knowing you will be in the clean-up position there at the end for what we leave out.

But I wanted to ask a question around the great public debate that is going on about entitlement reform. We keep hearing the warning that we must make substantial changes to Medicare or face bankruptcy of the Medicare system, and yet I am reminded that in 2010, we passed substantial Medicare reform. We did not give it that name, but we passed the Affordable Care Act and it resulted in powerful changes, both in how we deliver medical care, how we bill for medical care, and indeed research on medical care.

And we note now that in 2012, that the increase in medical spending for Medicare is now the slowest it has been in 15 years, that the Congressional Budget Office has revised its estimates, as the Chairman noted earlier, in just two years has revised its estimates for spending over the next ten years, saying it is going to be about 15 percent less than originally estimated, and that that is a savings well in excess of \$100 billion. So we are in a system that is substantially changing.

So I want to frame my question this way. I invite you to talk about how the Affordable Care Act changes the delivery of health care, any part of it, to reduce costs and what paths, what opportunities it shows us for making changes in costs in the future. And I know that you have really addressed that, Dr. Goodman, in part, when you talk about your hospital readmission study. You did it specifically. Dr. Blumenthal, I think you were hitting at it a little bit indirectly, so maybe if I just start with you on that question.

Dr. BLUMENTHAL. Thank you, Senator Warren. You are absolutely right. The Affordable Care Act was really two pieces of legislation, one that extended coverage to many uninsured Americans, another that attempted to initiate very important reforms in the delivery of health care.

It is true that we are seeing slowdowns in the overall cost of care, the rate of increase in the overall cost of care and in Medicare. I think it is a little premature to declare victory.

Senator WARREN. Fair enough.

Dr. BLUMENTHAL. We have seen repeated cycles of rapid increase and then slow down in health care costs over the last 20 to 30 years and they often coincide with insurance cycles rather than fundamental change in health care. Nevertheless, the Affordable Care Act does provide fundamental new tools. One of them is—among them are the penalties for readmission, the penalties for hospital-acquired infections that are above average, pay for value programs, and programs that have been initiated through the Cen-

ter for Medicare and Medicaid Innovation, which includes the pioneer ACO program, a version of the Affordable Care Act, and so on.

What I think we need most at this point is to bring all those different threads together in a comprehensive and synergistic program of health care reform. The Secretary has new authority to do that, but each of these initiatives is currently being implemented in a very particular way on its own basis, and without bringing them together in a comprehensive approach, and that is really what our Commonwealth Commission was about, taking these authorities, taking these ideas and saying, let us put them together in a comprehensive package. Let us cost them out and let us see what we can get if we really push them to their full advantage.

Senator WARREN. And because I take this suggestion very seriously, just make sure I am following all the way through. This is something that is within the capacity of our current structure. It is just an opportunity we have not yet seized, is that right? It does not require new legislation, for example?

Dr. BLUMENTHAL. I think it would require some changes in legislation. The kinds of reforms that we are proposing would require some changes in the legislation. Just as an example, changing the SGR formula, which is now quite toxic, and the fee-for-service approach to Medicare payment, though it is moving toward pay for value, it is doing it in a very kind of staccato, short, incremental way. We cannot afford to wait until all these different programs have been allowed to continue to prove themselves. They need to be knit together and pushed home to prevent us from rationing away critical benefits.

Senator WARREN. Thank you. I am going to be mindful of my time, because I am now out of time, but I will put this in the questions for the record to everyone and ask for more details on that one, as well. Thank you very much, and thank you all for being here.

Mr. Chairman.

The CHAIRMAN. Do you need some more time? Go ahead.

Senator WARREN. If—thank you. If the other three panelists would be willing to spend a little time on that question, I would be delighted.

The CHAIRMAN. Well, in case Senator Baldwin has to go someplace—

Senator WARREN. But I do not—

The CHAIRMAN [continuing]. Let us go on with you, and then depending on Senator Whitehouse, if you can hold on—

Senator WARREN. You bet.

The CHAIRMAN. Thank you. Go ahead.

Senator BALDWIN. Fabulous, another round. And I do have to run, so I very much appreciate that.

I made my opening comments somewhat personal about my own experience, being raised by my grandparents. As I hear the larger dialogue, I never want to forget the impact that some of these reforms have, not only on the immediate Medicare beneficiary and the quality improvements that we will have in our health care system, but the way it affects family members and caregivers. And I think in particular of the reform that is bundling.

A loved one in my family—not my grandmother—was hospitalized in another State—not Wisconsin, not a State represented at this dias right now—and in helping coordinate or understanding care needed, I talked with three specialists, a hospitalist, and a primary care physician not associated with the hospital of the hospitalization. I think of what difference that reform would make to our bottom line money-wise, this loved one's care, but also most Medicare beneficiaries have a support structure outside and it affects their lives, too.

I want to thank our witnesses for highlighting the many promising Federal, State, and private delivery reforms that are underway, and I really appreciate getting a chance to follow up on Senator Warren's questions about the Affordable Care Act. I know some incredible things are happening in my State around delivery reform, around Accountable Care Organizations, around data sharing, in particular quality and pricing transparency. But those promising developments are not evenly available throughout the State, and so the comments you have made about how do we ramp up the things that we know are working and have them fairly and abundantly available across the United States is such a key question and I really appreciate your bringing it up.

To that end, I want to ask Dr. Blumenthal, the Commonwealth Commission, one of the proposals that caught my eye was the creation of a new Medicare Essential plan with more comprehensive benefits as well as provider and enrollee incentives to achieve better care, better health, at lower cost. I am curious to know how many of these reforms that could drive, and in particular, what benefits should such a benefit package have that are not currently available in Medicare?

Dr. BLUMENTHAL. Thank you for that question, Senator Baldwin. The Commission did propose that a new Essential health benefit, Essential Health Plan, be available to Medicare beneficiaries. You know, in 1965, when Medicare was enacted, it was modeled and meant to be equivalent to the employer-based insurance of the day, which was actually an Aetna plan. And in those days, Aetna had a hospital plan and a physician plan and they were different and you could buy them differently.

Well, employer-based insurance has changed a lot. We now, like you in the Federal Employees Health Benefit Program, you buy one plan and it gives you the full range of benefits that you get. In Medicare, you have to buy A and then B and then D unless you are part of a Medicare Advantage plan. In other words, Medicare has become diverged markedly from the employer-based form of insurance that it was supposed to emulate and it has become much more complicated, and though still efficient administratively, it is extremely hard for some of our elderly folks to navigate because of its complexity.

We are advocating that you bring all those together into a plan that resembles an employer-based plan, where you make one purchasing decision, not necessarily Medicare Advantage but in the traditional health care system, and that you get A, B, and D. You get physician services, hospital services, and drug services together. The benefits would be comparable to what the current Medicare benefits are.

One thing that we would do is have a single coinsurance rate and a single deductible for all three of those, so you would not have a separate hospital deductible, a separate physician deductible, a separate drug deductible, which are incredibly confusing.

And the other thing that this plan would do is provide generous enough insurance so that Medigap plans would no longer be required. And that would save an enormous amount of money in administrative expenses, because Medigap plans have very, very high administrative expenses.

So the other thing that we envision for this is that it would have what is called a value-based insurance design, and what that means is it would encourage beneficiaries to make choices that are good for their health. It would do things like not have deductibles and coinsurance for diabetes drugs, for anti-hypertensives, for lipid-lowering drugs, for things that we know reduce disease burden and ultimately reduce costs. So that—and it would also reward, by the way, choosing high-performing health plans.

So in that combination of things, we do not really think it would be more expensive. We think it would be less expensive and a lot simpler and a much better choice than the current fee-for-service option.

Senator BALDWIN. Thank you.

The CHAIRMAN. Senator Ayotte.

Senator AYOTTE. Thank you, Mr. Chairman.

I appreciate all the witnesses who are here today.

You know, when I look at the issue with respect to Medicare, the challenges that we face with it, the Ranking Member mentioned, Senator Collins, in her opening statement, the fact that the Trustees have said that it will go bankrupt in terms of—in 2024. And one number that has always struck me is that your average family pays in roughly \$114,000 through payroll taxes and then, on average, takes out about \$355,000 in benefits. So just looking at the sheer numbers of the challenges that we face, we certainly need to do things differently if we are going to sustain these programs for people like my grandparents, that I am blessed to still have and around.

So some of the ideas that have been out there, and I know, Dr. Cubanski, that you had talked about them and I know there was lots of polling done on it, but ideas where we have looked at perhaps means testing further Medicare for those who are more fortunate later on in life so that they could afford even greater percentages of what they would pay for their health care to make sure that it truly remains a vibrant safety net as we think about the financial challenges I just laid out.

So I just wanted to get your thoughts on proposals that have been out there and what your thoughts are on them, on the eligibility end, meaning it is not so much an eligibility thing if we are going to means test but allow people who have been more fortunate, for example, in life—probably—hopefully me, later in life—to pay more or to perhaps even, if you get to a certain income level, not be provided—receiving your health insurance through some other means.

Ms. CUBANSKI. Thank you, Senator Ayotte, for your question. Yes, as you noted, we did do some polling on the question and this

was one of the areas where there was majority support for requiring higher-income seniors to pay more. Of course, seniors already do—and other Medicare beneficiaries already do pay more if they have higher incomes. So if you are making, as an individual, more than \$85,000 a year or a married couple more than \$170,000 a year, you pay a higher monthly Part B premium. And if you are enrolled in a Part D plan, you also pay a higher Part D premium. About five percent of the Medicare population today are paying those higher premiums.

One concern, of course, is that, as I noted in my testimony, half of the Medicare population has incomes of about 200 percent of the Federal poverty level and five percent of Medicare beneficiaries have incomes above around \$95,000 a year. So in order to really achieve significant savings from increasing means testing in the Medicare program, you have to go relatively far down the income scale in order to get larger percentages of Medicare beneficiaries paying higher premiums and higher costs, and that really does, I think, call into question the ability of those individuals to afford to pay higher premiums and higher cost sharing amounts than they are currently paying.

Senator AYOTTE. But assuming that we were able to make those changes at an income level that would still allow people, obviously, thinking about it—I do not think that any one change is going to get us to a point where, when you look in the gaps we have, to get where we need to be. And so I think we need to look at a variety of options and, obviously, take reasonable ways in which we implement those options to take into account people's ability to pay on these things. So I appreciate your thoughts on it.

And I wanted to also ask Dr. Goodman, the work that is being done at the Atlas program, you have clearly said that some hospitals—and I remember when I went to see the work being done by Dartmouth on the Atlas work that you are doing there, you showed me a map, or the people at Dartmouth showed me a map, and one thing that really struck me was the fact that there was such a geographical difference in terms of this readmission rate, but also there was a difference in reimbursement rate, as I recall, too, and that the difference in reimbursement rate did not necessarily equate to a better outcome in terms of the readmission rate.

And so looking at this challenge, what—taking account, I believe, the ten percent you said which would account for the condition, the health condition of the patient, what is the other 90 percent, and as this panel tries to tackle the challenges to make sure that this important program is there for future generations, what would you recommend to us the best steps to take?

Dr. GOODMAN. Well, thank you, Senator Ayotte, for asking the hardest question, because I think that this—and I think you have touched upon what are some of the difficult facts that are out there, which is that although we would like to think about improving the Medicare program and quality and in terms of the efficiency in a way that involves no pain to anybody, the fact is, is that this is a process that is going to involve tremendous change, including differences in the way providers behave and differences in the way that we invest our National wealth. And that has on the

ground implications for health care labor markets, for capital investments, and so forth.

You know, the revelation in terms of variation in Medicare spending per capita, even when doing the most stringent sort of risk adjustment for differences in population, is a reflection of differences in practice style and differences in the way that communities and health systems have, over very long periods of time, invisibly built their system. And sometimes—all the sort of successes in health care are attributed to design and the ills are always attributed to accident, and with geographic variation, much of this is by accident, that there are places that, for one reason or another, have a legacy, for example, a very high number of hospital beds per capita, very high supply of specialist physicians per capita, and in the fee-for-service environment, and in a culture of health care of which I am part of as a physician, where we are very much trained to be active and believing that more aggressive or specialist or procedurally oriented care is better, this is sort of the perfect storm for providing care that sometimes is very helpful but sometimes is of marginal benefit.

And so that variation in spending—the reason why more spending on the Medicare program in aggregate per beneficiary is not necessarily related to better outcomes or better quality is because of this large domain of marginal care that is delivered.

Now, how do you attack that problem? You could mandate particular structures of health care systems. That would then restrain the capacity to deliver care, which is not particularly beneficial to populations. I mean, we know that you could reduce readmission rates by having lower bed supply in certain regions. That is, in fact, what has happened. It is one of the reasons why certain parts of the country do so well on some of these metrics by accident. They grew a modest supply of beds. The health system evolved invisibly to care for patients in ways that they only needed to use that sort of bed supply.

I think that a more sort of reasonable approach is to align these incentives so that the incentives to providing good care are the incentives that lead to institutional health, organizational health. Organizations—health systems who have this ill-advised capacity now are really caught in a bind in what is a rapidly changing system of financing. So imagine places that have, in a well-intentioned way, have over-built their inpatient capacity and that gets filled up with admissions and readmissions. Not that they are putting patients in inappropriately, but it is just a practice style that evolves, and there are always many patients that, you know, on a given day could go in or out. In some places, they get cared for in the community. In other places, they come in.

These are—

The CHAIRMAN. We need to wrap up, Dr. Goodman.

Dr. GOODMAN. Very, very quickly. So these are the places that will, I think, benefit the most from these population-based shared savings plans like Accountable Care Organizations, where they have something to gain from reinvesting into community-based care, where there are no longer the incentives for more patients with DRG payments. Thank you.

Senator AYOTTE. Thank you, Doctor.

The CHAIRMAN. Senator Whitehouse.

Senator WHITEHOUSE. Thank you, Chairman.

I think we have all noticed that there is a huge overlay between our budget discussions and our health care cost discussions. Everybody from Paul Ryan to Barack Obama says that if you really look at the budget problem and the deficit problem, it is a health care problem.

And yet when we try to connect those dots, we have a hard time for, I think, the very practical reason that so few of the delivery system reform savings are scorable by CBO, which actually makes logical sense because a lot of these reforms are going to require innovation, they are going to require finding a sweet spot with incentives that direct doctors to the best treatment and patients to the best self-care, and we are going to have to kind of work our way to finding that. It is sort of, to me, a little bit like the early days of aviation, as people worked out the bugs, even though principles were clear, to the kind of fast, safe aircraft travel that we have now.

So I would like your thoughts first on how close we are getting to be able to put some meaningful scoring metrics behind delivery system reform.

Two, whether you think it would be helpful if the administration would quit talking vaguely about bending health care cost curves and actually put down a hard target with a date and a number for delivery system reform savings that people could then argue about and maybe discount if they felt it was improbable, but at least it was out there instead of just mush, basically, right now—a lot of hard working people, but no specific target.

And third, are there ways to take advantage, particularly Dr. Goodman, of that broad array of performance levels that States exhibit, as shown by the Dartmouth Atlas project, to posit into the out years, that certain States that exhibit very poor quality and very high cost are not going to be able to continue on that path, that there will be a time when, if you are more than a certain percent of an outlier away from the mean, we are just not going to fund that any longer. You are going to have to come into what other States have demonstrated they can do, because they are doing it.

So there is an array of options for either improving the scorability of this stuff, or developing it to the point where it is more scorable, or having the administration be more responsible about setting a hard, fixed target, or actually starting to carve out outliers for poor performance and high cost in a way that could generate a score, and I would like to have your comment on that. And it is a long question in a short period of time, so I would really like to ask you to actually think about that as a question for the record and so I can get an answer from each of you. This is a very talented panel, and I have left you a minute and 40 seconds for the four of you to share that complicated answer. Typical Whitehouse, says the Chairman.

[Laughter.]

Since I mentioned you specifically, Dr. Goodman, why do you not take a quick bite at it and then we will let the others answer it as a question for the record.

Dr. GOODMAN. And I will be brief, which is that I honestly think that the only hope of changing the ship is to change the financial incentives. And the push-back of providers is going to be so great from potential dislocation that would occur in fixed targets, so we leave targets with expectation that those savings will occur, that there has to be financing systems that it is very much in the organization's interest to improve care and improve efficiency.

And there are different models on this. They share many common features. I think the Accountable Care Organization is one of the more global models that has been articulated. It is in the ACA. We certainly know that that will evolve further. But get the incentives right. Behavior will follow. As long as there is good information, transparent information about performance for consumers and providers alike, we will do very well.

Senator WHITEHOUSE. Well, I eagerly look forward to answers from the other witnesses. This has real repercussions for us because even though cutting benefits and rationing care are the inept way of looking at health care, and even though they are so wrong it is almost criminal, according to George Halvorson, to go back to my original quotes, they are scorable. They are scorable. And if we come to a real crunch on this, that is going to give them an advantage. They will be wrong. They will be inept. But they will be scorable.

And so it is really important that we work on trying to find ways to press the delivery system reform savings into some mechanism that allows us to treat them in our budget discussions. And I would look forward to your thoughts for that very reason. Thank you.

Dr. BLUMENTHAL. Senator Whitehouse, just a brief comment. I did not emphasize it sufficiently, but the Commission did recommend that we set a National target for rates of increase in health care costs at GDP and that policies be adjusted to achieve that growth rate. So it was a part of our package of recommendations.

Also, as Senator Warren knows, my home State of Massachusetts has set such a target for the State as a whole and it is going to be very interesting to see how that plays out.

Senator WHITEHOUSE. It will be. Thank you.

The CHAIRMAN. Senator Warren.

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

I just wanted to give an opportunity to Dr. Cubanski, Dr. Goodman, and Dr. Thorpe, if they wanted to comment on the question I had earlier about how the Affordable Care Act changes have reduced costs and show paths for future savings that we should note, and I just wanted to give you a chance to do that on the record here.

Dr. Cubanski.

Ms. CUBANSKI. Thank you, Senator Warren. I would echo Dr. Blumenthal's remark that it is still a bit of a mystery about why cost growth has slowed. But, of course, it is a promising early indicator, since in the past three years now, we have seen Medicare cost growth at a really historically slow rate.

I would suggest that one of the important provisions in the Affordable Care Act is the creation of the Center for Medicare and Medicaid Innovation, which has authority to test, implement, and

expand some of these delivery system reform ideas that we may have seen in the private sector, but have not really seen in Medicare and certainly not in the traditional Medicare program. I think that is where, since, you know, 75 percent of the Medicare population is currently in the traditional Medicare system today, that is really where we have, I think, a lot of opportunity to achieve a lot more savings moving forward.

And I know that the Center for Medicare and Medicaid Innovation is rolling out very quickly a lot of these ideas, the Accountable Care Organizations, bundled payments, medical home. So it is really testing a lot of ideas, and those that do show promise for reducing costs and either increasing quality or not reducing quality can be expanded. The HHS Secretary has the authority to do that without needing to go back to Congress for legislative authority. So I think that is a positive step.

Senator WARREN. Thank you. Very valuable. Thank you.

Dr. Goodman.

Dr. GOODMAN. Just, again, very quickly, I mean, I think it has been a remarkable revolution in that we have gone from being the country that did the very best job of measuring and studying health care of any country in the world to now a country that is engaged in tremendous innovation. And the question, of course, is the sum total of that innovation, particularly if it is separate pieces of innovation, will they knit together to actually, aside from improving quality in parts, will it improve quality as a whole and efficiency as a whole, particularly if capacity is fixed and health care systems have this legacy of what they have been doing for 50 years.

And on this point, we do not know. We do not know, for example, whether the Accountable Care Organizations will deliver on their hope and promise. I certainly hope they do. It is unknown. It is still very worrisome. I am not comforted, either, by the recent slowdown in the growth of expenditures. We saw that before, in the 1980s. That was one of the effects of the Clinton health care reform plan that was not passed. We actually saw a slowing down of health care expenditures for a period of time and then a rapid acceleration. So we are not out of the woods yet and it may, indeed, require more Congressional action to pull us along.

Senator WARREN. Thank you.

Dr. Thorpe.

Mr. THORPE. Well, I certainly think the Act moved us in the right direction. It brings in, really, sort of limited, and in some cases pilots on payment reforms that I think are moving in the right direction. It provided funding for prevention in public health, moving us in the right direction. It has an Innovation Center, which is testing and trying out a variety of new models.

I think that my suggestion was to really take a two-part strategy, because I am just concerned with the remaining, I do not know if it is mentality or focus, that somehow, we are a pilot project away from a miracle. We are not. I mean, we need to act on what we know already that works, and we have an enormous amount of experience with randomized trials in the Medicare population that shows the components of care coordination that are effective. Medicaid programs are doing this. The private sector is doing this, as

well. We can scale and replicate best practice, things that we already know that work, and we just need to implement them.

So we need to do a two-part strategy. We need to implement what we know that works and do it program-wide, but do it in a way that we are getting feedback and constantly improving it, as Senator Whitehouse talked about. That feedback loop is critical and we need to learn from our experiences. And we need to continue to do targeted pilots in areas where we need selected new information.

But I think we need to make that transition. We do not have a decade to wait to find out what is coming out of these pilot projects. As Senator Whitehouse mentioned, unless we give the Congress more tools to generate cost savings, we are going to be in a persistent state of getting savings in Medicare and Medicaid over the next decade, of cutting benefits, cutting provider payments, cutting payments to health plans, shifting costs to States and to seniors, none of which solve anything with respect to the long-term cost of the program. They are simply a budget exercise.

So I think until we switch this mentality of having the budget drive health policy to one where we have health policy driving the budget outcomes, that is the transition we need to make.

Senator WARREN. Thank you, and thank you very much, Mr. Chairman. I appreciate it. This is an extraordinary panel and I am delighted to have the chance to get you all on the record on this. Thank you.

The CHAIRMAN. Okay. Senator Collins.

Senator COLLINS. Thank you, Mr. Chairman.

I just wanted to make one final comment on my part, and that is when I look at the slowdown in the rate of health care spending, I, like at least one of our panelists said, am not comforted by that fact at all. I think it is largely due to the recession, to the downturn in the economy and people delaying getting health care, people not being able to afford health care, people losing their health insurance. And I think the other factor are the cuts to providers, the reduced reimbursements that we have seen, the cuts in home health care.

So I do not think we have seen a transformation. I see it very differently from my colleague from Massachusetts. I do not think this is a result of some transformation. I think this is a result of the recession and the result of cuts to providers.

And one of my concerns is that if we keep cutting providers' reimbursements under the same system and do not reform the delivery of health care, we eventually are going to affect access and that concerns me greatly.

So since I am dealing with two Ph.D.s and two M.D.s, I am not going to ask for a response to my comments on whether they agree with that analysis or not. But I just wanted to say that for the record and again to thank all of our witnesses for truly excellent commentary today.

The CHAIRMAN. Well, we can do better. At least it is going in the right direction with CBO's reestimate is \$400 billion less over the next decade of estimated spending in Medicare. Now, it seems to me that we can do better. Clearly, the Accountable Care Organizations are one area, but they are just being implemented.

I had great hope for the co-ops, which is the acronym for the Community Oriented Insurance Company. It was going to serve consumers. And yet at the 11th hour on December the 31st, that was given away in the negotiations because of misinformation that was occurring. I asked HHS and the Finance Committee. I said, why did you give it away? They said, we did not. I said, well, I have talked to people in the room, including the Finance Committee staff, and said that to the question, are there any co-op applications in the pipeline, after 24 States had already been granted applications, they said, no, when, in fact, there were a bunch of additional States in the pipeline. Now we have got to go back and try to get it back. So we can do better.

Now, one of the things that I know Senator Rockefeller has great hopes for is this Independent Advisory Board. But it, of course, has been characterized in the political cauldron as a rationing board. Does anybody have any comments about that?

Ms. CUBANSKI. Sure, I will take a stab at this one. Senator Nelson, as you know, the Independent Payment Advisory Board has been subject to a great deal of controversy, and, in fact, none of the members have been nominated or appointed. But I think perhaps a bit of good news in the fact that CBO's Medicare spending projections are quite low over the coming decade, they have suggested that, in fact, the Independent Payment Advisory Board, if it is convened, would not actually be charged with making any recommendations because they would not—the spending would not exceed the targets that were spelled out in the Affordable Care Act.

I think, obviously, the verdict is still out on the establishment of the IPAB, but we are not likely to see it in action, at least over the coming decade, assuming CBO's projections hold true.

The CHAIRMAN. Well, this Friday, we are going to face another challenge, and although Medicare benefits are protected in the sequestration, Medicare providers, health plans, and drug plans will be reduced by two percent. So what is going to be the impact of this across-the-board reduction?

Mr. THORPE. I will take a cut at this. Certainly, if you look at, again, just this continued focus on cutting provider payments, I think to Senator Collins' point, is it over time just does have an erosive and corrosive effect on not only the payment rates, obviously, but in terms of access—potentially, access to care.

And in particular, if you look in the Medicare Advantage program, if the sequestration does come into place, since the Affordable Care Act has been put into place, again, between now and 2014, you would have about a cumulative reduction in payments of around ten percent. And given the way the program is structured, for better or for worse, that ten percent does come out of potentially efforts to do innovation and coordinating care, but it also comes out of the additional benefits that those plans are providing.

So, again, I just think that, and getting back to the IPAB discussion, I think until we get to these issues of structural reforms in the program, and I understand that they take time and they are long-term, but we have got to make them. We are not going to get this program under control until we do something about the growth in the incidence of chronic disease. We are not going to get the program under control until we do a better job of managing and gaug-

ing chronically ill patients, those patients that have five or more conditions that account for 80 percent of the spending. Those are the two challenges. Until we really take those problems head on, we are not, over the long term, really going to get control over spending in the program.

The CHAIRMAN. And several of you have mentioned diabetes as an example, creating overweight conditions which, as you get older, is going to be so much more of a diminution of somebody's good health.

Now, Senator Collins and I are also interested in Medicare fraud. Do you have any comments about sequestration on our ability to go after fraud? And we are only scratching the surface now. Do you have any suggestions of how we can do a better job of it? And I say this as someone who has to own up to it, because there is a lot of it in Miami. Comments?

Dr. BLUMENTHAL. Senator, I am not an expert on Medicare fraud. I do know that the new legislation, the Affordable Care Act, provided the Secretary with substantial new authorities and tools to take on Medicare fraud using pre-screening, looking at a predisposition to be involved with fraud rather than just a kind of catching after to the fact.

To the extent that sequestration reduces the resources that are available for that activity, it will be certainly counterproductive. It will reduce trust in the program. It will increase the cost of the program. And it will be penny wise and pound foolish.

The CHAIRMAN. And I am told that for every dollar that we spend in going after it, fraud, that we realize back a \$7 return for a dollar spent. And so I am concerned about that. And that is dollars that otherwise would not go into the system or dollars that would not be utilized to reduce the deficit. And we are going to highlight that in this committee.

One of the things we have not talked about is Medicare Advantage. Now, one of the thrusts of the health care bill was to lean out the excesses into Medicare Advantage. You will recall in 2003, in what was called the prescription drug bill, that also set up Medicare Advantage and that set up a 14 percent bonus per senior citizen over and above Medicare fee-for-service. That was going to drive Medicare into bankruptcy even quicker. So we had to lean that out in the health care bill. And we are just seeing the results of that, what is anticipated, coming this year, and some of the insurance companies being cut back on that bonus.

But there was an incentive put in it that the higher quality rating you had with stars as an insurance company, which is what offers Medicare Advantage, you were going to be able to, in fact, have more reimbursement for your per beneficiary reimbursement.

Any comments from you all about Medicare Advantage and its implementation as we are trying to lean it out?

Dr. GOODMAN. Just the—I mean, the difficulty that Medicare Advantage is, first, based upon average fee-for-service payments of a particular area perpetuates what is already irrational and unfair spending and transfer of funds, actually, from one group of citizens to the other for no demonstrable benefit. So it—and that is the larger problem. I mean, the larger problem is the tremendous geographic variation in per capita spending, which Medicare Advan-

tage was never really designed to provide the incentives to try to encourage the less efficient places to become more efficient. So I think there is unfinished business there besides reducing the 14 percent.

The CHAIRMAN. Dr. Blumenthal.

Dr. BLUMENTHAL. There are a couple of points that the Commission made and that I would like to emphasize. One is that Medicare Advantage—the new quality ratings that Medicare Advantage has put in place, this star rating which enables the high-quality plans to get rewarded extra, is a terrific idea. It is a little too generous. So you can get extra payments for being a two- or three-star plan. The Commission felt that there should be a sharper gradation, with more rewards for the four- and five-star and fewer rewards for the programs that are kind of average. So that was point number one.

Point number two is once you understand which of those programs really is delivering high value, that has good cost profiles and good value profiles, quality profiles, we should provide beneficiaries a reward for enrolling in those to encourage them to be at the high end of value, and that could involve payments that are modest but influential.

So I think those are the two points that I would make about the Medicare Advantage program.

The CHAIRMAN. And this is where I give credit to HHS, that I think they have implemented it in a way that it is now set to achieve the savings that it needs, and by comparing the quality rating of Medicare Advantage plans, allow seniors to vote with their feet by going to the higher-rated plans, which presumably then, with less reimbursement because they do not get a bonus if they are not quality higher rated, is going to have them to either change and get higher quality or else fall by the wayside. And, theoretically, the seniors go to the better-rated plans and there is an incentive for the insurance company to have that better-rated plan. I commend HHS, that I think they are doing it right, whereas you know I ding them when I think they are doing it wrong.

You know, another thing that we have not talked about is in the health bill, we provided for annual wellness exams for seniors, and lo and behold, in this first year and a half of experience, they are not taking much advantage of it. Why is that?

Mr. THORPE. I think it is a combination of probably two things. One is lack of knowledge about the benefit is a piece of it. It is an additional visit, perhaps, to your physician. It is not integrated in any type of comprehensive approach to dealing with wellness that would include an action—not only action plan, but something that you can have to act on.

So I would rather see these things more bundled comprehensively, combined with the care coordination component, work with nurse practitioners that could really manage people in terms of wellness benefits and prevention more coherently and more comprehensively. It is just a very fragmented approach, I think, to dealing with prevention, where we are focusing on identifying at-risk patients with separate types of benefits and separate types of visits, but not really doing it in an integrated, coherent way that

actually has physicians working with nurses, nurse educators, dietitians, and others to help them execute a personalized care plan.

The CHAIRMAN. Well, presumably, if you are an insured, a beneficiary, and in one of the Medicare Advantage plans, that the insurance company is going to insist that you do it for the obvious reasons. But if you are Medicare fee-for-service, what is the mechanism to achieve what you just said?

Mr. THORPE. Well, again, that is the problem, is that I think if you look at what goes on in having a care coordination nurse that is working with you to say that, did you get the care plan? Did you get the physical? Where is the care plan? Let us work on executing it. Somebody that, if you think about it, for a typical Medicare patient may be seeing a physician three or four times a year and they have multiple chronic conditions, well, what happens the other 361 days a year? They either have to rely on a friend, family member, and so on.

That is the real challenge, is how can you continue to engage and work with people when they are not in the provider's office to actually stay healthy, keep on track with your care plan, and that is the missing part of original Medicare. It does not have those components. And I was suggesting that we could build those components in, I think somewhat seamlessly, based on a whole host of experience we have with best practice MA plans, but also what different types of integrated group practices do to really do team-based care. We need to do this as a team.

The CHAIRMAN. So what was planned in the private sector ACOs, more implementing in Medicare fee-for-service.

Mr. THORPE. Yes, and I think ACOs are certainly a good model of that as long as they have this care coordination component built into it. I mean, if we are just stringing organizationally providers together and they are not changing their practice patterns, that does not bring us very far. We really have to change the way that we do prevention and care coordination as part of an ACO, but I think it is a step in the right direction.

But everybody is not going to be in an ACO. There is going to be a whole bunch of people who live in parts of the country that will never be enrolled in an ACO. So, again, I just think that we need to get on the business of making these structural changes in the program that really attack where the spending growth is and where the money is and where the real challenges are in terms of providing quality health care.

Dr. BLUMENTHAL. Senator, if I could tell a story that I think illustrates how we might get to where we need to be on prevention—

The CHAIRMAN. And also tell us why we need more primary care physicians.

Dr. BLUMENTHAL. Well, as a primary care physician in practice for 35 years, I am all for more primary care physicians.

I visited a practice outside of London not too long ago and I was taken to see it because I was told they had a great electronic health record, and that was my concern at the time. But what I discovered was that they had 100 percent compliance among their population with a series of 50 or 60 quality metrics, most of which included all the preventive measures that we think are valuable.

And the way they did that is that they had three things. First of all, they got paid more as a practice if they achieved those targets.

Secondly, they had an electronic health record which made readily apparent those—when people were not meeting their preventive goals, when the patients were not.

And third, they had a system. The system was a health care worker, an employee of the practice, whose job it was on every patient's birthday to go through, to look at their electronic health record and see if they had realized their preventive goals, and if not, to contact the patient and have them come in. And they would do anything that was required to get that patient there. They would send a car for them, a taxi. They would send someone to the home, whatever was required. And the reason was they had the knowledge and they had the incentive.

I do not think this is very complicated. We do not have the knowledge because we do not have good health care records in most practices, and we do not have the incentives because people are paid to see patients, not to prevent illness.

The CHAIRMAN. Thus, the reason for the Accountable Care Organization, so that you follow the patient and you are following up on them. Of course, that is what an insurance ought to do in a Medicare Advantage plan, follow up, pester them, make them take their medicine, et cetera.

Dr. BLUMENTHAL. Well, I think the insurance plan has limited influence. I think you have to get the patient's personal physician, because those are the people who influence the behavior of their patients.

The CHAIRMAN. And that was a reason of why the reimbursement in Medicare for primary care physicians and outside of Medicare was raised. Is that working?

Dr. BLUMENTHAL. I think it is way too soon to tell, and I also do not think that the increases will be sufficient unless we find a way to make the lifestyle more rewarding and get past this sort of gerbil-like, hamster-like process that now dominates primary care, the volume and fee-for-service process. So there is a lot to do in changing primary care. The patient-centered medical home is an aspiration in that direction. We need to think about how this accountable care process and the primary care infrastructure will come together, which is still something we need to explore.

The CHAIRMAN. Dr. Cubanski, in your Foundation's research on the prescription drug benefit, you found that seniors are overwhelmed when they are picking a drug plan. I looked at one of them and I was overwhelmed. And what you found in your report was that they pay \$300, on average, more than they need to pay for their coverage. Can you share more with us?

Ms. CUBANSKI. Sure. So as you may know, we have been tracking the Part D program since its inception in 2006, looking at the number of plans that participate in the marketplace, the plans that beneficiaries are enrolled in, and the costs of those plans. And research that we and others have done has shown that beneficiaries do not necessarily make the best choice in terms of picking plans that offer them the best value for the prescription drugs that they are taking.

A lot of people choose plans because their friends told them to sign up for a particular plan or because they are familiar with the name of the insurance company and it is a name that they trust, and so they will enroll in that plan and pay a higher premium than they need to in order to get the medications that they are taking.

So this is, I think, an ongoing concern with the Part D program, although we have seen the number of plans in Part D fall from the high levels in the early years of the program as CMS has imposed increasing restrictions and some regulations that have helped, I think, weed out a lot of the duplicative offerings in the Part D marketplace. But I think it still is a concern that beneficiaries do not necessarily have the tools that they need to make good choices.

There is, as you probably know, the Medicare Compare website that lets people type in all the drugs that they are taking and the pharmacy that they go to and will actually give them the list of the plans that offer the drugs that they are taking and will give them the lowest total annual cost. But I think people just still make decisions not necessarily based on cost, but they have other reasons that might not be factored in, such as, as I mentioned earlier, recommendations from family or friends or where they can still go to their local neighborhood pharmacy.

So I think it is an ongoing concern and it is not entirely clear how we can steer beneficiaries to better choices. You cannot necessarily force them into the lowest-cost plan, but I think perhaps we can do better providing them with more information about those low-cost options in their area.

The CHAIRMAN. By 2020, when all of the prescription drug costs for Medicare Part D are covered, what is the incentive to hold down the cost?

Ms. CUBANSKI. Well, I think plans still bear responsibility for the cost of the drugs that their enrollees are taking, and I think there is more that can be done to encourage beneficiaries to take lower-cost drugs, to switch from more expensive brand name drugs to generic drugs, because beneficiaries face out-of-pocket costs. It is the case that when the coverage gap is closed by 2020, beneficiaries will still have to pay 25 percent, on average, of the cost of their medication. So there is still expense involved for beneficiaries, even after the coverage gap is closed.

So I think there is incentive both for the plans to make sure that people who are enrolled are not over-utilizing really expensive medications and they can do some of that through the design of the formularies, but also from a beneficiary's perspective, if there are opportunities for them to take less expensive medications, including generics or cheaper brand name medications than the really expensive ones, the incentive will still be there, I think, in the financial structure and the cost sharing associated with benefit designs.

The CHAIRMAN. Should those who get their drugs in Medicaid, and, therefore, get their drugs from the government at a discount, but when they turn 65, under the law, get their drugs through Medicare where there is no discount, should there be a discount? That is called dual eligibles.

Ms. CUBANSKI. Right. I cannot answer the question of whether there should be a discount, but you are right to point out the disparity that now exists. Prior to 2006, when the dual eligibles re-

ceived their drug coverage through the Medicaid program and they were transitioned automatically to Medicare Part D coverage when Part D began in 2006, the rebate that was provided through the Medicaid program is not through Medicare. The HHS Office of Inspector General has suggested that Part D plans are not achieving the same low level of discounts as the Medicaid programs and so CBO has indicated that there is significant potential for savings, I think, of \$137 billion over ten years, if the Medicaid rebate was extended to dual eligibles in Part D plans.

The CHAIRMAN. Okay.

Senator Collins.

Senator COLLINS. I do not have anything.

The CHAIRMAN. Senator Warren.

Senator WARREN. Thank you.

The CHAIRMAN. Does any of the staff have any questions?

A final question. You all have been very patient. Time Magazine just did the cover story on how all the costs are run up in hospitals. Is there any rhyme or reason to the way costs are set in hospitals, and then the disparity on who gets billed and what the final payments are? Does anybody want to comment on this rather convoluted system?

Dr. Goodman.

Dr. GOODMAN. It is—you characterized it well. It is a convoluted system. Price is opaque to those who bear risk, the cost of the care, the patients themselves, their families. You know, whether the pricing is rational or not, I think what would be a tremendous help is if transparency were mandated. I mean, it is reasonable. It is the most basic expectation that a patient entering care should easily know what the price will be of their care if they ask. There should be no threshold for getting that information. It is incomprehensible. Eighteen percent of GDP, the services, the prices invisible to the consumer. How does that work? It does not work. It is remediable by making prices transparent. It needs to be a requirement that price be transparent.

The CHAIRMAN. Dr. Blumenthal.

Dr. BLUMENTHAL. Senator, the world of health care is an “Alice in Wonderland” world, and things that seem obvious and intuitive and right in health care can sometimes be more complicated. And by every common sense standard, it makes sense in health care to have price transparency, certainly to inform the consumer, as a respect for the consumer, and all that.

But there is some pretty good research that shows that people do funny things when they know the price of health care. If there is no good quality data that they understand that is paired with the pricing data, a substantial minority of individuals will choose a high-cost provider because they think it is equivalent to quality.

So I do not think we should assume without good study and without working on comparative and linked quality metrics that people will make good choices just because we give them the information. And this is not my work. It is work that has been published and well studied in randomized trials. It is just a funny world.

The CHAIRMAN. Well, all of you have been terrific. We will leave the record open for a week for Senators to ask additional questions in writing. Thank you.

Senator Collins, anything else?

Senator COLLINS. I just want to join you in thanking this excellent panel and also to reiterate how much I am looking forward to our partnership on this committee. Thank you.

The CHAIRMAN. Thank you.

The meeting is adjourned.

[Whereupon, at 5:12 p.m., the committee was adjourned.]

APPENDIX

**Questions for the Records
To Juliette Cubanski, Ph.D.**

From Chairman Bill Nelson

1. In a recent *Health Affairs* analysis, later reported by the Kaiser Family Foundation, researchers found that seniors spent on average \$368 more than they needed to on drug coverage through Medicare Part D plans (PDPs) in 2009 — their decisions complicated by the sheer volume of plans available and difficulties involved in determining what makes a plan a good choice.

What changes, based on Kaiser's research, need to happen to Medicare Part D to ensure that plan options are transparent, and that seniors don't "overbuy"?

Answer:

One suggestion would be to review the Medicare Compare website to see if there are ways to improve the visual experience so that beneficiaries clearly see the cheapest plan option, and perhaps present the difference in annual cost between the lowest-cost plan and all other plan options that beneficiaries see when they do a plan search based on their individual drugs. This would at least ensure that beneficiaries who use the Plan Finder have the opportunity to see how much they could save annually by choosing the lowest-cost plan available to them based on the current drugs they are taking (assuming they input this data in the plan finder). CMS could also make a more prominent announcement in the Medicare & You handbook that all beneficiaries receive around the time of the beginning of the annual open enrollment period that it is important to compare plans annually to see if lower-cost or better plan options have become available than the plan a beneficiary might currently be enrolled in.

A more aggressive approach could be to change the bidding and plan selection process to minimize the number of plan options available and make it easier for beneficiaries to compare plans and identify the lowest-cost option, along the lines of recommendations by Yaniv Hanoch and Tom Rice (Hanoch, Yaniv., and Thomas Rice. Can Limiting Choice Increase Social Welfare?: The Elderly and Health Insurance. *Milbank Quarterly* 2006; 84(1): 37-73) or Richard Frank and Joseph Newhouse (*Mending the Medicare Prescription Drug Benefit: Improving Consumer Choices and Restructuring Purchasing*; http://www.hamiltonproject.org/files/downloads_and_links/Mending_the_Medicare_Prescription_Drug_Benefit-Improving_Consumer_Choices_and_Restructuring_Purchasing.pdf)

2. The Kaiser Family Foundation has also reported on the increasing use of specialty tiers in the Medicare Part D program, and the impact of specialty tiers on cost-sharing for beneficiaries and the consequences for government spending. Specifically, the Foundation reported that:

“Enrollees face relatively high costs for specialty drugs, except for those receiving low-income subsidies, for whom the government pays much of the costs for specialty drug use. Plan incentives to manage specialty drug costs are attenuated during the coverage gap (when plans face no liability) and catastrophic coverage (where reinsurance from the government helps to limit liability). Thus, specialty drugs are a significant driver of Part D program costs to the government.” (*Medicare Part D 2009 Data Spotlight: Specialty Tiers, June 2009*)

What options are available to reduce spending for beneficiaries and the Federal government related to specialty tiers? How much of an impact do specialty tiered drugs have on the overall growth in spending in Medicare Part D?

Answer:

In a paper for the Kaiser Family Foundation, Richard Frank outlined some measures that the federal government could take to be a more prudent purchaser of prescription drugs (*Prescription Drug Procurement and the Federal Budget*; <http://www.kff.org/medicare/8307.cfm>); similar ideas were also incorporated in the paper by Richard Frank and Joseph Newhouse above. As stated in the report by Dr. Frank for the Kaiser Family Foundation:

“There are a number of ideas for addressing the spending levels that stem from the excess market power of unique drugs. One is to permit the government to negotiate when drugs are unique and Medicare is a major purchaser. Another approach would be to shorten the exclusivity period for biological products from 12 years to 7 years as a means to accelerate the injection of competition from follow-on biological products. Under both types of proposals, it is believed that when there are unique drugs where Medicare purchases a large amount of the product, the proposals would yield budget savings with little or no loss in social efficiency.

Frank and Newhouse (2008) advanced the idea of a system of binding arbitration for establishing a set of temporary administered prices of unique drugs in the period until competition from either generic (biosimilar) or therapeutic products occurred. Such temporary administered prices would focus on drugs that are both unique and where the federal government is a large purchaser of the product. The binding arbitration would only be triggered when both conditions were present. These temporary administered prices would apply to both Part B and Part D. Such a system would have to be mindful of the costs of R&D in the biologics area and assess whether prices remain at levels that offer a reasonable return to the risk investments. In essence, this proposal allows the government to pool the purchasing power across Part D plans and Part B to strengthen its hand in leveraging lower prices for unique drugs. Furnishing a complete projection of the savings stemming from temporary use of administered prices is beyond the scope of this paper, but if assuming even modest impacts of arbitration on prices, in the range of 10 percent to 15 percent, the savings could exceed \$6 billion over 10 years.”

I am not aware of data that suggest how much of the growth in Medicare drug spending is attributable to use of specialty drugs, but I would suggest directing this question to the Office of the Actuary within CMS or MedPAC – both of whom have access to Part D claims data, which would be a source to use to answer this question.

3. While the hearing focused a great deal on geographic variation of hospital readmissions, the Kaiser Family Foundation has also found evidence of significant geographic variation in Part D premiums; specifically, that some plan sponsors charge as much as two or three times more for the identical basic PDP from one region to another.

What, in your opinion, are the driving factors behind this geographic variation, and how does such variation impact costs to beneficiaries, and the federal government for the program?

Answer:

I am not aware of analysis that has been conducted that would indicate what the driving factors are behind geographic variation in Part D premiums, but the Kaiser Family Foundation is planning to do more analysis of this question in the near future. What we know from Part D risk score data (as published by MedPAC – see Chart 10-17 in the June 2012 databook: <http://www.medpac.gov/chapters/Jun12DataBookSec10.pdf>) is that beneficiaries' health status and utilization varies across regions, by plan type and low-income subsidy status. These factors are likely to influence plan costs, which are then reflected in their premiums. While the risk adjustment mechanism is designed to adjust for the health status of plan enrollees, there is concern and general agreement that the risk adjustment mechanism does not completely or perfectly make this adjustment. Clearly there is an impact on costs to beneficiaries associated with premium variation, since we see beneficiaries in different regions paying different amounts for the exact same plan that is offered across regions; the Foundation plans to try to quantify the magnitude of this impact in its upcoming work.

From Senator Sheldon Whitehouse

1. One of the challenges facing advocates of delivery system reform is the limited ability of the Congressional Budget Office (CBO) to estimate upfront that meaningful savings can be achieved from these reforms. Given this challenge, I request your comments on the following questions:
 - a. Is there research being used by the private sector on the savings associated with delivery system reforms that could help inform models used by CBO?
 - b. Do you think it would be helpful for the Administration to publicly announce a specific savings target – and a date for achieving the savings – for all of its activities related to delivery system reform?
 - c. What policy options would you recommend to motivate states that exhibit poor health care quality and high health care spending toward the national mean on those two metrics?

Answer:

- a. I am not aware of research being used by the private sector on savings associated with delivery system reforms that could help inform models used by CBO. However, the rapid-cycle evaluation being conducted by the Innovation Center may yield fruitful early results of potential savings within Medicare that could be adopted by CBO in their scoring methodology.
 - b. While it could be helpful to be more specific about a target date and specific savings associated with delivery system reform, there is also potential for such a step to backfire if the targets are not met, especially since many of these ideas are in their infancy and while they may achieve savings over time, it is not clear what that timeframe is exactly. However, if you are interested in an example of such a target, David Cutler, Zeke Emanuel, and Topher Spiro of the Center for American Progress have advanced such a proposal; for example, see: <http://www.americanprogress.org/issues/healthcare/news/2011/10/26/10509/rep/ace-fee-for-service-with-bundled-payments-in-medicare/>
 - c. At the state level, it seems that there are a great number of factors that could be behind variation in health care quality and spending, so it is important to understand what the policy levers are at the state level to influence quality and spending. Steps could be taken within Medicaid to encourage quality improvement, while payment incentives could be adopted (such as those that were incorporated in the Affordable Care Act) within both Medicare and Medicaid to improve quality and reduce spending at the program level that would play out in terms of improvements at the state level. But some state measures of quality and spending may also reflect conditions that exist within the private commercially insured population or among the uninsured, where the policy options may not be as obvious or easy to implement. Certainly the coverage expansions included in the ACA, to the extent that they bring more uninsured people into the ranks of the insured, will be helpful in addressing some quality of care metrics, and may also help reduce high spending levels, to the extent that some currently uninsured people who seek care in relatively expensive settings will be able to access care through more conventional settings such as doctors' offices and clinics.
2. Many of the witnesses discussed the growing prevalence of Medicare beneficiaries that have multiple chronic conditions and the disproportionate share of Medicare spending these individuals consume. Of this Medicare population, can you give me an estimate of

the percent that have mental or behavioral health conditions? In your opinion, how important is integrating the behavioral health provider community into new care delivery models? Can you give examples of communities that have integrated behavioral health into their delivery system particularly well?

Answer:

Analysis by the Kaiser Family Foundation of the Medicare Current Beneficiary Survey 2009 Cost and Use file shows that among beneficiaries with 3 or more chronic conditions, 51% overall report having a cognitive or mental impairment. In my opinion, it is important to involve all types of providers, including behavioral health providers, in new care delivery models. However I am not aware of research indicating communities where this type of integration has been done particularly well. Aside from communities, however, perhaps certain integrated systems, such as Geisinger, Group Health Cooperative, or Kaiser Permanent, could be looked to for examples of best practices in this area.

3. Dr. Cubanski, Kaiser Family Foundation recently released a compendium of policy options focused on Medicare. Chapter 3, the chapter on delivery system reform, listed "accelerating the implementation of payment reforms under the Affordable Care Act" as an option. Can you be more specific? Are there particular ACA-related Medicare payment reforms you think could be implemented on a larger scale or under more aggressive timelines?

Answer:

It is difficult to know without even preliminary results of evaluations what specific ACA-related Medicare payment reforms are showing promise and therefore worthy of implementing on a larger scale or under more aggressive timeframes. It may be more difficult to implement on a quicker pace the delivery system reforms that involve changing organizational and provider relationships, such as ACOs, but it may be more feasible to speed up implementation of payment reforms such as bundled payments, where CMS may be able to exert more authority over payment changes; perhaps by putting more money at risk, that could increase the financial incentives for providers to adapt to payment changes. While I am unable to make specific recommendations in this area, others have put forward proposals that you might wish to consider, including Zeke Emanuel et al. (<http://www.nejm.org/doi/full/10.1056/NEJMsb1205901>) and Cutler et al. (<http://www.americanprogress.org/issues/healthcare/news/2011/10/26/10509/replace-fee-for-service-with-bundled-payments-in-medicare/>).

**Questions for the Records
To David C. Goodman, M.D., M.S.**

From Chairman Bill Nelson

1. In your testimony, you argued that 33 measures of quality for ACOs leave gaps in the quality analysis.
 - a. In your opinion, is it dangerous to continue to add measures to one silo of care? Further, is there a danger of diffusing focus with too many measures?
 - b. We have different benefit structures for patients and different payment systems for providers. Do you believe that CMS has established an overall quality framework that has guided delivery system reform across the different payment models currently in the program? If not, please provide specific examples of contradictory or duplicative quality measures.

Answer:

The 33 measures mandated for ACO quality measures represent those that are relevant and readily available today. They do not represent the measures that are most useful for providers in improving care or for patients in evaluating an ACO. While the overall number of measures should not increase, the specific measures should improve as data collection becomes better organized and new quality instruments are validated. These measures should be integrated into the overall measure of care quality for Medicare. This is discussed in a recent paper (Meyer GS, Nelson EC, Pryor DB, et al. More quality measures versus measuring what matters: a call for balance and parsimony. *BMJ quality & safety*. Nov 2012;21(11):964-968.), and will be the topic of forthcoming papers from the Dartmouth Institute.

2. Is it true that focusing just on readmissions is not necessarily an indicator of overall quality? What are the consequences of only considering readmission? What additional factors should be considered that might show overall high quality care in a hospital with a high readmissions rate?

Answer:

Keeping patients healthy after a hospitalization is without question a good patient outcome. This does not mean that lower readmission rates necessarily indicate that patients are doing better. If a hospital begins to admit less ill patients, the chances of patients needing readmission will fall, without benefits to the patient population. Improvement methods that narrowly focus on the first 30 days of care after hospitalization may ignore the patient during the following months.

The risk of rehospitalization remains high for many months after discharge, even if not routinely measured. That long-term risk is simply a sign of the ongoing health needs of Medicare populations who have had a hospital stay. Improving the care of chronically ill patients requires attention not just to a 30 day period, but the entire care system. The challenge is immense, but can't be avoided if the goal is sustainable improvement of the overall care and outcomes of Medicare beneficiaries.

The tendency to focus on single specific quality measures, such as readmission rates, might have unintended consequences. There are concerns that the opportunity costs outweigh the benefit. (Joynt, et al. NEJM 2012;366:1366) That is, that the resources spend on avoiding the CMS penalty draw from other important, though unmeasured, patient care activities. Some are concerned that reducing readmission rates leads to higher mortality (N Engl J Med 2010; 363:297-298 July 15, 2010 DOI: 10.1056/NEJMc1001882), though a recent study in Veteran's Administration Hospitals did not find confirm this problem. (Kaboli PJ, Go JT, Hockenberry J, et al. Associations Between Reduced Hospital Length of Stay and 30-Day Readmission Rate and Mortality: 14-Year Experience in 129 Veterans Affairs Hospitals. *Annals of internal medicine*. 2012;157(12):837-845.) Still, the general idea is plausible – a focus on one aspect of care can lead to unexpected consequences.

The need for broad improvements of *systems* of care, of which discharge planning and care coordination are only two components, is evident in the strong association found between general health system factors and readmission rates. We found a robust relationship between regional inpatient intensity of care provided to Medicare beneficiaries and the risk of readmission; that is, in places where there was a greater tendency to use hospitals as the site of care, patients were more likely to be readmitted, irrespective of illness levels. This confirms other research underscoring the importance of primary care systems in reducing avoidable hospitalizations and the influence of local bed supply on overall admission rates. When a readmission is prevented, is the bed unfilled or is it filled with another patient? If so, could that patient be care for better and with less cost outside of the hospital. Under current payment models and care systems, the incentive is to fill the bed. In the absence of other interventions, reducing readmission rates may have no impact on total per capita inpatient days and costs within a community. This underscores the importance of aligning efforts to reduce readmissions with other policy and payment initiatives, such as global payments and accountable care organizations. Efforts to monitor improvements in care coordination and transitions need to be coupled with broader surveillance

of patient populations and cohorts, so that the promise of better care for patients leaving the hospital is also reflected in improved outcomes and lower costs for the population as a whole.

3. How much did Dartmouth consider socioeconomic factors when assessing readmissions? What socioeconomic trends were considered as part of the study?

Answer:

As a quality process measure, attaining low readmission rates should be the goal for all patients. Some hospitals face particular challenges in achieving a low rate for many factors, including caring for patients with fewer resources or higher co-morbidity. Although CMS penalties are based on relative adjusted rates during a period (three years), there is merit in tying incentives to improvement over time, comparing each hospital to itself. The Dartmouth Atlas report emphasizes this concept by presenting changes in re-admissions over time.

From Senator Sheldon Whitehouse

1. One of the challenges facing advocates of delivery system reform is the limited ability of the Congressional Budget Office (CBO) to estimate upfront that meaningful savings can be achieved from these reforms. Given this challenge, I request your comments on the following questions:

- a. Is there research being used by the private sector on the savings associated with delivery system reforms that could help inform models used by CBO?

Answer:

I am not aware of calculations that may have been done by private insurance plans.

- b. Do you think it would be helpful for the Administration to publicly announce a specific savings target – and a date for achieving the savings – for all of its activities related to delivery system reform?

Answer:

A specific target is an attractive idea for emphasizing the need for timely change. It would have more impact if tied to incentives for reaching the goal (or penalties for failure).

- c. What policy options would you recommend to motivate states that exhibit poor health care quality and high health care spending toward the national mean on those two metrics?

Answer:

I think that the focus should be on providers – hospitals and doctors. Better performance measures coupled with financial incentives, such as those embedded in ACOs, would improve care in many parts of the country.

2. Many of the witnesses discussed the growing prevalence of Medicare beneficiaries that have multiple chronic conditions and the disproportionate share of Medicare spending these individuals consume. Of this Medicare population, can you give me an estimate of the percent that have mental or behavioral health conditions? In your opinion, how important is integrating the behavioral health provider community into new care delivery models? Can you give examples of communities that have integrated behavioral health into their delivery system particularly well?

Answer:

Mental or behavioral conditions are a significant burden in Medicare beneficiaries. I am not, however, an expert in this field. I note that the National Health Policy Forum issued a report on this topic that can be found at http://www.nhpf.org/library/background-papers/BP_McareMentalHlth_11-27-06.pdf.

**Questions for the Records
To Kenneth Thorpe, Ph.D.**

From Chairman Bill Nelson

1. From your research on private plans, what do you believe are some of the best practices in the private sector that both Medicare and the new insurance marketplaces should adopt to promote healthy aging? Specifically, what targeted reforms show potential within the Medicare fee-for-service system? If payment codes should be realigned to incentivize coordination of care, what coding should be realigned and how, and further, how can Congress improve and build on those reforms, like transitional care payments and the ACO model, that incentivize coordinated care already?

Answer:

One approach for promoting healthy aging would be to include coverage of intensive lifestyle change programs like the diabetes prevention program (DPP). The program reduced the incidence of diabetes by 71 percent among overweight, prediabetic adults aged 60 and above. This would not only improve the health of seniors, but I have estimated it would save the Medicare program up to \$7 billion over a ten year period.

With respect to care coordination, the data shows that using team-based care (nurses, nurse practitioners, pharmacists, behavioral health workers) working in tandem with physicians provides better care at lower cost. Rather than using billing codes, Medicare should simply contract with health teams nationally (these could be administered by health plans, home health agencies, large physician groups or other providers to provide transitional care, comprehensive medication management, health coaching, and a 24/7 nurse care coordinator that quarterback the care plan with the patient, their family and the primary physician. Several best practice Medicare Advantage plans do this CareMore (now owned by WellPoint) and XL Health (now owned by United Health Group) use these techniques and provide care at about 15 to 20 percent less than traditional fee for service Medicare.

2. Please provide the Committee with the specifics on some of the more innovative models in Medicare Advantage that you have studied.

a. What are the barriers to traditional Medicare enacting similar successful reforms?

Answer:

Simply put, the fee-for-service payment model is the primary barrier to enacting similar reforms. Often we focus policy on the payment reform side of the equation first and fit the delivery model to the financing. A more fruitful approach would be to determine the delivery care model desired and then align the financial incentives that make it work. I provided two promising models of delivery system reforms as part of my written testimony.

b. Do you think that the outcomes in the models described are substantial enough for CBO to incorporate this research on savings in Medicare Advantage into its analysis of similar policy options in traditional Medicare?

Answer:

Yes. There are many studies, including randomized controlled trials enrolling seniors, that demonstrate quality improvements and savings within the Medicare population, with sufficient scale, detail, and experience for CBO to incorporate the findings into CBO's analysis.

c. What specific past CBO scores, based on the latest data, would you recommend the agency re-evaluate?

Answer:

First, it is imperative to be specific about what constitutes "prevention" and "care coordination" in proposals and to focus on evidence-based programs for Medicare. I think the dilemma is that the CBO has not really seen a comprehensive proposal that would include these two mission critical aspects. For an evidence-based prevention proposal with scorable savings, making the DPP a covered Medicare benefit is a ripe example. Years of research, including randomized control trials, showed that the DPP reduced the incidence of diabetes among pre-diabetic seniors by 71 percent.

As my written testimony indicated, including the DPP as a covered benefit in Medicare would reduce spending and improve the health of seniors at high risk for developing diabetes. There is a great deal of evidence that implementation of the DPP could have both a short and long term impact on improved health outcomes and effective cost reduction. The DPP can and should be added as a covered benefit under Medicare with no cost sharing. Expanding the DPP nationally in conjunction with care coordination through health teams would provide an effective and cohesive solution that focuses on eliminating excess weight, one of the main gateways to chronic disease¹. More specifically, as detailed in my September 2011 Health Affairs article², adding the DPP conservatively would produce net savings from just one group 60 to 64 year olds when they become Medicare eligible of \$2 to \$4 billion over ten years.

The design of these programs would be crucial and should include evidence-based best practices that our real world experience in Medicare Advantage and the private sector show work. For instance, the most recent data from MedPac show that network based HMOs in the Medicare Advantage program provide the Medicare covered benefits at 8 percent below traditional fee for service Medicare (Report to Congress, March 2013, p. 295). So if appropriately designed, the data show that care coordination and prevention do reduce spending, and I am sure CBO would examine these data.

¹ <http://content.healthaffairs.org/content/31/1/61.abstract>

² <http://content.healthaffairs.org/content/30/9/1673.abstract>

1. According to CMS, care for beneficiaries with multiple chronic conditions accounts for 93% of Medicare fee-for-service expenditures. Prescription drug adherence is a key part of managing chronic disease. Most recently, CBO found that prescription drug adherence actually offsets utilization of costly medical services. Please address the following:

- a. Given that ensuring prescription drugs are affordable is a key aspect of ensuring that seniors adhere to their prescription drug regimen, what targeted reforms can we make to lower prescription drug costs for seniors?

Answer:

Research shows that adherence is affected by a multitude of factors, with out-of-pocket costs being one of many. Medicare Part D has done a great deal to reduce the out-of-pocket costs for seniors and thereby reducing this barrier to adherence. Results from greater medication use under Medicare Part D and the offsetting savings from other medical services recently resulted in CBO's changing its methodology to account for the offsets. Certainly, more can and should be done to enhance adherence and gain additional benefits from the appropriate use of medications for Medicare beneficiaries.

For example, enhancing the medication therapy management (MTM) services under Medicare Part D could go a long way to deriving greater value. Evaluation of each patient's medications, whether prescription or over-the-counter and no matter

which doctor recommended them, are individually assessed to determine the medication is appropriate, effective for the medical condition, and safe given the co-morbidities and other medications being taken can improve health and lower costs. A pivotal Minnesota study using these services in a private health plan resulted in higher achievement of therapy goals (from 76 percent to 90 percent), improved HEDIS quality scores, and lowered per patient healthcare costs (dropping from

\$11,965 to \$8,195). The resulting savings exceeded the cost of providing the medication therapy management services by more than 12 to 1.³

Currently, MTM under Medicare Part D is only available to beneficiaries with high drug spends. Taking a closer look at beneficiaries with high Part A and Part B costs could yield additional benefits as appropriate medication use and self-management could reduce the need for hospital and physician services.

- b. What reforms can Congress make that would improve prescription drug adherence? In your response, please include both those reforms that build on provisions already enacted and new potential ideas for reforms. For new reform ideas, please describe how such a policy would be integrated with current prescription drug adherence activities in Medicare.

Answer:

There are several potential policy changes that show promise in promoting better medication adherence. First, programs to synchronizing medication refills that

have been implemented by Thrifty White and others have been shown to increase

³ Isetts, et al, "Clinical and economic outcomes of medication therapy management services: The Minnesota experience," 203-211.

adherence by almost ten percentage points by allowing patients to pick-up all of their medications at the pharmacy one day a month. An added benefit of these programs is that they allow pharmacists to review all of the patients' medications at the time of the monthly pick-up and identify changes that might need to be made to the patient's drug regimen.

Improving provider and pharmacist access to medication history information might also help promote adherence. Finally, allowing pharmaceutical manufacturers to collaborate with providers in promoting medication adherence might provide additional resources to help promote effective use of prescription medications.

4. Dr. Thorpe, in your written testimony, you noted that rising obesity rates among seniors account for an approximately 10% increase in Medicare program costs. You also state that "about 95 percent of spending in the program is associated with patients with one or more chronic health care conditions" and "over 53 percent of Medicare patients were treated for five or more chronic conditions during the year." A number of the most common chronic diseases, such as diabetes, cancer, and hypertension, have a strong correlation to obesity.

a. In your opinion, would reducing the rate of obesity among seniors in Medicare produce significant savings for the program?

Answer:

There is no doubt that reducing the rate of obesity within Medicare would produce significant savings. Obesity is a significant risk factor for the diseases you mentioned in addition to heart disease and stroke, arthritis, and even behavioral and emotional health. Starting at age 65, Medicare spends 34 percent more on obese seniors compared to normal weight seniors over their lifetime in the Medicare program. Reducing obesity both before seniors enroll in Medicare and even when they are already enrolled would save the program billions of dollars.

b. Do you believe that having a full range of treatment options for obesity in Medicare would result in better health outcomes for seniors? Currently, there is a statutory prohibition that precludes The Centers for Medicare and Medicaid Services (CMS) from even considering coverage of pharmaceutical products to treat obesity under Medicare, even though the program covers surgeries to combat obesity. Is this an issue Congress can and should address?

Answer:

Yes. Obesity is an epidemic and allowing an "all appropriate option" approach is the best way to reduce the toll. The exclusion included in current law was based on the lack of pharmaceutical options for obesity and a concern for abuse. The evidence has shifted dramatically with several FDA-approved medications now available and more innovation anticipated. We also have diagnostic measures for obesity that provide safeguards against misuse. Medicare covers bariatric surgery, but this option may not be the best or desired treatment choice for many patients.

I recently published an article examining the potential savings associated with covering weight loss drugs as part of the Medicare covered benefits (available at <http://www.healthconomicsreview.com/content/3/1/7>). The study suggests that 10 to 15 percent weight loss in obese and overweight Medicare enrollees could produce gross per capita saving ranging from about \$6,000 to \$13,000 depending on a variety of factors over a 10-year period. Potential savings were even greater over a lifetime. Collectively, among the estimated 11.2 million Medicare patients who are obese or overweight with at least one weight-related comorbidity, the savings could total in the billions of dollars over a lifetime.

Further, to the point of emphasizing both prevention AND care coordination, we have over a decade of published research from randomized trials that include Medicare patients, as well as the experience of best practices utilized by Medicare Advantage plans. As experience shows, care coordination for seniors works best if it includes the following features, many of which are outlined in Sections 3502 and 2703 of the Affordable Care Act:

- Interdisciplinary health teams that include nurses, nurse practitioners, social and mental health workers, pharmacists among others. Each team would have a nurse care coordinator that “quarterbacks” the execution of the care plan with the patient and family, others in the team and the provider practice.
 - Approaches that provide a “whole” person focus on preventing disease and managing acute, and mental health services.
 - Medical advice from a care coordinator available 24/7.
 - Assessment of patient health risks, targeted risk-based interventions, and development of an individualized care plan.
 - Comprehensive Medication Management.
 - Transitional care and health coaching.
 - Regular contact with enrollees.
 - Close integration of the care coordinator nurse and primary care (and specialist) physicians.
 - Evidence-based health coaching to develop patient self-management skills and facilitate behavior change.
- c. Finally, is there evidence to demonstrate that as little as a 5% reduction in body mass index (BMI) could lower rates of chronic disease?

Answer:

Yes data from randomized trials of the DPP show that each 1 kilogram (a little more than 2 pounds) reduction in weight among overweight and obese adults reduces the likelihood of becoming diabetic by 16 percent.

From Senator Sheldon Whitehouse

1. One of the challenges facing advocates of delivery system reform is the limited ability of the Congressional Budget Office (CBO) to estimate upfront that meaningful savings can be achieved from these reforms. Given this challenge, I request your comments on the following questions:

- a. Is there research being used by the private sector on the savings associated with delivery system reforms that could help inform models used by CBO?

Answer:

Yes, there are models in use in both in the public and private sector that could inform CBO models. There are also published research data that must be shared with CBO and included in CBO's analysis that shows how delivery system reforms can both improve healthcare quality and reduce spending.

There are many opportunities to advance change and improve health outcomes within our healthcare system, and a growing body of evidence suggests that more clinical and health status data could improve projection model accuracy and provide lawmakers with more information on the budgetary impact of health policy options. [My written testimony](#) highlights some of this published research literature as well. Medicare spending in some of the best practice Medicare Advantage plans was 15 to 20 percent lower than found in traditional Medicare. Caremore and XL Health are two examples. Randomized trials have shown transitional care provided by nurses or nurse cut readmission rates by 30 to nearly 60 percent among seniors with similar reductions in hospital spending. Comprehensive medication management and health coaching have also produced improvements in health among seniors with lower spending resulting.

Private sector estimates, particularly when it comes to employers, can be difficult to find publicly. Employers are naturally concerned with bottom line impact, but not necessarily drafting articles on their results and submitting them for peer review. That said, many health plans working with employers have done this analysis and have shared published results. For example, HSCS working with Boeing has implemented an "intensive" medical home for employees with high utilization and accompanying costs. For the Boeing Corporation, the program yielded a 20 percent drop in net spending and an almost 60 percent decline in missed work days after one year.⁴ Pitney Bowes and others are deploying value-based insurance/benefit design models to facilitate greater use of benefits shown to improve health, including reducing co-pays for wellness visits, medicines for chronic disease, and recommended screenings and vaccinations.⁵

For public programs, North Carolina has implemented patient-centered medical homes statewide for Medicaid recipients, Community Care of North Carolina (CCNC). Independent analysis completed by Milliman of the program estimates savings of up to 15 percent compared to projected costs (<https://www.communitycarenc.org/media/related-downloads/milliman-cost-savings-study.pdf>). Earlier this year, CCNC expanded to include Medicare and private pay patients through a program known as North Carolina First in Health.

The CCNC model operates well in both urban and rural settings and supports small provider practices as care management and coordination resources are available on a regional basis for primary care providers.

⁴ A Milstein & P Kothari, "Are Higher-Value Care Models Replicable?" Health Affairs Blog, Oct. 20, 2009.

⁵ JJ Mahoney, "Value-based benefit design: using a predictive modeling approach to improve compliance," J Mgd Care Pharm
2008 Jul; 14(6 Supp B):3-8.

The concept of shared savings and accountable care organizations is an outgrowth of the success of the Marshfield Clinic and others achieving significant Medicare savings in the Group Physician Practice Demonstration.

Overall, the key prevention and care coordination initiatives that have proven clinically effective and reduce cost include promoting physical activity and wellness; transitional care; comprehensive medication management; health coaching; and team-based, whole-person focused care. Long-term solutions for Medicare require greater use of coordinated care models and continuing the shift to a more integrated delivery system.

b. Do you think it would be helpful for the Administration to publicly announce a specific savings target – and a date for achieving the savings – for all of its activities related to delivery system reform?

Answer:

I have mixed feelings on the setting of specific targets. First, having a goal in mind is important in any effort, for how else can success be evaluated? That said, being too specific does not allow for the flexibility needed to adapt to changing circumstances or the realization that more time may be needed. Specific targets could also lead to decision-making driven more by achieving a specific savings target rather than on preserving and enhancing quality. It's not difficult to be cheap, but the goal is to improve health first and to achieve savings from the reduction in demand that better health affords.

I do believe there are several near-term opportunities to achieve savings. For that, I recommend four areas of specific focus: understanding and targeting hot spots of high-cost, preventable utilization; managing care transitions to eliminate gaps in care; enhancing self-management and adherence to treatment; and coordinating care among providers and across care settings.

c. What policy options would you recommend to motivate states that exhibit poor health care quality and high health care spending toward the national mean on those two metrics?

Answer:

States should be encouraged to take advantage of two sources of increased Medicaid funding in the ACA that will help beneficiaries prevent and manage chronic disease. The first is a \$85 million in grants funded through the Medicaid Incentives for Prevention of Chronic Disease initiative. These grants are to be used to test the effectiveness of providing incentives directly to Medicaid beneficiaries of all ages who participate in prevention programs, and change their health risks and outcomes by adopting healthy behaviors. The programs must address one of the following prevention goals: tobacco cessation, controlling or reducing weight, lowering cholesterol, lowering blood pressure, and avoiding the onset of diabetes or improving the management of the condition.

States should also be encouraged to develop programs that qualify for the temporary 90% federal matching funds for Medicaid costs associated with health homes services for individuals with two or more chronic conditions. These funds

are available for the first two years of a state's health home program and will help states afford the up-front costs of developing effective home health programs.

In addition, the sophistication of data analysis at the state level varies significantly state to state. States could use assistance in data analysis capabilities to understand their hot spots of costs, areas of poor health quality, and near-term opportunities for improvement. The State Innovation Model grants sponsored by CMMI may provide states with additional resources to support these types of analyses as well as opportunities for real reform.

2. Many of the witnesses discussed the growing prevalence of Medicare beneficiaries that have multiple chronic conditions and the disproportionate share of Medicare spending these individuals consume. Of this Medicare population, can you give me an estimate of the percent that have mental or behavioral health conditions? In your opinion, how important is integrating the behavioral health provider community into new care delivery models? Can you give examples of communities that have integrated behavioral health into their delivery system particularly well?

Answer:

Two out of three Medicare beneficiaries, including those also covered by Medicaid, have more than one chronic condition, reducing the quality of life for seniors and driving health care costs up significantly. Almost \$2 out of \$3 spent on health care in the U.S. is directed toward care for the 27 percent of Americans with multiple chronic conditions.⁶

Within the Medicare population, the prevalence of multiple chronic conditions is particularly high – as much as 65 percent of beneficiaries have multiple chronic conditions.⁷ Mental and behavioral health conditions are also common. According to my tabulations, 22 percent of Medicare beneficiaries were under treatment for a mental disorder in 2010. Among individuals dually eligible for Medicare and Medicaid, three out of five have multiple chronic physical conditions and two out of five have both a physical and mental disease or condition.⁸

We know that behavioral health factors largely into our overall health status, so it makes little sense to continue perpetuating a fragmented approach to the physical, emotional, and behavioral aspects of health. Recognizing the close relationship between physical and mental health, innovators in several states are focusing care coordination efforts to address the need for greater integration between primary care and behavioral health. Fortunately, the evidence base on both methods resulting from integrating behavioral health services with primary care is solid and growing. The level of integration can vary from providing linkages to telephonic support to physical co-location and full integration among primary

⁶ Ibid.

⁷ J.L. Wolff, B. Starfield, and G. Anderson, "Prevalence, Expenditures, and Complications of Multiple Chronic Conditions in the Elderly," *Arch Internal Med* 2002; 162:2269-76.

⁸ J. Kasper, M. Watts, and B. Lyons, Kaiser Family Foundation, "Chronic Disease and Co-Morbidity among Dual Eligibles:

Implications for Patterns of Medicaid and Medicare Service Use and Spending," Issue Paper July 2010. Available online
<http://www.kff.org/medicaid/upload/8081.pdf>.

care and behavioral health providers and services.⁹ The SAMHSA-HRSA Center for Integrated Health Solutions provides a good resource on both working models and core components of care (<http://www.integration.samhsa.gov/integrated-care-models>).

3. In an October 2012 issue brief that focused on the needs of people with multiple chronic conditions, you wrote:

“People with multiple chronic conditions are particularly vulnerable to poor quality of care given their frequent interaction with the health care system, the need for multiple providers, and the variety of health care settings encountered. The challenges are even greater for patients with behavioral health conditions given the significant lack of integration among mental and physical health providers.”

I see this lack of integration when it comes to our nation’s health information technology infrastructure. The behavioral health community was notably left out of EHR incentives provided by the HITECH Act. I am deeply concerned as we move forward with new delivery models, like ACO, that are increasingly dependent on health information exchange, the behavioral health community will have less and less a seat at the table. Do you think it is important for the federal government to support the “IT enablement” of behavioral health providers?

Answer:

Absolutely, health information technology deployed to facilitate collaboration – not just the reduction of paper records – offers significant potential. Some of the resistance may be due to privacy concerns and discrimination, but within a medical setting context, this information should be available to treating providers and incorporated as part of the patient’s personalized care plan.

There have been several pieces of legislation that suggest some innovative ways the government can help bolster health IT without significantly adding to federal spending. Legislation to create small business loan guarantees for providers to adopt new health IT systems passed the House overwhelmingly a few years ago but has not been taken up by the Senate. This would allow providers not eligible for HITECH incentives, such as behavioral health providers and pharmacists access to a special category of SBA loans to invest in health IT systems without expanding the SBA program itself.

Additionally, some innovative medical malpractice safe harbors linked to the meaningful adoption of health IT could provide a tangible incentive for these providers to adopt health IT. A recent report by the Center for American Progress estimates that savings upwards of \$5 billion over 10 years by providing some safe harbors from malpractice liability for physicians who document adherence to evidence-based clinical practice guidelines, use qualified health information technology and clinical decision systems that incorporate these guidelines. Of course, the key here as in any reform that would provide payment or any other incentive linked to quality, is to ensure that we are using a common framework of quality measures that have a demonstrated link to health outcomes. Quality measures must

be standardized and Congress needs to weigh in on developing a process that brings all stakeholders across the healthcare ecosystem together to evaluate and update quality measures and standards for health IT systems that carry out the measurement tasks in real time.

⁹ For a description of the continuum of integration with models of each described, see C. Collins, D. Hewson, and T. Wade, "Evolving Models of Behavioral Health Integration in Primary Care," Milbank Memorial Fund, available at <http://www.milbank.org/reports/10430EvolvingCare/EvolvingCare.pdf>, accessed December 22, 2011.

**Questions for the Records
To David Blumenthal, M.D., M.P.P.**

From Chairman Bill Nelson

1. CMS has undertaken a number of different pilot reforms over the past three years.
 - a. Do you believe quality measures across the different models and benefit structures are aligned? In your opinion, is the overall quality strategy at CMS integrated in such a way that it will support rapid dissemination of new data and “scaling up” of pilot programs in the future?

Answer:

We are making progress, but health care quality programs across the federal government still use different measures and require health care providers to collect and report the same information in multiple ways. Fortunately, a provision in the Affordable Care Act created the National Strategy for Quality Improvement in Health Care. A key goal of this national strategy is the alignment of measurement approaches across multiple federal programs, as well as coordination among public and private stakeholders. Such efforts are intended not only to improve the quality of care delivered to patients, but also reduce the administrative burden of measurement and improvement activities for providers.

Progress on the alignment of quality activities since the enactment of the law has been significant. In 2011, the first report published under the initiative identified three broad aims for the healthcare system as well as six priority strategies to achieve those aims. Input was solicited from a wide range of stakeholders, including federal and state agencies, local communities, provider organizations, clinicians, patients, businesses, employers, and payers. Last year, HHS released an updated progress report to Congress, detailing efforts made to further align measurement efforts, establish key indicators to track national progress, and encourage state adoption of the national quality strategy.

Work on this important initiative continues. HHS reports that the next version of the national quality strategy will include targets for a greater number of measures and track progress within the six priority areas. Such efforts will no doubt continue to improve coordination of quality measurement across federal programs, and—crucially—among all public and private stakeholders.

Coordination of measures is vital to reducing administrative costs in our health care system, and to enlisting the support of providers in improving our health care quality. Congress should continue to track the Executive Branch’s progress in this area, and should also examine current statutes to make certain that they do not in any way interfere with this effort at simplifying quality measurement.

2. Given that it is unlikely that the Commonwealth Fund report’s cost savings recommendations could be enacted at once and as written, what policies in the Fund’s report would be the easiest to

implement? What recommendations, if enacted alone, would achieve the highest level of cost-savings?

Answer:

The three policies that would be easiest to implement and we believe the Congressional Budget Office (CBO) is most likely to credit with the largest federal budget savings are incremental changes to Medicare payment policy, widespread adoption of bundled payment for acute care episodes, and further revisions to Medicare Advantage payment. More information on each of these recommendations is included in the testimony, as well as full Commission report. Our rough estimate of the federal CBO savings for these initiatives is approximately \$528 billion over 10 years. To the extent CBO also credited savings for primary care team initiatives, a new Medicare Essential plan, and administrative reforms, the total savings could be higher. In either case, we believe the federal budget score associated with a similar set of policies would likely be more than enough to offset the \$138 billion required to repeal the flawed Sustainable Growth Rate formula.

All these programs would be comparatively easy to implement and would improve the lives of physicians and beneficiaries.

3. Going beyond the hospital payment model, how could we extend and align our payment models into the physician reimbursement system? This Congress may have such an opportunity to address the outdated Sustainable Growth Rate (SGR) formula; please provide thoughts on how we can incorporate the payment alignment under discussion at the hearing into such a debate.

Answer:

Changing the way we reimburse both hospitals and health professionals is a key feature of the payment reform strategy endorsed by the Commonwealth Fund Commission in its most recent report. In a follow-up issue brief, Fund staff provided additional detail for a framework that repeals the SGR formula for physician fees and replaces it with a pay-for-value approach. Among other things, this strategy increases payments over time only for physicians and other providers who participate in innovative care arrangements that encourage accountability and strengthen primary care.

Such an approach would complement existing payment policy reforms that encourage providers to take responsibility for the cost and quality of care delivered to patients. To further encourage value and accountability, payment levels for providers and services could be revised consistent with the Medicare Payment Advisory Commission's 2011 recommendations, which make incremental changes to Medicare payment rates to more accurately reflect the cost of producing services. More detail on these specific proposals is available in MedPAC's report to congress and the Fund's recent "Paying for Value" issue brief.

4. In your testimony, you raised the idea of an integrated Medicare plan option within traditional Medicare. Please expand on this idea:
 - a. How is this different from the transitional care bundled payment that CMS is currently rolling out?

Answer:

The Medicare Essential plan described in the Commission's proposal would offer beneficiaries a new public insurance option with integrated comprehensive benefits, financial protection, and incentives to receive care from high-value providers. It combines Medicare Parts A, B, and D and supplemental coverage into a single plan with simplified cost-sharing, an out-of-pocket spending limit, and a value-based benefit design. This design would complement and utilize—but is separate from—the innovative Medicare payment methods (such as the bundled payment initiative) you mentioned. Under the Medicare Essential plan, cost-sharing for beneficiaries would be reduced when they obtain care from high-value providers who participate in initiatives such as bundled payment, medical homes, and accountable care organizations.

This approach recaptures the original promise of Medicare when passed in 1965. Then, Medicare's structure was modeled on mainstream private insurance coverage, which often separated the purchase of hospital and physician coverage. In the private sector, hospital, physician and drug coverage, as well as other benefits, have long since been melded into a single plan that is simple and easy to purchase, with a single set of deductibles and co-pays. Medicare, however, has not only continued the administrative separation of inpatient and outpatient care, but added to that complexity by creating Part C and Part D. Each of these four Medicare options (A, B, C, and D) is a daunting plan to evaluate, and the resulting confusion and cost is inflicted on our most vulnerable citizens who do not have the benefit of employers to help them sort out what's best for individuals. The goal of the Medicare Essential plan is to make Medicare coverage easy to understand and purchase, and to reduce administrative costs.

- b. How would such an integrated option in traditional Medicare interact with the currently more-integrated Medicare Advantage?

Answer:

Beginning in 2014, newly-eligible Medicare beneficiaries would be automatically enrolled in the Medicare Essential option with the choice of opting into any Medicare Advantage plan or the current basic traditional Medicare plan. Those currently enrolled in traditional Medicare would have the option to switch into Medicare Essential or remain in their current arrangement. Our actuarial firm predicted that 10 percent of the core Medicare population (excluding Medicare Advantage) would select Medicare essential in 2014. The model projected this proportion would increase over time to reach 90 percent of the Medicare population not enrolled in Medicare Advantage by 2023.

- c. The care coordination models studied by CBO showed that targeting of high-risk beneficiaries was extremely important in order to ensure savings. Would such a streamlined "Medicare plus" benefit be open only on beneficiaries with multiple chronic conditions and functional problems? If not, what would keep people from electing it when they don't really need the extra services, while those that do fall through the cracks?

Answer:

No, the Medicare Essential plan proposed by the Commission would be open to all beneficiaries, not just those with complex conditions and functional problems. The enhanced set of benefits would fill gaps that all beneficiaries now confront and return savings that all enrollees would benefit from. Indeed, ARC projects that such a plan would be attractive to a very large majority of beneficiaries. As mentioned above, the model projects that 90 percent of the Medicare population not enrolled in Medicare Advantage would choose the Medicare Essential option by 2023.

5. The Commonwealth Fund's report briefly raised the issue of price transparency. Has the Fund studied further some of the price transparency laws enacted or under consideration at the state level? What approach should Congress take as a next step to approach the issue of price transparency of health care services?

Answer:

The Commonwealth Fund Commission recommended enhanced transparency of prices, clinical outcomes, and patient experiences to help expand and inform meaningful choice by consumers. In recent years, a number of economists and health policy experts have persuasively argued that relatively high prices paid for drugs, devices, and hospital and physician services account for a large share of our country's excessive spending on health. Yet, a lack of transparency makes it difficult to see, much less address, price concerns.

Several states have made it a priority to improve information on costs and prices for patients and providers to further inform choice. As mentioned in the testimony, states such as Maine, New Hampshire, and Utah have taken the lead on creating all-payer claims databases—more information on these and other initiatives is available from the All-Payer Claims Database Council. The federal government could certainly encourage the continued collection and publication all-payer information on prices, quality, patient experiences, and outcomes of care. At minimum, such data would allow patients to understand the cost of certain procedures, inform efforts by providers to improve care by setting benchmarks and targets, and enable payers (both public and private) to develop more value-based insurance benefit designs.

From Senator Sheldon Whitehouse

1. One of the challenges facing advocates of delivery system reform is the limited ability of the Congressional Budget Office (CBO) to estimate upfront that meaningful savings can be achieved from these reforms. Given this challenge, I request your comments on the following questions:
- a. Is there research being used by the private sector on the savings associated with delivery system reforms that could help inform models used by CBO?

Answer:

While research on outcomes related to the type of payment and delivery system reforms endorsed by the Commission is ongoing, we are already beginning to see significant savings among early private sector adopters. For example:

- Geisinger Health System in Pennsylvania, through its ProvenHealth Navigator medical home model, has realized an 18 percent reduction in hospital admissions, a 36 percent reduction in hospital readmissions, and significant improvement on several quality indicators related to chronic care management.
- Appleton Medical Center and Theda Clark Medical Center in northeastern Wisconsin have redesigned acute care processes using Lean methodologies and achieved cost per case reductions of 15 percent to 28 percent and lower length-of-stay and readmissions rates.
- Virginia Mason Medical Center in Seattle, a health care delivery organization, has partnered with health plans and employers to develop standardized approaches to common conditions, decreasing the use of advanced imaging by 23 percent, increasing the availability of same-day appointments, and achieving 91 percent patient satisfaction.
- Blue Cross Blue Shield of Massachusetts has implemented an Alternative Quality Contract in which physician practices are paid a fixed rate, with bonuses for improved quality, leading to 3 percent savings in the program's first two years.

Certainly these early experiences and results can inform CBO's estimate of the impact of similar delivery system reforms going forward.

- b. Do you think it would be helpful for the Administration to publicly announce a specific savings target – and a date for achieving the savings – for all of its activities related to delivery system reform?

Answer:

As mentioned in the testimony and longer report, the Commission believes it is crucial to establish a specific spending target for the nation, as well as for states, regions, or localities. To achieve that target would almost certainly require urgent efforts to reduce current growth rates of health care spending. It is equally important to collect data to inform and enable action if growth exceeds targets. Setting a target for overall spending growth—across all payers, public and private, and across all providers in all areas—of no greater than economic growth per capita would provide guidance for reforms underway and any further policy action that is needed. Collecting data on total spending and sources of spending growth at the national, state, and local levels would enable state and local governments to set their own targets and develop focused policies for meeting them.

- c. What policy options would you recommend to motivate states that exhibit poor health care quality and high health care spending toward the national mean on those two metrics?

Answer:

Our collective experience with quality measurement and improvement across multiple industries suggests that establishing national, state, and local targets, and then measuring and publicizing progress toward those goals, can be a power motivator for improvement. Identifying both high- and low-performing areas has the potential to be useful, focusing our attention not only where the “trouble” lies, but also where to look for answers as to how and why things are going right. Learning lessons from both situations, and those in between, cannot happen until we systematically measure health system performance at multiple levels. Vast improvement across the entire U.S. health system cannot happen until we set ambitious goals.

2. Many of the witnesses discussed the growing prevalence of Medicare beneficiaries that have multiple chronic conditions and the disproportionate share of Medicare spending these individuals consume. Of this Medicare population, can you give me an estimate of the percent that have mental or behavioral health conditions? In your opinion, how important is integrating the behavioral health provider community into new care delivery models? Can you give examples of communities that have integrated behavioral health into their delivery system particularly well?

Answer:

Kaiser Family Foundation analysis of the 2006 Medicare Current Beneficiary Survey shows that 31 percent of all Medicare beneficiaries and 68 percent of those with Medicare disability insurance have some cognitive or mental impairment. Clearly it is important to improve care for all patients with high-cost, chronic conditions such as mental or behavior health issues. Fortunately, we do know there are care delivery interventions that both improve quality and lower costs for this population. The Fund has sponsored some work on specific behavioral health innovations, most recently publishing a 2006 report on promising practices in 17 states. Interventions included enhancing consumer-centered care, criminal justice/mental health collaboration, system integration, the use of performance incentives, quality improvement, and other promising practices. More information is available in a Fund brief entitled “State Behavioral Health Innovations: Disseminating Promising Practices” by Sylvia Perlman and Richard Dougherty.

3. In an October 2012 issue brief that focused on the needs of people with multiple chronic conditions, you wrote:

“People with multiple chronic conditions are particularly vulnerable to poor quality of care given their frequent interaction with the health care system, the need for multiple providers, and the variety of health care settings encountered. The challenges are even greater for patients with behavioral health conditions given the significant lack of integration among mental and physical health providers.”

I see this lack of integration when it comes to our nation’s health information technology infrastructure. The behavioral health community was notably left out of EHR incentives provided

by the HITECH Act. I am deeply concerned as we move forward with new delivery models, like ACO, that are increasingly dependent on health information exchange, the behavioral health community will have less and less a seat at the table. Do you think it is important for the federal government to support the “IT enablement” of behavioral health providers?

Answer:

Behavioral health was, indeed, left out of the HITECH Act. The reasons are not entirely clear, but if budgetary pressures permit, it would be highly desirable to give mental and behavioral health facilities the benefit of the same financial incentives that are available to health professionals (including mental health professionals) and hospitals. Since some hospitals do provide psychiatric care, their mental health services are eligible for inclusion in the HITECH incentive programs but only under the umbrella of hospitals generally.

4. I have repeatedly called on the Administration to set a cost-savings target for delivery system reform. Your report notes that, “The establishment of targets . . . can serve both as a metric to guide policy development and as an incentive for all parties to act to make them effective.”

Do you agree that there is a need for a defined, accountable target – whether the metric is cost savings or health outcomes - to drive meaningful progress on health care delivery system reform across our health care system?

Answer:

Yes, as mentioned above, the Commission believes it is crucial to establish a specific spending target for the nation, as well as for states, regions, or localities. In earlier reports, the Commission has also endorsed setting national targets for quality improvement. What will be particularly important in either case, though, is how to approach making sure the targets are achieved. Policies that seek to limit the growth of health spending or catalyze improvement in the delivery of health services must be consistent with the goals of a high performance health system. These goals, and a set of broad strategies consistent with them, are included in the Commission’s recent report on confronting costs.

From Senator Elizabeth Warren

1. In your oral testimony before the Committee, you said that the Affordable Care Act “provide[s] fundamental new tools” but that “we need ... to bring all those different threads together in a comprehensive and synergistic program of health care reform.” You also stated that “[t]he Secretary has new authority to do that.” Can you elaborate on this issue, specifically focusing on how the Secretary can use her existing authority to weave the initial efforts at cost control under the ACA into a comprehensive and synergistic program?

Answer:

An array of recent statutes, including the Affordable Care Act, provides the federal government in general, and the Secretary of Health and Human Services in particular, an array of tools to catalyze improvement in the delivery of health care services. The question is how the federal government can seize this unique moment to improve health system performance in the face of the significant complexity and pressure to contain costs. What is certain is that governmental business as usual is unlikely to succeed. Without close coordination driven by an overriding vision, the dutiful, line-by-line implementation of each individual Affordable Care Act, ARRA, and HITECH program will not suffice to take full advantage of this unique moment or to create the breakthroughs in performance needed to make our health system sustainable.

The Commonwealth Fund Commission weighed these considerations as it created the cost control framework outlined in the “Confronting Costs” report as well as last year’s “Performance Improvement Imperative” paper. In the performance improvement report, the Commission recommended that the federal government develop a comprehensive implementation plan to take full advantage of the opportunities in recent health reform legislation. Such a plan requires a vision and clear goals for performance improvement, collaboratively determined priorities, simplified administrative requirements, and rapid data-driven feedback.

One possible way to achieve these goals is to prioritize improvement in chronic disease care, in particular for patients with multiple, high-cost conditions. Under the Commission’s proposal, the Secretary would use the extraordinary new resources made available by recent legislation to create 50 to 100 voluntary “Health Improvement Communities” that utilize payment reform, primary care, and health information technology to mobilize public and private resources for the improvement of care provided to complex, high-cost patients. The potential savings are significant.

Improving care for the chronically ill is just one of many steps required to lower national health spending and bring about the dramatic change needed in the way health care is organized and provided. Clearly there are additional compelling priorities for performance improvement—among them, care for vulnerable populations, pregnant women, and newborn children. But the nation cannot prioritize everything at once; it must choose a strategy that promises significant gains in quality and efficiency within a short period. We simply cannot afford to wait.

2. In your testimony, you discuss bringing parts A, B and D into a single program with a single coinsurance rate and a single deductible for all three pieces of Medicare. Please elaborate on how specifically these separate programs might be combined and what would be the resulting impact on enrollment, administrative costs, and quality of care.

Answer:

Currently, Medicare beneficiaries who enroll in traditional Medicare must patch together multiple plans to receive adequate financial protection and prescription drug benefits, including supplemental Medigap coverage and a separate drug plan. This creates complexity and confusion for beneficiaries and results in higher administrative expenses because of the multiple insurance carriers involved and the lack of integrated claims administration.

The Medicare Essential plan described in the Commission's proposal and a forthcoming Health Affairs paper would offer beneficiaries a new public insurance option with integrated comprehensive benefits, financial protection, and incentives to receive care from high-value providers. It combines Medicare Parts A, B, and D and supplemental coverage into a single plan with simplified cost-sharing, an out-of-pocket spending limit, and a value-based benefit design.

Beginning in 2014, newly-eligible Medicare beneficiaries would be automatically enrolled in this new option with the choice of opting into any Medicare Advantage plan or the current basic traditional Medicare plan. Those currently enrolled in traditional Medicare would have the option to switch into Medicare Essential or remain in their current arrangement. Our actuarial firm predicted that 10 percent of the core Medicare population (excluding Medicare Advantage) would select Medicare essential in 2014. The model projected this proportion would increase over time to reach 90 percent of the Medicare population not enrolled in Medicare Advantage by 2023.

If financed by a budget-neutral premium, we estimate beneficiaries' out-of-pocket costs - premium and cost-sharing - would be 17 percent lower if they chose to use standard providers and 40 percent lower for high-value providers compared to current supplemental coverage. Much of these savings are attributable to streamlined administrative practices and an increasing proportion of beneficiaries received care from efficient, high-value providers. The estimated total system savings is \$180 billion from 2014 to 2023, including \$90 billion savings for employer retiree plans.

Significantly more detail about the Medicare Essential proposal endorsed by the Commission is included in the Commission report as well as a forthcoming Health Affairs paper by Karen Davis, Cathy Schoen, and Stu Guterman.