

Improving care for Medicare beneficiaries with chronic conditions

May 14, 2015

Statement of
Mark E. Miller, Ph.D.

Executive Director
Medicare Payment Advisory Commission

Before the
Committee on Finance
U.S. Senate

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

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

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

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

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

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

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

Background

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

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

Coordinating care is challenging even in a single health event. The challenge increases significantly for beneficiaries who have multiple events in a year, requiring interactions with a wide variety of providers who have little incentive or ability to coordinate their care. Without

effective care coordination, beneficiaries may have to repeat medical histories and tests, receive inconsistent medical instructions or information, experience poor transitions between sites of care, and use higher intensity settings when it is not necessary. Beneficiaries with multiple chronic conditions also have high rates of rehospitalization, which can result when hospitals do not coordinate with a patient's physician or post-acute care provider after the original hospitalization. In 2010, the 69 percent of FFS beneficiaries with two or more chronic conditions accounted for 98 percent of all Medicare FFS hospital readmissions (Centers for Medicare & Medicaid Services 2012).

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

Reasons for poor care coordination in FFS

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

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

FFS, which contains financial incentives for providers to increase volume, does not discourage duplicative services. If a physician performs a diagnostic test for a beneficiary, and that beneficiary visits a second physician who replicates the test, both physicians are paid the same rate. Thus, providers have little incentive to avoid duplicating services—for example, by

requesting a patient's test results from a different provider rather than simply repeating the test themselves.

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

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

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

practitioners from remaining in primary care practice, and leave primary care services at risk of being underprovided.

Policies to encourage care coordination in FFS

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

Adding or modifying fee schedule codes

One path to bolster Medicare's support of beneficiaries with chronic conditions requiring ongoing and episodic management is to add additional codes to the fee schedule for physicians and other health professionals for a bundle of care coordination services. CMS has taken steps along these lines. In 2013, CMS established and began paying for a Transitional Care Management (TCM) code that covers 30 days of transitional care provided to beneficiaries recently discharged from a hospital or skilled nursing facility (SNF). The TCM payment is designed to cover both an in-person visit with the patient as well as non-face-to-face activities supporting the beneficiary's transition home. In addition, starting in 2015, CMS will pay for a Chronic Care Management code, which is designed to support the ongoing, non-face-to-face management of patients with chronic conditions. The code does not require an in-person visit with the beneficiary.

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

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

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

Per beneficiary payment for primary care

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

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

Readmissions penalties

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

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

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

Medicare Advantage and beneficiaries with chronic conditions

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

MA payment reform

The Commission has long supported a private plan option in Medicare. Private plans have greater incentives to innovate and use care-management techniques that fill potential gaps in care delivery. However, until recently, Medicare payments to private plans were set at levels that strongly encouraged plan entry, and the most rapidly growing plan—the private FFS option—did not coordinate care but merely mimicked the FFS system. This option flourished because MA benchmarks, which are the basis of MA plan payments, were set at levels far above FFS

expenditures. These high benchmarks resulted in MA program growth, but at a high cost to taxpayers and all Medicare beneficiaries, who faced higher Part B premiums as a result of the program's higher overall Part B expenditures. Observing these trends, the Commission recommended that MA benchmarks be reduced in order to align them more closely with FFS expenditures. The Commission's objective was to create incentives for plans to be less costly than FFS, while quality incentives would incentivize plans to exceed FFS outcomes. Enacted legislation addressed the Commission's concerns with the PFFS option and reduced MA benchmarks, leading to greater efficiency in the MA program.

Plans are becoming more efficient; both the Medicare program and beneficiaries benefit

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

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

Special needs plans are available, but all plans should be able to manage chronic conditions

One feature of the MA program is that plans can choose to specialize in the care of beneficiaries with chronic conditions by offering special needs plans (SNPs). The chronic condition SNPs (C-SNPs) offer tailored benefit packages to an enrolled population consisting exclusively of beneficiaries with specific chronic conditions. As of April 2015, there were 52 MA contracts that included C-SNP offerings, enrolling just over 300,000 beneficiaries (or about 2 percent of total MA enrollment). The most common condition covered by C-SNPs is diabetes: 90 percent of the enrollment in C-SNPs is in plans for beneficiaries with diabetes (often in combination with other conditions). By having a plan that includes only beneficiaries with a specific chronic condition, a C-SNP offers a set of benefits that address the needs of that population. For example, C-SNPs for diabetics offer medical transportation as an extra benefit to ensure that diabetics have good access to health care professionals who will monitor the management of their disease. This kind of benefit is offered in a C-SNP in lieu of benefits that might appeal to a more general population, such as gym memberships or a foreign travel benefit.

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

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

conditions, and given that an enrollee of a plan may be relatively healthy on first enrolling in a plan but is likely to develop chronic conditions as he or she ages.

Certain categories of beneficiaries may continue to need SNPs

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

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

The risk adjustment system can be refined to improve payment for chronic conditions

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

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

Quality bonus payments give plans an incentive to improve care

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

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

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

conditions. It is therefore in the best interest of plans to perform well in providing care to beneficiaries with chronic conditions.

There are issues with the star rating system

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

Accountable care organizations (ACOs) and chronic care

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

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

regulatory relief for ACOs at two-sided risk¹, and reduced beneficiary copays to increase beneficiary identification with the ACO.

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

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

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

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

be prospectively attributed and the provider involved (e.g., the physician ordering direct admission to a SNF) must be a participant in an ACO at two-sided risk.

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

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

A strategy to encourage movement from traditional FFS to ACOs that is more consistent with the goals we discuss here would reward ACO providers both with shared savings from reduced utilization and with quality bonus payments when their quality of care exceeds traditional FFS in the relevant market. The first method of reward is already incorporated in the ACO model. The second method, not currently in the ACO model, is to reward providers organized into ACOs that can achieve *population* health outcomes that are better than those produced by traditional FFS in their market. This is being done in some manner in the MA program now; a redesigned approach could apply to both MA plans and ACOs. To be clear, providers who are not in an entity such as an ACO or MA plan that can take responsibility for a population of Medicare beneficiaries would not be eligible to receive such a bonus. The availability of a population quality bonus could make the ACO program more attractive to providers relative to traditional FFS without weakening

performance standards or accountability. Beneficiaries may also migrate to ACO providers because of lower cost sharing and higher quality, both features that would be of particular interest to beneficiaries with multiple chronic conditions. This movement of beneficiaries might also further encourage providers to join an ACO.

Conclusion

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

References

- Callen, J., A. Georgiou, J. Li, et al. 2011. The safety implications of missed test results for hospitalised patients: A systematic review. *BMJ Quality and Safety* 20, no. 2: 194–9.
- Centers for Medicare & Medicaid Services. Department of Health and Human Services. 2012. *Chronic Conditions among Medicare beneficiaries, Chartbook: 2012 edition*. Baltimore, MD: CMS.
- Elhauge, E. 2010. *The fragmentation of U.S. health care: Causes and solutions*. New York, NY: Oxford University Press.
- Kripalani, S., F. LeFevre, C. O. Phillips, et al. 2007. Deficits in communication and information transfer between hospital-based and primary care physicians: Implications for patient safety and continuity of care. *Journal of the American Medical Association* 297, no. 8 (February 28): 831–841.
- Pham H., J. Grossman, G. Cohen, et al. 2008. Hospitalists and care transitions: The divorce of inpatient and outpatient care. *Health Affairs* 27:1315-1327.
- Pham H., D. Schrag, A.S. O'Malley, et al. 2007. Care patterns in Medicare and their implications for pay for performance. *New England Journal of Medicine* 356, no. 11:1130-1139.
- McMillan A., J. Trompeter, D Havrda, et al. 2013. Continuity of care between family practice physicians and hospitalist services. *Journal for Healthcare Quality* 35, no. 1 (January-February): 41-49.
- Schoen, C., R. Osborn, P. T. Huynh, et al. 2005. Taking the pulse of health care systems: Experiences of patients with health problems in six countries. *Health Affairs Supplemental Web Exclusives* (July–December): W5–509–525.
- Were, M. C., X. Li, J. Kesterson, et al. 2009. Adequacy of hospital discharge summaries in documenting tests with pending results and outpatient follow-up providers. *Journal of General Internal Medicine* 24, no. 9 (September): 1002–1006.