

STATEMENT OF

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ON

**“A PATHWAY TO IMPROVING CARE FOR MEDICARE PATIENTS WITH
CHRONIC CONDITIONS”**

BEFORE THE

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Statement of Patrick Conway, MD, MSc
“A Pathway to Improving Care for Medicare Patients with Chronic Conditions”
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Chairman Hatch, Ranking Member Wyden, and members of the Committee, thank you for inviting me to discuss the Centers for Medicare & Medicaid Services’ (CMS) work to improve care for beneficiaries with chronic disease. CMS is working hard to ensure that all Americans receive better care; that we spend our health care dollars more wisely; and that we have healthier communities, a healthier economy, and ultimately, a healthier country.

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

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

¹ <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>

² Id.

³ Id.

⁴ Id.

care for Medicare beneficiaries with chronic conditions by encouraging better chronic care management in both fee-for-service and Medicare Advantage, while testing innovative models to help identify better ways to provide health care.

Establishing the Payment Framework for Success

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

HHS has set a goal of tying 30 percent of traditional, or fee-for-service, Medicare payments to quality or value through alternative payment models, such as Accountable Care Organizations (ACOs) or bundled payment arrangements by the end of 2016, and tying 50 percent of payments to these models by the end of 2018. HHS also set a goal of tying 85 percent of all traditional Medicare payments to quality or value by 2016, and 90 percent by 2018, through programs such as the Hospital Value Based Purchasing and the Hospital Readmissions Reduction Programs.

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

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

as complex as preventing or treating disease or something as straightforward as making sure a patient has time to ask questions.

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

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

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

Supporting Care Management in Fee-For-Service Medicare

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

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

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

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

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

CMS built on this work by adopting a policy in Calendar Year 2015 to pay separately for non-face-to-face care management services furnished to beneficiaries with two or more chronic conditions. This policy responds to the physician community, which has told us that the care coordination included in many of the evaluation and management services, such as office visits, does not adequately describe the typical non-face-to-face care management work involved with these types of beneficiaries. Providers will now be paid for expanding access to both in-person care and alternative (*e.g.*, over-the-phone) appointments, developing care plans, and coordinating care with other providers. Chronic care management can help to avoid adverse events like unnecessary hospitalizations, improve beneficiary outcomes, and avoid a financial burden on the

health care system. Successful efforts to improve chronic care management could improve the quality of care while simultaneously decreasing costs. Taken together, these policies signal CMS' commitment to improving care management for the chronically ill and better supporting primary care providers, which are frequently on the front lines delivering these services.

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

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

Hospital Readmissions Reduction Program: This program continues CMS' progress towards creating a payment landscape that supports integrated and high-quality care. When patients are consistently readmitted to hospitals, it can be a symptom of dysfunctional and poorly coordinated health systems. Under the Readmission Reduction Program, hospitals have a strong incentive to work collaboratively with other health care providers to manage care transitions and smooth beneficiaries' path back to the home. Beneficiaries with chronic illness, because of their vulnerability, are particularly at risk for admissions and readmissions.⁵ By reducing Medicare payments to hospitals with excess readmissions, this program creates incentives to better coordinate care and reduce readmissions for Medicare beneficiaries, including those with multiple chronic conditions. In Fiscal Year (FY) 2015, the maximum reduction in payments

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

under the Hospital Readmissions Reduction Program increased from two percent to three percent of base discharge amounts, as required by law. For FY 2016, CMS will assess hospitals' excess readmission rates and calculate penalties using five readmissions measures endorsed by the National Quality Forum.

Medicare Advantage

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

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

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

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

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

Chronic Condition Special Needs Plans (C-SNPs) restrict enrollment to special needs individuals with specific severe or disabling chronic conditions. C-SNPs focus on monitoring health status, managing chronic diseases, avoiding inappropriate hospitalizations and helping beneficiaries

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

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

move from high risk to lower risk on the care continuum. CMS has approved 15 SNP-specific chronic conditions for which C-SNPs can target enrollment.⁸ C-SNPs are expected to have specially-designed Plan Benefit Packages that offer benefits and services that go beyond the provision of basic Medicare Parts A and B services and care coordination required of all CCPs.

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

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

Delivery System Reform Demonstrations

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

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

⁹ <http://innovation.cms.gov/files/x/hpi-rfi.pdf>

Pioneer Accountable Care Organization Model: Nineteen ACOs are currently participating in the Pioneer ACO Model, which is designed for health care organizations and providers that are already experienced in coordinating care for patients across care settings. Results from the second independent evaluation of the Pioneer ACO Model show that Pioneer ACOs have generated gross savings of \$384 million in the Model's first two years. Pioneer ACOs generated Medicare savings of \$279.7 million in their first year and \$104.5 million in 2013.¹⁰ Medicare beneficiaries who are in Pioneer ACOs, on average, report more timely care and better communication with their providers, use inpatient hospital services less, have fewer tests and procedures and have more follow-up visits from their providers after hospital discharge. Earlier this month, the CMS Office of the Actuary certified that the Pioneer ACO Model meets the stringent criteria for expansion under the Innovation Center Authority. The Actuary's certification that expansion of Pioneer ACOs would reduce net Medicare spending, coupled with Secretary Burwell's determination that expansion would maintain or improve patient care without limiting coverage or benefits, means that we will consider ways to scale the Pioneer ACO Model into other Medicare programs.

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

Bundled Payments for Care Improvement Initiative: The Innovation Center is testing how bundling payments for episodes of care can result in more coordinated care for Medicare

¹⁰ See <http://innovation.cms.gov/Files/reports/PioneerACOEvalRpt2.pdf>

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

Comprehensive Primary Care Initiative: The Innovation Center is currently testing the Comprehensive Primary Care Initiative (CPC), which is a multi-payer partnership between Medicare, Medicaid, private health care payers, and primary care practices in four states¹¹ and three regions.¹² This initiative includes providing care management for those at greatest risk; improving health care access; tracking patient experience; coordinating care with hospitals and specialists; and using health information technology to support population health. Practices receive non-visit based care management fees from the participating payers, and the opportunity to share in savings. Results from the first year suggest that CPC has generated nearly enough savings in Medicare health expenditures to offset care management fees paid by CMS, with hospital admissions decreasing by two percent and emergency department visits by three percent. Results should be interpreted cautiously as effects are emerging earlier than anticipated, and additional research is needed to assess how the initiative affects cost and quality of care beyond the first year.

Multi-Payer Advanced Primary Care Initiative: The Innovation Center is currently supporting the Multi-Payer Advanced Primary Care Practice (MAPCP), which is a multi-payer initiative in which Medicare is participating with Medicaid and private health care payers in eight advanced primary care initiatives in Maine, Michigan, Minnesota, New York, North Carolina, Pennsylvania, Rhode Island, and Vermont. The demonstration completed its original three-year performance period at the end of 2014 but was extended for an additional two years in five of the

¹¹ Arkansas, Colorado, New Jersey and Oregon.

¹² New York's Capital District and Hudson Valley, Ohio and Kentucky's Cincinnati-Dayton region, and Oklahoma's Greater Tulsa region.

states.¹³ Under this demonstration, participating practices and other auxiliary supports (*e.g.*, community health teams) receive monthly care management fees from the participating payers and additional support (*e.g.*, data feedback, learning collaboratives, practice coaching). More than 3,800 providers, 700 practices, and 400,000 Medicare beneficiaries participated in the first year. Unlike CPC, the eight states participating in MAPCP convene the participants and administer the initiatives rather than CMS. During the first year, the demonstration produced an estimated \$4.2 million in savings. Also, the rate of growth in Medicare fee-for-service health care expenditures was reduced in Vermont and Michigan, driven largely by reduced growth in inpatient expenditures.

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

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

¹³ The five states are New York, Vermont, Maine, Rhode Island, and Michigan.

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

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

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

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

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

Conclusion

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

other stakeholders to continue to improve the Medicare program to better care for its most vulnerable beneficiaries.