

**EXAMINING BIPARTISAN MEDICARE POLICIES  
THAT IMPROVE CARE FOR PATIENTS  
WITH CHRONIC CONDITIONS**

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**HEARING**

BEFORE THE

**COMMITTEE ON FINANCE  
UNITED STATES SENATE**

ONE HUNDRED FIFTEENTH CONGRESS

FIRST SESSION

—————  
MAY 16, 2017  
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**TUESDAY, MAY 16, 2017**

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

The hearing was convened, pursuant to notice, at 10:04 a.m., in room SD-215, Dirksen Senate Office Building, Hon. Orrin G. Hatch (chairman of the committee) presiding.

Present: Senators Grassley, Roberts, Thune, Heller, Scott, Cassidy, Wyden, Stabenow, Cantwell, Nelson, Carper, Cardin, Bennet, Warner, and McCaskill.

Also present: Republican Staff: Chris Campbell, Staff Director; Brett Baker, Health Policy Advisor; Erin Dempsey, Health Policy Advisor; Jennifer Kuskowski, Health Policy Advisor; and Jay Khosla, Chief Health Counsel and Policy Director. Democratic Staff: Elizabeth Jurinka, Chief Health Advisor; Matt Kazan, Health Policy Advisor; and Beth Vrabel, Senior Health Counsel.

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

The CHAIRMAN. The committee will come to order.

I would like to welcome everyone to this morning's hearing on bipartisan Medicare policies to improve care for patients with chronic conditions.

It was almost exactly 2 years ago today that we formed a bipartisan working group co-chaired by Senators Isakson and Warner to work on legislation to address these issues. Now, that working group spent many months listening to stakeholders in the health-care community, both in person and through more than 850 formally submitted comments.

In December of 2015, the working group released a comprehensive policy options document. In October of last year, we issued a legislative discussion draft. Soon after that, CMS finalized four of our policy proposals in its 2017 Medicare Physician Fees Schedule Rule, and two provisions from our discussion draft were included in the 21st Century Cures Act which President Obama signed into law this past December.

In other words, several of the working group's policies have already been enacted, and we are working to get the rest signed into law and fully implemented.

Toward that end, we introduced the latest version of the CHRONIC Care Act, a bill that encompasses the working group's proposals, in April. The legislation currently has 17 bipartisan co-sponsors and has been endorsed by numerous organizations in the health-care community.

Today's hearing is the latest step in our efforts. The next step will come later this week, as we have noticed a markup for Thursday morning.

Now, I want to thank my colleague, Senator Wyden, for his work on this matter. His passion for improving care for those with chronic conditions has been a driving force behind this effort. And of course, we want to thank Senators Isakson and Warner, who have worked tirelessly to lead our working group.

Through their efforts, the committee has not only learned about the burden imposed on Medicare patients living with chronic conditions but also identified new policies to improve care coordination, increase value, and lower costs in the Medicare program without adding to the deficit.

Today's hearing will provide us with an opportunity to examine these policies more extensively so we can better understand how they will help patients and enable providers to improve care and produce better outcomes.

The bill includes a number of policies that would improve care for the chronically ill through increased use of telehealth by giving Medicare Advantage plans and certain Accountable Care Organizations enhanced flexibility to target telehealth services to Medicare patients with chronic conditions.

Senators Schatz and Wicker have been instrumental in this particular effort. And I am pleased to have them here with us to talk about how the CHRONIC Care Act advances their policy goals.

Now, I would be remiss if I did not also recognize the Finance Committee members who have joined Senator Schatz's and Senator Wicker's efforts to promote the increased use of telehealth services. In that regard, we appreciate the leadership of Senators Thune, Cardin, and Warner on these matters.

While many stakeholders offered key advice on telehealth policy, I want to thank the fine institutions in Utah for their help, specifically on the, quote, "telestroke" policy. Specifically, I want to recognize Dr. Jenny Majersik and Dr. Nicholas Johnson at the University of Utah, as well as Dr. Kevin Call with Intermountain Healthcare. I appreciate their willingness to share their experience and expertise using technology to properly diagnose individuals presenting stroke symptoms. And I look forward to hearing more on this particular aspect of telehealth here today.

Of course, our bill goes beyond telehealth, making improvements for beneficiaries who receive care across the Medicare spectrum, including fee-for-service, Accountable Care Organizations, and Medicare Advantage.

We have a panel of recognized experts here before us today to discuss all of these issues. And I want to welcome each of our distinguished witnesses.

Obviously, I am well aware that there are some contentious debates going on in the health-care space these days, and there is no

shortage of political and partisan points that people would like to make in a venue like this.

However, for today's hearing, I sincerely hope that we can maintain the bipartisan spirit that has driven our efforts on the CHRONIC Care Act. Toward that end, I respectfully ask that members of the committee focus their questions on the policy areas specifically addressed in the bill.

With that, I am going to turn the time over to Senator Wyden for any opening remarks that he would like to make.

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

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

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

And I want to thank you, Mr. Chairman, your staff, Senator Warner, Senator Isakson. This is an extraordinary hearing. And I will touch on why, but it could not have happened if you had not been willing to initiate a committee-wide process.

The CHAIRMAN. Thank you, Senator.

Senator WYDEN. So to begin, I want to thank you for all of the efforts to make this morning possible.

The CHAIRMAN. Thank you.

Senator WYDEN. Colleagues, I have looked forward to today for many years. That is because the Finance Committee is now beginning to tackle the premier challenge of American health policy, specifically by updating the guarantee of Medicare to better serve seniors with chronic illness.

When I was co-director of the Oregon Gray Panthers, Medicare had just two parts, A and B. If you broke your ankle and you had surgery in the hospital, you were covered by Part A. If you got a really bad case of the flu and you went to the doctor, you were treated by the doctor in their office, and that was Part B. That is not Medicare today.

Today, Medicare is cancer. It is diabetes. It is heart disease. It is strokes, and it is other chronic conditions. Seniors who have two or more of these chronic conditions now account for more than 90 percent of all Medicare spending.

And today, older people get their care in a variety of different ways. There is still fee-for-service, and there is also Medicare Advantage, Accountable Care Organizations, and a host of innovations being tested across the country.

Because Medicare is a guarantee, a promise of defined benefits, it is past time to update this promise so as to deliver to patients with chronic conditions the best possible care in the most efficient manner.

So as the chairman touched on, the legislation today begins this transformation. Older people will get more care at home, less in institutions. There will be expanded use of lifesaving technology, and that is why it is so good to see Senator Schatz and Senator Wicker here to talk specifics. There will be a stronger focus on primary care and expanded use of non-physician providers.

Now, in my view, still to come is ensuring that each senior with multiple chronic conditions has an advocate to guide them through

what can be a teeth-gnashing experience of trying to navigate American health care.

Two final points, one picking up on the debate about the Affordable Care Act. I would just say, colleagues, this is the way to do it right. Doors were opened here, not closed. There was bipartisan cooperation, not partisan reconciliation. The public was asked to shape the bill, not taken for granted.

And finally, I want to thank our partners. Chairman Hatch and I had Senator Warner and Senator Isakson coordinating this effort. The chairman has made mention of the fact that many colleagues, both on and off the Finance Committee, have really helped to produce what our witnesses are going to call this morning a model for how to take on tough challenges.

It has been an honor for me to be part of this bipartisan effort on and off the committee. And like you, Mr. Chairman, I am very pleased that our colleagues, Senator Schatz and Senator Wicker, are here with us today.

The CHAIRMAN. Well, thank you, Senator.

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

The CHAIRMAN. We are pleased to welcome Senators Roger Wicker and Brian Schatz to our hearing today.

As I mentioned in my opening statement, these two Senators have done a lot of work on telemedicine and telehealth issues.

We appreciate your support and your input today, and we look forward to hearing your remarks on these important issues and your perspectives on this important topic.

Senator Wicker will provide his statement first and then will be followed by Senator Schatz.

And, Senator Wicker, if you would, please proceed with your remarks, and then we will take Senator Schatz's next.

**STATEMENT OF HON. ROGER F. WICKER,  
A U.S. SENATOR FROM MISSISSIPPI**

Senator WICKER. Thank you, Mr. Chairman, Ranking Member Wyden, and my distinguished colleagues on this committee. It is a pleasure to be here.

Thank you for allowing me to share with you what we already know in my home State of Mississippi: telehealth works. I am glad to be here to discuss the promise of telehealth and to celebrate the progress your committee is making with the CHRONIC Care Act, which I have enthusiastically co-sponsored.

I would like to commend the leadership of the Senate Finance Committee for their years of work to address the cost and quality of chronic care in America. Today is a testimony to your efforts.

I am pleased to be here today with my friend, Senator Brian Schatz. He and I lead the Commerce Subcommittee on Communications, Technology, Innovation, and the Internet.

In the Commerce Committee, we have worked tirelessly to promote innovation by removing barriers to connectivity and expanding access to rural broadband.

In fact, it was during a 2015 hearing of our subcommittee on the potential of telemedicine when Senator Schatz and I decided to join forces to reform how Medicare reimburses telehealth. We were for-

tunate to form a team including Senators Warner, Thune, Cardin, and Cochran. And the result of our partnership was the CONNECT for Health Act, a widely supported legislative proposal for telehealth.

CONNECT for Health, S. 1016, is a product of hard work and determination. It is designed to improve quality of care and cut costs.

I thank the committee for including telehealth provisions inspired by our CONNECT bill in the bill we are discussing today. In so doing, you are recognizing the promise of telehealth.

I became interested in this topic because my home State of Mississippi has led the Nation in maximizing technology to improve patients' health. The University of Mississippi Medical Center in Jackson has been a leader in telehealth for over a decade. The team there has managed to increase access to quality care and cut costs by using services like remote patient monitoring and tele-emergency, reaching some of our State's most rural, vulnerable, and costly patients.

Mississippi is a very rural State. And in fact, we have some of the toughest health problems too. We have the fewest providers per capita and the highest rates of heart disease and type II diabetes. These health disparities and barriers to access are what drove University of Mississippi Medical Center to experiment and innovate with telehealth.

One of the many Mississippi telehealth success stories is the Diabetes Telehealth Network, a remote patient monitoring program that provides rural Mississippi patients who have uncontrolled diabetes with routine access to a provider through a medical tablet.

This partnership began following 100 chronically ill patients in the underserved Mississippi delta. The technology allowed providers to monitor and care for the patients remotely on a daily basis, following their vital signs and intervening when things did not look good.

Throughout the course of the first year, zero of the 100 patients were admitted to the hospital. Think about that. No emergency room visits for any of these previously chronically ill patients. This is excellent care that can improve patients' lives.

In fact, telehealth can save money also. The Mississippi Department of Medicaid found that if this remote monitoring program were extended to just 20 percent of Mississippi's diabetic Medicaid population, the State would save \$189 million per year.

So Mississippi Medicaid, like Medicaid programs in virtually every State, is expanding access to and coverage for telehealth and remote patient monitoring.

However, Medicare is behind the curve, limiting access for millions of seniors. Imagine the incredible impact that this technology could have if Medicare would allow its most vulnerable beneficiaries to use something like remote patient monitoring.

I am confident that the success we have seen in Mississippi can be replicated for patients across the United States upon enactment of the CHRONIC Care Act and ultimately enactment of CONNECT for Health.

We are still looking for co-sponsors, Mr. Chairman. And we will not stop until access to quality care through telehealth is realized

for Medicare patients. The CHRONIC Care Act is a step in the right direction.

We have more work to do in this space, and I look forward to continuing to work with each of you.

Thank you, sir.

The CHAIRMAN. Thank you. I think I am a co-sponsor, but if not, put me down, all right? [Laughter.]

Senator Schatz, we will take you now, and then we are going to turn to Senator Warner, who has played a significant role in this.

**STATEMENT OF HON. BRIAN SCHATZ,  
A U.S. SENATOR FROM HAWAII**

Senator SCHATZ. Thank you, Chairman Hatch, Ranking Member Wyden, and distinguished colleagues, members of the Senate Finance Committee, for holding this important hearing on bipartisan legislation.

I am happy to co-sponsor the CHRONIC Care Act, a bill that can help improve outcomes and disease management for people on Medicare who have chronic illnesses.

Right now, progress in modern technology has not translated into progress across the health-care system. That impedes the health system's ability to provide high-quality care, improve access to care, and to lower costs. And so it is time to bring Medicare into the 21st century by taking full advantage of telehealth and remote patient monitoring.

When we are talking about telehealth, we are talking about using technology to provide clinical services to patients remotely. Telehealth more broadly can also include non-clinical services, like provider training.

One type of telehealth relies on live video or audio or visual technology. It is like using a secure version of Skype or Facetime so that a patient can connect with his or her health-care provider. When these visits substitute for a traditional, in-person visit, they can save ER expenses. They save travel time, and they put patients back to work more quickly.

Health providers can also use store and forward technology, another type of telehealth, which is exactly what it sounds like. Providers can take an image, like an X-ray or other clinical picture, store it, and then send it to a specialist anywhere on the planet.

There is also remote patient monitoring. If a high-risk patient with a chronic disease needs to have her blood pressure or blood sugar monitored, she can use a device at home to collect and send that data to a provider remotely and continuously. This improves the outcomes for the patients with chronic conditions, and it saves money too.

The Veterans Administration, the Department of Defense, and the private sector are all taking advantage of telehealth and remote patient monitoring and improving access to care, improving quality of care, and saving money.

The problem is that Medicare is not. It is limited by an old law. Section 1834(m) of the Social Security Act, which puts restrictions on the use of telehealth, says that patients must be located in certain originating sites in order to use telehealth. They cannot be seen at home and can only be located in certain rural areas. Only

certain types of physicians and practitioners can use telehealth under Medicare. Physical therapists or occupational therapists, for example, cannot. And remote patient monitoring is hardly covered at all.

And that is why Senator Wicker and I, along with Senators Cochran, Cardin, Thune, Warner, and 13 other members of the Senate, and I think almost three dozen members of the House—and everybody is invited—have co-sponsored the CONNECT for Health Act over the past 2 years.

Our bill would lift Medicare restrictions on the use of telehealth and improve coverage of remote patient monitoring. I know the chronic care working group has worked in a similar bipartisan fashion to build consensus and find ways to advance legislation.

There are four provisions in both the CHRONIC Care Act and the CONNECT for Health Act that would help patients to lower costs. These include lifting 1834(m) restrictions that hold back patients who have had acute strokes or need home dialysis, and people enrolled in Medicare Advantage and Accountable Care Organizations.

While these provisions are an important first step, we still have further to go. We look forward to working with this committee to continue to advance the important provisions in the CONNECT for Health Act, including improving coverage of remote patient monitoring, lifting 1834(m) restrictions, including global and bundled payments, and giving the Secretary of Health and Human Services more flexibility to waive these restrictions if certain cost and quality metrics are met.

Thank you to Chairman Hatch, Ranking Member Wyden, Senators Warner and Isakson, and all of the members of the Finance Committee for the privilege of speaking before you today. And especially thank you to my partner on this legislation, Senator Wicker.

The CHAIRMAN. Well, thank you both very much. We are very appreciative that you would come and appear before the committee and give us your excellent remarks.

We will turn to Senator Warner now for whatever he would like to say.

**OPENING STATEMENT OF HON. MARK R. WARNER,  
A U.S. SENATOR FROM VIRGINIA**

Senator WARNER. Well, thank you, Mr. Chairman.

And I want to commend my colleagues and friends, and I am proud to be one of the original co-sponsors. And I think it is particularly great to see that you both wore purple ties today. You know, I think that color coordination gives it a little something extra.

Senator MCCASKILL. So did the chairman.

Senator WARNER. So did the chairman. [Laughter.]

The CHAIRMAN. Yes, I should be mentioned too, I think.

Senator MCCASKILL. It is a triplet.

Senator WARNER. I know. I think this shows when there is a will, there is a way to get to things.

This chronic care topic is obviously extraordinarily critical. And I want to particularly thank the chairman and the ranking member for asking Senator Isakson and I to work with both of you on this

chronic care working group. I know Senator Isakson is not here this morning yet. But as in so many projects I have worked with him on, he has been a great partner, as have you, Mr. Chairman, and Senator Wyden.

I echo as well what Senator Schatz and Senator Wicker said in terms of telehealth being a critical part of how we deal with chronic care and how we get Medicare right. The truth is, as our population ages and Americans survive acute illnesses to an extent previously unimaginable, we need to make meaningful reforms to our health programs so that we can move Medicare into the 21st century to keep our promises and ensure high-quality care.

Although the rate of increase in national health spending may be slowing, our aging population and the uncertainty around the Affordable Care Act mean that our public health systems will continue to face serious financial challenges.

I know this area particularly has been a topic for Senator Wyden for some time. And he has repeatedly pointed out the fact that if an individual has more than six illnesses in terms of chronic disease, well, that is only 14 percent of the Medicare population, but it accounts for about half of the Medicare spending. And as people continue to age, those numbers are only going to go up.

So that means tackling systemic reform. How we treat patients with chronic conditions, how we pay for quality, and how we measure value are key challenges in what we need to get right.

This chronic care working group, which we have been part of—and again, working with colleagues like Senator Wicker and Senator Schatz, I think we produced a good product. And I thank the chairman and the ranking member. Hopefully, we are going to be able to move on this, even if we cannot agree on other areas in the health-care field.

Because the truth is, our current system fails to adequately care for patients with chronic conditions. And unfortunately, while our health-care system does a great job of paying for individual procedures—surgery, chemotherapy, hip replacements, et cetera—it does not do a good job at paying health-care providers to coordinate care and to treat patients in a way that takes into account how these progressing conditions really do affect the lives of patients and their families.

This chronic care working group received over 530 comments submitted by the health-care community, and subsequently our staffs met with 80 individual stakeholder groups. We have put together a series of proposals that would, I believe, modernize our health-care system, including changes that would expand the telehealth services available to home dialysis patients—I have a daughter with diabetes, so I know how important it is to get that monitoring done at home—and provide greater availability of telehealth services to help ensure individuals presenting with stroke symptoms receive the best course of treatment. So some of the telehealth components of your legislation improve the design of Medicare Advantage to provide targeted, high-value services for individuals who need them most.

Another provision of what we are proposing would provide better care planning services by directing GAO to submit a report to Congress to inform the development of a payment code for comprehen-

sive care planning. This is an issue that I have been working on since my tenure in the Senate. It goes back to my time as Governor.

My mom had Alzheimer's for 10 years, did not speak for 9 of those 10 years. Trying to get that right and trying to make sure that we no longer maintain the distinction of being the only industrial nation in the world that has not had an adult conversation about that part of life is something that I think we took a step toward getting done in this chronic care working group.

Although not perfect, these initiatives move the Medicare system towards better coordination, better quality, better cost effectiveness, and take a step towards moving Medicare into the 21st century.

And I, again, want to thank, on behalf of Senator Isakson, both the chair and the ranking member for letting us work with you on this. And I think we have a good product.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you. We appreciate all the work, and we certainly appreciate both of you at the witness table. Thanks for being here.

Today we have the opportunity to hear from four other witnesses who will help inform our path forward on chronic care. I want to welcome these four witnesses and thank them for their willingness to testify today.

We will first hear from Katherine Hayes, the director of health policy at the Bipartisan Policy Center. Prior to joining BPC, Ms. Hayes was an associate research professor at George Washington University School of Public Health and Health Services. Prior to joining GW, Ms. Hayes served as vice president of health policy for Jennings Policy Strategies, Inc., practiced law at Hogan and Hartson LLP, and worked as a health policy adviser for two large Catholic health systems and Cardinal Glennon Children's Hospital.

Ms. Hayes has also served as health policy adviser to members of the Senate and House of Representatives in both political parties, served as a program consultant to the State of Missouri Medicaid Agency and as health and education policy adviser for the State of Texas in the Office of State-Federal Relations.

Ms. Hayes received a bachelor of arts degree in international studies from the University of North Carolina at Chapel Hill and a juris doctorate from the American University Washington College of Law.

Following her remarks, we will hear from Dr. Lee Schwamm, professor of neurology at Harvard Medical School and executive vice chairman of neurology at the Massachusetts General Hospital, where he is the chief of the stroke division. He also serves as director of the Partners National Telestroke Network as well as medical director for MGH Telehealth and as a co-chair of the Innovation Council and Partners Health Care.

He has authored over 250 peer-reviewed articles and has chaired or co-chaired many of the current practice guidelines for stroke and telehealth-enabled care delivery.

Dr. Schwamm graduated from the Harvard Medical School in 1991 and completed his neurological training and fellowships in

neurocritical care and vascular neurology at the Massachusetts General Hospital.

He is testifying here today on behalf of the American Heart Association and the American Stroke Association.

Third, we will hear testimony from John G. Lovelace, the president of UPMC for You, a managed-care organization that serves medical assistance and Medicare Advantage special needs plan recipients in 40 counties in Pennsylvania. He also serves as president of Government Programs and Individual Advantage for the UPMC Insurance Services Division as well as the chief program officer of Community Care, a behavioral health managed-care organization that is part of the UPMC Insurance Services Division. Mr. Lovelace also serves as board chair for the Association of Community-Affiliated Plans.

Mr. Lovelace received graduate degrees in rehabilitation counseling from the State University of New York at Buffalo and in information services from the University of Pittsburgh.

Finally, we will hear from Stephen Rosenthal. Mr. Rosenthal is the senior vice president of population health management for Montefiore's Integrated Delivery System as well as the president of the Care Management Company LLC. He is also an associate in the Department of Epidemiology and Social Medicine at the Albert Einstein College of Medicine.

Previously, Mr. Rosenthal spent a number of years practicing as a clinical audiologist. He holds a master's degree in science from Brooklyn College as well as a master's of business administration in finance, management, and information systems from Pace University.

Now, I ask you all to limit your opening statements to no more than 5 minutes each if you can.

And, Ms. Hayes, will you please proceed with your opening remarks?

**STATEMENT OF KATHERINE HAYES, DIRECTOR OF HEALTH POLICY, BIPARTISAN POLICY CENTER, WASHINGTON, DC**

Ms. HAYES. Chairman Hatch, Ranking Member Wyden, and other members of the committee, I am honored to be here today. I cannot tell you how many hours I logged sitting behind you in the staff seats when I worked for John Chafee from Rhode Island back in the day.

Today, BPC's health project is led by former Senate Majority Leaders Bill Frist and Tom Daschle. Our process for developing policy is very similar to the process that the chronic care working group took as it began to put together this CHRONIC Care bill. We are very impressed with the way this has worked out and commend the members of the committee for this open and transparent process.

And really, thank you very much for the opportunity to have been able to contribute our views to the process.

The committee's work in drafting the legislation really highlights the need of caring for chronically ill individuals. We have long known that patients with multiple chronic conditions have higher Medicare costs, and for decades policymakers have worked to address the needs of high-cost Medicare patients.

Patients with multiple chronic conditions, four or more chronic conditions, as you know, incur average annual Medicare costs that are five times higher than those with four or fewer chronic conditions. They have hospital readmission rates that are twice as high, and four times as many emergency department visits.

Increasingly, research shows that non-medical social services and supports not covered under traditional Medicare fee-for-service can reduce hospitalization, emergency department visits, and other expensive acute-care episodes when supports are targeted to frail and chronically ill individuals.

Examples of these services include non-emergency transportation to medical appointments and home delivery of low-sodium or low-sugar meals for patients with heart disease or with diabetes or other chronic conditions. Pilot programs tested in the community demonstrate that these types of services and supports have resulted in as high as 27-percent reduction in medical costs and significant reductions in avoidable hospitalizations.

The Medicare Advantage program has a number of barriers in current statute and regulation to the provision of these services. And the recommendations that the committee has put forward go a long way toward addressing those concerns. In fact, many of the recommendations that the Bipartisan Policy Center has put forward are very similar to the work that the chronic care working group has put forward.

In Medicare, there is a requirement called the uniform benefit requirement that requires all Medicare Advantage Plans to offer the same benefits to all enrollees. Research has shown the benefits of targeting services to certain high-cost beneficiaries. And with the plans that we have spoken to, they said they would very much like to provide a lot of these services, but there is not clarification in the law that they can do these things, such as providing home-delivered meals. In fact, there are limitations in regulations that allow them to do that.

For dual-eligibles, you have suggested aligning the grievance and appeals process. At the same time, you are allowing for coverage of services that are not primarily health-related. BPC has supported all of these.

In fact, we took a look at the cost of these services. We looked at four services—in-home-delivered meals, non-emergency medical transportation, minor home modifications, and targeted case management services—and found that within both the existing Medicare Advantage program, but also in other plans, such as Accountable Care Organizations or patient-centered medical homes, the cost of these services can be as little as \$5 a month when spread across the balance of Medicare beneficiaries.

In conclusion, I would like to thank the committee for proposing these policy changes that are recommended in the CHRONIC Care Act. But equally important, again, is the transparent and bipartisan nature of the process.

Through these policy changes, many frail and chronically ill Medicare patients could benefit from improved care coordination, access to care in the home and in a community-based setting, and the availability of non-Medicare-covered services and supports.

I am happy to answer any questions.

The CHAIRMAN. Well, thank you.  
 [The prepared statement of Ms. Hayes appears in the appendix.]  
 The CHAIRMAN. Dr. Schwamm?

**STATEMENT OF LEE SCHWAMM, M.D., PROFESSOR OF NEUROLOGY, HARVARD MEDICAL SCHOOL; EXECUTIVE VICE CHAIRMAN OF NEUROLOGY, CHIEF OF THE STROKE DIVISION, AND DIRECTOR OF THE PARTNERS TELESTROKE NETWORK, MASSACHUSETTS GENERAL HOSPITAL; ON BEHALF OF THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION, DALLAS, TX**

Dr. SCHWAMM. Chairman Hatch, Ranking Member Wyden, and other members of the committee, thank you for the opportunity to testify today on behalf of the American Heart Association and American Stroke Association about the CHRONIC Care Act.

We commend you for your bipartisan work to strengthen and improve the health outcomes for Medicare beneficiaries living with chronic conditions. Your legislation, if enacted, would help patients receive care that meets their unique chronic health-care needs as well as create incentives for the provision of coordinated care for high-cost beneficiaries.

The American Heart Association is pleased to offer our full support for this important legislation.

In addition to being a longtime volunteer for the American Heart Association, I am also a member of the American Academy of Neurology. And we have worked very closely with the AAN to improve Medicare's coverage of stroke telemedicine, or telestroke as you heard described today. We applaud you for including this common-sense provision in the CHRONIC Care Act.

As you know, stroke takes an enormous toll on families and on our Nation. It is the number-five killer and the leading cause of serious, long-term disability and dementia. As the baby boomers age, it is vitally important that we reduce the burden of this devastating disease on stroke survivors and their families and on Federal health-care programs. By improving access to telestroke care, we can ease this burden.

In the treatment of stroke, we often say "time is brain." That is because every minute that a stroke goes untreated, 2 million brain cells are dying along with 14 billion connections that go between them. And they do not grow back.

The clot-busting drug tPA and mechanical clot retrieval devices are highly effective treatments for the most common type of stroke and significantly reduce stroke-related disability, but they must be administered as quickly as possible after symptoms start. Patients who get tPA within 90 minutes from the start of their stroke are three times more likely to recover with little or no disability, and among patients who get a clot retrieval device for a major stroke within 150 minutes, 90 percent of them will recover with little or no disability. This is a game-changing treatment in the field of stroke.

I have seen firsthand countless examples of the miraculous difference these treatments can make for patients. But unfortunately, among Medicare patients, the national average tPA treatment rate is only about 2½ percent. There are several reasons why tPA rates

have remained low, including a shortage of stroke experts as well as patients arriving at the hospital too late.

The good news, however, is that telestroke has been proven to increase the percentage of stroke patients who get tPA and get it faster. One recent study of four urban hospitals in Illinois with low treatment rates found that their use of tPA increased two- to six-fold after telestroke was implemented.

Rapid and accurate diagnosis of stroke is a critical first step to ensuring that patients receive the best in evidence-based care. Even in urban settings, patients may still experience delays in diagnosis and treatment. When a patient presents at a hospital that does not have a stroke expert, the emergency department can use a telestroke network to get instant access to stroke expertise.

Despite the proven benefits of telestroke, Medicare's coverage of it is woefully outdated. The current policy, as you heard before, restricts coverage for telehealth services only to originating sites in very rural areas. I might add, for example, that 80 percent of people who live in Utah and Oregon live outside this designation.

The most significant step Congress could take would be to allow Medicare to reimburse for telestroke evaluations regardless of patient location, as the CHRONIC Care Act will do.

In addition to improving access to evidence-based care, we believe the greater use of telestroke will also result in cost savings to Medicare and Medicaid by reducing chronic disability and the need for expensive, long-term care. I believe this change in Medicare law is long overdue, and I am heartened by the growing number of lawmakers and organizations that have endorsed telestroke.

In addition to more than 170 bipartisan co-sponsors on telestroke legislation in the last Congress, organizations such as AARP, the American Hospital Association, and the American Medical Association have also expressed their firm support for lifting Medicare's coverage restrictions on telestroke.

In conclusion, telestroke is supported by a wealth of evidence and is a common-sense, cost-effective step the committee can take to reduce the burden of stroke as a chronic disease. I am convinced that expanding the use of telestroke will greatly improve the quality of care that stroke patients receive, increase the utilization of effective acute stroke treatments, reduce stroke-related disability for many Americans, and save the health-care system money. It is simply the right thing to do.

We greatly appreciate the thought and deliberations that went into the development of the CHRONIC Care Act and for the opportunity to express our strong support at today's hearing. I urge the Senate Finance Committee to act quickly on this legislation and send it to the full Senate and then the House for approval.

Thank you again very much for the opportunity to testify.

The CHAIRMAN. Thank you, sir.

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

The CHAIRMAN. Mr. Lovelace?

**STATEMENT OF JOHN G. LOVELACE, PRESIDENT, GOVERNMENT PROGRAMS AND INDIVIDUAL ADVANTAGE; AND PRESIDENT, UPMC FOR YOU, UPMC INSURANCE SERVICES DIVISION, UPMC HEALTH PLAN, UNIVERSITY OF PITTSBURGH MEDICAL CENTER, PITTSBURGH, PA**

Mr. LOVELACE. Good morning, Chairman Hatch, Ranking Member Wyden, and members of the committee. Thank you very much for the opportunity to be here this morning and to talk to you about the work of UPMC and the work that is affected by the CHRONIC Care Act.

I have had a remarkable opportunity over the past 20 years at UPMC to learn about services in Medicaid, Medicare, special needs plans, Children's Health Insurance, behavioral health, and the marketplace operations.

I have been able to expand that information by my role as the board chair of ACAP, where we work closely with 59 other health insurance and Medicaid health plans to create opportunities to improve care and coverage for the most vulnerable citizens. We believe this bill would accelerate the pace of innovation and quality of services for consumers, certainly throughout Medicare and, therefore, into other coverage options.

As part of an integrated delivery and financing system, UPMC health plan and the companies of the Insurance Service Division at UPMC work very closely with world-class hospitals and providers to provide Medicare beneficiaries and other plan members with access to affordable, innovative plan benefits. Our collaborative and integrated delivery system model aligns financial incentives between payer and provider to promote higher-quality outcomes at lower costs. It also gives us unique insight into the effectiveness of new care modalities and payment methodologies.

With more than 3 million covered lives, we offer a wide range of commercial and government-sponsored services.

Since their creation in 2003, special needs plans have faced uncertainty in the form of continuing temporary congressional authorization. These plans are specifically designed to serve the most frail, medically complex, and vulnerable Medicare beneficiaries by ensuring that each plan member receives an individualized care plan as well as access to better-tailored and more coordinated services than he or she would otherwise have in fee-for-service Medicare or the broader Medicare Advantage program.

While Congress has repeatedly recognized the value of these plans as part of Medicare, the uncertainty of their future has likely constrained State investment in efforts to integrate Medicare and Medicaid for dually eligible beneficiaries.

UPMC currently covers 23,000 dually eligible beneficiaries. We are the second-largest stand-alone four-star dual plan in the country, and we are positioned to begin in January with the coordination with Medicaid long-term services and supports rolling out through Pennsylvania through 2018 and 2019.

We are very supportive of the CHRONIC Care Act's initiative to make SNP authorization permanent. And we are supportive of the conditions which are laid out under which that might happen.

We have also had the opportunity to work through the initiation of value-based insurance designs in Medicare. Pennsylvania is one

of seven States in which this is covered. This offers the opportunity, as Katherine suggested, to create special incentives for people with chronic disease to participate more actively in their health care. Our particular program focuses on people with diabetes, congestive heart failure, and depression. And it allows people to engage in incentive programs that are completely voluntary, to engage in health coaching and wellness supports to improve their care.

It is an opportunity, I think, we hope to see expanded in the bill in the coming year, and we will have an opportunity to prove its value as we move forward into 2020.

Another challenge to rural independence in the presence of chronic illness is the presence of reliable access to care. While we have made great strides in delivering high-quality, appropriate care, there are many services that are not readily or at least not efficiently delivered face-to-face in a patient's home or in a community setting. To this end, plans and providers are increasingly adopting telehealth technology to provide patients with access to a growing array of remotely accessible services, as you have heard already this morning.

While speed and convenience are one factor of the success of telehealth, the value and promise of this technology are something much bigger. Also valuable is the promise to develop healthy, active, and busy patients, but also to reach individuals in rural areas, residents in nursing facilities, and chronically ill patients living at home and in community-based settings where physical travel may be costly, complicated, and burdensome.

UPMC has analyzed data from a number of initiatives that we support currently in telehealth, including telepsychiatry in Medicaid, telestroke, teledermatology, and so forth, as well as online synchronous access to primary care physicians face-to-face on the Skype methodology.

Our evaluations on these to date have indicated there is not an incremental cost to this. Rather, it replaces services people would otherwise get in doctors' offices, urgent care centers, and emergency centers.

The CHRONIC Care Act includes provisions that expand coverage of telehealth within Medicare Advantage. We believe this represents an important step toward improving program flexibility to better meet the needs of beneficiaries.

We appreciate the opportunity to be here this morning. I would be happy to answer any questions after we are done. And thank you for the opportunity to speak.

The CHAIRMAN. Well, thank you for taking time to be with us and help us to understand this even better.

[The prepared statement of Mr. Lovelace appears in the appendix.]

The CHAIRMAN. We will now turn to Mr. Rosenthal, and we will take your testimony at this time.

**STATEMENT OF STEPHEN ROSENTHAL, SENIOR VICE PRESIDENT FOR POPULATION HEALTH MANAGEMENT, MONTEFIORE HEALTH SYSTEM, YONKERS, NY**

Mr. ROSENTHAL. Thank you, Mr. Chairman, Ranking Member Wyden, and members of the committee.

I appreciate this opportunity to discuss solutions to one of the most vexing problems facing the Nation's health systems: how to effectively and efficiently care for the growing numbers of Americans who suffer from chronic conditions.

I commend the committee for its unrelenting focus on this topic.

Montefiore Health System is a premier academic health system and university hospital for the Albert Einstein College of Medicine. We serve 3.1 million people living in the New York City region and the Hudson Valley, a combination of urban, rural, and suburban communities.

Approximately 80 percent of the patients discharged from our hospitals are enrolled in Medicare, Medicaid, or both programs, or are uninsured.

Montefiore has deep roots in treating chronic disease, dating back to our founding in 1884 by Jewish philanthropists as a care facility for patients with chronic illness. Today, we are one of the largest health systems in the country, and we have more than 400,000 patients in risk arrangements across Medicare, Medicaid, and commercial insurance.

As one of the Nation's original 32 Pioneer ACOs, Montefiore has achieved overall savings from Medicare of over \$70 million out of a total cost of care of \$2.2 billion over 5 years. We are now participating in the next-generation ACO program with 55,000 beneficiaries, and we are optimistic we can continue to achieve savings from Medicare and reinvest those savings in our delivery system.

When we applied to become a Pioneer ACO, Montefiore was a four-hospital system serving primarily Bronx County, one of the Nation's poorest and most disproportionately disease-burdened counties. Today, the Montefiore ACO network includes 13 hospitals, three Federally Qualified Health Centers, and more than 3,800 primary care and specialty physicians, almost 30 percent of whom are in practice in the communities they serve.

Yet it is our decades-long experience providing care for the 1.4 million residents of the Bronx, 75 percent of whom receive their health-care services through Medicare and Medicaid, that gives us the experience to successfully manage the care of beneficiaries who are attributed to our ACO.

If you have any doubts about the importance of this concentration, consider this. In our experience, 5 percent of the 400,000 individuals covered by Montefiore's value-based contracts account for 65 percent of the total cost of care, and that is largely because of chronic conditions.

I would like to just briefly discuss several provisions in the CHRONIC Care Act, which build upon provisions included in the next-generation ACO program, and offer you our support for them.

In our experience, prospective attribution is one of, if not the most important critical component in two-sided risk models. While retrospective assignment of patients may be appropriate in one-sided risk models, in two-sided risk arrangements, prospective at-

tribution allows us to quickly identify beneficiaries with a history of high costs and high utilization, as well as those with the potential for becoming high-cost and high utilizers.

Prospective attribution allows an ACO to deploy resources within a sufficient period of time to have an impact on the beneficiary's care and/or remain attributed to the ACO to the end of the measurement period.

Your proposal to expand the ability of ACOs to employ telehealth solutions that we have been discussing is an excellent way to provide patient access to services to best manage their chronic disease. To serve our urban and rural populations faced with challenges of getting to office appointments, telehealth technology can be a successful alternative to being there.

In addition, this tool can provide specialty consults for primary care physicians in more rural locations and locally as an alternative for mental health services where visual contact can be an important part of care.

I would also ask the committee to consider an expansion of the definition of telehealth to include audio only and those modalities that allow communication between providers, care managers, and patients in a seamless fashion, especially in low-income communities that may not have access to video conferencing technology.

Finally, allowing ACOs to offer incentives to their patients is visionary. While there may be a cost for developing the infrastructure to administer the benefit, it would not only benefit the patient directly, but also the provider by improving his or her quality scores, the ACO itself by increasing its potential for shared savings, and the Medicare program by lowering the total cost of care to the system.

Incentives could potentially encourage patients to remain within an ACO network without limiting their choices in any way.

On behalf of the Montefiore ACO and the entire Montefiore health system, I thank you for your efforts to advance accountable care with proposals that I believe have the potential to improve quality and lower costs.

I look forward to working with you to achieve our shared goal of a better health system for all Americans.

Thank you. I will be happy to answer any questions.

The CHAIRMAN. Well, thank you.

[The prepared statement of Mr. Rosenthal appears in the appendix.]

The CHAIRMAN. And thanks to all four of you. You have added a lot to this discussion and this understanding.

We will turn to Senator Wyden first.

Senator WYDEN. Thank you very much, Mr. Chairman. Again, my thanks for your making this a bipartisan effort.

Let me begin by trying to see if you can paint a picture of what it is like for somebody who is 75 years old trying to navigate this byzantine maze of doctors' visits and multiple prescriptions and test after test after test.

It seems to me, and I am reflecting on my days when I was co-director of the Gray Panthers, this is a labyrinth that can be challenging if you are, say, in your 30s and you are fairly healthy. So I think it would be very helpful if the four of you, who are real ex-

perts in this, could really paint a picture for what it is like if you are a senior who has multiple chronic conditions: cancer, say, heart disease, you know, diabetes, and what happens if you are basically out there on your own.

In other words, if you are in a good Medicare Advantage plan, you will be able obviously to have some help in an Accountable Care Organization. Ms. Hayes talked about a patient-centered health plan.

But the reality is, for lots of seniors, they are really out there on their own.

And, Dr. Schwamm, you are, of course, an authority on this. Paint the picture of what it is like for somebody who is 75 years old to get up in the morning and wonder how the heck they are going to be able to juggle all this stuff through the day.

Dr. SCHWAMM. It is a very important question and observation. And I will answer that in two ways. One is, when the patient comes into the emergency room with a stroke, so many times they are an older patient. Sixty-five to 70 percent of all the strokes we see are in Medicare beneficiaries. They are on multiple medications. They have not been taking all their medicines; they either did not have the money or they did not understand the prescription or something got changed. They did not make it to their last doctor visit. So often we see a failure of prevention.

Twenty-five percent of strokes happen in people who have already had a stroke. So the issue is not knowledge, and the issue is not a desire to improve their health. The real issue is the challenges of navigating this incredibly complex system.

From the perspective of what it is like to be a patient in this community, the average length of stay in the hospital now after a stroke in the United States is 4 days. So in 4 days, you come into the hospital, you have a new disability, and you cannot speak well or you cannot move your arm or you cannot walk, you get given a hundred pieces of paper and 55 things get explained to you. You are discharged from the hospital.

And unfortunately for most of our patients, it is up to them to figure out how to pull a team together of advocates and providers and really make sure that they follow through on all the instructions that we provide.

Senator WYDEN. What I am struck by, and, again, I am just trying to reflect on the days when I ran the legal aid office for the elderly. We handled trying to help patients in these cases.

I gather that in the example that you are talking about, where somebody is not part of a coordinated care plan, they are not part of a Medicaid plan, Medicare Advantage, or an Accountable Care Organization even, when you discharge them from the hospital, I gather in a lot of instances if you ask the patient whom you might even send records to, whom could you make a follow-up call to so that somebody who is knowledgeable in the health field would actually be able to pick up where the hospital left off, that in many instances, if a person is not in some kind of coordinated care program, things break down almost at that moment after the hospital visit. Is that right?

Dr. SCHWAMM. Very much so. And it is not that providers are doing something wrong. Everyone is doing their best. But when you

have just had a stroke or your mom has just had a stroke, you are not in the right frame of mind to absorb a lot of new information.

One of the things we do at Mass General, at my hospital, is that we make a phone call within the first few days to every patient who is discharged home from the hospital to make sure that they are taking the right medication.

We frequently find that they have a cabinet full of medicines at home, and they do not know whether to take the old ones or the new ones. They do not even really understand what happened to them.

So I cannot agree with you more about the need for a better way to navigate this complex health-care system to prevent what we all know is coming down the road, which is another major medical illness or event if we do not get things sorted out properly.

Senator WYDEN. My colleagues all have questions, but I appreciate particularly your point about the role of the providers. That is what has been at the heart of this bipartisan effort. Nobody thinks providers are getting up in the morning and saying, "Gee, I really want to be rotten today to people with chronic conditions." Quite the opposite. I think they share this frustration about the lack of whom to turn to, particularly if you are not part of a Medicare Advantage plan or one of these others.

So you have been very helpful. I will have some questions for the rest of you on the second round. But I want it understood, particularly on that last point I made—and the chairman has been kind enough; we meet every Wednesday and we talk about it—to have it understood that for the future, for the long term, I want somebody to be the point person, the point person for coordinating care for the people who are now essentially out there trying to make their way through this byzantine system on their own. We can do better than that. We are better than that as a country.

So you all have been great.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Senator Roberts?

Senator ROBERTS. Well, thank you very much, Mr. Chairman.

And, Senator Wyden, I could not agree with your comments more.

Let me ask the panel this. Medication is a routine and the most prevalent means by which we prevent and control chronic disease. But we read stats time and time again that show a large number of individuals with these chronic illnesses do not take their medication as prescribed.

Included in the CHRONIC Care legislation is a provision that directs the Government Accountability Office to study the extent to which Medicare prescription drug plans use programs that synchronize pharmacy dispensing so that individuals may receive multiple prescriptions on the same day to facilitate comprehensive counseling and promote medication adherence.

As a long-time champion of medication therapy management and through the work I have done with Senator Carper, who has taken the lead in this—and I thank him for that—on identifying and strengthening other medication adherence strategies like MTM and

Med Sync, I want to ensure that we are targeting these adherence efforts to the patients who will benefit from them the most.

Do you have any recommendation, any person on the panel, for us to consider within this CHRONIC Care package or in further legislation that will help us ensure we are targeting the right patients to improve adherence?

Dr. Schwamm, do you want to take a shot at that?

Dr. SCHWAMM. You know, every visit that I have with a patient, the first part of the visit is, we go over the medication list to make sure that it is accurate in our health system. And I would say that more than half of my patients are on at least 1½ pages of medicines. And we go through each one. And half the time, they cannot even tell me what the medicine is for, they just recognize the name, and they tell me that they take one or two pills of it.

We know that for every additional medicine a patient is prescribed, their adherence to the regimen goes down. So the more you are on, the less able you are to take them. And if patients use something as simple as a pill dispenser, for filling up the pills on Monday for the whole week, they increase their likelihood of adherence.

It seems crazy to me that we do not invest more money in making sure that the therapies we know are proven to be effective when taken routinely, get taken routinely.

So again, I would encourage the committee to try to target the patients who have the conditions for which we have the best evidence that these medications reduce the risk of re-hospitalization, major adverse events, like stroke and heart disease and heart failure, and work hard to strengthen programs that will encourage us to build new and innovative systems for ensuring that medication adherence is happening.

Senator ROBERTS. I appreciate that.

Would anybody else would like to comment?

Yes, sir.

Mr. ROSENTHAL. Well, I would just add to what Dr. Schwamm has said. One of the things we do, because it is very difficult often for many physicians to reach out to large numbers of their patients, we use a number of PharmDs, and they go out and help patients—because, as we pointed out, many of them have as many as 8 to 10 prescriptions—with the goal of trying to appropriately outline a plan using these pharmacists who work directly with the physicians to best manage the medications the patients are on, because it enhances the compliance ultimately and avoids unnecessary medical consequences. So we have added that.

Senator ROBERTS. Mr. Lovelace, you indicated you had a comment.

Mr. LOVELACE. Thank you. Yes, we similarly have used extenders, pharmacists and nurses particularly, to interact with patients and other physicians around complicated regimes. And the three key questions to ask people, I think, in this complicated process are: Do you understand why you are taking this? Can you afford to take it? And does it make you feel bad in some way? And if the answer to any of those things is “No,” “I do not understand,” or “Yes, it makes me feel bad,” then insurance rates go way down. So

the opportunity exists to sort of get more direct interaction with a patient around the experience with the drugs.

Many people, as Dr. Schwamm has said, have eight medications prescribed by seven doctors. So only the patient knows the whole regime, not the prescribers. The pharmacist is an opportunity to pull it all together.

Senator ROBERTS. What about over-the-counter? Seniors watch TV a lot, and you see all of these ads that say very positive things about the medication they are trying to sell or promote. And then they always list everything that could happen to you, at the bottom. But I think probably a lot of seniors go in and buy these products, adding to their prescriptions. The mix of that I am not too sure works very well.

Would you comment on that and how we could get our arms around that one?

Dr. SCHWAMM. Well, I am not sure I can tell you how to get your arms around it. But I think there is a misperception that things you can buy over the counter are not drugs or medications. And I counsel my patients frequently that they need to tell me everything they take on a regular basis, including things they buy in the health-food store or what we might call nontraditional medications. Because many times, patients may be taking things that interfere with the effectiveness of the treatments we are trying to get them to take.

And as I mentioned before, it is the number of things you take every day that leads to you not taking them regularly. So that includes over-the-counter medicines as well. And we know that over time we discover that there are harmful effects for many of the things we had presumed to be benign or only have beneficial effects.

Polypharmacy is the name that is used sometimes to describe this mixture of medications, and the idea of reconciling those medicines and looking for interactions between them is incredibly important.

If you practice in an integrated health-care system, the software that you use to prescribe medicines will often alert you to dangerous interactions between medicines that you might not have been aware of. So I think anything we can do to strengthen the support at the time of prescribing and at the time of visits that will help providers and patients understand dangerous interactions between medicines is very important.

Senator ROBERTS. I thank you for that.

And my time is expired. And I just want to thank again Senator Carper for working with me, and I am working with him on this legislation. Thank you.

The CHAIRMAN. Great.

Senator Stabenow?

Senator STABENOW. Well, thank you very much, Mr. Chairman.

And I want to echo Senator Roberts's concerns about what is happening on medications and appreciate very much what all of you are doing.

And, Mr. Chairman, I want to thank you for the hearing today—I am a proud co-sponsor—and, Senator Wyden, for your passion on

this, the CHRONIC Care Act. It is a product of 2 years of bipartisan work and engagement of hundreds of stakeholders.

And I think this is just a very, very important model of how we should be going forward, frankly. When we did the last major health reform that is now under such great political debate, we had a hundred meetings and hearings in the Senate between the Finance and the HELP Committees.

So I would hope that we are going to be focusing on improving quality, lowering costs, lowering premiums, creating more quality. And I would very much hope—and I am very sincere in this—that whatever product comes forward in the Senate, before it comes to the floor, that we have an opportunity to have a hearing on impact, because this is really important. This represents one-fifth of the gross domestic product, and it affects every single American.

The other thing that I would say—because it is so important as we are looking at this discussion, which is very positive, thoughtful, and the right discussion—is that for seniors, people with multiple chronic conditions, people in nursing homes, and so on, the bill that came over from the House is exactly in the opposite direction: \$880 billion being cut from Medicaid. And in Michigan, three out of five seniors in nursing homes and half the people with disabilities are covered by Medicaid.

So I am just underscoring this, why it is so important that we have input, because this bill, the CHRONIC Care Act, is very positive. And what has come to us from the House is very, very negative and would undercut everything that we are talking about.

I want to specifically talk about the Value-Based Insurance Design today. It is not something that everyone in the public really would be thinking of in terms of an improvement in the system, but I would probably have to say this is a Michigan export.

In 2005, Dr. Mark Fendrick started the University of Michigan Center for Value-Based Insurance Design. They have done terrific work in evaluating innovative health-plan benefit designs to improve care and lower costs.

And Senator Thune and I have worked on this, as well as many others. And this bill would take this from a pilot in seven States, as you know, to the opportunity for every State to use this.

So first, Mr. Lovelace, I know you mentioned that your health plan is participating in the VBID model. And I wonder if you could talk a little bit more about that: the types of plan designs that you have incorporated. Have you used them in other commercial plans? And have you seen any results so far? And what would those results be?

Mr. LOVELACE. Sure, I would be happy to. We have about 8,000 enrollees in Medicare Advantage who are eligible to participate in the Value-Based Insurance Design program, who have the combination of conditions that are targeted. And we have had the opportunity to have a lot of consultation with Dr. Fendrick and his staff around what he knows and what he has learned and how that informs the program. And he has really been very supportive of our work in this area.

I think it would be fair to say at month number four that we do not really have any results yet. The plan we have designed basi-

cally is a series of six \$25 incentives which we have to pay in checks as people choose to achieve certain goals.

The drill basically is, the first incentive is, do you agree to talk to a health coach? You have agreed to participate in the process. The second step is, you set some goals for yourself. They are whatever you want them to be. They could be diabetic-related, they could be something else.

The next four steps really are that you establish some steps along the goals and you work on the steps. You do not have to achieve them. You do not have to lose weight if that is your goal. You do not have to have an A1C under 9 if that is your goal. But you do have to make an effort to work on it.

Most people who have been offered a chance have been enthused about it. It is a lot of time to spend on the phone with health coaches. And Medicare recipients on the whole like to talk on the phone to people. [Laughter.]

They like some help, because they are often bewildered by the whole system. And anybody who has a glimmer of how to get through this in one piece is helpful. So it has been also an engaging experience.

We are pleased by the uptake early on, and we look forward to evaluating this as we move along.

We do have incentives in our commercial programs with some very nice results. We have incentives around health and wellness issues, including setting goals around things like weight loss and blood pressure control, that have a different kind of financial payoff to people, that essentially eliminate your deductible by engaging in healthy behaviors. And we have about 85-percent uptake in this actually. It is significant; you can save about \$1,000 a year in your deductible if you engage in certain behaviors.

It definitely catches people's attention; \$500 did not actually. So we have sort of experimented to find where the level is that people pay attention, and it seems to be about \$1,000.

Senator STABENOW. Thank you so much. It turns out health care is complicated. Who knew?

Mr. LOVELACE. I did not know. [Laughter.]

Senator STABENOW. All right. I am out of time.

The CHAIRMAN. You are.

Senator STABENOW. I do not know if anyone had a quick comment.

I am out of time, so I guess I will leave it there, Mr. Chairman.

The CHAIRMAN. Thank you. Thank you, Senator.

Senator Carper, you are up.

Senator CARPER. Thanks, Mr. Chairman.

To one and all, welcome. Thank you for trying to help us and help us really better assist the folks whom we represent.

My mom died a number of years ago. She had dementia for the last years of her life. So did her mother, so did her grandmother. And she lived down in Florida near Clearwater, and my sister and I would take turns going down and seeing her. About every other month we would take turns.

And one of the things that my mom did was, she had what looked like a fishing tackle box in her house that had no fishing tackle in it, but it had a lot of medicines. And she would take one

before breakfast, one at breakfast, something after and throughout the day and into the night. And she reached a point in her life where she could not do it on her own. My dad was deceased, so we hired people to come and be with her part of the day and eventually 24/7, to help her.

One of the things that we found out was, she had seven doctors, and they were prescribing a total of 15 different medicines. The doctors never talked to each other. And we were convinced that some of the medicines she was taking were just fine for her conditions, but some were probably not.

And so one of the things that Senator Roberts and I are doing with the help of our staffs is to figure out what are better ways to do that, and I am sure there are.

But you all have talked about this already, but just talk to us about best practices. I do not care who goes first, but just talk about practices to deal with situations like that. I know they are commonplace. But somebody has figured this out, doing a pretty good job. Just give us some idea what the best practices are.

Ms. Hayes, would you go first, just briefly?

Ms. HAYES. Sure. I think some of the best examples have been done through dual special needs plans, particularly those—there are a couple of States that have been more forward-thinking.

One in particular that I am familiar with is in Massachusetts. And they have done just an amazing job of providing the sort of coaching that dual-eligibles need to make sure they get their drugs at the right time, to make sure that when they are discharged from the hospital, they have what they need.

But most importantly, and to Senator Wyden's point, they have someone they know whom they can call at the plan. They have a phone number and the name of a person whom they can call when they need help, or their caregiver can, if, as in the case of your mother, she is not able to do it.

Senator CARPER. All right; thanks.

Dr. Schwamm?

Dr. SCHWAMM. This is the concept of the patient-centered medical home, which I view as really a kind of recreation of the era of Marcus Welby, you know? There was someone in the doctor's office who knew you, knew you well, and knew your circumstances, and there was a community around you that would tell you that you needed help if you looked like you were struggling.

We live in a very different society now, but we need to figure out ways to coordinate the care so somebody in the end takes ownership for that person and really owns the health issues around them and makes sure that the medicines are reconciled, makes sure that the specialists are coordinated. Because, as was just said a minute ago, medical care is really complicated now.

Senator CARPER. Yes, thank you. I was watching the audience when you said "Dr. Marcus Welby." And the people under 30 were, like, you know—

Dr. SCHWAMM. Did anybody know what I was talking about?

Mr. LOVELACE. Well, I do.

Senator CARPER. Those millennials were wondering, but we knew. [Laughter.]

Mr. LOVELACE. It is a place where there is a particular role, I think, for telemedicine and telemonitoring, in terms of reminders to people, in terms of texts, in terms of monitoring what is in the pillbox. There are a lot of technology solutions that can support the effort of physicians and caregivers. They certainly do not replace them, but they certainly can help coordinate them beyond the points that Katherine and Dr. Schwamm made.

Senator CARPER. All right. Thank you.

Mr. ROSENTHAL. You raise an important aspect: the benefits of a clinically integrated system using technology and with some care-coordinating capabilities within that. What we do through the depth and breadth of our large, clinically integrated system can begin to incorporate the information for our medical records so that all the physicians know what everyone else is doing and the information about medications and the like is incorporated within that system.

And then we take responsibility for those individuals and have a care-coordinating process within our operations so there is someone trying to be accountable for those individuals who have those complicated health issues.

Senator CARPER. All right. Thanks very much.

One of the issues that I have focused on, my staff and I have focused a great deal on with some of our colleagues, is the issue of obesity. And we are not getting any slimmer. And there is, I think, reason to believe that we are going in the wrong direction.

But so many bad things flow from being heavily overweight. I was in a hospital in Dover, DE not too long ago and went into one of the operating rooms. They had a hoist. And I said, what is this for? And they said this is for people who are really heavy. And I said, like, how heavy? And they said one person was 700 pounds, 800 pounds, just unbelievable stuff.

But in terms of getting us on the right track to do a better job of reversing this trend, epidemic really, toward obesity, just give me maybe each of you one piece of advice for what we should be doing here at this level to help win this war.

And, Mr. Rosenthal, do you want to go first?

Mr. ROSENTHAL. Well, I think it actually begins at a very young age. I think adolescent obesity begins the whole sequence that brings individuals to the complicated illnesses that obesity can lead to. So it begins in the school, in the school health systems.

We are very active in the school health systems. We have one of the largest networks of school-based health care, educating our young children today on eating habits, exercise. And if we can begin at those early ages, I think we can begin to actually stem the tide on obesity.

Senator CARPER. All right, thanks.

Mr. Lovelace?

Mr. LOVELACE. I would certainly agree with that. And I think it is mostly—it is not that we do not know what to do. We know we should not smoke, we know we should not be 700 pounds, we know we should not eat cheeseburgers for breakfast, but people do it anyway.

So I think it is a matter of, as Mr. Rosenthal said, ingraining early what healthy eating and exercise are and how they fit into

life so it is an expectation, not something you have to learn and force yourself to do if you are an adult.

Senator CARPER. Thank you.

Dr. Schwamm?

Dr. SCHWAMM. These are very important contributors to stroke risk. And stroke rates are on the rise in younger Americans now, shockingly and very depressingly. Avoiding a sedentary lifestyle and making affordable, healthy food choices available routinely is critical.

A study just came out last month showing that one diet soda a day triples your risk of stroke and dementia. So, you know, “we are what we eat,” and we really need to be focused on healthy food.

Senator CARPER. Thank you.

Katherine?

Ms. HAYES. Yes. I think education on what to eat and the importance of physical activity are absolutely important. But I think there are a lot of confusing messages out there in marketing.

My mother has heart disease and diabetes and has been struggling so long to keep her sugar levels low. And because she is not able to go upstairs and use the kitchen in our home—she lives with us—she was buying prepackaged meals that were convenient. And there is so much salt in them that she ended up in the hospital last week because she had too much sodium and started having heart problems again.

So I would agree: making healthier foods more available and education.

The CHAIRMAN. Time is up, Senator.

Senator Thune?

Senator THUNE. Thank you, Mr. Chairman.

I want to thank you and Senator Wyden for holding this important hearing. I am pleased with the progress that we have made so far with the bipartisan CHRONIC Care Act, and I look forward to continuing to work with you and the members of this committee on ways to further promote care coordination so that we can improve outcomes for Medicare beneficiaries.

And I also want to again recognize Senators Wicker and Schatz, who were here earlier, and the rest of the CONNECT for Health working group for teaming up to increase access to telehealth technologies. The inclusion of a number of CONNECT for Health Act provisions in the CHRONIC Care Act is a step toward improving beneficiary access to timely and effective health care.

Dr. Schwamm, thank you for being here today. Earlier this year, I introduced the Furthering Access to Stroke Telemedicine, or FAST, Act which seeks to break down existing barriers related to the use of telestroke technology.

I should say, though parts of South Dakota fall into a health professional shortage area and may meet the geographic requirements that exist under the current law, you mentioned in your testimony that even some urban and suburban regions do not have access to stroke neurologists to make timely diagnoses.

So could you talk about how geographic and originating-site restrictions on telehealth technology have limited access to effective, but time-sensitive treatments for stroke victims, both in rural and urban areas?

Dr. SCHWAMM. Yes. I think it would surprise people on the committee to know that 90 percent of the strokes in the United States every year are occurring outside of that coverage area. So the area for which Medicare has designated coverage is actually a relatively small geographic swath of the United States, and it is not very densely populated. So the places that need this treatment are not far from where you and I live.

When I first started doing this work about 15 years ago, hospitals 15 or 20 miles away from the Mass General Hospital in Boston were not treating with tPA because they did not have the availability of a stroke expert.

It is very straightforward to provide the necessary information that you need at the bedside to make a diagnosis of stroke—review the brain scan, examine the patient, talk to the family, and make a decision with the bedside physician—with the technology we have available today.

So the main barrier now is simply creating an environment where people feel there is no option, and stroke expertise must be available. This is a standard of care, and every hospital needs to be able to provide this basic evaluation. We would not accept the idea that you could come into a hospital with a heart attack and be told, “Gee, I am sorry, we do not have a heart expert available. We will just have to send you to another hospital an hour away, and if you do not get treatment when you arrive there because it is too late, you know, I am very sorry.”

We have to have that same attitude toward stroke. And this opening up of the geographic restriction, I think, will encourage many more hospitals to be able to initiate these kinds of services which are broadly available in the U.S. and in Europe.

Senator THUNE. In your testimony, you also noted the potential savings that can be found by investing in telestroke technologies instead of treating the last effects of stroke after the episode occurs.

What are some of the issues faced by stroke survivors who do not receive timely care versus those who do, as well as the costs associated with those conditions?

Dr. SCHWAMM. Well, you know, there are huge hidden costs of stroke on our society. I am sure many of the members have had a family member who has had a stroke. Patients become disabled, often cannot return to live at home. Or if they do live at home, they often need close to 24-hour care. Loved ones, spouses, children have to give up working or reduce their work in order to be available and help take care of their loved one.

If people need chronic care and residential care, they often go through all their savings first and then end up on Medicaid and then end up in a nursing home chronically with frequent readmissions to the hospital for bedsores, for pneumonia, for urinary infections, for recurrent strokes. So it is a very, very debilitating disease. And as you know, it happens in an instant. Your life changes in an instant.

The math is actually pretty simple, in the sense that we know that telestroke increases the use of tPA. That has been shown time and time again. We know that every treatment with tPA saves

money, because it avoids long-term disability in a substantial portion of patients who receive it.

A study back in the late 1990s estimated about \$4,000 of savings per treated patient because of the reduced burden of this. And if you multiply that together with 500,000 Medicare beneficiaries who would be eligible for consultation if the restrictions were removed, you can see that savings are going to accrue.

Now, whether they accrue to Medicare's budget, the State budgets, or to other payers, someone smarter than me will have to figure out, but it is just the right thing to do, to find a low-cost way of providing a treatment we know is effective and that we would encourage the hospital to do anyway if they had a stroke expert on hand.

The cost of the telestroke consultation itself is trivial. Really what we are talking about is spending more money giving tPA to reduce long-term disability, which is the highest level of evidence recommendation of every major professional society.

The CHAIRMAN. Senator, your time is up.

Senator THUNE. Mr. Chairman, I would just mention too, I want to associate myself—I understand that Senator Stabenow already talked about the Value-Based Insurance Design model demonstration, which is some legislation that we have worked on. And so I would think she has covered that base already. Thank you.

The CHAIRMAN. Well, thank you, Senator.

Senator Cardin?

Senator CARDIN. Thank you, Mr. Chairman. I want to thank you and Senator Wyden for bringing this hearing forward. And this is how we should be conducting our business: on a bipartisan basis and process. And I thank you, and I think it is going to lead to some good results and passage of legislation.

I want to follow up on Senator Thune's point on telehealth. I have seen it firsthand in my State in Pocomoke City, a very rural part of Maryland where we have a VA facility, where they do not have the type of specialists that you would have in most communities. So ophthalmology is performed through telehealth, and it is working very, very well.

On dealing with the stroke victims, we have three programs in Maryland working today, one in Carroll County, Westminster, a rural area, working with the University of Maryland. It is working very well. We have a program working in Hagerstown, which is also working well, in conjunction with a major center. So we have programs in our State that are performing extremely well.

Also incorporated in this bill is how to deal with dialysis patients. With a stroke victim, saving the costs by reducing disabilities at the time of intervention is critically important. With a dialysis patient, it becomes a matter of cost and getting to a center and trying to have some degree of normalcy in your life. And to be able to do tele-examine so that a person can get care in their home can save a great deal for a family and make a person much more mobile.

So my question to you is—this bill moves us forward in telehealth. But be a little visionary. Where do you see telehealth going? What can we look forward to doing, and what obstacles are in the way? And what concerns do we have as we move more to-

wards a telehealth system so people can get more timely and more cost-efficient care?

Dr. Schwamm, if you could start, and then if others have views, I would be curious as to where you see us going and what we need to change in order to be able to accommodate this type of health care.

Dr. SCHWAMM. It is one of my favorite topics, so thank you for the question.

Just briefly to comment on the dialysis issue, anything we can do to improve convenience to access will increase the delivery of those services and do so at a lower cost.

We spend a huge amount of money on ambulance transport for dialysis patients to and from dialysis, for example. That is another hidden cost that could be dramatically reduced by using telehealth in these circumstances.

My hope and my vision is that 10 years from now, 15 years from now, we will not be calling it telehealth, we will just be calling it health care. There is no reason why this artificial dichotomy, this false dichotomy of in-person versus virtual, is going to persist. Because we do not call it mobile banking and think about it as a completely different enterprise and have separate costs and decide that you cannot do certain transactions. Anything you can do that way saves everybody money, makes it more convenient, makes it more desirable.

I really think we have to examine the health-care encounter, and there is more than one type, deconstruct it into its individual parts, and reassemble them in a way that is patient-centered, not doctor- or hospital-centered. If we do that right, we will figure out how to provide better care sooner, and we will be able to intervene upstream before diseases manifest themselves.

We also have to fund research to make sure that what we decide to do is evidence-based and not simply what feels like the flavor of the day or what seems most attractive to consumers. We must be driven in this area just the way we are in medical care in general, which is by developing evidence and testing our hypotheses.

We also do not want to create a new digital divide where we disenfranchise a new class of vulnerable people because they do not have access to technology in the same way. So these are all very important parts of really weaving telehealth into health care.

Mr. LOVELACE. If I could just build that out a minute, I think as you have heard earlier, starting with Senator Wyden's comments, the health-care system is really designed for the convenience of health-care providers, not for the convenience of users. And this is a move, I think—this sort of customization of health care to make services more accessible, more convenient, more timely—is a movement toward a more consumer-friendly model that will engage people in a better way to manage their care, especially chronic disease care over time, with improved access to quality standards.

And I think telehealth, as to Dr. Schwamm's point, has the ability to allow for more monitoring of consistency of care and coordinated standards rather than what happens behind the door.

Senator CARDIN. I would be interested also if you believe that in the reimbursement structures there are certain areas that are particularly unfriendly towards advancing technology.

Dr. SCHWAMM. I think the restrictions on State licensure and some of the regulations around billing and attestations as to whether the physician is licensed in the location where the patient is living are a barrier. I think it would make a lot more sense to require physicians to be licensed in the State where they are rendering care rather than where the patient is located.

It is crazy that if a patient who lives in New Hampshire and sees me in the office in Boston every day for their care has a crisis and needs my help, that under the law I technically should not provide any medical advice to them if they call me from their home in New Hampshire. There is a lot of opportunity there, I think, to really rethink what it means to be licensed to practice medicine over telehealth.

Senator CARDIN. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Senator CARDIN. Mr. Rosenthal, did you want to respond?

Mr. ROSENTHAL. Well, I was just going to add to what Dr. Schwamm said. I think in the future, technology will be evolving so quickly that it will become a component of our everyday life. And I think making sure that we understand the impact of those tools on the health outcomes becomes important.

So I think the opportunities are enormous. And I appreciate the committee's vision on that.

The CHAIRMAN. Senator Bennet?

Senator BENNET. Thank you, Mr. Chairman. And thank you and the ranking member for holding this important hearing and for your leadership over many years on chronic care issues.

I also want to thank Senators Isakson and Warner for convening the chronic care working group. A lot of good work has been done there, and I think some thoughtful solutions about how to improve care for the sickest Medicare enrollees are coming to the fore now.

Over 70 percent of health-care spending in the U.S. is linked to care for those with more than one chronic condition. And we have to improve care for those with diabetes, Parkinson's, and heart disease. These are our loved ones who are making multiple doctor visits, managing complicated instructions, and may need a caregiver to help with daily tasks.

So, Mr. Lovelace, the Independence at Home Act would help improve care for patients while they are in the comfort of their own home. It would also reduce costs. I would like to thank Senators Portman, Markey, and Cornyn for their leadership on this bill, which would make the Independence at Home demonstration a national and permanent program.

The Independence at Home model makes it possible for different health-care professionals to provide access to care 24 hours a day, 7 days a week to beneficiaries with multiple chronic conditions.

According to CMS, the Independence at Home payment model saved about \$3,000 per participating beneficiary. And I am pleased to see an extension and expansion of the act included in the CHRONIC Care Act.

If we were to go further and make this a national program, would programs at UPMC and those in my home State of Colorado, do you think, be able to serve even more chronically ill patients with higher quality and better, cost-effective care?

Mr. LOVELACE. Absolutely. We are fans of Independence at Home as a model. We have a version not quite exactly the same as Independence at Home that we employ in our health plan, with roving mobile care managers, nurses, social workers, nurse practitioners, who visit people on a regular basis. It provides much more ability to have eyes-on consistency managing chronic conditions as they begin to get worse rather than waiting until the emergency room. So we are definitely supportive of expansion of that act.

Senator BENNET. Have you been able to measure cost savings in your own operation as a result?

Mr. LOVELACE. We do not really do Independence at Home as it is laid out in the bill. But in terms of our own efforts, it does produce significant reductions in unplanned care, certainly improvements in adherence to medication. People go in and measure out your pillbox. It has costs itself; it costs money. So I think on the whole, it is probably, while it saves a lot of unplanned money, it does cost money to do. It is kind of a break-even for us at this point.

Senator BENNET. Dr. Schwamm, did you have something you would like to add?

Dr. SCHWAMM. Yes. You know, I just was reflecting on your comment about Parkinson's disease. And if you go to a typical neurology clinic in this country and you have Parkinson's, you will probably be seen once every 6 months for 30 minutes. I would argue being seen for 5 minutes a day once a month over those 6 months to adjust your medications, to look for signs of worsening, would probably be time and money better spent and would save that poor family, you know, 60 to 70 hours of travel and recovery since the debilitating nature of the disease makes ambulation difficult.

So there are better ways to spend even the dollars we are spending now.

Senator BENNET. And that is actually a fascinating and very practical point. Why are we seeing somebody for—what are the disincentives to doing it the way that you describe?

Dr. SCHWAMM. Well, the first would be that you do not get paid. So the system does not get paid; the doctor does not get paid. The patient spends a lot of money taking the day off from work or having a loved one come with them, driving, parking, waiting in the waiting room for, you know, 1 or 2 hours, not being able to see someone at night or at a time that is convenient for them.

As was mentioned before, it is really doctor-centered care or hospital-centered care. Telemedicine, again—I think what we are seeing now is there is so much demand for this that we are seeing urgent care solutions and other things pop up in the cracks of our existing health-care system. But once the flood gates are open and we have reimbursement, I think you would see a tremendous amount of innovation and creativity at better meeting the needs of patients.

Senator BENNET. Thank you for that.

The CHRONIC Care Act that we are discussing today is taking important steps to increase care coordination for those who have multiple chronic conditions. We were just talking about some examples of that. For instance, it would allow Medicare Advantage plans to offer supplemental benefits designed for chronically ill beneficiaries, such as enhanced disease management.

Medicare Advantage plans make sense for many seniors, as they align with their hospital, doctor, and prescription drug benefits. That is why I worked with Senator Portman on the Medicare Plus Act, which would enroll the top 15 percent of highest-cost Medicare beneficiaries into a Medicare Advantage plan or an Accountable Care Organization rather than a fee-for-service plan.

The plan or ACO can work with their doctors and hospitals to coordinate better their services and medications.

What do you think we should keep in mind, to anybody on the panel, as we continue to work on our proposal and other proposals here to better coordinate care for the sickest and highest-cost patients? What are some unintended consequences we should try to avoid? And, you know, I think that you guys actually have today done us a lot of good by pointing out that not enough of the health-care system seems to be patient-centric. It seems to be focused more on folks who are delivering the care. And we love the people who are, but really this is about the patient, having the patient not to have to fight the system to get the care they need when they need the care, so that in the end it is cheaper.

I wonder if any of you sort of have a meta-observation about what we ought to keep in mind.

Dr. SCHWAMM. I think the most important thing we have to understand when we move toward value-based purchasing and other measures is, what is the outcome of interest? Are we looking at cost? And if we say we are looking at quality, quality from whose perspective? Is it patient-reported outcomes and the things that matter most to patients? Or is it things that are just easy to measure because we can measure them in our claims data?

So much work needs to be done to build these patient-reported outcome measures that are meaningful, that are medically meaningful, and that can have costs tied to them so we can really monitor what we are doing.

Senator BENNET. Does anybody else—I am sorry, Mr. Chairman; I realize I am out of time.

The CHAIRMAN. That is all right. If you have anybody else who wants to comment—

Mr. LOVELACE. Just a brief comment. One of the great failures of the health-care system, I think, is blaming the patient for failure of compliance. And it is much more driven by people not being able to comply with what is instructed or not having enough understanding of what is suggested or not having the wherewithal to do that.

So thinking more in the ACO, MCO version of what the partnership is, people who use services need to be engaged more actively rather than passively. So we sort of assume people will participate, and oftentimes, they would if they could, but they cannot.

The CHAIRMAN. That is fine. You did fine.

I have to say, as chairman of this committee, this has been one of the best panels we have ever had. I have not asked any questions. I used to be a medical liability defense lawyer, so I have dealt with a number of these problems. And you folks have really covered this about as well as I have ever heard it covered before. And I just want to commend you for it.

Now, Senator Wyden has a question that he would like to ask. Senator WYDEN. Thank you very much, Mr. Chairman.

And I very much share your view with respect to this panel. I think that this is the Finance Committee at its best. I mean, this is tackling a big—

The CHAIRMAN. I think it is the panel at its best myself.

Sorry, I—

Senator WYDEN. I was giving you the credit for bringing them. All right.

Let me ask about one other issue that we have talked a lot about in Oregon. You touched on it, I think, just sort of collaterally, you know, Ms. Hayes, and that is that a big part of our challenge here is that a lot of these patients with multiple chronic conditions face challenges that probably do not fit into the, quote, “medical box,” but clearly have ramifications for their health.

I think someone mentioned access to transportation. Certainly the inability to get access to good nutrition affects diabetes.

In our part of the world, people always talk about the fact that you may have a patient with heart problems and it is very hot and very humid, and they cannot get access to an air conditioner. And maybe a really cheap air conditioner would save enormous sums in terms of the person having to be hospitalized.

And in effect, these are conditions that might not be, quote, “technically medical” but disproportionately hurt patients with multiple chronic conditions.

So I think, Ms. Hayes, you were the one who touched on it. I think I would like to hear you just kind of describe, as we wrap up, what you think the role is for services that do not fit the classic box of being medical, but have enormous ramifications for a person’s health.

Obviously MA, the Medicare Advantage program, has tried to incorporate some of that. But as we wrap up what the chairman has correctly said has really been an exceptional panel, we are counting on all of you to stay with us as we try to move this across the finish line.

I think sometimes, as I have talked to people, people have said, excuse me, Ron, you are going to pass a major Medicare bill in this kind of climate? And I said that we have put a lot of work into this. We have a good cross-section of the Senate represented on this committee. So we are going to be calling on you for your help as we try to get this across the finish line.

And just to wrap up, if you would, for me, Ms. Hayes, give us your sense of what we ought to be doing for the long term as it relates to treatment for these services that do not probably fit the classic box.

You know, people always say to me, in health, the costs find coverage, that this is like an aphorism. Well, that sounds like it is

pretty good for the provider, but it probably is not so great for the patient.

What would you do for the patients in the area that we are talking about, the classic being the air conditioner for somebody who has a heart problem and could be helped out with modest costs?

Ms. HAYES. I think one of the most important components of this legislation is that you are allowing plans or allowing reimbursement models that are working under a benchmark or a capitation system to cover anything that is reasonably related to improving or maintaining health and functional status so long as it is part of a care plan developed by a care team.

And this allows providers to sit down with patients, with family members, with their caregivers, and really talk to them about what they need and base their care plan on what they need rather than what the Medicare program covers.

And you know, someone has suggested to me, actually one of my staff at one point said to me, are you telling me that you would allow Medicare to cover a dog-walking service? And I said, well, you know, if a plan working under a capitated system determines that it is better to bring in a dog walker for grandma on a day when there is 6 inches of snow on the ground to avoid a hip fracture, maybe we should consider that so long as it is within that payment model and it is to the benefit of the plan to provide these services.

Senator WYDEN. Why don't we do this? I know Senator Warner has additional comments.

Could you furnish us two or three of the models that you think have been particularly good at picking up on this area that I am talking about, the services that do not technically fit what would be called the medical condition? Could you just furnish that for us?

Ms. HAYES. Yes, I will be happy to.

Senator WYDEN. Thank you, Mr. Chairman.

The CHAIRMAN. Well, thank you.

Senator Warner, you will be the last one.

Senator WARNER. Thank you, Mr. Chairman. I appreciate that and recognize sometimes when a member comes in after a long hearing—I will try not to take my whole 5 minutes, but I want to at least—

The CHAIRMAN. That will be great. [Laughter.]

Senator WARNER. I want to start, though, by thanking you and the ranking member and also for the wisdom of appointing Johnny Isakson to serve on this effort as well.

I think, echoing what Senator Wyden said, we have a great product here. You know, it may not be the whole enchilada, but it is an area where we can find common ground. And I would commend both of you and commit anything I can do to assist getting it over the finish line.

I believe not only in the value of this product, but the value of showing that even in these challenging times, this committee on this challenging subject can move a product. Count me 100-percent in in any way I can help.

The CHAIRMAN. Thank you, Senator Warner. We appreciate that.

Senator WARNER. Let me just very briefly, Ms. Hayes, ask two very brief questions. One, two parts of the bill that I particularly

like, having been a former Governor—and candidly I could probably get comments from everybody, but I will just go to Ms. Hayes on this—but the challenge with dual-eligibles and the challenge with folks who kind of float between Medicare and Medicaid is the amount of time it takes to qualify or requalify for one program after another. You know, we do have an appeals process, a streamlined appeals process for grievances, in this legislation. To my mind, that is a great step forward. Do you want to make a comment on that?

Ms. HAYES. Sure. I think that has been one of the major challenges of the existing financial alignment initiative demonstrations, because of the differences in Medicare and Medicaid laws. And I think that will move forward.

One of the most promising things that has come out of this demonstration is the concept of a three-way contract in which a State can sit down with CMS and a plan and negotiate a contract to provide services with uniform requirements between the Medicare and Medicaid program so you do not have patients working with—it is bad enough to be 78 years old and have Medicare, but to be 78 years old and have Medicare and Medicaid when the program rules do not align—

Senator WARNER. Right. Well, that goes back to—we had those issues back when I was Governor.

There is one final point I just want to raise. I mean, Senator Isakson and I—and he has been a great partner, again—have championed a long time the Care Planning Act and this whole question about not limiting by any means anyone's choices, but expanding choices and trying to urge families to sit down with their caregivers, with their religious figures, with medical personnel, and really just kind of think through the part of life that we are all going to go through.

Increasingly, you know, we have gotten a lot of folks with lots of chronic illnesses who also have cognitive impairments. And one of the things that our bill does is introduce a GAO study to identify barriers to care planning that would take place, particularly for folks who have these chronic illnesses and chronic impairments.

I know, again: do as I say, not as I did, because I was a relatively well-informed individual, I was a Governor of Virginia, but we did not sit down and have those conversations with my mom before it was too late for her to participate.

So I think this is, again, an important step forward. I appreciate the chairman's and the ranking member's support of this provision. But a quick comment on that and then I will sign off.

Ms. HAYES. Sure. And I think the way you have structured it, the way you have structured reimbursement, would allow a care team to sit down and talk to the family member. My mother was just discharged from the hospital, and they asked if she had a care plan. They gave her one going in and going out, and she was not educated on this and she was afraid and did not understand what they wanted her to do. But telling her, mom, you know, I have a care plan, an advanced care plan, this is really something that is important. And it benefits not only the patients, but their families who have to make such a terrible decision.

Senator WARNER. And I would simply close out by saying, again, Mr. Chairman and Ranking Member, we ought to prove the cynics wrong and get this legislation passed. Thank you for your great work.

The CHAIRMAN. Well, thank you. And we appreciate your support.

We really appreciate the four of you. You have been wonderful witnesses on what we consider to be a very, very bipartisan discussion. And we intend to get this bill through. And I think you have made our lives a little better in getting it through because of the excellent testimony you have brought here today. So I just want to personally thank each and every one of you.

I have not asked any questions, because I wanted everybody else to have the opportunity to. But I have listened carefully, and all I can say is, you have done a great job and you have represented an awful lot of wonderful people in ways that they have not been represented before. So we are grateful to have you here.

And with that, we are going to recess until further notice.

[Whereupon, at 11:48 a.m., the hearing was concluded.]

## APPENDIX

### ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

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

WASHINGTON—Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a hearing to examine the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 and ways to improve health outcomes for patients living with chronic illnesses:

I'd like to welcome everyone to this morning's hearing on bipartisan Medicare policies to improve care for patients with chronic conditions.

It was almost exactly 2 years ago today that we formed a bipartisan working group co-chaired by Senators Isakson and Warner to work on legislation to address these issues.

That working group spent many months listening to stakeholders in the health-care community—both in person and through more than 850 formally submitted comments.

In December of 2015, the working group released a comprehensive policy options document.

In October of last year, we issued a legislative discussion draft. Soon after that, CMS finalized four of our policy proposals in its 2017 Medicare Physician Fee Schedule Rule. And, two provisions from our discussion draft were included in the 21st Century Cures Act, which President Obama signed into law this past December.

In other words, several of the working group's policies have already been enacted, and we're working to get the rest signed into law and fully implemented.

Toward that end, we introduced the latest version of the CHRONIC Care Act—the bill that encompasses the working group's proposals—in April. The legislation currently has 17 bipartisan cosponsors and has been endorsed by numerous organizations in the health care community.

Today's hearing is the latest step in our efforts. The next step will come later this week, as we've noticed a markup for Thursday morning.

I want to thank Ranking Member Wyden for his work on this matter. His passion for improving care for those with chronic conditions has been a driving force behind this effort.

And, of course, I want to thank Senators Isakson and Warner, who have worked tirelessly to lead our working group. Through their efforts, the committee has not only learned about the burden imposed on Medicare patients living with chronic conditions, but also identified new policies to improve care coordination, increase value, and lower costs in the Medicare program without adding to the deficit.

Today's hearing will provide us with an opportunity to examine these policies more extensively so we can better understand how they will help patients and enable providers to improve care and produce better outcomes.

The bill includes a number of policies that would improve care for the chronically ill through increased use of telehealth, by giving Medicare Advantage plans and cer-

tain Accountable Care Organizations enhanced flexibility to target telehealth services to Medicare patients with chronic conditions.

Senators Schatz and Wicker have been instrumental in this particular effort and I am pleased to have them here with us to talk about how the CHRONIC Care Act advances their policy goals.

I would be remiss if I did not also recognize the Finance Committee members who have joined Senator Schatz and Senator Wicker's efforts to promote the increased use of telehealth services. In that regard, we appreciate the leadership of Senators Thune, Cardin, and Warner on these matters.

While many stakeholders offered key advice on telehealth policy, I want to thank the fine institutions in Utah for their help, specifically on the "telestroke" policy. Specifically, I want to recognize Dr. Jenny Majersik and Dr. Nicholas Johnson at the University of Utah as well as Dr. Kevin Call with Intermountain Healthcare. I appreciate their willingness to share their experience and expertise using technology to promptly diagnose individuals presenting stroke symptoms, and I look forward to hearing more on this particular aspect of telehealth here today.

Of course, our bill goes beyond telehealth, making improvements for beneficiaries who receive care across the Medicare spectrum, including fee-for-service, Accountable Care Organizations, and Medicare Advantage.

We have a panel of recognized experts here before us today to discuss all of these issues and I want to welcome each of our distinguished witnesses.

Obviously, I'm well aware that there are some contentious debates going on in the health-care space these days and there is no shortage of political and partisan points that people would like to make in a venue like this. However, for today's hearing, I sincerely hope that we can maintain the bipartisan spirit that has driven our efforts on the CHRONIC Care Act. Toward that end, I respectfully ask that members of the committee focus their questions on the policy areas specifically addressed in the bill.

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PREPARED STATEMENT OF KATHERINE HAYES, DIRECTOR OF  
HEALTH POLICY, BIPARTISAN POLICY CENTER

Chairman Hatch, Ranking Member Wyden, Senators Isakson and Warner, and members of the committee, thank you for the opportunity to discuss important policy changes that can help health-care providers and health plans improve health outcomes for chronically ill patients. The committee's work in drafting the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 demonstrates that bipartisanship in health care is not a thing of the past. These policies address the unique needs of chronically ill patients and promotes patient and family-centered care. The Chronic Care Working Group's bipartisan, transparent, and deliberative process of seeking feedback and an ongoing dialogue with the stakeholder and patient community should serve as the model for smart policy development in Congress. The Bipartisan Policy Center greatly appreciated the opportunity to share our input with the Working Group as part of that thorough process.

Since 2007, BPC's Health Project has worked with stakeholders including patients, health-care providers, plans, States, and Federal policymakers to develop solutions that to promote better quality of care, while limiting the growth of health-care costs in Federal health programs. Under the leadership of the Health Project's Co-Chairs, former Senate Majority Leaders Bill Frist and Tom Daschle, BPC has released a series of reports and policy recommendations to address acute care and long-term care needs of frail and chronically ill individuals. On our efforts in long-term care delivery and financing, former White House and Congressional Budget Office Director Alice Rivlin and former Health and Human Services Secretary and Governor Tommy Thompson co-chaired the efforts.

In February 2016, BPC issued incremental recommendations on policies to improve long-term care financing. Last fall, we released a report focused on better integration of Medicare and Medicaid services and supports for individuals who are

dually eligible for Medicare and Medicaid coverage.<sup>1,2</sup> Last month, BPC issued a report that provides recommendations to remove barriers that health plans and providers face as they seek to treat chronically ill Medicare beneficiaries.<sup>3</sup>

#### CARE NEEDS OF CHRONICALLY ILL INDIVIDUALS

Research conducted by BPC and others makes clear that the presence of chronic conditions, particularly when paired with functional or cognitive impairment, is a key driver of utilization of medical services for Medicare beneficiaries. Medicare data from 2015 demonstrate that the number of chronic conditions that a patient has is directly correlative to higher Medicare spending and rates of hospitalization—as the number of chronic conditions rise, so do average Medicare costs per beneficiary.<sup>4</sup>

For instance, compared to beneficiaries with fewer than four chronic conditions, the Medicare beneficiaries who have four or more chronic conditions:

- Incur average annual Medicare costs that are more than five times as high;
- Have hospital readmission rates that are twice as high; and
- Have four times as many emergency department visits.

The presence of functional and cognitive limitations among chronically ill beneficiaries is also highly predictive of Medicare costs. Functional impairments are defined by difficulty in performing activities of daily living, such as bathing or transferring to and from bed without assistance.<sup>5</sup> Cognitive impairments can include diminished intellectual capacity associated with dementia or Alzheimer’s disease, which can present safety concerns for patients.<sup>6</sup> Medicare patients with functional or cognitive impairment have expenses that are more than three times as high as those without functional or cognitive impairment.<sup>7</sup>

BPC’s research indicates that there are roughly 3.6 million community-residing “Medicare-only” beneficiaries (*i.e.*, beneficiaries are not eligible for full Medicaid benefits) who have three or more chronic conditions and functional or cognitive impairment. In addition, there are roughly 7.5 million Medicare beneficiaries who are dually eligible for full Medicaid benefits. The two populations have complex needs for services and social supports to address their multiple chronic conditions, frailty, and cognitive deficits. For dual-eligible beneficiaries, Medicaid covers many of the long-term services and supports (LTSS) that the beneficiary needs, but the LTSS is often not well integrated with medical care covered under Medicare. For frail and chronically ill Medicare-only individuals, the supports and services are not covered under Medicare, although they could be made available if there were more flexibility and financial incentives for Medicare Advantage (MA) plans and health-care providers.

#### POLICIES TO IMPROVE INTEGRATION OF MEDICARE AND MEDICAID BENEFITS FOR DUAL-ELIGIBLE INDIVIDUALS

In its September 2016 report, BPC made several recommendations to reform Dual-Eligible Special Needs Plans (D-SNPs) within the MA program, and to consolidate regulatory authority within the Centers for Medicare and Medicaid Services (CMS) for policies applicable to dual-eligible beneficiaries.<sup>2</sup> Most of these recommendations are very similar or consistent with the CHRONIC Care Act.

<sup>1</sup>Bipartisan Policy Center, “Initial Recommendations to Improve the Financing of Long-Term Care,” February 2016. Available at: <https://bipartisanpolicy.org/library/long-term-care-financing-recommendations/>.

<sup>2</sup>Bipartisan Policy Center, “Delivery System Reform: Improving Care for Individuals Dually Eligible for Medicare and Medicaid,” September 2016. Available at: <https://bipartisanpolicy.org/library/dually-eligible-medicare-medicaid/>.

<sup>3</sup>Bipartisan Policy Center, “Improving Care for High-Need, High-Cost Medicare Patients,” April 2017. Available at: <https://bipartisanpolicy.org/library/improving-care-for-high-need-high-cost-medicare-patients/>.

<sup>4</sup>Centers for Medicare and Medicaid Services, “Multiple Chronic Conditions,” CMS Database of 2015 Data on Chronic Condition Prevalence and Medicare Service Utilization Statistics, Accessed May 3, 2015. Available at: [https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC\\_Main.html](https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/MCC_Main.html).

<sup>5</sup>Sally Rodriguez, Diane Munnevar, Caitlin Dulaney, et al., “Effective Management of High-Risk Medicare Populations,” Avalere LLC and SCAN Foundation Report, September 2014. Available at: <http://avalere.com/news/avalere-issues-white-paper-on-the-management-of-high-risk-medicare-populati>.

<sup>6</sup>Ibid.

<sup>7</sup>Ibid.

Specifically, among other recommended policies in the report, we recommended:

- Permanently reauthorizing D–SNPs, but requiring that D–SNPs integrate clinical health services, behavioral health, and LTSS by January 1, 2020;
- Authorizing CMS to align the Medicare and Medicaid grievance and appeals processes for D–SNPs in a manner that benefits the dual-eligible individual; and
- Consolidating regulatory authority for reimbursement structures serving dual-eligible beneficiaries into a single office or center within CMS, such as the Medicare-Medicaid Coordination Office.

These changes will break down the financial siloes between Medicare and Medicaid-covered services to allow for an integrated approach to meeting a D–SNP enrollee’s medical needs and LTSS needs, while also making the navigation of benefits more manageable for D–SNP enrollees. The CHRONIC Care Act’s policy provision to make the Medicare-Medicaid Coordination Office the central contact point for aligning Medicare’s Federal grievance and appeals processes with the corresponding processes of State Medicaid programs would minimize conflicting overlap between the two programs.

These three policy changes—when combined with other BPC recommendations for improving three-way contracting models for the delivery of Medicare and Medicaid benefits—can enhance the ability of health plans and providers to meet the medical and non-medical needs for dual-eligible beneficiaries. By financially and clinically integrating Medicare-covered services with Medicaid social support and LTSS benefits, we can improve health outcomes of dual-eligible beneficiaries through a reduction in avoidable hospitalizations, emergency department visits, and hospital readmissions, particularly for patients with complex chronic conditions, as shown in a recent report examining the Senior Health Options program in Minnesota.<sup>8</sup>

POLICIES TO BREAK DOWN BARRIERS TO INTEGRATING SOCIAL SUPPORTS IN CARE  
MODELS SERVING MEDICARE-ONLY BENEFICIARIES WITH CHRONIC ILLNESSES

As a part of an April 2017 report, BPC recommended policies designed to improve the ability of MA plans, Accountable Care Organizations (ACOs), and other alternative payment model (APM) participants to furnish and finance valuable non-Medicare-covered supports and services for frail and chronically ill Medicare-only patients.<sup>3</sup>

Among other recommendations, BPC recommended the following policy changes that are very similar to changes proposed under the CHRONIC Care Act:

- Modifying the MA “uniform benefit requirement” to allow MA plans to target non-Medicare-covered social supports, as MA supplemental benefits, to certain high-need, high-cost Medicare-only enrollees with chronic conditions;
- Allowing MA plans that target non-Medicare-covered supports to chronically ill enrollees to have an exemption from the MA program rules that limit the coverage of supplemental benefits to only those services and items that are “primarily health-related”; and
- Establishing a prospective voluntary enrollment process in the Medicare Shared Savings Program (MSSP) for ACOs, through which beneficiaries can actively choose to have their care and spending attributed to a specific ACO.

These policy changes and others included in BPC’s April 2017 policy recommendations can help to modernize the Medicare program in response to evidence showing that non-Medicare-covered supports can play a critical role in improving health outcomes.<sup>3</sup> A growing body of research demonstrates that the provision of non-medical social supports and services, which are not covered under the traditional Medicare benefit, can reduce hospitalizations, emergency department visits, and other expensive acute care episodes when the supports are targeted to frail and chronically ill patients. Examples include non-emergency transportation to medical appointments for frail individuals or home delivery of nutritious, low-sodium and low-sugar meals for patients with congestive heart failure, diabetes, and other chronic conditions. In pilot programs tested in the community, the provision of these targeted non-medical supports resulted in as high as a 27 percent reduction in medical costs and signifi-

<sup>8</sup>Department of Health and Human Services Assistant Secretary for Planning and Evaluation. Minnesota Managed Care Longitudinal Data Analysis. March 2016. Available online at: <https://aspe.hhs.gov/report/minnesota-managed-care-longitudinal-data-analysis>.

cant reductions in avoidable hospitalizations.<sup>9</sup> Other interventions, such as minor home modifications to reduce the risk of falls,<sup>10</sup> or targeted case management to help coordinate a patient’s medical and social support needs, have also been shown to improve health outcomes.<sup>11</sup>

Despite the clear value of many non-Medicare-covered social supports in reducing the risk of avoidable Medicare expenses, the Medicare program has established regulatory and payment policy barriers that limit the ability of MA plans, ACOs, and other APM participants to integrate non-Medicare-covered supports into their care models for high-need, high-cost Medicare-only patients. If a health plan or provider organization is accountable for the quality of care provided to a beneficiary population and is accepting financial risk by working within a spending benchmark, the Medicare program should provide flexibility to allow the MA plans and providers that meet quality thresholds to furnish non-Medicare-covered supports in a targeted way to frail and chronically ill Medicare-only beneficiaries, as a part of a person- and family-centered care plan for frail chronically ill Medicare-only patients. Our recent work and policy recommendations from the April 2017 report make clear that with these flexibilities, the MA plans, ACOs, and other providers could make these non-Medicare-covered supports available to targeted beneficiaries in a manner that does not add new costs to the Medicare program.

#### *Medicare Advantage Policies*

In the MA program, there are two principal regulatory barriers that prevent MA plans from financing high-value non-Medicare-covered social supports for targeted groups of chronically ill enrollees. First, the Social Security Act requires that if an MA plan offers a supplemental benefit that is financed through MA rebate dollars, the MA plan must offer that supplemental benefit to all enrollees—and may not, in most cases, target the supplemental benefit to subsets of enrollees who meet eligibility criteria. Second, MA program regulations and guidance require that supplemental benefits must be “primarily health-related”—a distinction that often leads to uncertainty for plans seeking to offer non-Medicare-covered social supports as supplemental benefits. These regulations and guidance policies also place specific restrictions on the ability of MA plans to offer certain types of supplemental benefits, such as a durational limitation on the offer of in-home meal delivery and a limitation on the availability of minor home modification benefits to only include shower and bathroom-related modifications. In combination, these two policy barriers can often prevent MA plans from tailoring supplemental benefit offerings to meet the needs of the specific chronically ill enrollee.

BPC conducted an analysis of the projected costs of offering an illustrative set of non-Medicare-covered social supports to Medicare-only MA enrollees who resided in the community and had three or more chronic conditions and functional or cognitive impairment. BPC’s recommendations aim to provide the flexibility for patients to receive non-Medicare-covered supports and services as part of a care plan developed by providers and care teams in consultation with patients and their families. For this population, BPC recommended allowing coverage of “any item or service reasonably related to improving or maintaining health or functional status, if the services are part of that care plan. To facilitate estimating costs of providing these types of services and supports, we projected the costs of in-home meal delivery, non-emergency medical transportation, minor home modifications, and targeted case management services.

The analysis suggests that if the uniform benefit requirement were waived, in conjunction with flexibility on the “primarily health-related” benefit requirement, MA plans could offer the four illustrative non-Medicare-covered supports—to chron-

<sup>9</sup>Jill Gurvey, Kerry Rand, et al., “Examining Health Care Costs Among MANNA Clients and a Comparison Group,” *Journal of Primary Care and Community Health*, June 2013. Available at: <http://www.mannapa.org/wp-content/uploads/2014/07/MANNA-Study.pdf>; See also Joseph J. Cronin, “Florida Transportation Disadvantaged Programs: Return On Investment Study,” Florida State University College of Business, March 2008. Available at: [http://tmi.cob.fsu.edu/roi\\_final\\_report\\_0308.pdf](http://tmi.cob.fsu.edu/roi_final_report_0308.pdf).

<sup>10</sup>Bipartisan Policy Center, “Healthy Aging Begins at Home,” May 2016. Available at: <https://bipartisanpolicy.org/library/recommendations-for-healthy-aging/>.

<sup>11</sup>Lauren A. Taylor, Caitlin E. Coyne, et al., “Leveraging Social Determinants of Health: What Works?”, Blue Cross Blue Shield Foundation of Massachusetts, June 2015. Available at: [http://bluecrossfoundation.org/sites/default/files/download/publication/Social\\_Equity\\_Report\\_Final.pdf](http://bluecrossfoundation.org/sites/default/files/download/publication/Social_Equity_Report_Final.pdf); See also Roy Ahn, “Health Care Innovation Awards Complex/High-Risk Patient Targeting: Third Annual Report,” 143, NORC at the University of Chicago Report Commissioned by the CMS Center for Medicare and Medicaid Innovation, February 2017. Available at: <https://downloads.cms.gov/files/cmml/hcia-chspt-thirdannualrpt.pdf>.

ically ill enrollees who meet the criteria—as supplemental benefits within current budgets that do not require additional Medicare spending. BPC’s analysis indicates that if the four non-covered supports were targeted to chronically ill enrollees and the costs of providing those services were spread across the entire enrollee population, MA plans could provide those four supports for merely \$5 per member per month. If the provision of these non-Medicare-covered social supports reduced hospitalizations, emergency department visits, and other Medicare spending for the targeted group of enrollees, there is also a potential for savings.

#### *Accountable Care Organization Policies*

Many ACOs report that the lack of a voluntary enrollment pathway for beneficiaries contributes to significant year-to-year fluctuations in the makeup on an ACO’s attributed beneficiary population (for whom the ACO is assuming financial risk), while simultaneously impeding improved patient engagement in the care process by beneficiaries who ultimately are attributed to the ACO. While the Next Generation ACO demonstration includes a voluntary enrollment option, voluntary enrollment is not currently available for most ACOs operating in the MSSP. This problem not only inhibits the ability of ACOs to better coordinate the delivery of Medicare-covered services that a beneficiary receives, but also provides a strong disincentive for ACOs to invest in non-Medicare-covered supports for attributed beneficiaries with chronic conditions and frailty. While providing these non-covered supports and services can improve health outcomes over the long-term, beneficiaries may not be attributed to the ACO year after year. When a beneficiary is aware that he or she is being cared for under an ACO arrangement and actively selects that ACO, there is greater potential for coordination between the patient and the care team. For these reasons, BPC recommended that CMS establish a voluntary enrollment option for all ACOs, in a manner similar to the proposal included in the CHRONIC Care Act.

#### *Other Policy Options for Both MA Plans and ACOs*

In addition to the policies included in the CHRONIC Care Act, BPC also recommended policies that could improve financial incentives for both MA plans and ACOs to provide non-Medicare-covered supports to their enrolled or attributed beneficiaries. These recommendations could be addressed by CMS, without additional statutory changes from Congress, and could augment the great work of the committee on the CHRONIC Care Act. The recommendations are also similar to options that the committee included in its Chronic Care Working Group Options Paper. Among other options, BPC recommended that CMS test the potential for incorporating a frailty adjustment factor into the Medicare risk adjustment model that is used for the MA and ACO programs. Such a frailty factor could address significant under-prediction of the actual medical expenses of the highest cost beneficiaries, while also better accounting for the costs of beneficiaries with functional impairment. With more accurate risk adjustments for frail patients, MA plans and ACOs would have greater incentive to integrate non-Medicare-covered supports into care models for chronically ill beneficiaries. BPC also recommended that CMS examine options for adding a new quality measure to the MA and ACO quality measurement programs that would assess the extent to which the MA plan or ACO actively integrates non-Medicare-covered supports into the care model for chronically ill beneficiaries. Given that MA quality bonuses and higher ACO sharing rates are tied to quality measure performance, MA plans and ACOs could have a strong incentive to incorporate non-Medicare-covered supports into their care models, in response to the new quality measure. If done well, this could also remove incentives for plans to avoid the sickest beneficiaries.

#### CONCLUSION

BPC applauds the hard work that the committee and its Chronic Care Working Group have taken to develop thoughtful bipartisan legislation to better address the needs of Medicare beneficiaries with complex chronic conditions. Through the policy changes included in the CHRONIC Care Act, many frail and chronically ill Medicare patients could benefit from improved care coordination, access to care in the home and community setting, and availability of non-Medicare-covered social supports. We appreciate the opportunity to continue to work with the committee in confronting the health care delivery system challenges facing this vulnerable population.

PREPARED STATEMENT OF JOHN G. LOVELACE, PRESIDENT, GOVERNMENT PROGRAMS AND INDIVIDUAL ADVANTAGE; AND PRESIDENT, UPMC FOR YOU, UPMC INSURANCE SERVICES DIVISION, UPMC HEALTH PLAN, UNIVERSITY OF PITTSBURGH MEDICAL CENTER

Chairman Hatch, Ranking Member Wyden, Senator Casey, Senator Toomey, and members of the committee, on behalf of UPMC Health Plan and the over 3 million people we serve, primarily Pennsylvanians, thank you for the opportunity to testify today on S. 870, the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. We are proud to support this legislation and grateful for the opportunity to discuss the critical issues of care coordination and improved health-care services for Medicare beneficiaries with chronic care needs.

By way of background, UPMC Health Plan and the integrated companies of the UPMC Insurance Services Division (collectively, “UPMC”) are pleased to submit the following comments on Medicare policies that improve care for patients with chronic conditions, including those advanced by the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 (S. 870).

UPMC Health Plan and the UPMC Insurance Services Division are part of the University of Pittsburgh Medical Center health system (the “UPMC System”), an Integrated Delivery and Financing System (IDFS) that combines comprehensive provider-led clinical practice with a value-driven payer model to align payer-provider financial incentives and promote higher quality outcomes for patients. The UPMC System includes more than 25 hospitals, 600 affiliated physician and outpatient office sites, 3,600 employed physicians, and international clinical partnerships in 12 countries. UPMC System hospitals were recently named to the *U.S. News and World Report* Honor Roll of America’s Best Hospitals, and are ranked nationally in 15 specialties. The UPMC System is also closely affiliated with the University of Pittsburgh, which has been among the top 10 recipients of National Institutes of Health research funding since 1998; in collaboration with the University’s Schools of Health Sciences, the UPMC System provides ongoing education and training to nearly 1,800 medical residents and clinical fellows, as well as an average of 500 nurses per academic semester.

UPMC is pleased to offer a full range of commercial individual and group health insurance, Medicare Advantage (MA), Medicare Special Needs Plans (SNP), CHIP, Medicaid, behavioral health, dental, vision, employee assistance and workers’ compensation coverage products. Our MA plan, UPMC for Life, serves approximately 160,000 members combined through the MA Part C/D and SNP programs. Through our Medicaid managed care organization, UPMC for You, we provide coverage to more than 400,000 enrollees across 40 Pennsylvania counties, and our behavioral health managed care organization, Community Care Behavioral Health, manages mental health and substance abuse services for almost 1 million Medical Assistance enrollees in Pennsylvania. In January 2018, UPMC will expand its portfolio to include Pennsylvania’s Community HealthChoices, a Managed Long-Term Services and Supports (MLTSS) program that is expected to serve more than 360,000 individuals who are disabled, placed in nursing homes, or dually eligible for Medicare and Medicaid. We will be rolling this program out across Pennsylvania through 2018 and will complete that roll out in 2019. Since beginning operations in 1996, UPMC’s Insurance Services division has been recognized multiple times for its dedication to quality and the provision of outstanding customer services across its product lines, which collectively provide commercial or government programs coverage to more than 3 million members.

We thank Chairman Hatch, Ranking Member Wyden, and all the members of the Senate Committee on Finance (the committee) for the opportunity to comment on ways in which the Medicare program can improve care for patients with chronic illness. We applaud the Chronic Care Working Group’s ongoing efforts to improve the quality and integrity of the Medicare program for those beneficiaries living with chronic conditions, and support the recent re-introduction of the CHRONIC Care Act in furtherance of those efforts. We previously submitted comments in response to the Working Group’s 2015 chronic care “Policy Options” document (*see* January 29, 2016 letter), and we sincerely thank the Working Group for both their consideration of our input and their continued dedication to solving the challenges of serving chronically ill Medicare beneficiaries. We share the committee’s belief that better care coordination, appropriately tailored and aligned incentives, and new and innovative policies designed to improve overall care delivery, manage costs, and foster improved outcomes will positively impact both Medicare beneficiaries and our Na-

tion's efforts to responsibly control the ever-escalating cost of medical care. It is with this support and shared belief in mind that we respectfully offer for the committee's consideration the following comments.

#### I. PERMANENT AUTHORIZATION FOR MEDICARE SPECIAL NEEDS PLANS

Since their creation in 2003, Special Needs Plans (SNPs) have grown significantly and now provide targeted coverage and support to more than 2 million of the most vulnerable Medicare beneficiaries. While SNPs were originally established on a temporary basis, Congress has repeatedly recognized the value of SNPs as part of the Medicare program, and has consistently found cause to extend authorization for SNPs over the past 14 years; today, there are more than 500 SNPs operating nationwide. The story of SNPs is one of success for both the Medicare program and the beneficiaries it serves, and the fundamentally individualized nature of SNP coverage means that every beneficiary enrolling in the program is likely to receive better tailored and more coordinated services than he or she would otherwise have in fee-for-service Medicare or the broader Medicare Advantage program. UPMC has long been committed to serving beneficiaries in Special Needs Plans (SNPs) by offering high quality, cost-effective SNP products that place a strong emphasis on care management and service coordination. UPMC currently provides coverage to more than 22,000 dually eligible Medicare members through UPMC for Life Dual, among the largest stand-alone 4-Star dual eligible SNPs (D-SNP) in the Nation and the 17th largest D-SNP overall. We remain committed to continue serving the vulnerable SNP population, and we thank the sponsors of the CHRONIC Care Act for once again recognizing the critical importance and value of the SNP program.

Section 201 of the CHRONIC Care Act would permanently authorize I-SNPs, D-SNPs, and C-SNPs, and would impose certain additional conditions on SNP contracts to promote service integration and improve coordination. We enthusiastically support the permanent authorization of SNPs. Plans and States, and by extension beneficiaries, rely upon the continued availability of SNPs when planning for their future. States are particularly sensitive to uncertainty in funding or authorization for SNPs; the program integration that is necessary to truly realize the value and effectiveness of SNPs requires significant administrative effort and long-term investment in Medicare-Medicaid coordinating activities. Faced with uncertainty regarding continued authorization, some States undoubtedly place otherwise promising integration initiatives on the shelf for fear that they invest limited resources into constructs or models that could be invalidated in a few short years. The elimination of the historic uncertainty surrounding continued SNP authorization will improve stakeholder confidence, materially reduce the need for contingency planning, and is likely to encourage additional State activity and innovation related to Medicare-Medicaid integration; each of these results will further the ability of SNPs to reliably serve Medicare's most vulnerable beneficiaries now and in the future.

Equally important is that the CHRONIC Care Act takes a thoughtful and forward-looking approach to this significant policy change: the Act both establishes future requirements to promote integration and provides flexibility to recognize that not all States may take the same approach, or move at the same pace, toward full integration of regulatory, financial, and delivery system structures between Medicare and Medicaid. We believe that both aspects of the Act's SNP authorization are important to ensure the continued quality and evolution of SNPs, while still providing States and Plans with the tools necessary to continue innovating for the benefit of SNP-eligible beneficiaries. We urge all members of Congress to support this policy as part of the CHRONIC Care Act.

#### II. OPPORTUNITIES TO FURTHER ENHANCE THE DELIVERY OF HOME- AND COMMUNITY-BASED SERVICES THROUGH SNPs

The provision and coordination of effective, high-quality medical care for seniors with multiple chronic conditions is increasingly complex and costly. While many beneficiaries with chronic conditions may be able to avoid or delay nursing home placement with appropriate home- and community-based services and supports (HCBS), coverage of these services has historically been limited. Over time, stakeholders have increasingly identified the positive outcomes associated with appropriate care delivered at home rather than in an institutional setting, and we appreciate the committee's shared recognition of this premise. Promising programs like the Independence at Home (IAH) demonstration evince an important public commitment to pursue the potential savings and quality improvements that can be realized through the delivery of tailored, team-based primary care to beneficiaries in their homes.

## III. EXPANDING SUPPLEMENTAL BENEFITS

The clinical practice of medicine is constantly evolving. This is true not only because of advances in clinical practice and technology, but also because medical science is increasingly recognizing that a “one size fits all” approach to medicine is not the most efficient method for delivering effective care. Similarly, our understanding of overall health, and how socioeconomic factors contribute to an individual’s health in both positive and negative ways, continues to evolve and change. While clinical practice increasingly incorporates tailored or individualized care, the current capacity of our health-care system to address social determinants of health is somewhat limited; this is often true even where an individual’s providers, advocates, and payers agree about the adverse health effects of a patient’s barriers to things like food, clothing, transportation, and social support. A prerequisite to effectively overcoming these barriers for Medicare beneficiaries is the implementation of a financing structure that not only makes appropriate services available (some of these services are available through community and social service agencies today), but that actually makes them *accessible* for beneficiaries, whether through additional administrative coordination or through “linking” services like transportation and communication. Historically, Medicare’s flexibility to address these issues has been constrained primarily by the program’s “uniformity” requirement, which limits the ability of MA and SNP plans to offer beneficiaries tailored support services except where those services are made available to all members. Important initiatives like the CMS Value-Based Insurance Design (VBID) Model are beginning to incorporate more benefit flexibility regarding uniformity requirements, but we believe that there is still a significant opportunity to advance the concept of targeted, non-traditional services and supports for the benefit of a broader MA population.

We applaud the committee’s Chronic Care Working Group for formally recognizing one such opportunity in its 2015 “Options Paper,” and we support the adoption of supplemental benefit flexibility as provided by section 302 of the CHRONIC Care Act. This provision of the Act offers tremendous potential to positively impact not only the lives and overall health of chronically ill MA beneficiaries, but also long-term expenditures in the MA program, particularly with respect to avoidable acute care. The act’s approach to expanding allowable supplemental benefits for chronically ill MA beneficiaries provides critical authority for CMS to establish the details of implementation within well-considered statutory guidelines; it will promote a collaborative approach between CMS, MA plans, and other stakeholders. The Act’s implementation date of 2020 provides for an appropriate implementation schedule, and it will likely allow implementation to be informed by early results from the current VBID Model demonstration. We look forward to working with CMS on this important initiative following the CHRONIC Care Act’s enactment.

The CHRONIC Care Act’s expansion of supplemental benefits is a significant step forward for the MA program, and we hope that CMS will continue to work with MA plans and stakeholders to provide maximal flexibility related to the provision of unique supplemental benefits as part of a beneficiary’s individualized health-care plan. While a risk-bearing ACO or MA plan today has financial incentives to efficiently and effectively manage a beneficiary’s care, current Medicare rules create marked gaps in the ability of these entities to address social determinants of health that may be significantly contributing to a beneficiary’s health and care utilization. For example, a beneficiary suffering from COPD might repeatedly present to the emergency department for breathing difficulty during the summer. After exhausting medication and other clinical interventions, the beneficiary’s primary care team or care manager might reasonably conclude that the most effective intervention is in fact a window air conditioning unit. While we recognize that this type of purchase is well outside the boundaries of traditional Medicare program reimbursement, the use of a risk bearing entity’s rebate dollars in this scenario would be money well spent in support of beneficiary health and a reduction in emergency department utilization. We believe that this level of flexibility is appropriately balanced with CMS authority to adopt this approach exclusively in the future for risk-bearing entities without altering the existing MA bid structure, ACO cost methodology, fee-for-service reimbursement rules, or approved supplemental benefits. This approach would allow the agency to collaborate with stakeholders and ensure that such flexibility is carefully implemented, subject to appropriate measurements of success, and designed in a manner that will only reduce, not increase, Medicare program costs.

## IV. TELEHEALTH SERVICES

There is growing recognition among stakeholders that telehealth services have the potential to not only add convenience and increase patient access to care, but also

to improve the overall quality of care, reduce delivery system inefficiencies, increase patient adherence and engagement, and ultimately reduce long-term costs in the Medicare program. Unfortunately, current law (SSA section 1834(m)) narrowly limits the types of services for which the Medicare program will provide reimbursement. Even in the MA program, plans are disincentivized from offering telehealth services because they must either be paid for through rebate dollars or incorporated into an additional enrollee premium charge. Critical to any consideration of telehealth reimbursement in Medicare is the growing recognition of telehealth as a service setting or modality rather than a distinct service; patients access telehealth services in place of, rather than as a supplement to, similar face-to-face care. A 2014 analysis of UPMC's e-visit program, Anywhere Care, found no evidence that e-visits or other telehealth initiatives were additive to UPMC Health Plan members' care costs; in fact, data indicated that members who utilized an e-visit had a lower overall cost of care for the conditions treated than members who sought the same care in an emergency room, urgent care center, primary care office, or retail clinic. While we understand the caution with which policymakers have to date viewed changes in law that are necessary for broader Medicare coverage of telehealth, we applaud the Working Group and the sponsors of the CHRONIC Care Act for recognizing the positive impact that telehealth is likely to have for Medicare beneficiaries.

With more than 20 distinct telehealth services available through UPMC providers, UPMC has and continues to be an ardent supporter of developing and utilizing innovative telehealth and remote monitoring technologies. Our current services include tele-primary care, tele-stroke, tele-dermatology, tele-psychiatry, tele-cardiology, remote specialty consultation, and both pre- and post-surgical care, among others. The availability of these services allows UPMC to rapidly deliver world class specialty care and comprehensive consultations to rural patients who may be several hours from the nearest specialty practice or clinic, nursing home residents who do not have 24/7 access to many types of care, and chronically ill patients living in home- and community-based settings for whom physical travel is often costly, complicated, and burdensome.

As an example, consider a medically complex rural nursing home resident with CHF and diabetes who is in need of a sophisticated gastrointestinal surgical procedure. Without access to telehealth services, this patient would likely spend a full day traveling to a major metro area for a pre-surgical consultation. Her trip will likely be coordinated with those of other residents, all of whom will spend hours on highways or in waiting rooms while trying not to significantly deviate from the necessary routine of their medication regime or blood sugar testing. A month later, she would repeat the process for her scheduled surgery. In the following weeks, she would spend at least another 2 full days traveling back and forth for follow-up care. This scenario is disruptive to the patient, increases the risk of complications due to the stress of extended post-surgical travel, and includes significant secondary costs for travel and associated patient support. By contrast, effective use of pre- and post-surgical telehealth services could have limited the patient to a single trip for surgery. In this way, telehealth can not only reduce the total cost of care, but also makes care like surgical procedures less disruptive, and in many ways less stressful, for patients. In addition to post-surgical follow-up care, UPMC's remote monitoring program tracks chronically ill patients who have been identified as "high risk" for inpatient readmissions. By example, the system tracks blood oxygen levels and blood pressure of patients with congestive heart failure (CHF) to facilitate rapid outreach and intervention in the event of any concerning clinical data. In 2014, the program reduced 30-day readmission rates for participating CHF patients by 7 percent when compared to non-participating CHF patients.

While UPMC and others have successfully implemented a host of telehealth services to support patients' physical health, the increased patient access associated with telehealth may be even more significant for mental and behavioral health issues, which disproportionately impact Medicaid-eligible members (and by extension, dual-eligibles) who face additional structural and socioeconomic barriers to accessing care. UPMC's behavioral health managed care organization, Community Care Behavioral Health, recently implemented a pilot program to provide telepsychiatry services for Medicaid members in rural Pennsylvania. This program resulted in a 25% improvement for 30-day patient engagement, and a significant reduction in inpatient readmission rates for those patients who were able to access a telepsychiatry resource. Given the positive implications for quality and cost savings that we have seen through this and other telehealth initiatives, we believe that broader, more flexible reimbursement policies for telehealth have real promise to improve

overall care costs, quality of care, and patient satisfaction across a range of both physical and behavioral health services.

We appreciate the Working Group’s insightful recognition of telehealth’s potential in their 2015 Policy Options document, and are encouraged by the inclusion of expanded telehealth services for Medicare Advantage as provided for by the CHRONIC Care Act. We support adoption of the act’s telehealth provisions, and we look forward to continuing to work with the committee and with CMS to identify additional opportunities to employ cost-effective telehealth interventions in the future.

#### V. VALUE-BASED INSURANCE DESIGN

As you are aware, UPMC Health Plan is currently participating in the CMS Innovation Center’s VBID Model. The nuances of VBID implementation may vary among participating plans, but the Model is fundamentally designed to leverage cost-sharing and other plan design elements in order to encourage enrollees’ use of high-value clinical services. UPMC Health Plan has extensive experience implementing value-based and consumer-driven plan designs in commercial employer group coverage. Our experience with this approach in the commercial insurance market over a number of years has been positive, and our data from that experience demonstrates that a thoughtful combination of incentives and enrollee engagement efforts can be combined to produce meaningful cost savings. We are excited to partner with CMS in evaluating the expected positive impact of VBID for Medicare beneficiaries, and we look forward to continued collaboration as the Model demonstration period continues.

The VBID Model is currently operating in seven States, with three State expansion scheduled for 2018. Section 301 of the CHRONIC Care Act would expand the Model to every State by 2020. As stated above, we believe that the VBID Model holds significant promise of positive results in Medicare. We appreciate that the committee and the act’s sponsors share our belief in the potential of VBID, and we support the act’s proposed expansion thereof. During the demonstration period, we will collectively have an opportunity to learn from this innovative initiative and to modify guidelines based on these findings.

#### VI. CONCLUSION

We again thank the Senate Finance Committee and the members of the Chronic Care Working Group for this opportunity and their consideration of their comments. We salute the committee’s continued pursuit of meaningful, cost-effective solutions designed to improve the Medicare program for beneficiaries with chronic conditions. We would be pleased to engage in further dialogue on this important topic and to provide additional information or data on our foregoing statements to support the committee’s efforts in this regard. We look forward to continued collaboration in the future.

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#### PREPARED STATEMENT OF STEPHEN ROSENTHAL, SENIOR VICE PRESIDENT FOR POPULATION HEALTH MANAGEMENT, MONTEFIORE HEALTH SYSTEM

Thank you, Mr. Chairman and members of the committee.

My name is Stephen Rosenthal. I am senior vice president for population health management of Montefiore Health System and the chief operating officer of the Montefiore Accountable Care Organization.

I appreciate this opportunity to discuss solutions to one of the most vexing problems facing the Nation’s health system: how to effectively and efficiently care for the growing numbers of Americans who suffer from chronic conditions. I commend the committee for its unrelenting focus on this topic.

Montefiore Health System is a premier academic health system and the University Hospital for Albert Einstein College of Medicine. We serve the 3.1 million people living in the New York City region and the Hudson Valley, a combination of rural, urban, and suburban communities. Approximately 80 percent of the patients discharged from our hospitals are enrolled in Medicare, Medicaid, or both programs, or are uninsured. The Health System includes 11 inpatient hospitals and more than 200 outpatient sites, including a rehabilitation hospital, a State of the art surgical/specialty center campus “hospital without beds,” a multi-county ambulatory network, a skilled nursing facility, a school of nursing, two home health agencies and New York State’s first freestanding emergency department. With our new member

and affiliate locations in Westchester, Rockland, and Orange counties, our regional integrated delivery system focuses on delivering patients highly specialized clinical expertise close to their home.

Our model is unique among our colleagues in that we have for many years combined nationally recognized clinical excellence with accountable, value-based care that is delivered where, when and how patients need it most.

Montefiore has deep roots in treating chronic disease, dating back to our founding in 1884 by Jewish philanthropists as a care facility for patients with chronic illnesses. Today, we are one of the largest health systems in the country, and we have more than 400,000 patients in risk arrangements across Medicare, Medicaid, and commercial insurance. We take a great deal of pride in the role we play as a national leader in the movement toward value-based care, and in sharing our journey and learnings with colleagues and policymakers.

As early as 1995, Montefiore's leadership recognized the need for transformational change in a health-care delivery system serving a preponderance of government program beneficiaries and formed the Montefiore Independent Practice Association (MIPA) to enable it to negotiate value-based contracts with health plans. An IPA is similar to an ACO. It is an organized group of providers, with its own governing body, that come together as an integrated network focused on improving the quality of care for individuals and a population while lowering costs.

A year later, CMO, Montefiore Care Management (CMO) was formed to provide the infrastructure to manage the care of the patients covered by those contracts. Before the term was widely used, we employed a population health management approach, focusing on identifying and stratifying the at-risk population—primarily those with chronic conditions—and engaging them with targeted care management interventions.

More than a year before the passage of the Patient Protection and Affordable Care Act, Montefiore's president and CEO, Dr. Steven M. Safyer, long an outspoken advocate for accountable care, established a high-level planning group in anticipation of Federal, State, and private payer opportunities focused on population health management.

Montefiore was one of 10 organizations that participated in NCQA's beta testing of its accountable care organization accreditation standards and processes, and we eagerly applied to become a Pioneer Model ACO when that initiative was announced by CMS in 2011. The Pioneer ACO program, established as part of the Affordable Care Act, was a catalyst for the expansion of ACO and risk-based programs. It also allowed us to create aggregate-level population health interventions for the Medicare fee-for-service population. As one of the original 32 Pioneers, we have achieved overall savings for Medicare of nearly \$70 million out of a total cost of care of more than \$2.2 billion. We are now participating in the Next Generation ACO program with 55,000 beneficiaries, and we are optimistic that we will continue to achieve savings for Medicare and reinvest our share of those savings in our delivery system.

When we applied to become a Pioneer ACO, Montefiore was a four-hospital system serving primarily Bronx County, one of the Nation's poorest and most disproportionately disease-burdened counties. Today, the Montefiore ACO's network includes 13 hospitals and three federally qualified health centers and extends to the whole of New York City and to Westchester, Rockland, Orange, and Sullivan counties in New York State's Hudson Valley, beyond the Montefiore Health System itself, in fact. The network comprises more than 3,800 primary care and specialty physicians, almost 30% of whom are in private practices in their communities.

Yet it is our decades-long experience providing care for the 1.4 million residents of the Bronx, 75% of whom receive their health-care services through the Medicare and Medicaid programs, that gave us the expertise to successfully manage the care of the beneficiaries attributed to our ACO.

In addition to being the Nation's poorest urban county (almost one-third of its residents live in families with incomes below the Federal poverty line), the Bronx is the most disease-burdened county in New York State, ranked last among 62 counties on both "health factors" and "health outcomes," and with highly elevated rates of diabetes and chronic cardiac and pulmonary conditions.

CMO has care management teams with expertise in diabetes, chronic kidney disease, cancer, heart disease, asthma, and COPD, and behavioral health as well as one team that specialize in helping patients and their families with care transitions and one composed of pharmacists that assists patients with understanding and ad-

hering to their medication regimens. The CMO's quality improvement and provider relations staff assist physician practices on quality improvement and data reporting and transformation of practices into Patient Centered Medical Homes (PCMHs).

We reach out to our highest risk patients who have multiple chronic and acute care problems to conduct comprehensive health assessments that cover both medical and behavioral problems and socioeconomic challenges including housing, employment, nutrition, and access to health care. We identify all of the providers they are seeing to develop with them a comprehensive care plan and to help them coordinate their care.

We appreciate that our patients need access to high quality providers, who understand their language and culture, are available when needed and are willing to coordinate with the other providers our patients see. Our patients need information about their conditions, help in learning self-management skills and linkages to community and government sponsored social service agencies to resolve their socioeconomic challenges.

And that is why we applaud the committee's focus on helping health-care systems care for their patients with chronic conditions, which are difficult to deal with under the best of circumstances and often require multiple providers to properly control.

If you have any doubts about the importance of this concentration—for the health of the patients as well as the Nation's health system, consider this. In our experience, 5% of the 400,000 individuals covered by Montefiore's value-based contracts, including the 55,000 Medicare beneficiaries currently attributed to our NextGen ACO, account for 65% of the total cost of care—and that is largely because of chronic conditions.

As I said, Montefiore has enjoyed success in managing value-based contracts, including the ACO model. But we have learned that to be continually successful an ACO has to continually evolve and build its arsenal of interventions and incentives that promote primary care, and adherence to personalized care plans, as well as efficiently use scarce financial resources. To that end, I applaud the ACO provisions included in the CHRONIC Care Act, some of which build upon provisions included in the NextGen ACO program, and offer you our support for them.

In our experience, prospective attribution is one of, if not the most critical component to success in two-sided risk models. While retrospective assignment of patients may be appropriate in one-sided risk models, in two-sided risk arrangements, prospective attribution allows us to quickly identify those beneficiaries with a history of high costs and high utilization of services, as well as those whose medical records indicate the potential for becoming high cost and high utilizers. Without prospective attribution, it is difficult to effectively deploy resources to generate savings, because patients that the ACO provides care coordination services during the performance period may not be attributed to the ACO for a sufficient period of time to have an impact on their care, or be attributed to the ACO at the end of the year.

(As an aside, when we send out the notification letter to our newly attributed beneficiaries each year, it is not unusual for us to be asked by some beneficiaries if their spouse, who did not have the claims history with a particular provider to merit attribution, could also become part of the ACO so they could benefit from our care coordination services.)

Another component to an ACO's success is increasing patient access to services necessary to manage chronic disease. Your proposal to expand the ability of ACOs to employ telehealth solutions is an estimable way of doing that. To serve our urban population that faced challenges getting to office appointments, Montefiore initially focused its attention on a home visiting program. But as the evidence has built that telehealth technology can be as successful in urban settings as it is in rural areas—and as our service area has expanded beyond the high rise neighborhoods of the Bronx—we have begun to investigate solutions that we believe will be cost effective and contribute to improved quality of care, including telehealth and other technology-based interventions.

In fact, we are presenting a paper at a session of the annual meeting of the American Psychiatric Association next week that describes preliminary results from a pilot of a smartphone behavioral care management platform. The data indicate a threefold increase in the number of contacts Montefiore's care managers were able to make with behavioral health patients and enables them manage caseloads of up to 120 patients, a significant measure of efficiency given the low-income, ethnically

diverse population in the pilot. This application does not fit the traditional definition of telehealth but it is typical of the innovative approach you are looking to advance.

I urge you to contemplate an expansion of the definition of telehealth to include audio-only and all modalities that allow communication between providers, care managers and patients in a seamless fashion, especially in low-income communities that may not have access to videoconferencing technology. The potential for technology to improve patient engagement and care is not only applicable to chronic care, but to the vulnerable elderly as well.

Finally, I am intrigued by your proposal to ACOs to offer beneficiaries incentives to obtain primary care services from its network providers. We—and I suspect, most other ACOs—already offer incentives to our providers for meeting both quality and cost metrics. Why not allow us to offer similar incentives to their patients? While there may be a cost to developing the infrastructure to administer the benefit, it seems to me to have the potential to be a win-win-win-win proposition. It could benefit the patient directly, both financially and in terms of improved health; the provider, by improving his or her quality scores; the ACO itself by increasing its potential for shared savings; and the Medicare program by lowering the total cost of care to the system. Such an incentive may be especially effective in a low-income, price-sensitive population like the one we serve. We know that patient outcomes are significantly improved if they access their providers regularly and when needed. Providing an incentive to promote compliance is likely to encourage that.

Research demonstrates, and our actual experience shows, that patients who regularly fail to keep scheduled appointments with their physicians or other providers are at higher risk for complications and deterioration of their health status. While it is difficult to track with exactitude, the no-show rate among the population that Montefiore has care management responsibilities for is in the neighborhood of 20%, a rate that potentially endangers the health of the individuals and our ability to meet quality metrics and cost saving targets associated with the value-based contracts covering them.

An added benefit to an incentive is the potential to encourage patients in the fee-for-service program to stay within the ACO network, without limiting their choice in anyway. Keeping patients within the network is a fundamental challenge for ACOs in a fee-for-service environment, and you have proposed an innovative solution to this issue.

It is exactly that kind of creative thinking that has led Montefiore to continually evaluate and modify its approach to population health. The result for us has been an increased focus on the socioeconomic determinants of health; partnerships with government agencies, community organizations and businesses to provide the full range of services our patients require; and special arrangements with providers such as skilled nursing facilities to ensure that our patients are ensured the highest quality, most cost-effective care across the continuum of care.

On behalf of the Montefiore ACO and the entire Montefiore Health System, I thank you for your efforts to advance accountable care with proposals that I believe have the potential to improve quality and lower costs. I look forward to working with you to achieve our shared goal of a better health system for all Americans.

Thank you. I will be happy to answer any questions you have.

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PREPARED STATEMENT OF LEE SCHWAMM, M.D., PROFESSOR OF NEUROLOGY, HARVARD MEDICAL SCHOOL; EXECUTIVE VICE CHAIRMAN OF NEUROLOGY, CHIEF OF THE STROKE DIVISION, AND DIRECTOR OF THE PARTNERS TELESTROKE NETWORK, MASSACHUSETTS GENERAL HOSPITAL; ON BEHALF OF THE AMERICAN HEART ASSOCIATION/AMERICAN STROKE ASSOCIATION

Chairman Hatch, Ranking Member Wyden, and other members of the committee, thank you for the opportunity to testify on behalf of the American Heart Association/American Stroke Association at today's hearing about the CHRONIC Care Act (Creating High-Quality Results and Outcomes Necessary to Improve Chronic Care Act, S. 870). I commend you for your bipartisan work to strengthen and improve health outcomes for Medicare beneficiaries living with chronic conditions. Your legislation, if enacted, would help patients receive care that meets their unique chronic health-care needs, as well as create incentives for the provision of coordinated care services to high-cost Medicare beneficiaries. This represents an important step forward in moving the Medicare program away from a system based

on episodic care to a more responsive and comprehensive health care program. The American Heart Association is pleased to offer our support for this legislation.

We recognize that implementing policies that facilitate increased care coordination, incentivize high quality care, and increase the Medicare program's efficiency while improving health-care outcomes and reducing costs is a considerable challenge with no single policy solution. We applaud the committee for including several provisions in this legislation that take significant steps forward to improving care coordination for individuals with cardiovascular disease and stroke. We support policies that would allow Medicare Advantage (MA) plans to use additional, clinically appropriate telehealth technologies. We also support proposals that would give MA Plans more flexibility to vary benefit structures based on chronic conditions and offer a wider array of supplemental benefits than they currently do. In addition, we support the request for studies by the Government Accountability Office on medication synchronization and obesity drugs. These and other provisions in the bill will be extremely beneficial to individuals suffering from cardiovascular disease and stroke.

However, we are particularly grateful that Congress included a provision that would expand the use of telehealth for individuals with stroke. In addition to being a long-time volunteer of the American Heart Association, I am also a member of the American Academy of Neurology. The American Heart Association/American Stroke Association has been working very closely with the AAN to improve Medicare's coverage of stroke telemedicine—or "telestroke" care, as it is now commonly called. We applaud the Finance Committee for including this common-sense provision in the CHRONIC Care Act.

Stroke takes an enormous toll on families and on our Nation. It is our Nation's No. 5 killer and a leading cause of serious, long-term disability and dementia.<sup>1</sup> As the Baby Boomers age, it is critically important that we reduce the burden of this devastating disease on stroke survivors, their families and on Federal health-care programs. According to MedPAC, stroke is the leading Medicare diagnosis for inpatient rehabilitation stays,<sup>2</sup> and a leading diagnosis requiring nursing home care. A report released by the American Heart Association earlier this year projects that this burden is only going to increase: despite better prevention, the number of people living with stroke will increase from 7.5 million Americans in 2015, to 11.2 million in 2035, a 50 percent increase over the next 20 years. The study also estimates that the medical costs of stroke in the U.S. will more than double, from \$37 billion in 2015, to \$94 billion in 2035.<sup>3</sup> By improving access to telestroke care, we can ease this burden.

#### TIME IS BRAIN

In the treatment of stroke, we often say that "time is brain." For every minute that a stroke goes untreated, 2 million brain cells and 14 billion connections between them die, and they don't grow back. The clot-dissolving drug Alteplase (or tPA) and mechanical clot-removal devices are highly effective treatments for the most common type of stroke—acute ischemic stroke—and significantly reduce disability from stroke by restoring blood flow to the affected areas of the brain, but they must be administered as quickly as possible after stroke symptoms start. Research from the American Stroke Association's Target: Stroke initiative shows definitively that stroke patients who get treated with tPA within 60 minutes of hospital arrival do significantly better than those treated more slowly. In particular, we have found that for every 15 minute reduction in treatment time, 5.1 percent more patients recover so completely that they can return directly home from the hospital.<sup>4</sup> Ischemic stroke patients who are treated with the clot-busting drug within 90 minutes of symptoms starting are nearly three times more likely to recover

<sup>1</sup> Benjamin, E.J., et al. "Heart disease and stroke statistics—2017 update: a report from the American Heart Association," *Circulation*, 2017;135:e1–e458.

<sup>2</sup> Medicare Payment Advisory Commission. "March 2016 Report to the Congress: Medicare Payment Policy," March 15, 2016. Accessed online at: <http://www.medpac.gov/-documents/-reports>.

<sup>3</sup> American Heart Association/American Stroke Association. *Cardiovascular Disease—A Costly Burden for America: Projections through 2035*, February 14, 2017. Accessed online at: [http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm\\_491543.pdf](http://www.heart.org/idc/groups/heart-public/@wcm/@adv/documents/downloadable/ucm_491543.pdf).

<sup>4</sup> Fonarow, G.C., Zhao, X., Smith, E.E., et al. "Door-to-needle times for tissue plasminogen activator administration and clinical outcomes in acute ischemic stroke before and after a quality improvement initiative," *JAMA*, 2014;311:1632–1640.

with little or no disability.<sup>5</sup> Similarly, more than 90 percent of patients treated with a clot retrieval device within 150 minutes of stroke onset recover with little or no disability.<sup>6</sup>

I have seen firsthand the miraculous difference these treatments can make for patients, but unfortunately, only about 3.4 to 5.2 percent of patients receive the clot-busting medication<sup>7</sup> and even fewer patients are treated with clot retrievers. Among Medicare-eligible patient discharges, the national average tPA treatment rate is only 2.4 percent.<sup>8</sup> There are a number of reasons why treatment rates have remained so low, including long distances to stroke center hospitals, a shortage of vascular neurologists, and patients not arriving at the hospital within the treatment time window.<sup>9</sup> The good news, however, is that the use of telestroke has proven to be extremely effective in increasing the percentage of stroke patients who receive Alteplase and in reducing the time it takes to get the treatment started.

#### TELESTROKE IS EFFECTIVE

Rapid and accurate diagnosis of acute ischemic stroke is a critical first step to ensuring that these patients receive the optimal care. A variety of conditions can mimic acute stroke, but many rural hospitals and even suburban community or inner-city hospitals do not have stroke neurologists available in house or on-call around-the-clock to examine and diagnose patients in-person. Even in urban or suburban settings, where approximately 94 percent of strokes occur, patients may experience delays to diagnosis and treatment. To a large extent this is because there is a shortage of vascular neurologists, many hospitals do not have any, and in those that do neurologists having competing demands on their time that prevent them from being in the Emergency Department 24/7 in person. Telemedicine can meet this need. We estimate from 2014 data that the number of Medicare beneficiaries 65 and older who have a stroke and would be newly eligible for a telestroke consultation to be approximately 522,000. This would include individuals in rural areas that do not meet the current and fairly narrow definition of “rural” for Medicare payment of telestroke services.

When a patient presents at a hospital that does not have a stroke expert readily available, the Emergency Department physician can use a telemedicine network to immediately consult with a stroke expert. Using fully interactive and secure audio-video systems, the stroke expert can interact with the patient and the bedside physician and swiftly and accurately obtain the proper history, perform the NIH Stroke Scale, (a brief stroke severity scale), review the CAT scan and confirm the diagnosis of stroke. The interpretation of the brain imaging is critical to ensure that the patient is not having a hemorrhagic stroke or other diagnosis that would make use of tPA unsafe.

This use of telemedicine in the acute treatment of stroke has greatly improved the percentage of patients who receive the recommended acute stroke treatment, as numerous studies have demonstrated. One recent study of four urban hospitals in Illinois with low tPA treatment rates found that their utilization of tPA increased by two to six times after telestroke was implemented.<sup>10</sup> Moreover, the outcomes for stroke patients who are cared for in hospitals with telemedicine support have been comparable to those achieved in other stroke centers and have surpassed those achieved by general hospitals without telemedicine support or stroke units.<sup>11</sup>

Despite the proven benefits of telestroke, Medicare’s coverage of it is woefully outdated. The current Medicare policy of limiting coverage for telehealth services to those patients originating in only rural areas has hampered the development of suf-

<sup>5</sup> Marler, J.R., et al. *Neurology*, 2000;55(11):1649–55.

<sup>6</sup> Goyal, M., et al. *Radiology*, 2016;270(3):888–97.

<sup>7</sup> Adeoye, O., et al. “Recombinant tissue-type plasminogen activator use for ischemic stroke in the United States: a doubling of treatment rates over the course of 5 years,” *Stroke*, 2011; 42:1952–1955.

<sup>8</sup> Kleindorfer, D.O., Yingying, X., et al. “U.S. Geographic Distribution of rt-PA Utilization by Hospital for Acute Ischemic Stroke,” *Stroke*, 2009;40:3580–3584.

<sup>9</sup> Schwamm, L.H., et al. “Recommendations for the implementation of telemedicine within stroke systems of care: A policy statement from the American Heart Association,” *Stroke*, 2009;40:2635–2660.

<sup>10</sup> Cutting, S., et al. “Telestroke in an urban setting,” *Telemed. J. E.-Health*, 2014;20(9): 855–7.

<sup>11</sup> Schwamm, L.H., Holloway, R.G., Amarenco, P., Audebert, H.J., Bakas, T., Chumbler, N.R., et al. “A review of the evidence for the use of telemedicine within stroke systems of care: a scientific statement from the American Heart Association/American Stroke Association,” *Stroke*, 2009;40:2616–2634.

ficient telestroke coverage. The most significant step Congress could take would be to allow Medicare to reimburse for telestroke evaluations for patients regardless of their location, as the CHRONIC Care Act would do.

#### TELESTROKE SAVES MONEY

In addition to improving access to the recommended care, we believe that greater use of telestroke will also result in health care cost savings by reducing chronic disability and the need for more extensive and ongoing medical care. Several studies have clearly shown that the use of tPA is cost-saving for stroke care. According to a study published in the *New England Journal of Medicine*, stroke patients receiving clot-busting therapy were at least 30 percent more likely to have minimal or no disability at 3 months, compared to patients who did not receive this treatment. These patients also have shorter hospital stays and are more frequently discharged to their homes rather than to more costly nursing homes.<sup>12</sup> Another study found that the average cost savings when administering tPA was \$4,255.00 in 1996 dollars per treated patient, largely as a result of decreased utilization of nursing home and rehabilitation care by the patient.<sup>13</sup> Yet another study aimed at evaluating the cost utility of telestroke networks estimated net savings of \$1,436 per patient, even after accounting for the costs of implementing the telestroke network and administering tPA.<sup>14</sup>

In fact, the American Heart Association has estimated that the Medicare and Medicaid programs could save as much as \$1.2 billion over 10 years, even after the costs of providing more telestroke evaluations and more tPA treatments are factored in. I understand that the Congressional Budget Office may not allocate the full amount of savings to the Federal Medicare and Medicaid programs since some of the savings that results from reducing the need for nursing home care accrues to State rather than Federal Governments and to patients and their families. I would argue, however, that even if the Federal Government's savings from Medicare and its share of Medicaid savings is more modest or takes time to be realized, taking this step to improve the quality of stroke care is still highly cost-effective and is the right thing to do for patients.

I believe this change in Medicare law is long overdue, and I am heartened by the growing number of lawmakers and organizations that have endorsed telestroke care. I want to thank Senators John Thune, Brian Schatz, and Roger Wicker for also introducing stand-alone legislation to expand Medicare's coverage for telestroke evaluations. Companion legislation in the House achieved 171 bipartisan cosponsors in the last Congress and is well on its way to exceeding that number this year with 77 co-sponsors already. In addition, organizations such as AARP, the American Hospital Association, the American Medical Association, and the National Coalition for Health Care have also expressed their support for lifting Medicare's restrictions on telestroke coverage. Finally, the Medicare Payment Advisory Commission, in its June 2016 report to Congress, found telestroke to be one of the most beneficial and cost-effective applications of telehealth and suggested that policymakers may want to expand Medicare coverage of telestroke to urban settings,<sup>15</sup> as the CHRONIC Care Act would do.

In conclusion, telestroke is supported by a wealth of evidence and is a common-sense, cost-effective step that the committee can take to reduce the burden of stroke as a chronic disease. I am convinced that expanding the use of telestroke will greatly improve the quality of care that stroke patients receive, increase the utilization of effective acute stroke treatments, reduce stroke-related disability for many Americans, and save the health-care system money. These win-win opportunities are rare in health care, and I urge the Senate Finance Committee to act quickly on the CHRONIC Care Act and to send it to the full Senate and then the House for approval. Thank you again for addressing the challenging issues related to caring for Medicare patients with multiple chronic conditions. We greatly appreciate the

<sup>12</sup>The National Institute of Neurological Disorders and Stroke rt-PA Stroke Study Group. "Tissue plasminogen activator for acute ischemic stroke." *N. Engl. J. Med.*, 1995;333:1581-1587.

<sup>13</sup>Fagan, S.C., Morgenstern, L.B., Petitta, A., Ward, R.E., et al. "Cost-effectiveness of tissue plasminogen activator for acute ischemic stroke." *Neurology*, 1998;50:883-890.

<sup>14</sup>Demaerschalk, B.M., Switzer, J.A., Xie, J., Fan, L., Villa, K.F., and Wu, E.Q., "Cost utility of hub-and-spoke telestroke networks from societal perspective." *Am. J. Manag. Care*, 2013;19:976-85.

<sup>15</sup>Medicare Payment Advisory Commission. *June 2016 Report to the Congress: Medicare and the Health Care Delivery System*. June 15, 2016. Accessed online at: <http://www.medpac.gov/documents/reports>.

thought and deliberations that went into the development of this bill and for the opportunity to express our strong support at today's hearing.

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

Thank you, Chairman Hatch. I have looked forward to this morning for many years. That's because the Finance Committee is beginning to tackle to the premier challenge of American health-care policy—specifically, by updating the guarantee of Medicare to better serve seniors with chronic illness.

When I was director of the Oregon Gray Panthers, Medicare had two parts—A and B. If you broke your ankle and had surgery in the hospital, you used Part A. If you got a bad case of the flu, and you saw the doctor in the office, you used Part B.

That is not Medicare today. Today, Medicare is about cancer, diabetes, heart disease, strokes, and other chronic conditions. Seniors who have two or more of these chronic conditions account for more than 90 percent of Medicare spending. And today, seniors get their care in a variety of different ways. There's still fee-for-service, but there is also Medicare Advantage, Accountable Care Organizations, and other innovations being tested today.

Because Medicare is a guarantee of defined benefits, it's past time to update this promise so as to deliver to patients with chronic conditions the best possible care in the most efficient manner. The legislation we will discuss today begins this transformations: more care at home and less in institutions. Expanded use of life-saving technology. A stronger focus on primary care. In my view, still to come, is ensuring that each senior with multiple chronic conditions has an advocate to guide them through what can be a teeth-gnashing experience of navigating American health care.

I'd like to make two final points. First is to contrast this with the partisan handling of the debate over the future of the Affordable Care Act. In this instance, the doors were open, not closed. There has been bipartisan cooperation, not partisan reconciliation. And the public was asked to help improve the bill, rather than being taken for granted.

Finally, I'd like to thank my colleagues, especially Chairman Hatch and Senators Isakson and Warner. We'll hear later this morning about how this process has been a model for bipartisanship and regular order, and it's been an honor to be a part of that process.

I look forward to hearing from our witnesses.

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## COMMUNICATIONS

ALLIANCE FOR HOME DIALYSIS  
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Chairman Hatch, Ranking Member Wyden, and members of the Finance Committee, on behalf of the Alliance for Home Dialysis (Alliance), we are pleased to support the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which seeks to improve the care and treatment of Medicare beneficiaries with multiple chronic conditions.

The Alliance represents patients, clinicians, providers, and industry working to promote policies that facilitate treatment choice for individuals in need of dialysis, and to address systemic barriers that limit access to the many benefits of home dialysis. These issues are particularly important given the nearly half million Americans who are currently living with End Stage Renal Disease (ESRD) and depend on dialysis for survival.

Home dialysis—peritoneal dialysis (PD) and home hemodialysis (HHD)—is an important treatment option that offers patients significant quality of life advantages, including clinically meaningful improvements in physical and mental health. Currently, 10.2 percent of incident dialysis patients and 11.5 percent of prevalent dialysis patients receive treatment at home.<sup>1</sup> However, a recent report by the Government Accountability Office found that home dialysis could be clinically appropriate for at least half of ESRD patients.<sup>2</sup> Patients who choose home dialysis have shown improved clinical outcomes, including reduced cardiovascular death and hospitalization<sup>3,4</sup> lower blood pressure,<sup>5</sup> reduced use of antihypertensive agents,<sup>6</sup> and reduced serum phosphorus.<sup>7</sup> Studies have also shown that patients have better mental health outcomes, including social function, which is vitally important for overall well-being.<sup>8</sup> The Alliance believes that more patients than are currently receiving home dialysis are suitable for, and could benefit from, home dialysis.

The CHRONIC Act would expand access to quality care in the home by authorizing home dialysis patients' clinical assessments via telehealth. Providing access to physicians and practitioners through telehealth may encourage more patients to adopt home dialysis as a treatment option. In addition, with this change, patients cur-

<sup>1</sup>United States Renal Data System (USRDS), *2015 Annual Data Report: Epidemiology of Kidney Disease in the United States*.

<sup>2</sup>Government Accountability Office, "Medicare Payment Refinements Could Promote Increased Use of Home Dialysis," published November 16, 2015. Available at <http://www.gao.gov/products/GAO-16-125>.

<sup>3</sup>Weinhandl, E.D., Liu, J., Gilbertson, D.T., Arneson, T.J., and Collins, A.J.: "Survival in daily home hemodialysis and matched thrice-weekly in-center hemodialysis patients." *J. Am. Soc. Nephrol. JASN* 23: 895–904, 2012.

<sup>4</sup>Weinhandl, E.D., Nieman, K.M., Gilbertson, D.T., and Collins, A.J.: "Hospitalization in daily home hemodialysis and matched thrice-weekly in-center hemodialysis patients." *Am. J. Kidney Dis., Natl. Kidney Found.* 65: 98–108, 2015.

<sup>5</sup>Kotanko, P., Garg, A.X., Depner, T., et al. "Effects of frequent hemodialysis on blood pressure: Results from the randomized frequent hemodialysis network trials." *Hemodial. Int., Int. Symp. Home Hemodial.* 19: 386–401, 2015.

<sup>6</sup>Jaber, B.L., Collins, A.J., Finkelstein, F.O., Glickman, J.D., Hull, A.R., Kraus, M.A., McCarthy, J., Miller, B.W., and Spry, L.A.: FREEDOM Study Group, "Daily hemodialysis (DHD) reduces the need for anti-hypertensive medications" [Abstract]. *J. Am. Soc. Nephrol.* 20: SA-P02461, 2009.

<sup>7</sup>FHN Trial Group, et al.: "In-center hemodialysis six times per week versus three times per week." *N. Engl. J. Med.*, 363: 2287–2300, 2010.

<sup>8</sup>Finkelstein, F.O., Schiller, B., Daoui, R., et al.: "At-home short daily hemodialysis improves the long-term health-related quality of life." *Kidney Int.* 82: 561–569, 2012.

rently on home dialysis would no longer have to travel as frequently to a hospital or facility-qualifying site to interface with an approved practitioner, which can increase quality of life and facilitate employment options.

As the Committee looks to further expand and improve access to quality care in the home for ESRD patients, we encourage the examination of the scope of telehealth services under the law. The Alliance supports permitting patients and their physicians the option to participate in telehealth encounters that include not only video interaction, but also the transmission of clinical data through technologies like remote patient monitoring.

The Alliance appreciates and agrees with the testimony and work Senator Wicker and Senator Schatz have done on the CONNECT Act. Senator Wicker testified, "Imagine the incredible impact that this technology could have if Medicare would allow its most vulnerable beneficiaries to use something like remote patient monitoring. I am confident that the success we have seen in Mississippi can be replicated for patients across the United States upon enactment of the CHRONIC Care Act and ultimately enactment of CONNECT for Health." We could not agree more.

The CHRONIC Act will make a meaningful difference for patients with ESRD, and we thank you for the significant effort that went into this legislative accomplishment. We look forward to continuing to work with you to further this work. If you have any questions, please contact Michael Spira at michael@homedialysisalliance.org or 202-466-8700.

**Participating Organizations (2017)**

American Association of Kidney Patients  
 American Nephrology Nurses Association  
 American Society of Nephrology  
 American Society of Pediatric Nephrology  
 Baxter  
 Cleveland Clinic  
 DaVita  
 DEKA Research and Development  
 Dialysis Clinic, Inc.  
 Dialysis Patient Citizens  
 Fresenius Medical Care  
 Greenfield Health Systems  
 Home Dialyzors United  
 International Society for Peritoneal Dialysis, North American Chapter  
 Medical Education Institute  
 National Kidney Foundation  
 Northwest Kidney Centers  
 NxStage Medical  
 Outset Medical, LLC  
 Renal Physicians Association  
 Satellite Healthcare  
 Southwest Kidney Institute  
 The Rogosin Institute  
 TNT Moborg International Ltd.

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**AMERICAN COLLEGE OF PHYSICIANS (ACP)**

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The American College of Physicians (ACP) applauds Chairman Hatch and Ranking Member Wyden for holding this hearing concerning Medicare policies that will improve care for patients with chronic conditions. The College appreciates the sustained commitment of the Senate Finance Committee to address reforms that would provide physicians and patients with additional tools needed to treat chronic illness.

ACP is the largest medical specialty organization and the second largest physician group in the United States. ACP members include 148,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to

the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

Two years ago, the Chairman and Ranking Member of this Committee established a bipartisan chronic care working group led by Senators Johnny Isakson and Mark Warner to analyze current law, discuss alternative policy options, and develop bipartisan legislation that would be presented to the full Finance Committee for consideration. The Chronic Care Working Group has accomplished this goal with the release of a bipartisan policy options document and subsequently the introduction of bipartisan legislation, the Creating High Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act. We also commend the Committee for the process that it developed for the consideration of chronic care legislation as it was receptive to the input of stakeholders, including ACP, as we provided the Committee with our expertise and the real world experience of our internists who treat individuals with chronic conditions on a daily basis

**S. 870, The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act**

ACP was pleased to offer a letter of support, along with our recommendations for improvement, for S. 870, The Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act that was introduced in the Senate earlier this year. This bipartisan legislation sponsored by the Chairman and Ranking Member of the Finance Committee along with members of the Chronic Care Working Group, would implement a broad array of reforms to Medicare to provide physicians with additional flexibility and resources to treat patients with chronic conditions.

Many of the sections of the CHRONIC Care Act were consistent with ACP's recommendations to the Committee on policies to include in this legislation. The specific sections of the legislation that we support are listed below:

***ACP Supports the Following Sections of S. 870, as Introduced***

- **Section 101—Extending the Independence at Home Model of Care**

The Independence at Home Model of Care is a demonstration project under Medicare to test a payment incentive and service delivery model that uses physician and nurse practitioner-directed home-based primary care teams for Medicare beneficiaries with multiple chronic illness. This section would extend this demonstration for an additional 2 years. ACP is supportive of this model of care and supports expanding this demonstration project if results continue to be positive.

- **Section 303—Increasing Convenience for Medicare Advantage Enrollees Through Telehealth**

This section would allow a Medicare Advantage plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B. ACP is supportive of this policy as it would expand the role of telemedicine as a method of health-care delivery that may enhance patient care.

- **Section 305—Expanding Use of Telehealth for Individuals With Stroke**

This section would expand the ability of Medicare beneficiaries presenting with stroke symptoms to receive a timely consultation via telehealth to determine the best course of treatment, beginning in 2018. ACP is supportive of this policy as we support lifting the geographic restriction for the purposes of identifying and diagnosing strokes through telehealth.

- **Section 401—Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization**

This section would give Accountable Care Organizations (ACOs) in the Medicare Shared Savings Plan the choice to have their beneficiaries assigned prospectively at the beginning of a performance year. ACP is supportive of this section as we encourage giving ACOs the choice to have retrospective or prospective assignment of beneficiaries and allowing beneficiaries to voluntarily align with their main doctor for ACO assignment.

***ACP Recommendations for Improvement***

We would also like to provide our recommendations for two additional sections that we respectfully request that you add to the bill that will improve care management

codes for individuals with chronic conditions and encourage the use of chronic care management services.

**Improving Care Management Codes for Individuals with Multiple Chronic Conditions**

This legislation does not address the issue of new chronic care management codes, as was initially referenced in the Chronic Care Working Group Options Document. While we acknowledge this was likely due to the fact that CMS did address it in the FY 2017 Final Rule on the Physician Fee Schedule, we believe this warrants attention by the committee within legislation because there is a 40 minute time gap for chronic care management services not recognized by the existing CCM codes in the final rule.

As you are aware, the 2017 Medicare Physician Fee Schedule Final rule established a new Complex Chronic Care Management code for doctors that provide Complex Chronic Care Management services to patients that last at least 60 minutes in length and for each additional 30 minutes thereafter, which ACP supports. CMS currently provides a code for Chronic Care Management services that last at least 20 minutes but has failed to initiate any new codes for these services that last between 20–40 and 40–60 minutes. ACP remains concerned that the fee schedule fails to adequately value chronic care services between 20–60 minutes, which could lead to more barriers to care for chronic care patients.

**ACP Recommendation**

We urge the Committee to include a section on Improving Care Management for Individuals with Multiple Chronic Conditions that would require CMS to establish two new codes (perhaps initially as G codes) that would recognize the value of care for clinicians who treat patients with chronic care conditions between 20–40 minutes and 40–60 minutes.

**Encouraging Beneficiary Use of Chronic Care Management Services**

ACP is disappointed that this legislation does not address the issue of beneficiary cost sharing, as was initially referenced in the Chronic Care Working Group Options Document. This proposed policy would waive the beneficiary co-payment associated with the current chronic care management code as well as the complex chronic care management code that was recently approved by CMS. We believe waiving this beneficiary co-payment is critical in the effort to improve care to individuals with chronic conditions and it would require a legislative remedy to do it, as explained by CMS.

Waiving beneficiary cost-sharing, both the co-insurance and deductible, will incentivize beneficiaries to receive these CCM services. Currently, physicians are required to get authorization from patients to initiate CCM services—this is a means of ensuring that these patients are aware of these services and remain engaged partners. As a part of the discussion around this authorization, physicians notify patients that they will be responsible for the co-payment amount associated with CCM. At the time of this discussion, the physician is likely unaware of any supplemental coverage that the patient may have so they must inform the patient that he or she may be required to pay the copayment amount. If the discussion of a co-payment were no longer required because of the elimination of beneficiary cost-sharing, physicians would be more likely to have the discussion with beneficiaries about providing the CCM services that the patient needs. Further, waiving cost-sharing would eliminate any unintended discriminatory impact on beneficiaries of modest means, who more likely will not have any supplemental coverage.

**ACP Recommendation**

We urge the Committee to include a section that would move chronic care management services to the preventive services category under Medicare FFS to eliminate any beneficiary cost sharing associated with these services. Alternatively, you could insert a provision in this bill that would allow CMS to give physicians the option of routinely waiving the copay for chronic care management codes for patients with chronic conditions.

We are pleased that this legislation has been marked-up and approved by the Senate Finance Committee with a unanimous vote, and urge Senators to include our suggested recommendations as this bill moves toward consideration in the Senate. We appreciate the sustained commitment of the Chronic Care Working group to improve the health of our patients with chronic conditions.

***ACP Supports S. 1016, The CONNECT for Health Act***

ACP is pleased that the Committee has recognized the expansion of telehealth services in Medicare as an additional tool to improve the health of patients with chronic conditions. We recently submitted a letter of support for S. 1016, The CONNECT for Health Act, that would substantially expand the use of telemedicine and remote patient monitoring (RPM) services by physicians and other clinicians to improve care of patients enrolled in Medicare. We support the expanded role of telemedicine as a method of health-care delivery that will improve the health of patients with chronic conditions by enhancing patient-physician collaborations, increasing access to care and members of a patient's health-care team, and reducing medical costs when used as a component of a patient's longitudinal care.

The CONNECT for Health Act implements reforms to Medicare to improve the services offered to patients with chronic conditions by:

- Giving Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) with two-sided risk the ability to furnish telemedicine and RPM services to their Medicare patients not subject to geographic restrictions and originating site requirements under current law. ACP would prefer broadening this to allow all MSSP tracks (including those ACOs with one-sided risk) to remove those restrictions to expand the use of telehealth services.
- Allowing Medicare Advantage plan to offer additional, clinically appropriate, telehealth benefits in its annual bid amount beyond the services that currently receive payment under Part B. ACP is pleased that this provision is consistent a section in the CHRONIC Care Act that would implement this policy.
- Requiring that Medicare cover the use of RPM services by Medicare providers for certain Medicare beneficiaries with chronic conditions. ACP believes that the use of RPM services for patients with chronic conditions could help control and manage those conditions and improve the health outcomes for those patients while lowering costs.
- Lifting geographic-site restrictions for telestroke evaluation and management sites where the Medicare beneficiary is located. ACP believes that expanding the use of telemedicine for Medicare stroke is an area where evidence supports cost-effectiveness, safety, and positive health outcomes associated with telemedicine. Additionally ACP has previously supported stroke telehealth-services in the CHRONIC Care Act.

We are grateful that the sponsors of the CONNECT for Health Act, Senators Brian Schatz (D-HI) and Roger Wicker (R-MS) offered their testimony on the role that this legislation would serve in improving the health of seniors with chronic conditions at the recent Finance Committee hearing regarding bipartisan policy options to improve chronic care. We look forward to working with the Committee to implement these reforms in Medicare and help our physicians transform their practices to expand on the use of telehealth services to improve the care provided to patients with chronic conditions.

**Conclusion**

We appreciate the steadfast commitment of the Finance Committee to address the urgent need to reform Medicare to improve the care of individuals with multiple chronic conditions. We respectfully urge Congress to incorporate our suggested reforms to the Chronic Care Act by requiring CMS to establish two new codes to improve the value of care for physicians who treat patients with multiple chronic conditions and eliminating the beneficiary co-payment associated with the chronic care management code. We look forward to working with the Senate to improve and advance legislation to improve the health of seniors with chronic conditions and welcome this opportunity to provide our views on this issue.

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CENTER FOR MEDICARE ADVOCACY  
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The Center for Medicare Advocacy, founded in 1986, is a national, non-partisan education and advocacy organization that works to ensure fair access to Medicare and to quality health care. At the Center, we educate older people and people with disabilities to help secure fair access to necessary health-care services. We draw upon our direct experience with thousands of individuals to educate policy-makers about

how their decisions affect the lives of real people. Additionally, we provide legal representation to ensure that people receive the health-care benefits to which they are legally entitled and the quality health care they need.

Many Medicare beneficiaries have chronic conditions and need a range of health-care services in a variety of health-care settings in order to maintain their functional status and to avoid unnecessary and costly hospitalizations. As discussed below, the Center for Medicare Advocacy submitted recommendations on chronic care reform to the Senate Finance Committee on June 22, 2015, which we summarize below. We focus in this Statement on *Jimmo v. Sebelius*, a nationwide class action lawsuit addressing Medicare coverage of maintenance nursing and maintenance therapy, an issue of particular concern to Medicare beneficiaries who have chronic conditions.

#### **Finance Committee's Request for Comments on Chronic Care Reform**

In response to the Committee's request for comments on chronic care reform, the Center for Medicare Advocacy submitted a number of recommendations on June 22, 2015.<sup>1</sup> Among the Center's key recommendations were the need to assure full implementation of *Jimmo*; integration of oral health into covered and coordinated health-care services; removing current barriers to medically necessary care, such as therapy caps and the 3-day prior hospitalization requirement for coverage of post-acute care in a skilled nursing facility (SNF); integration of prescription drug coverage into traditional Medicare; streamlining payment systems to provide incentives for appropriate care; opposing site-neutral payments for different types of care; protecting Medicare beneficiaries from cost-shifting; improving access to care in Medicare Advantage and Part D plans by improving the administration of utilization management tools and beneficiary appeals processes; and assuring high quality care in all settings.

#### ***Jimmo* and the Maintenance Level of Care and Services**

Despite the Medicare program's long-standing recognition that Medicare coverage is appropriate to maintain a patient's functioning,<sup>2</sup> a myth developed among health-care providers and Medicare adjudicators that Medicare covers care and services only if a beneficiary is expected to improve.

On January 18, 2011, the Center for Medicare Advocacy and Vermont Legal Aid filed a nationwide class action lawsuit to dispel the myth and to assure that patients in both traditional Medicare and Medicare managed care—in skilled nursing facilities, home care, and outpatient therapy—receive medically necessary nursing and therapy services to maintain their function and to prevent or slow their decline or deterioration. *Jimmo v. Sebelius*, Civ. No. 11-cv-17 (D. Vt. Jan. 18, 2011). Six organizations representing beneficiaries with chronic conditions—Alzheimer's Association, National Multiple Sclerosis Society, National Committee to Preserve Social Security and Medicare, Paralyzed Veterans of America, Parkinson's Action Network, and United Cerebral Palsy—were also plaintiffs, illustrating the particularly harsh effects of the myth of improvement on people with chronic conditions. Although Parkinson's, for example, will not “go away,” as an acute condition might, patients with Parkinson's may need nursing care or therapy services in order to slow the inevitable course of their disease and to keep them functioning at the highest level possible.

*Jimmo* was settled by the parties in October 2012. Chief Judge Christina Reiss of the Federal District Court in Vermont approved the Settlement on January 24, 2013. Relevant language from the settlement confirms Medicare coverage for medically necessary maintenance therapy services at skilled nursing facilities, home health, and outpatient therapy:

[U]nder the SNF, HH, and OPT maintenance coverage standards, skilled therapy services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a qualified therapist (“skilled care”) are necessary for the performance of a safe and effective maintenance program. Such a maintenance program to

<sup>1</sup>The full set of recommendations is available at <http://www.medicareadvocacy.org/center-comments-to-senate-finance-committee-regarding-chronic-care-reform/>.

<sup>2</sup>See, for example, 42 CFR § 409.32(c) (“Even if full recovery or medical improvement is not possible, a resident may need skilled services to prevent further deterioration or preserve current capabilities”) and 42 CFR § 409.33(c)(5) (Maintenance rehabilitation therapy is a covered service “. . . when the specialized knowledge of a qualified therapist is required to design and establish a maintenance program based on an initial evaluation and periodic assessment of a resident's needs . . .”).

maintain the patient's current condition or to prevent or slow further deterioration is covered so long as the beneficiary requires skilled care for the safe and effective performance of the program. When, however, the individualized assessment does not demonstrate such a necessity for skilled care, including when the performance of a maintenance program does not require the skills of a therapist because it could safely and effectively be accomplished by the patient or with the assistance of non-therapists, including unskilled caregivers, such maintenance services will not be covered under the SNF, HH, or OPT benefits.<sup>3</sup>

Similar maintenance language addresses nursing services.<sup>4</sup>

*The New York Times* heralded the settlement in an editorial as a “humane Medicare rule change” that may even lead to savings.<sup>5</sup>

That prediction has indeed proven true. The Center for Medicare Advocacy spoke with the director of rehabilitation at a home care agency based in Michigan that has provided maintenance home care services to its clients since the *Jimmo* settlement. The company reports that the rate of hospitalization of its patients declined from 32.0% to 14.2% over the past 3 years.

If Medicare beneficiaries with chronic conditions receive medically necessary and appropriate maintenance nursing care and therapy services and are able to avoid some hospitalizations as a result, both beneficiaries and the Medicare program benefit. Beneficiaries can receive medically necessary nursing care and therapy without being hospitalized and the Medicare program can achieve substantial savings. There is no question that many home health visits, outpatient therapy services, and even days in a SNF can be covered for the cost of a single day in the hospital.

#### **Barriers to Full Implementation of *Jimmo***

Proper implementation of the *Jimmo* settlement should lead to improved Medicare coverage of care for all Medicare beneficiaries, including those who have chronic conditions. Unfortunately, we continue to hear regularly from beneficiaries who are denied maintenance coverage because they “are not improving” or have “plateaued.” Some of these inappropriate denials of coverage and care occur because of public policies that limit the effectiveness of the settlement. These policies include Medicare payment policies, quality reporting measures, and fraud investigations that target appropriate maintenance activities, among other activities.

For example, proposed quality reporting measures for SNFs, as required by the IMPACT Act, reflect solely an expectation of improvement. (The May 4, 2017 Notice of Proposed Rulemaking contains such language as “Residents receiving care in SNFs include those whose illness, injury, or condition has resulted in a loss of function, and for whom rehabilitative care is expected to help regain that function”).<sup>6</sup> Although many individuals go to SNFs with an expectation of improvement, improvement is not the sole purpose of therapy in a SNF. *Jimmo* also recognizes that many residents may need physical, occupational, or speech therapy in order to maintain their function and to prevent or slow their decline. By evaluating, measuring, and reporting SNFs’ performance solely on an improvement scale, however, the proposed quality measures undermine Medicare beneficiaries’ ability to receive therapy for necessary and legitimate maintenance purposes. Maintenance goals must be included as additional appropriate quality measures for SNFs.

Similarly, audits may have targeted legitimate maintenance goals. In 2010, the Inspector General issued a report, *Questionable Billing for Medicare Outpatient Therapy Services*, which was based on the premise that outpatient therapy is intended solely “to improve a beneficiary’s functional level.”<sup>7</sup> “Questionable” billing practices identified by the Inspector General included billing for therapy services throughout a year, rather than for a limited period of time, and billing that exceeded the annual therapy caps—factors that could reflect ongoing, legitimate, and appropriate maintenance therapy. Following issuance of the national report, which was based on the language of the pre-*Jimmo* Medicare Manual, the Inspector General conducted a series of audits of therapy providers who provide outpatient therapy services to Medi-

<sup>3</sup>*Jimmo v. Sebelius*, Civ. No. 11-cv-17, ¶IX 6 (D.Vt. January 18, 2011), <http://www.medicareadvocacy.org/wp-content/uploads/2012/12/Jimmo-Settlement-Agreement-00011764.pdf>.

<sup>4</sup>*Id.*, ¶IX 8.

<sup>5</sup>Editorial, “A Humane Medicare Rule Change,” *The New York Times* (October 24, 2012), <http://www.nytimes.com/2012/10/24/opinion/a-humane-medicare-rule-change.html>.

<sup>6</sup>82 Fed. Reg. 21014, 21048–21049 (May 4, 2017), <https://www.gpo.gov/fdsys/pkg/FR-2017-05-04/pdf/2017-08521.pdf>.

<sup>7</sup>OEI-04-09-00540 (December 2010), <https://oig.hhs.gov/oei/reports/oei-04-09-00540.pdf>.

care beneficiaries under Part B. In one such report, for example, the Inspector General describes as the sole purpose of physical therapy—“to restore maximal functional independence to each individual patient by providing services that aim to restore function, improve mobility, and relieve pain.”<sup>8</sup> The audit found fault with the therapist’s billing for a patient for whom “There was no expectation of significant improvement within a reasonable and predictable period of time.”<sup>9</sup> The audits’ failure to recognize the legality of maintenance therapy as appropriate for Medicare Part B coverage undermines the provision of medically necessary and appropriate maintenance therapy.

Thank you for the opportunity to submit comments on Medicare policies to improve care for patients with chronic conditions. As a final comment, we urge Congress to add any new benefits and opportunities for improved care and coordination to traditional Medicare that are added to Medicare Advantage.

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COLLEGE OF HEALTHCARE INFORMATION MANAGEMENT EXECUTIVES (CHIME) AND  
ASSOCIATION FOR EXECUTIVES IN HEALTHCARE INFORMATION TECHNOLOGY (AEHIT)

The College of Healthcare Information Management Executives (CHIME) and the Association for Executives in Healthcare Information Technology (AEHIT) are pleased to submit a statement for the record of the May 16, 2017, Committee on Finance hearing entitled, “Examining Bipartisan Medicare Policies that Improve Care for Patients with Chronic Conditions.” We appreciate the committee’s interest in this timely issue and welcome the opportunity to offer perspective from the nation’s healthcare chief information officers and chief technology officers on how technology can be leveraged to improve care for patients with chronic conditions.

CHIME is an executive organization serving more than 2,300 CIOs and other senior health information technology leaders at hospitals and clinics across the nation. CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating health-care transformation. Within CHIME is AEHIT, an organization launched in 2014 which represents more than 300 chief technology officers and provides education and networking for senior technology leaders in health care. CHIME and AEHIT members represent some of the earliest and most prolific adopters of electronic health records (EHRs) and other health IT resources, such as telehealth as a means to improve patient care and outcomes.

Several converging factors present federal regulators and congressional leaders with a unique opportunity to pursue and implement policies to bolster the digital infrastructure that will play a pivotal role in transforming care delivery for patients, especially those with chronic conditions. The committee’s consideration of the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017 is timely, as opportunities exist to enhance care delivery by modernizing federal policies to enable existing technology to augment the current care delivery paradigm.

*Expanding Access to Telehealth for the Chronically Ill*

Telehealth technologies offer a multitude of benefits to patients and clinicians alike. Telehealth and remote monitoring services are being leveraged in a variety of ways to meet patient care needs, especially those with chronic conditions. For instance, disease monitoring services can be less expensive, more efficient and more convenient for patients with chronic conditions or multiple co-morbidities to stay connected with their care team.

Adequate reimbursement for hospitals and other health-care providers for employing such services is a complex and evolving issue and, thus, has been a barrier to standardizing the provision of these valuable services. Efforts to revamp the federal Medicare telehealth policies have lagged behind both state and private payers as

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<sup>8</sup>HHS Inspector General, *A South Texas Physical Therapy Practice Claimed Unallowable Medicare Part B Reimbursement for Outpatient Therapy Services*, A-06-14-00064, page 1 (June 2016), <https://oig.hhs.gov/oas/reports/region6/6140064.pdf>.

<sup>9</sup>*Id.* 4.

well as within the Department of Veterans Affairs (VA). Federal leadership is necessary as providers and health systems explore alternative care models to accommodate and encourage innovation and efficiency in health-care delivery.

A great deal of innovation is underway to develop health-care technologies that meet consumer needs often outside traditional care settings. These and other new technologies will be critical for advancing provider success in alternative payment models (APMs) and across federal reimbursement programs. Congress must pursue opportunities to incent and support the use of new and innovative technologies, rather than impede them as some existing federal policies do today.

The provisions in the CHRONIC Care Act that would enable expanded access to telehealth under Medicare Advantage (MA) plans and in Accountable Care Organizations (ACOs) serve as incremental, but important, steps to improving telehealth access for patients and revisiting the inadequacies in federal reimbursement for services. Further, the expansion of telehealth services for use in home dialysis under Section 102 would also be a positive step forward.

Specifically, Section 305, Expanding Use of Telehealth for Individuals with Stroke, would be of value to the industry as access to telestroke services grows. The benefits of leveraging telehealth to identify and administer early treatment to individuals suffering a stroke are indisputable. While telestroke programs are common, there is still room for growth.

CHIME and AEHIT members support<sup>1</sup> the Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act<sup>2</sup> (S. 1016). We encourage the committee to consider if any of the CONNECT for Health Act provisions could be included in the CHRONIC Care Act or if a broader telehealth bill could be considered this Congress.

The committee should also consider how to address cross-state licensure concerns, often imposing troublesome legal barriers to a physician wishing to offer telehealth services to a patient in another state. Policies should allow licensed health-care providers to offer services to patients, using telemedicine, regardless of what state a patient resides in, notwithstanding whether the patient is within a traditional care setting or in one's home.

#### *Improving Chronic Care Through Interoperability*

A high degree of data fluidity is imperative for reducing waste and improving quality within the U.S. health-care system. Chronically ill patients are likely treated by numerous health-care providers across the continuum, making the need for policies that foster interoperability and meaningful data exchange even more critical. The adoption and use of electronic health records (EHRs) has resulted in the mass digitization of patient data, and with proper policies to enhance health data exchange, can revolutionize a provider's timely access to a patient's health history. Important policy goals such as advancement of team-based care, identifying chronically ill populations and empowering individuals and caregivers, will not be possible unless we are able to confidently and consistently identify patients.

The 21st Century Cures Act<sup>3</sup> declared Congress's interest in an interoperable health IT infrastructure. The committee should encourage the Office of the National Coordinator for Health IT (ONC) to include chronic care as they establish and set the agenda for the new Health Information Technology Advisory Committee. Understanding how current technology can be used to improve chronic care as well as to evaluate current shortcomings, such as the lack of ubiquitous interoperability and meaningful data exchange, should be an area of work for the new advisory committee.

#### *Patient Identification for Chronic Care*

Robust health histories and the ability to track patients who could be at risk to develop a chronic condition will be invaluable for prevention and treatment. The concept of a longitudinal health-care record should reflect the patient's experience across episodes of care, payers, geographic locations and stages of life. It should consist of provider-, payer-, and patient-generated data, and be accessible to all members of an individual's care team, including the patient, in a single location, as an

<sup>1</sup> <https://chimecentral.org/wp-content/uploads/2014/11/CHIME-AEHIT-Letter-of-Support-for-Connect-for-Health-Act-2017-.pdf>.

<sup>2</sup> <https://www.congress.gov/115/bills/s1016/BILLS-115s1016is.pdf>.

<sup>3</sup> <https://www.congress.gov/114/bills/hr34/BILLS-114hr34enr.pdf>.

invaluable resource in care coordination. Without a standard patient identification solution, the creation of a longitudinal care record is simply not feasible.

Congress acknowledged the lack of a national solution to identifying patient is an interoperability and patient safety issue in the FY17 Omnibus Committee Report.<sup>4</sup> Congress then went on to clarify that the ONC and the Centers for Medicare and Medicaid Services (CMS) can provide technical assistance to private-sector patient identification efforts.

Health-care technology has, and undoubtedly will continue to, alter how health care is delivered. As the committee considers how to improve the quality and efficiency of care for the chronically ill, we urge members to ensure that the federal policies in place enhance rather than hinder care delivery. CHIME and AEHIT members look forward to working with committee members, Congress, the Administration and all other stakeholders to explore how we can better prevent chronic illness, and treat those with chronic disease, with technology.

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CONNECTED HEALTH INITIATIVE (CHI)

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May 16, 2017

Hon. Orrin Hatch  
Chairman  
Committee on Finance  
U.S. Senate  
Washington, DC 20510

Hon. Ron Wyden  
Ranking Member  
Committee on Finance  
U.S. Senate  
Washington, DC 20510

Dear Chairman Hatch and Ranking Member Wyden:

The Connected Health Initiative (CHI) represents a broad consensus of stakeholders spanning the health care and technology sectors who seek your partnership in realizing the benefits of an information and communications technology-enabled American health-care system. We commend your progress, including convening a hearing to examining bipartisan Medicare policies that improve care for patients with chronic conditions. We applaud your leadership in bringing forward the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017, which would take crucial steps to remove barriers to the use of telehealth, and we commit to work with you to move the country towards a more efficient and effective health-care system.

Today, more than 133 million Americans suffer from chronic conditions such as diabetes, chronic obstructive pulmonary disease, and mental illness. This population is expected to increase to approximately 171 million by 2030. America's health-care spending is expected to reach \$3.5 trillion in 2017, representing 18 percent of the entire U.S. economy, and this spending number is projected to reach 20 percent of the economy by 2025. A strong and growing body of evidence has clearly demonstrated that the wide array of connected health technologies available today improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill. Further, the integration of these connected health technologies has been proven to reduce health-care costs significantly. Today, these connected health innovations represent a main driver in an Internet of things (IoT) marketplace valued at over \$250 billion in the United States. These tools, including wireless remote patient monitoring health and wellness products, mobile medical device data systems, converged medical devices, and cloud-based patient portals, are revolutionizing the health-care care industry by allowing the incorporation of patient-generated health data (PGHD) into the continuum of care. Further, these advanced products and services present the ability to improve research and bring about the faster development of new therapies and cures and to improve meaningfully the lives of the American populations most in need today, such as veterans and those who live in rural areas. A 21st-century health-care system must integrate and embrace these innovative technologies to improve patient care and lower costs.

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<sup>4</sup><https://www.congress.gov/114/crpt/hrpt699/CRPT-114hrpt699.pdf>.

As a community, we believe that any legislation aimed at improving the American health-care system should reflect the benefits today's technology offers by permitting caregivers and patients to flexibly utilize innovations already used in many other facets of their lives to improve patient health care and lower costs. Despite the proven benefits of connected health technology to the American health-care system, U.S. government policies have largely ignored these solutions. For example, due to Centers for Medicare and Medicaid Services (CMS) policies that have remained unchanged for over 16 years, Medicare "telehealth" reimbursements are minuscule (*e.g.*, \$14 million in 2014), and remote monitoring technologies are ignored. You can move away from the backward-facing and outdated policies regarding the use of connected health technology in place today. We seek a partnership with you in revisiting these policies, and we are confident that our unique viewpoints and experiences can lend practical and innovative insights.

We also urge you to consider further opportunities to improve the lives of countless Americans with chronic conditions by leveraging connected health innovations. Specifically, we urge you to consider incorporating key provisions of the recently reintroduced Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act, which has been spearheaded by Senators Schatz, Wicker, Cochran, Thune, Cardin, and Warner, into the CHRONIC Care Act. The CONNECT for Health Act provides a carefully crafted approach to helping countless Medicare recipients realize the benefits of connected health technology by lifting arduous limitations on the use of telehealth, as well as empowering Medicare physicians to utilize remote monitoring technologies. While we support the passage of the CONNECT for Health Act as standalone legislation, incorporating all provisions from it into the CHRONIC Care Act would augment the latter, and would ensure that responsible and secure connected health solutions may be incorporated more broadly throughout the continuum of care to improve patient health outcomes.

Led by you, the 115th Congress has a historic opportunity to make the American healthcare system the greatest in the world by leveraging the wide array of connected health technologies available today, as well as paving the way for future innovations, through the CHRONIC Care Act. We are dedicated to realizing the potential of use of connected health technology solutions to improve the U.S. healthcare system, and we welcome the opportunity to assist you in any way.

Sincerely,

Morgan Reed  
Executive Director  
Connected Health Initiative  
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HEALTH CARE TRANSFORMATION TASK FORCE  
601 New Jersey Avenue, NW, Suite 450  
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June 9, 2017

U.S. Senate  
Committee on Finance  
Dirksen Senate Office Bldg.  
Washington, DC 20510-6200

The Health Care Transformation Task Force<sup>1</sup> applauds the Chronic Care Working Group for its efforts in advancing bipartisan Medicare policies to improve care for beneficiaries with chronic conditions. In particular, the Task Force supports the recently reintroduced Creating High-Quality Results and Outcomes Necessary to Im-

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<sup>1</sup>The Health Care Transformation Task Force (Task Force) is a consortium of private-sector stakeholders that to accelerate the pace of delivery system transformation. Representing a diverse set of organizations from various segments of the industry—currently including patients, payers, providers, and purchasers—we share a common commitment to transform our respective business and clinical models to deliver the high quality, person-centered care at a lower cost. Our organizations aspire to put 75 percent of their business into value-based arrangements that focus on the Triple Aim of better health, better care and lower costs by 2020. We hope to provide a critical mass of policy, operational, and technical support from the private sector that, when combined with the work being done by CMS and other public and private stakeholders, can increase the momentum of delivery system transformation.

prove Chronic (CHRONIC) Care Act of 2017 (S. 870) as a stepping stone to improved quality of care through value-based payment arrangements.

In previous correspondence with the Working Group (February 2016),<sup>2</sup> the Task Force indicated its support for refinement of the CMS-Hierarchical Conditions Category (HCC) model to account for interactions between behavioral and mental health conditions and physical health outcomes. The Task Force is encouraged by the implementation of this policy as well as the implementation of additional provisions of the Working Group's Discussion Draft.

The following comments focus on our priority policy options within the CHRONIC Care Act of 2017, with a particular focus on efforts that advance our members' collective goal of putting 75 percent of our business into value-based payment arrangements by 2020, and promote the broader private sector movement toward value-based care. We encourage the Committee to continue this important work and look forward to additional legislation that would provide for more impactful improvements to Accountable Care Organizations than the provisions included in the current bill.

## **I. Expanding Innovation and Technology**

### ***a. Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees***

Provider networks and Medicare Advantage plans should be able to tailor care to beneficiaries who are chronically ill in ways that best meet their needs. These types of flexibilities will improve clinical outcomes, slow disease progression, and minimize barriers to quality care. We support the Committee's proposal to expand the testing of the CMMI VBID Model to allow a MA plan in any state to participate in the model by 2020, and also ask that this expansion apply to Employer Group Waiver Plans (EGWPs) within Medicare Advantage. Achieving savings without negatively impacting quality is a core goal of the transformation to value-based payment arrangements, and the VBID Model shows promise in this space. The testing phase will be important to determine if the supplemental benefits offered under the VBID model not only reduce barriers to care for high need individuals, but stimulate positive health outcomes while reducing overall costs. To that end, the Task Force also supports increased flexibility within the VBID model to allow MA plans to make positive benefit changes mid-year in order to best meet the needs of their chronically ill beneficiaries.

### ***b. Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees***

The use of supplemental benefits for chronically ill Medicare Advantage enrollees is a patient-centered approach to care that the Task Force supports. Enhanced benefits that would be especially beneficial include those that address barriers to effective treatment. Many of these benefits are not currently covered under the Medicare program given that they are not primarily health-related services (*i.e.*, social services). Important examples of supplemental benefits that address the social determinants of health and reduce barriers to care include transportation, meal services, and exercise and wellness programs. All of these approaches have been known to improve health and overall function as specified by the proposal. We encourage specific inclusion of these services in the bill as examples of supplemental benefits that would be able to be offered in the MA program under the current proposal.

We also ask that the Committee consider allowing MA plans to offer "benefits in lieu of benefits" (*i.e.*, substituting a needed benefit for an unnecessary one, as already offered under commercial plans). This type of flexibility would incentivize use of VBID within Medicare Advantage, and would allow plans to offer enhanced benefits to targeted enrollees. This policy is well-aligned with the Committee's proposal to expand supplemental benefits in MA, as it encourages plans and providers to work together to meet the needs of chronically ill individuals in the most efficient and effective way possible.

### ***c. Providing Accountable Care Organizations the Ability to Expand Use of Telehealth***

Telehealth has moved beyond an innovative approach to beneficiary access to provider services, and has become a part of routine care models. The Task Force therefore supports the extension of the NextGen ACO telehealth waiver to all MSSP

<sup>2</sup> <http://hctf.org/resources-tools-archive/2016/2/1/task-force-letter-to-senate-flnanee-committee-on-chronic-care-policy-options>.

tracks, so that provision of telehealth services under value-based payment arrangements is not unnecessarily limited. We believe that telehealth payments should not be restricted geographically. We also believe that the originating site requirement should be eliminated entirely for ACOs and other similar risk bearing entities. With the assumption of risk, ACOs and other entities are held accountable for unnecessary utilization and waste, and therefore should not be restricted in their ability to provide telehealth services. Further, ACOs and other similar entities are held accountable for quality of care of their attributed patient population, and are therefore incentivized to provide face-to-face encounters with patients when it is clinically necessary.

The Task Force also supports the provision of telehealth services to patients in their home, as this reduces barriers to care for many patients who have mobility or transportation limitations. Bringing care to patients where they are follows a patient-centered approach that will likely improve clinician-patient relationships and increase adherence to treatment/therapy plans, all while lowering the cost of care. We recommend that the CHRONIC Care Act reference the language and principles included in the CONNECT for Health Act (S. 2484/H.R. 4442), which was informed by the experiences of multiple provider organizations.

## **II. Identifying the Chronically Ill Population**

### ***a. Providing Flexibility for Beneficiaries to Be Part of an Accountable Care Organization***

Allowing Medicare FFS beneficiaries to voluntarily elect to be assigned to the ACO, or other similar risk-bearing entity, in which their main provider is participating will increase the number of beneficiaries participating in the program, and the amount of care subject to value based payment arrangements. Given that Task Force members are committed to transitioning away from fee-for-service, we support increased participation in ACOs and other risk models. Voluntary alignment is an important component of a robust attribution model, which itself is necessary for accepting accountability for a population of patients. A robust attribution model is one that reflects a patient declaration of “Yes, this is my provider group” and a provider group declaration of “Yes, this is our patient.” Robust attribution makes a population “more known,” and if ACO attribution is maintained and shared by a payer (including Medicare), it can be used to support information exchange, optimize care coordination, and align incentives across all providers. Simply allowing patients to voluntarily elect to be part of an ACO is not enough, however. ACOs must actively engage in outreach and education that will help patients better understand the benefits and implications of participation.

## **III. Empowering Individuals in Care Delivery**

### ***a. Eliminating Barriers to Care Coordination Under Accountable Care Organizations***

The Task Force emphasizes that meaningfully engaging beneficiaries as partners in care and delivering patient-centered care that meets the needs of patients and families is the best way to encourage beneficiaries to consistently seek care within their ACO and access preventive care or disease management as needed. As proposed, a flat rate payment to Medicare FFS beneficiaries under the ACO Beneficiary Incentive Program would not effectively impact the highest-need, highest-cost population. The Task Force supports policies that lower the out-of-pocket cost burden for beneficiaries, but believes that these supports should reflect the amount and level of acuity of care. For example, a previous proposal by the Chronic Care Working Group contemplated waiving cost-sharing for items/services that treat a chronic condition or prevent the progression of a chronic disease. The Task Force is supportive of this approach, as it more directly addresses the needs of those with chronic illness by correlating with each patient’s out-of-pocket burden.

Thank you for the opportunity to provide this comment. Please contact Task Force Executive Director Jeff Micklos ([jeff.micklos@hcttf.org](mailto:jeff.micklos@hcttf.org), 202-774-1415) or Caitlin Sweany, Director of Transformation Facilitation and Support ([caitlin.sweany@hcttf.org](mailto:caitlin.sweany@hcttf.org), 510-506-8972) with any questions.

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May 23, 2017

U.S. Senate  
 Committee on Finance  
 Dirksen Senate Office Bldg.  
 Washington, DC 20510-6200

Dear Mr. Chairman,

I'm pleased to submit for the record the results of a study we commissioned examining the impact of integrated care for chronically ill, functionally impaired seniors living in seniors housing.

### Background

According to the Partnership to Fight Chronic Disease, more than 190 million Americans, or about 59 percent of the population, are affected by one or more chronic illness. Over the next 15 years (between 2016 and 2030), 80 percent of the U.S. population will experience one or more chronic conditions, costing more than \$42 trillion in medical care spending and losses in employment productivity. The frail elderly population in the United States suffers from multiple chronic conditions, uses the most health-care services and, not surprisingly, drives most of the costs in our health-care system. As baby boomers continue to age, millions more Americans will join this vulnerable population, adding additional pressure to deliver quality outcomes at the lowest cost.

### Findings

Bloomfield, NJ-based Juniper Communities—an owner and operator of senior communities in New Jersey, Pennsylvania, Florida, and Colorado—developed a model called Connect4Life, which promotes the integration of housing and supportive services with clinical care to prevent illness and restore well-being. **New research by Anne Tumlinson Innovations demonstrates that Connect4Life contributed to better clinical outcomes for frail seniors and suggests the potential for Medicare cost savings.**

Compared to the 2012 Medicare Beneficiaries Survey (MCBS), Juniper Communities' population is older, frailer and more cognitively impaired than the research study's cohorts: all Medicare beneficiaries, frail individuals living in the community and similarly frail individuals in other seniors housing communities. Nevertheless, Juniper's performance on key clinical measures was determined to be significantly better than the performance of a similarly frail Medicare population:

- The hospitalization rate was 50% lower.
- The re-hospitalization rate was over 80% lower.
- Emergency department use was 15% lower.
- Juniper's residents also used fewer services.

The Connect4Life model features three key components, each of which contributed to these results:

1. **Co-located services.** Connect4Life provides on-site delivery of primary care and other clinical services, such as comprehensive therapy, pharmacy, and lab services, which fosters prevention and cost savings.
2. **Coordinated record keeping.** The model utilizes one electronic health record that must be used by all providers to share clinical data and performance on various quality metrics. This allows common access to real-time information, increased transparency, and better care coordination.
3. **Human touch.** A human navigator connects patients to caregivers and drives communication between all providers. The navigator also ensures seamless access to and coordination with other services provided through strategic partnerships and alliances.

### Research Implications

Juniper Communities' Connect4Life model affirms the value of integrating clinical care and supportive services in a seniors housing environment to manage population health—in this case, Medicare beneficiaries with chronic conditions, functional limi-

tations and complex social needs. Connect4Life presents a unique opportunity to create value for frail seniors and their families, government, and seniors housing operators.

For the full white paper, visit <http://www.junipercommunities.com/>.

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NATIONAL ASSOCIATION OF SPECIALTY PHARMACY (NASP)

The National Association of Specialty Pharmacy (NASP) appreciates the hard work of the Chronic Care Working Group and thanks the Committee on Finance for holding this important hearing to improve care for patients with chronic conditions; we submit the following written testimony for the record. NASP is a 501(c)(6) non-profit trade organization serving as the unified voice of specialty pharmacy in the United States and dedicated to education, national policy advocacy, and engagement of all stakeholders in the specialty pharmacy industry. Our focus is on specialty drugs, or medications, which are more clinically complex than most prescription medications and are used to treat patients with serious, chronic and often life threatening or life altering conditions including cancer, hepatitis C, rheumatoid arthritis, HIV/AIDS, multiple sclerosis, cystic fibrosis, organ transplantation, human growth hormone deficiencies, hemophilia, and other bleeding disorders.<sup>1</sup>

A specialty drug may be classified as such due to the way it is administered, the side effect profile, the disease or condition it is used to treat, special access conditions required by the manufacturer, payer authorization or benefit requirements, patient financial hardship, special handling, or any combination of these. Based on these characteristics, the payer, provider, specialty pharmacy and/or the manufacturer can or will identify the therapy as requiring specialized services. As a result, specialty prescription medications cannot be routinely dispensed at a typical retail community pharmacy because the typical retail pharmacy does not have the required infrastructure to provide the patient care or other support services that specialty medications require. Specialty drugs are often confused as being only a “limited distribution drugs (LDD).” This is not the case as there are specialty drugs that are not part of a limited distribution network.

Historically, the cost of a medication has been used to designate a medication as specialty. Cost should not be the only reason a medication is classified as “specialty.” In fact, there are many low-cost medications that are classified as specialty because of the unique and labor intensive services required to assure proper utilization and maximize the clinical outcome. For example, select generic oral chemotherapy medications and certain generic immunosuppressant medications require special handling processes and a comprehensive, coordinated care approach to ensure successful therapeutic outcomes similar to those of higher cost therapies. Even though these medications are low cost, they are still considered specialty therapies by plan sponsors. A medication’s classification should be based on the services provided in support of the drug and/or disease state and not just its cost.

The wide range of current specialty drugs require specialized services to ensure appropriate utilization, access and maximize patient outcomes. As a result of this growth and the emerging, evolving and expansive specialty drug pipeline, the practice of specialty pharmacy has also evolved. As more and more patients are living with chronic diseases for which just a few short years ago there were no effective treatment options available, the expert services that specialty pharmacies provide drive adherence and persistency, proper drug and disease management, mitigation of side effects, and dosing optimization ensuring clinically appropriate and safe medication use. The specialty pharmacy’s patient-centric model is designed to provide a comprehensive and coordinated model of care for Medicare beneficiaries suffering from chronic illnesses and complex medical conditions achieve superior clinical outcomes, expedite patient access to care and positively impact the total cost of care for these most vulnerable of beneficiaries.

Specifically, many specialty drugs require significant patient education on both the disease and the prescribed drug therapy. Many specialty pharmacists have specialized areas of clinical expertise, which the prescribing physician relies upon to help explain the nature of the disease and manage the patient’s journey. Furthermore, this pharmacist then explains to the patient the prescribed regimen for the

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<sup>1</sup> The National Association of Specialty Pharmacy recently defined both Specialty Drug and Specialty Pharmacy: <http://naspnet.org/wp-content/uploads/2017/02/NASP-Defintions-final-2.16.pdf>.

prescribed drug. It is through these services that the specialty pharmacist acts as an extension of the physician's office to educate the patient on his/her disease and empowers the patient to use the medication appropriately. This education is a very important part of improving beneficiary outcomes and reducing unnecessary drug spend.

A specialty pharmacy is a state-licensed pharmacy that solely or largely provides medications for people with serious health conditions often chronic in nature requiring complex treatment plans and medications. In addition to being state-licensed and regulated, NASP believes that specialty pharmacies should also be accredited by independent third parties. Accreditation represents a commitment to quality, safety, accountability and the consistent delivery of quality, cost effective health care. Plan sponsors, health plans and other payors recognize the value of independent, third party accreditation and most often require this as a condition of participating pharmacy network provider participation. Accreditation organizations help pharmacies develop their specialty pharmacy capacity and verify their capabilities to manufacturers and third-party payers. Accreditation organizations create standards that are designed to create a consensus around the practice of specialty pharmacy and generally address four primary areas of specialty pharmacy practice, which encompass the overall provision of pharmacy care for patients receiving these medications. These areas of focus include the organizational infrastructure to support the provision of specialty pharmacy care, patient access to medications via manufacturer requirements and benefits investigation, clinical management of the patient, and quality.

Specialty pharmacies serve a critical role in the healthcare delivery system because they connect patients who are chronically and often seriously ill with the medications that are prescribed for their conditions, provide the patient care support services that are required for these medications, and assist patients who are facing reimbursement challenges for these highly needed but also frequently expensive medications. Specialty pharmacies do not establish the price of the specialty drug, but are a significant partner in driving the value of the drug towards a successful therapeutic outcome.

At present, these valuable patient-focused services are under substantial threat due to the assessment of fees that select pharmacy benefit managers and Medicare Part D Plan Sponsors began in 2015 for pharmacies participating in Medicare Part D networks. These fees, termed Direct and Indirect Remunerations (DIR) are charged against specialty pharmacies based on their performance in a number of primary-care focused "quality metric" categories, which are totally unrelated and irrelevant to specialty pharmacies and patients they serve. The DIR fees have therefore morphed away from reflecting post point of sale price concessions (*i.e.*, rebates) to the application of percentage based network participation fees being assessed against specialty pharmacies retroactively for performance with respect to quality metrics which do not apply to the specialty pharmacy nor does the specialty pharmacy have the ability to influence. This transition is threatening the specialty pharmacies' ability to continue to provide the high touch patient care support services that these patients and mediations require. This transition is so dramatic that in January 2017, the Centers for Medicare and Medicaid Services (CMS) recognized the impact of these DIR fees,<sup>2</sup> which have upended the overall pharmacy industry, clawing back the resources that fund comprehensive, coordinated patient care and support services, and stand to threaten the continued ability of independent specialty pharmacies to provide Medicare beneficiaries services critical to prescription drug adherence for complex medications. CMS and Congress should protect Medicare beneficiaries, and the Medicare budget, by ensuring that any DIR or other fees apply quality or performance measures that are reasonable and valid-until such is determined DIR fees should be suspended.

In addition, to ensure optimal access to advanced clinical management services, NASP believes that each plan sponsor should disclose the specialty pharmacies that it has in-network for each of the formulary drugs within the oncology, immunomodulators, multiple sclerosis, HIV/AIDS, HepC and immunosuppressant classes. By doing so, CMS and Medicare beneficiaries will know which specialty pharmacies are in-network by drug and can therefore truly determine if each Medicare beneficiary has access to each of the formulary's specialty drugs. By adopting this process, the agency will also have greater visibility into the network adequacy of each plan. This visibility will help CMS ensure that each Medicare beneficiary will truly

<sup>2</sup> <https://www.cms.gov/newsroom/mediareleasedatabase/fact-sheets/2017-fact-sheet-items/2017-01-19-2.html>.

have access to their needed specialty medications regardless of the plan he or she chooses.

Thank you again for holding this important hearing. We look forward to working with you on developing improvements to address barriers to high-value chronic care medical management via specialty pharmacy services. For more information please contact our Executive Director, Sheila Arquette, [sarguette@naspnet.org](mailto:sarguette@naspnet.org).

