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Senate Finance Committee
219 Dirksen Senate Office Building
Washington, DC 20510
Submitted electronically via chronic_care@finance.senate.gov

RE: Improving Care for Medicare Beneficiaries with Chronic Conditions

Dear Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner:

Aetna is one of the nation's leading diversified health benefit companies, providing members with resources to enable better informed decisions about their health. We are pleased to respond to the Senate Finance Committee's recent request for proposals that increase care coordination, streamline payment systems, and provide increased access to quality care for Medicare beneficiaries with chronic conditions.

We applaud the Committee's focus on chronic care. Incenting early care coordination can delay progression to costlier and debilitating diseases. However, for those at the highest utilization, additional more focused efforts are needed to complement new chronic care incentives. As the Committee considers proposals to improve care for Medicare patients with chronic conditions, we ask you to consider a pilot program to not only coordinate and improve care for high cost beneficiaries but also reduce cost in Medicare fee-for-service (FFS).

In order to test different approaches, we ask that the Committee's chronic care working group consider the development of models led by Medicare Advantage plans and provider-based Accountable Care Organizations (ACOs). In testing different models, the most successful model would allow flexibility to structure payments in a variety of ways to reduce the amount of federal spending on high cost beneficiaries, while improving quality.

Improving Quality and Cost for Medicare Beneficiaries

As the Committee noted in its letter to stakeholders, according to MedPAC, the costliest 10 percent of Medicare beneficiaries accounted for almost 60 percent of annual FFS spending in 2010. According to research conducted by Avalere Health, the top 10 percent of costliest Medicare beneficiaries had per member per month (PMPM) spending 6.5 times the average FFS PMPM cost for all beneficiaries.

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[Attachment 1: Characteristics of High-Cost Medicare Beneficiaries produced by Avalere]

This population is more likely to have chronic conditions, including chronic kidney disease, heart failure, and chronic obstructive pulmonary disorder (COPD). More than half (51 percent) of these individuals have five or more comorbid conditions. This population is also more likely to be dually eligible for both Medicare and Medicaid.

Finally, spending on Part A services represents a larger share of total Medicare spending for these high cost beneficiaries (59 percent) compared to the average FFS population (43 percent), offering an opportunity to drive efficiency through coordinated care that prevents hospital admissions and readmissions.

Most importantly, the sickest and most vulnerable Medicare beneficiaries too often do not get the quality of care that they need and deserve. The highest cost beneficiaries are often in and out of facilities, seeing sometimes dozens of providers and taking dozens of medications. Yet all of these services do not necessarily translate into higher quality of care. Medicare FFS offers little comprehensive medical management infrastructure, including care management for the highest cost Medicare beneficiaries, even though they are the individuals who could benefit most from it. Unmanaged Medicare FFS utilization may not improve care, and it also exposes beneficiaries and their families to potentially unlimited out of pocket costs.

Model of Care Delivered Through MA Plans or ACOs

Given the significant impact this population has and will continue to have on our health care system, we believe now is the time to begin, in earnest, to foster real collaboration among payers and providers who touch these patients and to focus on integrated approaches that improve quality and patient outcomes and experience as well as lower costs.

Focused efforts could be led by Medicare Advantage plans or ACOs by delivering integrated, coordinated care to the costliest 10 percent of Medicare beneficiaries at a cost to the federal government that is lower than the current FFS system. Programs for high-cost beneficiaries should take a patient centered approach that includes the use of integrated case management. Our comments below describe a program that offers a new approach to improving outcomes and lowering costs.

Effective care management programs have proven results that will help improve outcomes and lower costs for beneficiaries with chronic conditions. For example, Arizona's Mercy Care Plan was able to lower the rate of hospital days by 43 percent, reduce the hospital readmission rate by 21 percent, decrease the average hospital stay length by 21 percent and had a 19 percent reduction in emergency department visits. Similarly, Maine's NovaHealth partnership was able to provide preventive care for 99 percent of patients, while achieving fewer hospital days for 50 percent of patients, fewer hospital readmissions for 45 percent of patients, and an overall reduction in medical costs ranging from 16-33 percent.

[Attachment 2: Thomas F. Claffey, Joseph V. Agostini, Elizabeth N. Collet, Lonny Reisman and Randall Krakauer. Payer-Provider Collaboration In Accountable Care Reduced Use And Improved Quality In Maine Medicare Advantage Plan Health Affairs, 31, no.9 (2012):2074-2083]

Program Specifics: Additional Benefits, Lower Cost Sharing, High Quality Provider Networks

The high cost beneficiary approach differs from existing pilots and programs because it utilizes flexibility and program design features not currently available under the Medicare Advantage, Special Needs Plan (SNP), or Medicare Shared Savings Program or Pioneer ACO construct. This patient centered approach would provide enhanced benefits not currently covered under the Medicare program, including in-home personal care, transportation, and meal services, while reducing or eliminating cost sharing to remove barriers and improve health outcomes.

The program would also establish high-quality provider networks that ensure patients are receiving integrated coordinated care, and would limit participation to high-performing Medicare Advantage plans or ACOs. This program would explore new enrollment approaches, such as requiring identification of high cost enrollees and proactive outreach on behalf of health plans, providers and CMS, along with the potential for passive and continuous enrollment. Finally, programs would be subject to enhanced performance metrics, stronger quality standards, and ongoing evaluation and monitoring by the Centers for Medicare & Medicaid Services (CMS).

Payment Models

The payment model would include the use of risk adjustment to account for the complex health needs of the population. Depending on whether the model is led by an MA plan or an ACO, CMS could test different payment methodologies to determine how best to achieve savings. For models led by MA plans, CMS could guarantee savings and set a capitated payment, for example, 98 percent of the projected FFS cost for the high cost population. For ACOs, CMS could test other shared savings models and include features such as the use of a medical home or bundled payments. The current Part D payment methodology and framework would be used to deliver drug benefits to enrolled beneficiaries.

Opportunity for Savings is Significant

Research conducted by Avalere concluded that under a capitated payment rate 5 percent less than FFS rates, the proposed program for high cost beneficiaries would decrease federal spending by over \$80 billion dollars over the 2015-2024 federal budget window. Under a capitated payment rate 1 percent less than FFS rates, Avalere estimated savings to the federal government of almost \$17 billion for this same period.

* * *

We appreciate the opportunity to submit this proposal to the Committee for your consideration.

If you have any additional questions, please feel free to contact me.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Kelmar". The signature is fluid and cursive, with a large initial "S" and a stylized "K".

Steven B. Kelmar
Executive Vice President, Corporate Affairs