



**Chronic Care Management: Is Medicare
Advantage Leading the Way?
DaVita HealthCare Partners
Alliance for Health Reform
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ED HOWARD: We'll try to get started, and we've got a lot of ground to cover and a lot of education for all of us to accomplish. My name is Ed Howard. I want to welcome you on behalf of Senator Blunt, Senator Cardin, our Board directors at the Alliance for Health Reform to this program that examines how Medicare Advantage plans, which now provide coverage to some, what, 15 million Medicare beneficiaries, work for those beneficiaries with chronic conditions. And just to emphasize the importance of that issue, let me remind you two-thirds of Medicare beneficiaries, at least two-thirds in traditional fee-for-service Medicare, have two or more chronic conditions and account for more than 90% of Medicare spending. And we have the unexpected pleasure of welcoming to the dais on this topic, Senator Wyden. He's the senior Senator from Oregon. He's the ranking member of the Senate Finance Committee. Senator Wyden's been interested in healthcare issues for Medicare beneficiaries for as long as he's been in Washington, and long before that as a matter of fact, and here in Washington he's known as someone who looks for opportunities in healthcare and other areas to display his commitment to what he calls principled bipartisanship, which kind of ties in directly with the mission of the Alliance for Health Reform. So, it makes it even more fitting that he kick off this discussion of how best to address the care needs of Medicare beneficiaries with chronic conditions. And I should say that he's been working on this issue with Senator Johnny Isakson of Georgia, his Republican colleague, who unfortunately could not join us today, but we're delighted to welcome to this briefing the Honorable Ron Wyden.

[Applause]

SENATOR RON WYDEN: Thank you and it's good to be with the Alliance. I think it would be cruel and unusual punishment to give you a big speech. Ed asked me to talk for about 45 minutes or so. [Laughter.] That nice young woman in the front, she thinks I'm serious. Her face got all pale. [Laughter.] She was worried that I was going to talk for 45 minutes. But no. What we're doing today is just really launching the program and let me give you a couple thoughts and then, Ed, if you want to open it up for a couple questions we can even do that. Whatever is your pleasure.

I was director of the Gray Panthers Senior Citizens Group for about 7 years before I got elected to Congress. And this was in the days when I had a full head of hair and rugged good looks and I very much enjoyed that kind of period because I was teaching gerontology at several of our universities and really felt I was getting in on the ground floor of Medicare, this wonderful advance passed by Lyndon Johnson in 1965, we all know that makes this a special year for Medicare.

Medicare, back then, was like if a senior broke their ankle and if the senior didn't have too bad a break they went to see the doctor and the doctor took care of it in the office and it was Part B of Medicare. And if it was a really serious break they'd go to the hospital, get treatment, and head home. And back in those early years of Medicare 70% of Medicare spending was for hospital care. That number has dropped dramatically. We're going to talk a little bit about it. But suffice it to say, that was Medicare circa 50 years

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ago. Today, folks, that is not Medicare. In fact, I can tell you, you'd never see another political commercial if it was just about broken ankles. You wouldn't see Democrats and Republicans beating each other up about broken ankles. Today, Medicare is about chronic disease. It's about cancer, it's about diabetes, it's about heart disease, it's about strokes, and if you put Alzheimer's on top of it, that's the entire program. That's the whole ballgame, right there. It's about chronic disease and the percentage of Medicare spending that was for hospital care now has fallen to about 40% and something like two-thirds of those who are on Medicare are now dealing with multiple chronic conditions. So, in a sense, Medicare has become the country's premier chronic care program and certainly this is going to be the challenge of our time. In fact, half of all American adults have at least one chronic condition.

So, today there are far fewer people in the hospital. People who are in the hospital stay shorter periods of time, and you're going to have services in the community play a much bigger role, and that's where there are kind of two pieces to the puzzle. The first is that, in many parts of the country, there's Medicare Advantage. How many of you know what Medicare Advantage is? Okay. Medicare Advantage, they're basically programs run by the private sector where, in effect, that's Medicare for that particular area. You have a coordinated program where they basically cover all of the services for an older person outpatient, and very often there are more choices in it, and they can offer coordinated care that often you won't get in fee-for-service medicine.

So, what we want to do is we want to build on that. We want to build on Medicare Advantage plans so they can be more to coordinate care for people who have these chronic conditions, and we want to hold them accountable in order to have good outcomes. So, what we do in this legislation that Ed referred to, and it's the first big bipartisan Medicare Reform Bill on chronic disease in the Congress—it's bipartisan in both the Senate and the House. In the Senate—anybody here from Georgia? Okay. Thank your Senator, Johnny Isakson. And he's been a great partner. Anybody here from Vermont? Congressman Peter Welsh. He's the leader. How about Minnesota? Anybody here from Minnesota? Eric Paulson. So, we've got two Republicans, two Democrats working together. And what we do is we, in effect, say that we are going to transform this program that just treats sickness to one that also promotes wellness, and it focuses most on patients at risk and it's called the Better Care Lower Cost Act.

So, the Medicare Advantage program gives us a jump start in that direction because it's already moving to coordinate care. But what we also do is make changes for the half of the country that doesn't have Medicare Advantage. How many of you come from areas that really are mostly fee-for-service—don't have much Medicare Advantage? Everybody here got Medicare Advantage? Alright. Well, even in my state, which has the high – second highest percentage of Medicare Advantage in the country, more than half of the seniors and half of the state are in non-MA programs, so they're in fee-for-service medicine.

Here's the kind of challenge we have there. If you have people with chronic conditions and you want to get a doctor and a nurse and, say, a pharmacist to work together they can't get one collective payment for taking care of those seniors. They're all paid in kind of fee-for-service, dopey, silo-driven kind of medicine, so there's no incentive to coordinate care. So, the future of chronic illness, for at least four senators—two Democrats, two Republicans—is let's build on MA, because that's a good model for coordinating care, and where there is fee-for-service medicine let's at least start creating some incentives to break down the walls, focus on prevention, focus on more options on an outpatient basis. And why don't we use that as an open salvo. Softball questions are especially welcome. If anybody's got any of those, but let's talk about what you're interested in for a few minutes.

ED HOWARD: There are some—there are microphones that you can use. If you want to go to them and ask Senator Wyden a question we have time for just one or two, and if you do, I'd appreciate you identifying yourself and your affiliation if you have one. Let me just take advantage of the slowness in uptake here and ask you to talk a little about the importance of having Republicans and Democrats and whether or not that's really going to get you to where you want to be.

SENATOR RON WYDEN: Here's why it's so important. Neither side in the United States Congress has enough votes to have it exclusively their way. So if you're the most partisan person and you say, in the United States Senate, I want my view on chronic care, transportation, or taxes, or anything else, you don't have automatically enough votes to have it your way. You've got to have a bipartisan coalition, so you either build the group of Democrats and Republicans in the Senate or it just doesn't happen.

Now, the most important things in our country are bipartisan. You look back at some of the great social welfare triumphs and they have invariably been ones that have been bipartisan. So this is not something that is just a nice sounding phrase where Congress people stand up and they're wearing blue suits and red ties and they stand up and talk about being bipartisan. This is something that you really need to do; number 1, to pass it and, number 2, in a country where there are sharp differences of opinion, if you're going to sustain it you'd better have bipartisan support.

ED HOWARD: And let me ask my co-moderator, Kent Thiry from DaVita—

SENATOR RON WYDEN: Let's see if we can get those shy people out there to open up, too. Go ahead, Kent.

KENT THIRY: I'll take a question. Senator, you know better than 90% of the folks in the Senate, that the challenges are moving from the siloed fee-for-service care to the beauty of integrated care, and that that kind of change takes investment, and the good news is that there's a lot of gold at the end of the rainbow, but it takes some time. And reimbursement uncertainty, just like revenue uncertainty in other industries, that

uncertainty can dramatically dampen investment in innovation and change because there's not enough multi-year longitudinal stability. What are your thoughts about that?

SENATOR RON WYDEN: Well, Kent, Kent's being too logical for Washington, DC. I mean, clearly, you can't get—it's almost chicken and egg. You know what these opportunities are for coordinated care but you can't get people to make the investments for the coordinated care until they know that the reimbursement systems are going to be predictable and the like. How many of you have heard of SGR, the reimbursement system for Medicare? Right now, as the ranking Democrat on the Finance Committee, we'd very much like to get permanent repeal and replace of the SGR system. This is broken. It's a dysfunctional mess. It really is a fiction, by the way. I mean, it sort of exists but it's sort of honored more in the breach than in the compliance. And Kent, if we can do that and people will help, then have the certainty and predictability about what's coming in terms of Medicare reimbursement, I think that will be a big plus for people being willing to make some of these investments. I mean, for example, telemedicine. Telemedicine is one of the primary tools that we use in our bill, particularly to reach people in rural areas. I mean, part of the challenge has been there isn't as much MA in rural areas as there is in more metropolitan areas, so if you want to extend it you have to advance innovations like telemedicine and, Kent, that would be a perfect example of the kind of investment that we need and, to encourage more of it, you need the predictability and the certainty that the country's finally getting out from under fee-for-service medicine.

I sometimes say what we need to do is take fee-for-service medicine outside in the back and just give it a dignified burial because really there's nothing else I know of that drives inefficiency in such a profound way. I mean, nobody would go to the store and buy sort of stuff one piece at a time if, in fact, you could do more if you could buy a bigger package and it was coordinated and the services were all within kind of, you know, one package. But, for some reason, much of the country, and that's why I mentioned Oregon, we have the second highest—I think we had a Minnesotan right there—you all have the highest percentage of MA in the country. You beat us by like 2%. But even in these states with high percentages of MA, more than half of the seniors still get their care in outdated, clunky, fee-for-service, silo-driven kind of medicine and that's what we're trying to change, both in MA and in the Chronic Care Bill.

ED HOWARD: I think we have a couple of takers from back there, from the audience back there. If we can get short questions we can handle both of you.

AUDIENCE MEMBER: Thank you for your time.

ED HOWARD: Do you want to identify yourself, sir?

TOMMY RATLIFF: Oh, yes. My name is Tommy Ratliff. I work at Evolent Health is the company. I just had a quick question, kind of on the lines of coordinated care. I know you just mentioned telemedicine and I know in-home visits are kind of a big way to have beneficiaries become more engaged, which is a key component of coordinated care. What

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else can Congress do, or even the private industry do to boost beneficiary engagement to help with that coordinated care front.

SENATOR RON WYDEN: What we're going to try to do is find a host of new ways to involve seniors and attractive approaches both in terms of prevention and in terms of coordinated care. One bill you're going to hear a bit about is Senator Portman from Ohio, he and I have introduced a Medicare Better Health Rewards program. And the reason that that's so important is, you know, Medicare provides a free physical to seniors, thank you ACA, by the way. And the challenge, however, is a lot of seniors get that free physical and they walk out without any real sense of direction in terms of what they would do to promote their health. So what we did is we worked with the Oregon Health Sciences Center and the Cleveland Clinic and put together legislation that, for the first time, when older people save Medicare money they would get to share in the savings. Now, these are not going to be huge sums. There's nobody—I mean, if you walk or you go home and you say, Ron Wyden said that, you know, seniors are going to be able to buy Condos in Hawaii with this bill, that's not the case. But relatively small sums of money that create incentives, you know, carrots rather than sticks, I think is something that's pretty opportune. So both on the prevention side and, in terms of coordinating care and one of the things that will be a feature of the Chronic Care legislation is, as you know, in MA, a lot of the MA plans already have one person who coordinates the care for the older person. We've got to figure out how to do that on the private side where you don't have these MA plans, and that's one of the reasons why a collective payment, when you don't have an MA plan, invites one person to coordinate care, check in with seniors, have them indicate that they're paying attention and there are a bunch of providers who are doing pretty interesting things.

I was at a hospital not long ago and they pointed out to me that for all their patients of modest means, when the patient leaves the hospital, the patient goes home with a scale. Goes home with a scale. And that's because they just want to be able to stay in touch about efforts to lose weight. So there's a lot of different ways to do it with, for a pretty modest role for government.

KIRK THIRTY: And let me go ahead and add a few bullet points underneath everything the Senator said, which is totally on. I think if we can create the right environment for investment we are in an ecosystem today, through the technology inflection point in America where we can get spectacular advances in patient engagement. Talk about the scale example the Senator just mentioned. There's now scales that will electronically, through Wi-Fi, communicate with the caregiver and so you know whether or not the patient's gaining weight, which could mean that they're accumulating fluids, which could mean they're congestive heart failure is about to get to an acute stage. In addition, the use of social messaging can create patient engagement—chat rooms and other forms of interaction with nurses, physicians, dietitians, social workers—with a frequency, intensity, and familiarity unlike anything that's ever existed in healthcare, just like it's affecting every other aspect of American life. Remote monitoring technologies are spectacular now. Everything from FitBits and their potential use for certain populations,

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but all sorts of other formats. And even more sophisticated websites. We have thousands and thousands of kidney care patients, for example, who now get very intense interactive dietetic advice from a very well developed website, which also gives them feedback on what to buy, what to buy that they can also cook that tastes okay for the other members of their family because otherwise they won't do the specialized cooking if they have to cook one meal for themselves and one meal for their children that's too different that can destroy compliance in a mommy or daddy. So, this patient engagement frontier, if we create the right regulatory environment, could be an explosive source of patient engagement innovation in the next 10 years.

ED HOWARD: Great. We have time for one last question if you can direct it.

MARIE CASTELLI: Hi. My name is Marie Castelli. I'm with a company called Press Ganey and I want to thank you, Senator Wyman, for all of your work on healthcare. We appreciate it.

My question is about the overlap between the current SGR reform bill and your Better Care, Lower Cost Act. I'm wondering where there might be elements that overlap or potentially, if the SGR reform becomes something that is viable in the near future whether there are elements of what you have in your bill that we could include in that and whether there's been any thoughts to that.

SENATOR RON WYDEN: Great question. And yes, we've spent a fair amount of time on that. The question is, and right now we're waiting to see what the Republicans, who are in the majority in the Senate and the House, want to do with respect to SGR. You know, what I sought to do last year was get permanent repeal and replace, and I continue to believe that had we gotten a vote on the floor last year in the Senate—Senator Sessions objected and so we couldn't get a vote on permanent repeal and replace. I think we might have won. We certainly would've gotten a lot of votes because a great many senators of both political parties think that this idea of 17 patches—we've got 17 patches at this point. How many of you are in your 30's or something? Raise your hands. Twenties-thirties? At the rate we're going we're going to be on Patch number 75 when you guys are on Medicare because all we do is keep patching it up every 6 months, every year. You know, it's time, as Kent was asking about with respect to investment, to, you know, finally repeal and replace this system and put an alternative out there for the country that really resembles the kind of coordinated and integrated care that we're talking about.

So, we'll have to see what the Republicans have on offer. But what I tried to do, even the last Congress because you could see it in the work done by the Senate Finance Committee, is take some of the elements of the Better Care Lower Cost Act and put them in SGRs so as to kind of, you know, jump start it. And I'm particularly interested in this idea of getting a collective payment for providers in the non-MA world to have an advantage to work, you know, to work together. Because it seems to me that if you have people who want to specialize in the healthcare challenge of our time, which is, you know, chronic disease, and yet you don't give them an invitation in the reimbursement

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system to join forces, you can't get the objectives of the bill which Senator Isakson correctly named. After one discussion he said I like this. Better Care Lower Cost. So you bet. The goal is going to be to get as much as the water temperature will bear into the various proposals that may come along. But I can't tell you right now what is on offer from Republicans who are in the majority in both the Senate and House. But I want permanent repeal and replace.

Let me take one last one and we can wrap it up.

MARIE CASTELLI: Thank you.

REBECCA ADAMS: Hi. I'm Rebecca Adams with CQ Roll Call. I wanted to talk about the Call Letter and advanced notice. On February 20th, CMS put out the Advance Notice and Call Letter that would change MA rate, and I wondered if you could talk a little bit about the importance of that. They're going to be finalizing that on April 6th. The plan, the Call Letter, as you probably know, called for a very slight reduction in rates that CMS said would be made up for in coding intensity and they would – the plans would, on average, get a slight uptick in payment. So I wondered if you could look into your crystal ball and just talk about the importance and talk about what you might expect.

SENATOR RON WYDEN: I never want to deflect a question from an enterprising journalist, but I'm still kind of sort of going to do that. Here's – I think everybody knows that my view is you have to have realistic MA rates. And certainly there has been an effort in the past to ratchet down where there hasn't been that kind of reimbursement system. But I'm not going to take a position on your thoughtful question, shooting from the hip and not having a chance to talk with my colleagues. I want to talk to members of the committee and then we'll have some more to say. But it is not exactly an atomic secret that I feel very strongly about having reasonable reimbursement rates for MA and historically in my part of the country, Oregon, in particular, has been penalized for doing a good job. More than anything, let me leave you with this. I think the work that you're doing here today with the Alliance, with Ed and Kent and this, this program, is some of the most important work—some of the most important work being done in American healthcare today. And, if you're wondering if it's important, I'll tell you both political parties—both of them—have missed the importance of the chronic care debate in the past. You can go back and look at the discussion about the Affordable Care Act, and there was virtually no discussion—virtually no discussion—of chronic disease at all. In fact, that only time it really touched on it was I was able, with my colleagues, to get an experimental program where Medicare would start, as part of a demonstration, caring for more seniors at home, which, thus far, has been quite a success. The VA is doing that for the VA population. So what you're doing today, what we have the good fortunate of having the Alliance shepherd, is especially important because neither party has really taken advantage of all of the opportunities, as Senator Isakson quite correctly said, to offer better care, lower cost, and to focus on a population which now dominates the flagship program in American healthcare that's Medicare, and really has gotten short shrift in the past. So, God speed. Look forward to hearing the results of the program.

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ED HOWARD: Thank you very much Senator Wyden. [Applause]

SENATOR RON WYDEN: Thanks, Ed.

ED HOWARD: Okay, we are off to an exciting start here and we're going to continue that level of engagement and involvement. I've asked our panelists to join us at the dais at this point. I'll move my brownie to the other position here. Do you want to make sure people know who you are.

Alright. Thank you so much, Senator Wyden, and I noticed that his Deputy Chief of Staff on Finance was getting a little nervous, so he knew he had to leave. Let me repeat what I mentioned in passing, that Senator Isakson, obviously, Senator Wyden's collaborator in this chronic care initiative, was invited to join us today but couldn't do it and, of course, to restate the obvious, the Alliance takes no position on any legislation, nor do we make policy recommendations, but we love it when people discuss policy options because that's the way we try to educate our audiences and ourselves about what's out there as a possibility.

And I should say that today's briefing builds on the session that we held in early December that sort of described the basics of the Medicare Advantage program, and there's a one-page summary of that session in your packets. Now, the Medicare program's looking to better manage beneficiaries' chronic conditions, obviously, with the goals, as the Senator pointed out, of both improving quality and lowering the costs of care. And we know that many beneficiaries still don't receive the coordinated services they need to manage their conditions.

You heard a lot about payment, both in the session that we did in December and in Senator Wyden's remarks, and it's important to note that there is traditional fee-for-service; there is Medicare Advantage; there is the kinds of practices that would be promoted in the legislation that Senator Wyden and his colleagues are putting forward; there are Accountable Care organizations—ACOs—that are available in most areas, and in each of these now existent options there are different tools and methods available to manage chronic care, and that's what our focus is today.

Obviously, we are pleased to have, as a partner in today's program, the same group that co-sponsored the December briefing; that is, DaVita Healthcare Partners. It's a merger of both healthcare partners which manages and operates medical groups and affiliated the physician networks in half a dozen states, and DaVita, which is a leading provider of kidney dialysis services here in the U.S. and, as you have already discovered, we are fortunate to have co-moderating today's briefing with me, DaVita Healthcare Partners CEO Kent Thiry. His biographical information is in your packets you'll find with those of the other speakers.

Kent, you had a couple of chances to ask questions. Maybe you can now give us some answers.

KENT THIRY: Well, I don't know about answers, but it's our thinking, and we're the largest independent medical group in America. We're not an insurance company. We're not a health system with hospitals, we're a pure physician caregiver organization with more Medicare Advantage patients than any other entity in America of our type—three hundred twenty thousand—and we've been doing it for years and years. And we believe it's a strategic tool for the American healthcare system that there is no other place that's so successfully improves health and drives down costs. There is no other place where there's as much quality data and one of the most powerful things to reflect on with respect to data is it's completeness, its timeliness, and its integrity. And this program ranks very highly in all of those regards.

It also, at this point, has strategic impact on the rest of the healthcare ecosystem in America because once MA penetration reaches a certain level in your city it begins to, those integrated care practices, start to ripple into—even the fee-for-service side of the ledger—once a physician or a physician group or hospital has a certain percentage of Medicare Advantage patients that they're managing on a global basis, they're managing on a longitudinal basis, that they put in an instituted incremental case management and care management and disease management and special programs for the chronically ill, once that reaches a certain percentage of what a hospital or a physician group does those practices tend to ripple into and affect all of the other care in those offices and those health systems and there's increasing data to show this tremendous pick up and ripple effect. So we believe that America is appropriately, and Congress is appropriately, and CMA is appropriately delivered a foundation, a vehicle, for truly driving transformative care over the next 10-15 years, and a lot of that is because the Medicare Advantage program allows for a focused, time-intensive, and sustained investment in keeping the chronically ill from becoming more chronically ill and, most particularly, from being acutely ill. And I'll stop with that.

ED HOWARD: Great. Thank you, Kent. And you have some slides that were prepared for Kent and we're having some technical difficulties. I hope they don't persist through the program. Well. This is what it would've looked like as he talked.

KENT THIRY: So, on this side of our business this is what we do. I won't repeat, but we're unique and it's entirely a physician caregiver organization and we have almost a million capitated lives, meaning we provide, again, longitudinal integrative care for all of them in Medicaid, in duals, in commercial and, most particularly, in Medicare Advantage. I don't know if they have anything else that pop up there or not.

That star ratings, they're worth discussing because they're imperfect but very, very important and this is just to communicate two things. One, just selfishly, that we're really good at what we do; and, second, hopefully to provoke a conversation about how to take these metrics and make them even more powerful. We are fervent, we are zealots when it

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comes to transparency and accountability, particularly on clinical outcomes, and we think there's more that we can do in working with Congress and CMS to develop more clear, more thoughtful, more precise, and more aggressive goals and targets so that we're all celebrating when they're achieved, and all providers have to report against them in a very accountable way.

Next, if there's another, I don't know. And we do a lot of stuff. I'm not going to use up this valuable time, but it's—and this is what you get through improving health over time with patients you take care of year after year, that we pursue proactively to come in and see us, that have far more time with a primary care physician than they ever do in Medicare fee-for-service. We're talking about 5 times as much time, 10 times as much time, 15 times as much time with dietitian support and social worker support. When you do that, even low Medicare fee-for-service admit per thousand area, which is, this is southern California, one of the lowest Medicare fee-for-service admit, hospital admission per thousand geographic areas in all of America, still we come in far, far below by keeping people healthy and giving them attention at home. And, next.

And this is the other part of what we do. We're the largest independent medical group in America. The other thing we do is take care of 35% of the kidney care patients in America. This is the most recent 5-star rating system from CMS applied to kidney care, and again, just hopefully to pay the price of admission for potentially being listened to with respect to talking about policy, we think the price of admission for that is delivering quality today that invites you, engages you, allows you to have a debate about policy for tomorrow. And here, you can see according to the most recent 5-star rating system from CMS, our kidney care facilities are dramatically, dramatically outperforming the other 65% of the industry. It's not even close. Being a big blue bar is a good thing on this. Let me leave it at that. Next. And thank you very much.

ED HOWARD: Okay. Great. Thanks very much, Kent. A nimble performance as well as a substantive one. We're going to start the program of speakers today from the panel the same way we started the panel in December by hearing from Mark Miller. He's the Executive Director of Medicare Payment Advisory Commission, MedPAC. Obviously, as we have heard, one of the critical factors in providing high quality, cost efficient care to beneficiaries with chronic conditions is the system of paying the providers to furnish that care and Mark knows more about how Medicare pays providers in its different systems than just about everybody. So, Mark, thank you so much for being with us.

MARK MILLER: I appreciate it. I think I'm probably going to be the odd man out for this presentation. I think Bob and Helen will talk about specific programs that are related to chronic care management and their outcomes. I've been asked to thread together a few points by the Alliance and so I think my presentation is a little bit different than the following two. I'm also going to have to really motor given the time here. And so. Sorry about that.

So, I'm going to start here and a way to think about Medicare at this particular point in time is there's three payment systems. So you have traditional fee-for-service, you have about 30 million people there. You have about 16 million people in Managed Care plans, MA. These are, as you've already heard, these are plans that are paid on a capitated basis for the beneficiary and are expected to take care of the entire, or almost the entire range of care for the beneficiaries. More recent development is the Accountable Care Organization. There's about 5 million beneficiaries in those. These are a fee-for-service animal and because maybe, I'm going to assume fee-for-service and managed care knowledge here because I assume you all attended the session before and you all listened to what I said before, so I'm going to tell you about ACOs just very quickly here because I've really got to keep moving here.

So this is a set of providers who come together and they take fee-for-service payment but they're agreed to be judged against a per capita spend for the patients that are attributed to them and if they come below that spend then they share in the savings.

Here's another way to think about the ACO. Managed Care organizations market and enroll people. They build networks and they pay claims and, consequently, they have relatively high overhead—10% and 15% when you count those things and a profit margin in there. The ACO, the attribution is done by the Medicare program and the claim is processed by the Medicare program and so their overhead can be thought of as being similar. But the thought process in the legislation that created them is they're still about trying to coordinate care and reduce unnecessary utilization like the MA plans, and I'll try and say a couple more things about that.

The next thing that I need to mention is—the Alliance asked me to mention—that all MA plans are not the same. So the predominant enrollment is in an individual market kind of MA plan where you recruit people and enroll them in the Managed Care plan. But there are certain plans that are actually not open to everyone and a particular set of them are called Special Needs Plans. And this might come up in these conversations which I assume is why the Alliance wanted me to mention these. The thought process here, just so you kind of understand where these came from, was okay, Managed Care plans are generally open to all Medicare beneficiaries. That's not quite true, but generally it's true. But these are plans that are not open to everybody. You focus on specific populations and the thought process is you build networks and services and plans of care that are aimed at certain types of populations. The three populations are dual eligibles, people who are eligible for both Medicare and Medicaid; the chronic conditions special needs plans, which are built around a specific chronic condition, so diabetes, congestive heart failure, and whatever the case may be; and then, finally, institutionalized SNPs, which are people who are either institutionalized or in the community but need an institutionalized level of care.

The Commission studied these a few years back, had some very specific things to say about D SNPs, Dual SNPs, and C SNPs, the Chronic Condition SNPs, but I'm going to skip over that and leave it for question.

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So, the next thing I want to get you to is, so you have these three payment systems—fee-for-service, Accountable Care organizations, Managed Care plans—but they all operate differently. They pay differently, to the extent they have benchmarks in ACOs and MA. They're different. They all have different quality metrics. They have different ways of dealing with risk adjustment. They have different ways of dealing with patient engagement. And so, I'm going to make a couple of comments about each of these sections, then I'll be out of here.

In payment policy, again, we have a pretty good understand what goes on in fee-for-service. There's different siloed payment systems. We pay differently for in-patient versus out-patient care. We pay differently for skilled nursing facility and, say, home health care. And we have different units, whether it's a specific service, an admission, 60 days of home health—very different payment systems and the takeaway is not focused on coordination and driven by volume is sort of the takeaway there.

Managed Care, as I said, gets the prospective payment and is a capitated payment, is asked to take care of almost all of the care of the patient but to understand how they're paid, there is a baseline that is set administratively in law. They bid below that baseline, they take the difference, and they can use that difference to provide extra benefits to the beneficiary. There is value to the plan in doing this because, remember, when they offer those benefits they also have the administrative cost and the profit that goes along with that. The ACO also has a benchmark and if they come below that benchmark they can share in the savings, so there's not an extra benefit but there's a share in the savings.

Now, where the Commission is starting to think about this, and this is longer run, we're making recommendations on fee-for-service and ACOs and MA in the short run, but in the longer run the Commission is starting to think well, look, the program should be financially neutral to the choice. We shouldn't encourage people and pay more to go to one option or another because our research suggests that these options perform differently in different markets. In some markets Managed Care comes under and saves money relative to fee-for-service, in some markets it doesn't. In other markets ACOs tend to come in under fee-for-service and in other markets they don't; and then, finally, there are markets in which fee-for-service neither ACO nor MA comes in below fee-for-service. And so we're trying to think about a payment system that is relatively neutral and lets the best model perform in any given market. Keep in mind, performing also involves quality, which I'll come to in just a second. Those statements were really just payment statements.

The next thing I want to focus you on just briefly is payment needs to contemplate risk adjustment. So if I get a less healthy patient than you get, my payment should reflect that, and if risk adjustment is not accounted for then you're going to get patient selection. Suffice it to say, all three payment systems address risk adjustment separately. I won't grind you through the details; I'll take it on question, but I do want to point out one thing that the Commission has said with respect to MA plans. We did some work and we

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figured out that within the risk adjustment system we're probably, our risk adjustment system is underpaying for the plans who take a lot of chronic condition patients and overpaying for plans who have more healthy patients and we made some recommendations, for example, inserting a straight ahead condition count into the risk adjustment that we think, for example, would bring a better balance in the risk payments. We've also made some other recommendations, but again, I'll leave that to question.

Just in case you're having a bad time we're going to talk about quality and then we're going to talk about patient engagement and I'll be done. Okay.

So, the next thing is on quality and, as I said, it's not just—the Medicare program is trying, as everybody has said, you know, up to this point, to extract efficiencies in terms of cost out of the marketplace. But the other thing that Medicare is always trying to do is to get those efficiencies but also have high quality care. And so you've seen, over time, injections into fee-for-service, value based purchasing, peculiar to the silos. They tend to be lots of measures and process oriented. You have the 5-star system in MA, which Kent has already referred to, and I think he put it well. It has some issues but generally there's a platform there to work with, and there, the quality scores raise the benchmark and if a plan performs better they get more revenue than a neighboring plan, where all other things being equal, has lower quality. And then, in the ACO, it works a little bit different. The benchmark remains the same, how much you share is adjusted by how well you do in quality. And here, again, in case you're missing the theme, the Commission is starting to say look, we need to get a common set of small number, outcome-based measures where the beneficiary can look at fee-for-service, ACO, and MA in their market and have some rational way of comparing, and also the program can have some rational way of rewarding and penalizing good performance and bad performance.

Now we're up to the last topic, and the last topic is patient engagement. Now there's a couple of different ways to think about patient engagement. One of them is how do you send signals to the patient to engage into the coordination of the care and the management of their particular health needs? We think that the tools in fee-for-service are particularly weak on this. It's very fragmented. The payment systems don't encourage it. There is first dollar coverage, which gets in the way of beneficiary decision making, which we can talk about if you want to get into that. In MA, we generally think of the tools as being fairly strong. You enroll, you have a set of providers, you can literally manage care—prior authorization, that type of thing—and you can set price signals within the managed care benefit. One sidebar, these tools, as strong as they are, may not be highly effective for certain populations and perhaps the populations we're going to talk about today, particularly the mental health experience, I think, in Massachusetts has been very difficult and some of these tools are hard going among certain populations.

And then, I would say ACOs probably, in the end, because they're really sort of fee-for-service models, have a weak set of tools and there is at least one recommendation—and this is the last point, I swear to God—that the Commission made here where we said within the ACOs a beneficiary is attributed to an ACO but they can go anywhere they

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want. They can see an ACO provider but they can go outside of that. And we've been talking to ACOs pretty extensively for the last year and a half and one of the ideas that we had was to allow the ACOs to forgive cost sharing for primary care services. So the beneficiary, the story to the beneficiary is you've been attributed to an Accountable Care Organization, and if you go to that primary care physician you don't pay a co-payment. Then the ACO has a funnel in which they can start working with the beneficiary to manage their care from that point. And that's something that we said. And I'm done.

ED HOWARD: Terrific. Thank you very much, Mark. And I was taking furious notes. We will come back with some of the questions that you expected to have asked of you in the Q&A section.

Right now we're going to turn to Dr. Bob Master, who heads the Community Care Alliance of Massachusetts. Bob's a physician. He's board certified internal medicine and CCA is a nonprofit group that provides care to thousands of low income older people and persons with disabilities and we've asked him to focus today on some of the key concerns in serving Medicare beneficiaries with chronic conditions and to point out some of the models that hold promise in caring for that population. And maybe you can comment on Mark's observation about mental health services as well.

BOB MASTER: Yes, we're living the dream when it comes to mental health services. But thank you very much. Commonwealth Care Alliances, I'll describe later, has several thousand people with 4+ chronic illnesses and concurrent issues of social challenges and economic challenges. We're fully integrated, dual eligible, special needs plan with the responsibility for all the Medicaid as well as Medicare benefits.

So let's go through what does the face of chronic disease look like in our population? And Anna tells us all we need to know. She is a 65-year-old woman in a low income community in Massachusetts whose had years and years and years of multiple sclerosis and paraplegia, a neurogenic bladder—that's enough of a problem for life—wheelchair dependent, getting Medicaid services except not getting wheelchairs fixed and adapted at the right time and a fixed amount of personal assistance to live independently without any kind of tuning that. That's not her only problems. That would be enough. And then the array of other issues. She has an addiction, heavy cigarette smoking, and chronic lung disease as a consequence of years and years of that. As she enters middle age, she has lifelong depression, mental illness, prior to her neurologic condition, and prior suicide attempts. She also has complications related to things like her paralyzed bladder and recurrent urinary tract infections and needs for self catheterization. And in the two years prior to enrollment with us, Anna's life was essentially back and forth to the hospital for what are predictable complications of these underlying chronic illnesses. Chronic obstructive lung disease, pneumonias, neurogenic bladder, urinary tract infections. She also had a bed that hadn't been changed—same mattress for 20 years and spending too much time in it because of her paralysis—decubitous ulcers, deep seated infections, needs for recurrent hospitalizations. And there's a story here about the decline and this interplay between one's quality of life, desire to live, and just the cascading complications of

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chronic illness, and the cost issues which were all recurrent hospitalizations and secondary post-hospital care.

One of the problems, from a system point of view, that we're trying to fix, primary care and I think of myself as a primary care physician in a time when I was in a typical practice where you saw 3-4 people an hour and dealt mainly with the medical issues, wholly inadequate as organized to care for the complexity of Anna's needs. And essentially, the more socially and medically complex people are like Anna the more they are on their own. They are on their own. And they are basically touching the healthcare system in many parts, usually emergency rooms and hospitals, but they are adrift in that system. The key point that Anna, I think, illustrates is 90+ percent of all hospitalizations are the result of failures—missed opportunities to effectively intervene on, prevent, or manage the complications of chronic illness, and that was the drive there. And that's the cost issues. It's these dramatic, dramatic costs. And what do we see as the opportunity, and this speaks to the issue that I think Senator Ron Wyden was making, you can't do this in a fee-for-service world or maybe even in an attributed ACO world; that you have to have global payments and an accountable clinical entity that can fully manage their care. And we see that in the dual demonstrations and in the evidence of the movement of fully integrated special needs plans; that you really need to enhance and greatly redesign primary care, and you need to invest in a lot of community based support services. And when you do that we believe all the costs and all the efforts there are the only way that you're going to get a handle on the hospitalizations, the declining health, post-hospital care and costs.

So, what are the models of primary care? If we look here, instead of a doc alone in a room it's interdisciplinary teams. Instead of spending 3% or 4% of a total spend you're spending 12%. A dramatically increased spend. What does Anna need? She needs a lot of services. She needs personal assistance, bided durable medical equipment and supplies, transportation, movement to specialists, integrated behavioral health. The only way you can get that is individualized care plans that determine an array of services, not a distant insurance contract model of covered services and benefits. That you need to think about primary care, not as a building but as a concept in people's homes, and you need to integrate behavioral health, and you have to be available 24/7, and, if you're going to have a system of care for thousands of people like Anna in communities you need essentially a web-based integrated electronic medical records system that's not in a building, clinic, or a hospital but that is in communities all over. And that's an investment—an infrastructure investment in a redesigned and enhanced model of primary care.

And that's what we're really trying to do and it's quite a challenge, and also quite rewarding. Commonwealth Care Alliance, we're nonprofit. We were created many years ago by our advocacy community in Massachusetts to respond to this challenge and the need for a different vision of care, and a belief that you need a total clinical system of care for people like Anna and that simply didn't exist. Today we have a language for some of this. You know, I like the word Accountable Care Organization. That speaks to

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what we think we are—a specialized, population-based, Accountable Care Organization that doesn't have people being attributed to us. We are fully at risk with risk-adjusted premium for all of the Medicare and Medicaid services.

Today we have about 6600 dual seniors, and counterparts on Medicaid. Seventy-five percent are nursing home certifiable and today we have, in our primary care network of over 40 practices around the state, over 100 teams of nurses and nurse practitioners, integrated behavioral health integrated into them. We have almost 1,000 full-time equivalent personal care assistants are funded as individualized care plans and as part of that in our senior program. The most challenging is our one-care, under age 65 program—people with very severe mental illness. We were the first out of the gate with the new demonstrations. We have over 10,000 individuals in that program in the last year, about 3,000 of which have very severe and persistent mental illness and concurrent substance abuse, and we found a community care option to the psych hospital to be virtually nonexistent in Massachusetts. On any given day we'll have 35 to 50 people in psych hospitals and they could be served, 70% could be served in other venues and they don't exist. They've not been built out. It's been a cost shift to Medicare and we'll talk more about that in the questions.

What we found in the under age 65 population, mental illness, developmental disabilities, severe physical disabilities, is there is an extreme sum set that does not have, never had, and never will be able to have a relationship with primary care—C5, quadriplegic, partially vent dependent—not going to be seen in a primary care office. And so, we have two models of care there: primary care network that we wrap and enhance, and a second model that we have to build it top to bottom ourselves, specialized primary care for people with extreme mental illness or severe physical disabilities where we provide psychiatry, mental health clinicians, physicians, nurse practitioners, and nonprofessionals as part of robust teams.

Some of the statistics we really have, and it's a little bit—but the only way we could make it is have dramatic reductions in hospitalizations, and it's been in the range of 48% to 50% over the risk adjusted matched populations in fee-for-service. If we didn't do that we'd be broke because we're putting so much investment in the front end we wouldn't have that. And studies in Massachusetts for seniors, 66% reduction in permanent nursing home placement, and we have achieved, even as a FITA SNP, a 4-1/2 star rating over all these years and we agree with Inovalon that the deck is stacked against us and other dual and FITA SNPs as well.

By and large—these are nice graphs—there's continuous learning. We've been at this for about 12 years and we're continuing to improve. Our trends of hospitalization rates continue to drop and trend as well as issues of readmission rates.

And the last, I think, is just a summary, if you have this. What is the problem, what is the opportunity? And I think I'll stop and turn back the remaining 48 seconds of my time to the moderator. Thank you

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ED HOWARD: Terrific. Thanks very much. We'll give it back to you in the Q&A, I promise, Bob. But right now, we'll turn to Helen Kurre. She's our final speaker, and she is the Director of Medical Practice Integration for Providence Health Plans which provides coverage to about 400,000 Medicare beneficiaries with what CMS judges as 5-star out of 5-star possible quality plans in several western states. Those plans are part of the Providence Integrated Health System that cares for more than 3 million patients a year and we've asked Helen to tell us how her plans help beneficiaries manage chronic conditions and maybe provide some perspectives on the challenges and the perspectives and connect us back to the policy considerations that could be useful to members of our audience.

Helen, thanks for being with us.

HELEN KURRE: Alright. Thank you very much for inviting me. So, Providence Health and Services is out in the west and we have a over 150-year history at delivering healthcare to the communities we serve. Providence Health Plans was formed as a not-for-profit organization about 30 years ago, predominantly in Oregon and a little bit in Washington, to deliver better connected care experiences for the members that we serve in the northwest.

The population that we serve at Providence Health Plans is about 46,000 Medicare Advantage members. We have over 400,000 total lives that we cover through commercial Medicaid and other ASO arrangements. We do offer dual eligible plans as well.

As an integrated delivery system one of the things that I do want to comment on is that about one-third of our Medicare Advantage members seek care by a Providence employee primary care physician. So our network is broad enough that two-thirds of our membership have a choice to see a provider, primary care provider, that is affiliated, partnered with us, but not employed by Providence. And we really attribute our utilization success to having been in MA for 28 years. We've had a strong collaboration with our providers, that's a theme that I'm going to talk about. The health plan maintains low margins and we return surpluses to primary care which contributes to primary care's collaboration on quality, utilization, and even being open to MA patients.

Senator Wyden referred to this, and we have a very high percent engagement in the MA program in our state. Another unique feature of Oregon is that we have a very competitive insurance market. We're one of 19 MA plans that's offered in the state, so we're quite fragmented. I think the impact of having a high MA penetration combined with the competition results in collateral improved care that non-MA patients received because the providers implement systems and structures in their practices. And we'll comment that we have a pretty significant fee-for-service access problem in Oregon.

We take a several prong approach to how we deliver the care that we do. We have invested heavily in healthcare analytics, using claims data, EHR data when we can get a

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results, health reassessment data, to identify trends, patterns, and proactively impact care patterns that we're seeing of our members, and by our providers, with the goal to improve the care for our patients.

We work with our members. We have a host of nurses who engage with members directly to improve their health status. Our nurses apply the patient activation measure, which is a tool that they can use to assess the members' knowledge, skills, and confidence with the goal to help move them along the patient activation measure so that they can better care for themselves and, in the spirit of member engagement, we also utilize motivational interviewing to educate, motivate, and empower members to take control of their chronic conditions.

We collaborate with providers—let me go back on working with members. One of the things that we don't do is get in between the members and their primary care provider. Our goal is to strengthen the relationship between our members and the primary care providers. And separate from that, we do collaborate with our providers and, first and foremost, is making an investment in primary care. Our reimbursement model is Shared Savings, and our long quality bonus program that we've had in place long before CMS 5-star, helps to do that. We participate in the comprehensive primary care initiative which helps to support the care that primary care providers participating in initiatives can deliver in Oregon. And we feel that our investment in primary care has resulted in systems of care that our primary care providers have been able to implement to manage downstream costs and, again, this is a test by the CPC as well. So our payment model allows for innovation by our organization and primary care providers and that innovation goes back to primary care providers doing care management in their practices, primary care providers doing phone-based visits to what we're seeing now being e-visits, we are seeing behavioral health integration in the primary care practice, and we're looking forward to more tele-health opportunities as well as implementing an elder in-home program which will be an intensive in-home comprehensive care program for the frail and vulnerable members.

Our member engagement rates in our care management programs is very high, as you can see here. Our care management programs range from complex case management to disease management programs, educational programs that our nurses provide for the five conditions that you see there, to simple care coordination activities. We provide this at the plan level, we coordinate with any care coordination or care management functions that a primary care provider might be having and we take referrals into our plan as well as help make any transitions that we need to for the medical home neighborhood.

And these rates are significantly higher than what you might see for fee-for-service engagement rates for the diabetes self management training, just to give you a scale idea. The G0108 and 09 codes for the diabetes self management training and fee-for-service were about 5%.

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And so what we've really achieved are great outcomes. The 25 plus years we've been an MA have really had an impact. We have had favorable utilization trends and high quality and both of these are validated through national benchmarks. I'm showing you that disease management purchasing consortium data here, which shows a 36% decreased trend between 2002 and '13. Our PHP, Providence Health Plan, event rates are 42% below the national average for those where we have disease management programs for who are nurses at the health plan are working with our members. And, like Dr. Masters experienced, in MA we also have a low 30-day readmission rate of 9% and we've had that for two consecutive years. We are one of 11 MA PD plans out of nearly 400 to have achieved those CMS 5-star rating and, of those 11 plans, we're only 1 of 5 that are not a staff model HMO.

One of the interesting things that we've done is taken our competencies at the health plan and either transferred them or transferred the knowledge to various ACO models that we have in our delivery system. So, one being the Medicare Shared Savings ACO, but also various employer group direct to physician ACOs that Providence has. Some of these competencies include that around population management, providing proactive care that's not bound to the context of an office-based visit. How we deliver care management, from risk stratification to patient activation, effective innovation. Now, we've already tested in the MA space. We're bringing that innovation over to the ACOs. And one of the harder things to make a difference in is creating that culture of improvement, working with providers on performance transparency, working with providers on their willingness to look at data and, quite frankly, to believe the data and want to improve on it. We believe integrating quality into operations is important, that it's operational not a project. And some of the areas where we've had learnings from our HMO or MA plan to consider in the ACO models include the referral concept, not from the old gatekeeper days, but really from the idea of helping to get the member engaged to get their care coordinated through their primary care provider or their medical home and to have their care received by their medical neighborhood.

We think we've learned a lot from prospective assignment and understanding who the patient population is and we believe that that is something that we need to figure out how to translate into the ACO model. In lieu of not having prospective assignment how do you know who your population is? And, in the end, we provide a high value plan option, and we feel that comes from the high density of MA patients we have in our PCP practices, the strong collaboration, our care management, the member engagement—all of that really has helped to create a plan that is low cost and high quality and a great option for our Medicare beneficiaries in our community.

ED HOWARD: Terrific. Thank you very much. We now have your opportunity to rejoin the program as we had some opportunities with Senator Wyden's part of the program. I neglected to tell you before. You probably know it. There is a green card in your packets that you can use to write a question on and it'll be brought forward and those of you who are having to leave, before you end up in the hallway, please fill out the blue evaluation form that you'll find in your packets because we want to hear from you, if you're

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particularly from Congressional staff, as Senator Wyden noted, we really want to make sure that you get the best chance to get educated on the things you think you need and that'll help us adjust our programs to meet that goal.

I would ask you, I remind you to identify yourself and your institutional affiliation if you go to the microphone and, coincidentally, we have someone at the microphone. Mike.

MIKE MILLER: Thanks Ed. I'm Mike Miller. I'm a health policy communications physician. Mark talked about sort of the structure of MA, fee-for-service, ACOs, but mostly around the Medicare Part A and Part B. I wonder, Mark, if you had any data on how many of the 60 million enrollees in MA are also getting the Part D benefits through their MA plan, and then if the other speakers could talk about the importance of pharmaceutical Part D benefits integrated into the rest of MA as it relates to care coordination and efficiency, etcetera. Thank you.

MARK MILLER: I don't have that number right in my head, but I would expect that the vast majority of them are getting their Part D benefit as part of their MA, as part of their MA plan.

KENT THIRY: And I'll just add to that just a comment on the clinical and economic importance of integrating the pharmaceutical aspects of care to the rest. I'll just give one example in our C SNP type of plan that was referred to by a couple of the other speakers where we provide integrated medication management to our dialysis patients and we do this for about, at this point, half the patients that we have in America so it's almost 20% of the patients in America and after between 24 and 30 months versus a control group there's a 14% drop in hospitalizations and a 21% improvement in survival. So, it is hard for people that don't have a mother who's 84 with diabetes and hypertension and some heart issues and some chronic pain, like my mom, it's hard for you to envision what it's like to have 7 or 8 prescriptions and 13-14 pills and they're different colors and trying to integrate that into your life, and the incredible consequences when you can't. So it's truly clinically and economically one of the most powerful levers and therefore so important to the second part of the question, to keep the Part D type of issues integrated with the A and the B.

ED HOWARD: Anybody else?

HELEN KURRE: At Providence Health Plans, the majority of our Medicare Advantage members receive Part D services through our health plan. The combination of having our in-house pharmacists who have the data at their fingertips to share with our nurse care managers to deliver very effective medication therapy management programs has been really beneficially. I believe that's reflected in our star ratings overall.

The one gap that I would comment on is that I think we need to do a better job—we, the great big we—at figuring out how can we share back pharmacy claims data back with our providers. Providers know who they prescribe medications for and the challenges around

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medication adherence. They don't know who picks up prescriptions and when they pick them up.

ED HOWARD: What kind of adherence or compliance percentages are we talking about? Do you have those kind of data?

HELEN KURRE: I have our data and we're a high performing plan so our adherence rate is around—the anti-diabetic agents and statins and whatnot—are somewhere around 80%. One of the new guidelines the ACC/AHA guidelines around statin intensity is really looking at our patients receiving the right dose of their statin for the condition that they have. That's been a challenge for providers because providers think that they're prescribing and because of concerns over toxicity patients actually aren't filling the medications and that's one of the barriers we're seeing.

BOB MASTER: I wanted to follow up. Like you in Providence, we have a fully integrated Part D. It has to be that way and I would just say I think one of the untapped opportunities of that, among many, and for the seriously mentally ill, since I'll come back to this challenging population, is that we find that these, more often than not, people are receiving multiple prescriptions for psychoactive medications from multiple disconnected providers. And in the most irrational way imaginable, this is Massachusetts that has probably the best on-going, on the ground primary care system so I can only imagine what it looks like anywhere else, and that gives us real opportunity to start to try to rationalize that, to try to move the risks of issues of adverse reactions to medications with multiple disconnected providers without information are enormous in these populations. We've already seen it. It came to us that way. And so, the opportunity of integrating Part D and, as you mentioned, the data is really, this is the opportunity really for the first time, perhaps, in people's lives, to have some rationalized approach to medical management.

KENT THIRY: Let me just add to Ed's direct question, the corresponding percentage of typical compliance in an unmanaged population with some chronic conditions is probably in the 40-55 percent range. So when Providence and we, and Bob, talk about 80 to 95 percent it's a spectacular change. And you don't want to think about this just in terms of the very extreme cases where Bob and his people in their beautiful work, if you're talking about a 58-year-old with diabetes and hypertension, so there are millions and millions of Americans like that, some just never bother to do it after their 7-minute normal fee-for-service PCP interaction with no follow up from a nurse or social worker. Some have economic issues and just can't afford it and so start cutting back. Some, every month, just refill the prescription a week too late. That's a 25% leakage rate in compliance right there. Some are too busy and so you kind of go on down the list. So these are not unusual Americans. These are people like us in the room who end up that without the right patient engagement, without the right proactive follow-up, without the right education, and without the right technology, that compliance slips down very, very quickly and leads to dramatic acceleration of the demise of the diabetic condition or the hypertensive condition and the interaction thereof. So it's not just 2% of America that has a medication

compliance issue. It's a hefty percentage of the chronically ill that are in an unmanaged environment.

ED HOWARD: Very good. Yes, go right ahead.

DAVID FEGLEY: Hello. My name is David Fegley. I'm with the Association for Community Affiliated Plans. My question is primarily for Mr. Miller. I was wondering if you could share any of the work that MedPAC is working on right now in regards to either a short term or long term fix to the star rating system, particularly as it pertains to the D SNP Medicare Advantage Plans.

MARK MILLER: What I can share, I think is what your question is about, there's been an issue churning in the 5-star world about plans and I think somebody up here made this comment, I think, how disadvantaged it is if you have dual eligible population and it's much harder to hit the five stars. So, a couple things that we would point out. In the risk adjustment work—and I'm jumping away from the five stars for just a half a second—we also found that there's big differences between partial and full duals. And so one point I would get across is that we're trying to take a look at the 5-star system and understand a little bit better when people say, well, it's the duals, whether that's a uniform statement because we all say the duals and I know there are people at this table who understand this much better than me, but the duals are not the duals. There's a whole bunch of populations underneath that word. So there's that.

The second thing, and we talked about this, I think in our December public meeting, but I can't remember which meeting it was, we also parsed it a bit and looked at the number of disabled beneficiaries and, again, saw a stronger pattern there, so I'm not prepared to say we know what the problem is and we know what the solution is but we're beginning to think you need to look at the performance of the plan and disaggregate a bit to which populations they have, and we're beginning to think that the disability populations may have a lot to do with it.

And then, the other piece that came out of some of our work was, and I think other people have seen this too, is some of the compliance measures on the D side that feed into the stars seem to be dragging down some of these plans. I actually had a question on the compliance stuff. For the people at the table who were talking about compliance, in your organizations, is compliance measured by anything beyond filling the script, or is it script fills?

HELEN KURRE: I was referring to our star measures in the Part D on the medication adherence there are three measures that do look at an adjusted fill, percent of days covered.

MARK MILLER: So let me ask it just a little bit differently. Inside your organizations do you have measures anything beyond the filling of scripts?

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HELEN KURRE: So whether or not patients are actually taking their medications—they fill it, but are they actually taking it?

MARK MILLER: Yes. And the big disconnect for us, at this level, is we can measure kind of fill rates but that doesn't necessarily mean compliance and so I've always felt blind.

HELEN KURRE: It certainly is closer than prescribing rates but one of the things that we look at is through our MTM program. We have a better understanding actually if they're taking it and comparing it to our claims data.

KENT THIRY: What we would add is, separate from those measures, two points. One is the degree of patient engagement to the extent to which when you talk with the patient you can find out if they're taking it independent of fill, so that's a constant part of our medication management, but secondarily, for many of our chronically ill we send people to their home and we have nurse practitioners who are dedicated. A hundred percent of their job is to visit home to home and we have a smaller number of physicians who are 100% home physicians. And one of the reasons we do that is to evaluate more what the actual dietetic environment it is, what the actual drug compliance is, because you go look in the medicine cabinet and see what's been used and not used, and you've been there before so you can start to assess that. So it doesn't end up being sort of statistically presentable, which is why we end up doing some of the other metrics, but for the chronically ill that's important.

BOB MASTER: And I would say that if I had to think of one outcome measure that really relates to compliance would be the measure of hemoglobin A1C's in a diabetic population and obviously, if you have a substantial percentage that have hemoglobin A1C's of 7, 7-1/2 or below, that's probably as good a measure of compliance for medication as any.

ED HOWARD: And, Bob, I think you're probably as likely to have an answer to this as anybody, although others are certainly welcome to chime in, but how about the factor of low income enrollees? Does that present a larger barrier to getting the kinds of compliance levels that you're trying to get to?

BOB MASTER: You know, income—there are so many challenges in the low income population, but within that, there's just a wide variation. So I would say, if I were to say, we do remarkably well with our low income senior population in terms of their family support, in terms of long term services and supports that are there when there's ADL dependencies. Where we see it fall of, in another segment, is really the younger populations that have just this complex mix of social determinance in their lives—intermittent homelessness, substance abuse, alcohol, mental illness, and chronic illnesses. This is an extraordinarily challenging issue. A great deal of trauma in people's lives, distrust of the healthcare system, healthcare system is a source of that trauma for many. You put all that together and you have real challenges around trust and compliance.

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KENT THIRY: I would say our experience there's a powerful correlation between being lower income and health status and access to health services. When you make \$15 an hour you don't have the same flexibility to get off of work and go and see your doctor. If a fee-for-service doctor you're going to see them for 7 minutes and get that flu shot or get whatever specific condition you came in for done, but they're not going to see if you recently contracted diabetes. They're not going to offer any follow-up. They don't often have the same educational status to think of asking about those things, and so we find a tremendous, powerful correlation between folks at lower income and the way that they access the healthcare market, which is why Medicare Advantage to them is a gift, which is why a higher percentage of Medicare Advantage is lower income than Medicare fee-for-service.

ED HOWARD: Go ahead. Helen.

HELEN KURRE: In our dual eligible population we also have seen a difference. The question to me is really about the solution and reweighting the measures and whether not that changing the design of the CMS star program frequently does create administrative burden for health plans and providers. So, this was a solution. Is it the right solution, does it create different problems are the sort of things that are yet to be determined.

MARK MILLER: The other thing that we tried to talk about, and maybe this actually returns to the question which I took off point, we also tried to think about, in a different context, is the notion of saying if you have a quality metric you don't want to adjust that metric, and I'm pretty sure you guys would agree with this too, and say okay, if you have more poor people then it's okay for poor people to not have compliance or not have, you know, whatever the quality metric. And what we've tried to talk about is the notion of you keep the measure relatively transparent and so a plan may perform more or less well on a given quality metric, but you may adjust the impact of the payment effect on the basis of how many, you know, poor folks or non poor folks that a plan has, so that you keep the transparency and some pressure to improve, but you have some adjustment for the actual dollar impact on, in this conversation, the plan.

ED HOWARD: Good observation. The schedule says we're almost out of time. What I'd like to do is to take the questions from the people who are standing and I know you'll be as brief as you can to get your point across, and we'll exercise the co-chair's prerogatives to extend the program long enough to accommodate all of you. Yes, go ahead.

MARSHA MARSHALL: I'm Marsha Marshall with the National Coalition on Mental Health and Aging and I want to thank Dr. Master for all they do for the population with both serious mental illness and other behavioral health problems. But one of the fundamental issues of our interest is what are you doing about behavioral health workforce issues, because that certainly affects your compliance.

BOB MASTER: Good point. I mean, and behavioral health workforce, we're talking about everything from the professional level—psychiatry, nurse clinicians, social worker—on down to the nonprofessional community health worker and the like. And obviously I think what we're saying is that the robust interdisciplinary team has to include that mix. They have to be together integrated with primary care. It's siloed. And to the extent possible, sited in the world where people with mental live, so with often human service providers. That's the north star and I guess if you don't know where you're going all roads get you there, that at least tells you where you're going.

ED HOWARD: Yes, go ahead.

CHRIS METZLER: Hi. I'm Chris Metzler. I'm with American Occupational Therapy Association. We're ready to be part of the behavioral health workforce any time we can work that out, that's where their roots are. I have two things. One, to say that it's been interesting to hear aspects of the models like increased home visits, because occupational therapists work on engagement past the knowledge stage to integrating the right behaviors into their habits and routines. And doing that in the home or the normal environment is important so it sounds like you're integrating some of those things. My second thing is as a consumer. My mother's been on Medicare Managed Care for a long time. She's never had case management. So I've been looking for research on the models and I would love a second panel to talk about the real models—how you work with the primary physicians, how you work with the pharmacists, how you work to get my mother to the right neurologist so she's not shopping for 8 neurologists over the past year for her Parkinson's disease, somebody to make sure she gets her skin screening for melanoma. All of it—because she's had it—all of these things are not paid attention to. The first case management she had came after a hospitalization. It was a separate company that did case management visits, wasn't of value at all. Now they've integrated it so it's a person she can call and talk to, but they don't do anything about her care. So I'm wondering if there's any look to evaluating where Medicare Advantage is spending money on care management and then, further, a little more on is there any research on the types of models that are being used? Thank you.

KENT THIRY: I'll give our own answer that in our environment two things can trigger the assignment of a clinical quarterback, a case manager, whatever label you want to use. One is the primary care physician can activate that after he or she would sit with your mother and assess the totality of her condition and her environment and her support network. And secondarily, we have some software algorithms which identify patients that, for whatever reason, we might think are slipping through our primary care or outreach practices, so those are the two ways. And then, once you're assigned one, then they are the clinical quarterback that we all dream of.

BOB MASTER: Very quickly, I think rather than having primary care over here and then there's another function of care coordination over there, to the maximal extent possible we really have that in the same people. An interdisciplinary team—nurse, nurse

practitioner, physician—that does the primary care, but they also, I guess, have the checkbook and they can order, authorize services and coordinate services as well.

CHRIS METZLER: I just wanted to say, she's not in either one of your programs, and if I could move her I'd put her in one of those. But I am concerned about the expenditures that are being claimed for what is very minimal and even negligent case management.

ED HOWARD: Could I just ask more broadly, is there not a patient satisfaction quotient for some of the quality metrics that would help you identify what the good plans are and what the less good plans are?

HELEN KURRE: Well, that's the intent of the star rating system, to make all of that transparent. And whether it's the clinical measures that are looking at what percentage of members are receiving evidence based care or satisfaction measures or experience measures, such as those around the Health Outcome Survey, or the CAP Survey—all of that boils up into the CMS star ratings program and that certainly is transparent.

MARK MILLER: And, I mean, in some ways the point I think you're making indirectly is managed care plan isn't a managed care plan. I mean, there's a lot of variation out there. You can see it in the quality metrics. You can see it in the spend and all the rest of it. There's variation just like there is in fee-for-service. Some parts of the country practice patterns are very different than other parts of the country. So I think the answer is along the lines that have been said here, which is are there measures that can help a consumer point more directly to a plan that they want. And I think there's also some assumption that people will move out of plans when they're not performing well and go to plans that perform better. The thought process is, if you do better on 5 stars you get paid more than the neighboring plan, let's pretend, you know, the plan you were talking about. That gives that plan more resources, they can offer more services, and, in theory, are going to draw people out of the poor performing plan. That's what the intent of the five stars are. There are issues in that measurement process and there will be until the end of time, but that is the intent and the direction that I think it's trying to go.

ED HOWARD: Great. Go ahead, Kent.

KENT THIRY: I just want to add to it. It's one thing to identify the patients in need but the second thing is the regulatory and reimbursement environment has to create incentives and a runway for making these kinds of investments which have a long term return for society. The current proposed rule, for example, advocates moving to a new risk adjustment model that is no more predictive than the old one, the R-squared, which is a statistical measure of predictiveness that is no better, and takes money away from the most sick. And if you think about the whole beauty of the Medicare Advantage program you always want it to lean toward incentivizing pursuit of the sick and the most at risk of being sick and create incentives for us to make these massive long term investments in order for society, that patient, and their family, and that employer to get the return. And so, we hope that a lot of people are looking carefully at this new model because there's

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no logic to us, at this point, to not only take money out of the program but to take it away from the most sick and the most at risk of being sick, and it creates tremendous risk of people beginning to focus on pursuing the healthy elderly as opposed to the sick elderly, which is where we live. We're not a plan. We're a provider group. We don't want to leave our patients. We can't leave our patients. We're in the geographies we're in. We're with the doctors we're with and to take money away from the most sick to us is really scary.

BOB MASTER: I just have to echo that well said and this is an existential threat to us. We're a provider entity that is caring for, is designed for the sickest and, as we look at this proposed change, it's potentially catastrophic.

ED HOWARD: And that actually is a response to a question we got on a card, so I'm glad you gentlemen both addressed it. The last question is coming up, and folks are going to take, if they haven't done it already, they're going to take the time listening to the question and answer to fill out the evaluation form, if I were to press you a little bit on that. Yes, sir. Go ahead.

DAVID LIPSHUTZ: Thank you. David Lipshutz from the Center for Medicare Advocacy. I think we heard quite a bit about some promising programs in Medicare Advantage and some promising potential outcomes of enrollees, however, by and large, these positive outcomes have not necessarily been reflected in much of the rest of the Medicare Advantage program. We know that, on the average, Medicare Advantage beneficiary actually tends to be healthier than the non Medicare Advantage enrollee, and despite the fact that Medicare Advantage plans, as referenced by Senator Wyden earlier, continue to get over payments with respect to payment to traditional Medicare over the years, we haven't seen significantly improved outcomes from Medicare Advantage enrollees. So how do we translate some of these positive health outcomes to the rest of the Medicare Advantage program with an answer other than we need to continue Medicare Advantage overpayments?

KENT THIRY: I'll take a first stab at that and other folks can add. Very important question. First, you know, we can comment authoritatively on what we do and the metrics are very, very clear, and an area where there's already parity, and we're generating a lot of value in that context. But more broadly, when you introduce structural change in anything, particularly in sort of a complicated, high-fixed cost, ecosystem like healthcare, and so suddenly you say, okay, there's going to be 500 organizations that are suddenly going to take Medicare Advantage lives, 20,000 lives each out of the 140,000 people they cover—Medicare, commercial, Medi-Cal—now go start doing it. In real life, you would always expect some element of a failure rate even if it is a great idea because some of those organizations are not going to be nimble enough to attract the talent, to invest the capital and the technology, to incur the operating losses when you're changing so much to deal with the organizational friction with conflicting incentives, with surgeons who want to put folks in and not deal with managed care. And so, it would've been grotesquely naïve to presume that every organization that takes on the formidable

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challenge of creating an actual integrated care environment was going to succeed. You would instead say oh, a third will fail. They might stay in it because it's embarrassing to get out or it's hard to get out or they still have strategic hopes, but in the meantime they're adding no value. Anyone who actually is an operating executive, we have 67,000 teammates in America, so physicians, nurses, social workers of every type in states across the nation, we would've said a third of the groups that do it will totally fail because it's hard and it takes sustained investment and talent. Another third will do a mediocre job in their first 5-6 years, and then the final third will actually succeed. And the good news is that they're going to create the examples, the anecdotes, the pressure, the technology precedence, they're going to provoke systemic behavior, they're going to develop new clinical protocols so people will move around, so and for America that winning third, those practices and insights are going to start filtering to the rest of the population. And that's exactly what we're seeing now, the fruits of 15 years of a mixed track record really starting to blossom. But, Mark, you, in some ways, I'm precocious in answering when you're on the panel.

MARK MILLER: I know that this was a question directed to others. Our position on this has been clear and I said it in the comments, we are seeking a payment system that's neutral to the model and that, you know, doesn't pay one model over another model and that the performance of the model, both in terms of saving money or if it doesn't save money at least improving quality, would be the judgment of how the dollars would flow. But we've taken the position that there were years of overpayments in MA and we have called for a financially neutral system. I assume this wasn't headed to me, but maybe you had intended it that way.

BOB MASTER: And I'd just like to comment that as a fully integrated dual eligible specialties plan that's a care system, not a primary insurer, although we have those functions, we really have no business being in Medicare Advantage. The mismatch between Medicare Advantage and all of the elements and regulatory oversight issues and quality oversights could not be greater. I could go through one species of insanity after another. But that's where we are, and maybe in the future, entities like ours, will go to another—the Medicare-Medicaid coordinating office might morph into a place that does integrated care and others that put a more appropriate framework on it. I don't feel like we're a part of that. We're forced to be in that world but it doesn't reflect what we are.

ED HOWARD: So, it sounds to me like we may be talking about this topic for the next period of time. We may not wrap it up before the Easter recess, even next year.

Thank you all for staying with it. I'll remind you that there will be a video recording of this briefing available on the Alliance website at allhealth.org probably tomorrow, if not, the next day, and a couple of days after that we'll have a transcript posted. We'll try to send a note out telling you that all this stuff is available. All of the materials in your kits are available on our website as well.

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Thank you so much for helping, I think, a very largely and useful conversation take place on a very complicated topic and thanks to our colleagues at DaVita for both being a major part of the program and helping us put it together. I'll ask you to join me in thanking the rest of the panel for an absolutely wonderful conversation.

[Applause]

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