The Better Care, Lower Cost Act of 2014

Sponsored by:

U.S. Sen. Ron Wyden, D-Ore.

U.S. Sen. Johnny Isakson, R-Ga.

U.S. Rep. Erik Paulsen, R-Minn.

U.S. Rep. Peter Welch, D-Vt.

The Future of Medicare is Better Care, Lower Cost

The current debate over the future of Medicare largely features two viewpoints: cut benefits or defend the status quo. Sen. Johnny Isakson, Rep. Peter Welch, Rep. Erik Paulsen and I have worked on an alternative to these limiting views: better care at lower cost.

Today's Medicare population is much different than it was in 1965 – seniors are living longer, but with more cancer, heart disease, stroke, and diabetes – yet Medicare has failed to adjust to today's realities. Given the coming age wave, the cost of caring for Medicare beneficiaries will continue to grow unless the program shifts its focus to improving care for the chronically ill.

The *Better Care, Lower Cost Act* removes the barriers preventing Medicare providers from focusing on the chronically ill and helps ensure seniors have access to specialized, patient-centered chronic care no matter where they live. Specifically, the *Better Care, Lower Cost Act*:

- Removes federal rules and practices that prevent providers from specializing in chronic care and from targeting higher-risk patients who would benefit most from specialized, targeted care.
- Empowers nurses and physicians to lead care teams essential to better quality, less expensive care.
- Prioritizes areas of the country where chronic disease is most prevalent.

To explain our legislation easily, we have developed a fictional patient, "Mrs. Jones," a typical American senior with diabetes and heart disease.

Before the *Better Care, Lower Cost Act*: Mrs. Jones doesn't have a primary care provider but wants one, and isn't getting the care she needs. This is bad for her health and her pocketbook. Lack of coordinated, individualized care for her conditions means she has high out-of-pocket expenses and providers who may not even communicate with one another. Trying to avoid the time and expense of seeing all of her specialists, she attempts to manage her conditions on her own. Despite her best efforts, she ends up being rushed to the emergency room and leaves with a big bill for her visit.

After the *Better Care, Lower Cost Act*: Mrs. Jones has a much different experience because barriers – such as the ACO attribution rule – have been lifted, and nurses are highly engaged as part of the care team. At her first visit to her nearby doctor – who is part of a Better Care Program –individual care plan is established detailing exactly how she and her physician will manage her diabetes and heart disease. A few days after her visit, a nurse calls to make sure she's picked up her new prescriptions. Her co-pay for her follow-up visit with a cardiologist, recommended by her physician, is waived to make sure she goes, and a home visit by a dietician is arranged. She stays healthier and her care costs are lower. With a focus on patient engagement and better health outcomes, Mrs. Jones' diabetes does not leave her stranded in the emergency room, and her conditions are managed at a lower expense to her and to the taxpayer.

In response to the need to move away from fee-for-service, this proposal makes providers and plans who want to specialize in chronic care responsible for the cost, care and outcomes of their enrolled patients, while maintaining key consumer protections. High-quality providers and plans approved to participate would receive a risk-adjusted, capitated payment determined by calculating total cost of care for similar beneficiaries outside of the program.

Today, 68% of Medicare beneficiaries are like Mrs. Jones, suffering from two or more chronic conditions. They also account for ***93% of Medicare spending***. If *The Better Care, Lower Cost Act* can save even five percent on Mrs. Jones by giving her better, specialized care, the savings would top $25 billion annually.

Summary: The Wyden-Isakson-Paulsen-Welch *Better Care, Lower Cost Act*

The Problem: Medicare is not doing enough to take care of chronically ill patients, and the limitations of the fee-for-service system prevent a coordinated focus on these patients and their needs. This is critically important because most Medicare enrollees suffer from multiple chronic conditions. According to CMS, in 2010, 68 percent of Medicare enrollees suffered from two or more chronic conditions, and accounted for 93 percent of Medicare spending (roughly $487 billion annually). Additionally, 98 percent of hospital readmissions involved beneficiaries with multiple chronic conditions. There are existing models of care that are meeting the needs of some chronically ill patients – at lower costs – but the vast majority of these innovative care delivery models are located in the Pacific Northwest, the Midwest, and Northeast, leaving millions of Medicare enrollees across the country without access to proven, integrated models of care.

Our Solution: The *Better Care, Lower Cost Act* removes the barriers that prevent Medicare providers from building on existing successful delivery models, and provides a framework for encouraging innovative chronic care delivery across the country. Specifically, our bill:

Provides Critical Support for Providers

To support providers and plans wanting to actively engage and care for this population, this proposal: does not include any form of the attribution rule, encourages specialized team-based care with rewards for improving patient's outcomes, uses telemedicine and knowledge networks to increase access in rural areas, and includes vital case management services proven to increase medical compliance.

Focuses on the Unique Needs of Medicare Enrollees

To help transition Medicare from a program that simply treats sickness to one that promotes wellness, this proposal identifies the patients most in need and provides them with better care *before* becoming the most acutely and persistently ill. To improve standards of care for Medicare enrollees, the bill provides for changes to medical school curricula in order to better respond to the evolving needs of the chronically ill.

Ends Geographic Disparities in Integrated Care

This proposal creates incentives for higher quality, lower cost Medicare coverage nationwide that is open to Medicare beneficiaries regardless of income or place of residence. With a "Better Care Plan" (BCP) designation, a state-licensed and certified provider may practice at the top of his/her license, removing barriers to care that currently exist in parts of the country with provider shortages.

Pays for a Medicare Program Taxpayers Want and Beneficiaries Need

In response to the need to move away from fee-for-service, this proposal makes BCP providers and plans fully responsible for the cost, care and outcomes of their enrolled patients, and directs CMS to determine spending based on the experience of similar patients that are not enrolled in a BCP.

WHAT'S THE DIFFERENCE?	ACCOUNTABLE CARE ORGANIZATIONS (ACOS)	BETTER CARE PROGRAM (BCP)
Care Coordination	Care coordination is lacking in traditional fee-for-service because there is no code to pay for such services. ACOs that put a priority on care coordination must do so without payment.	A code isn't necessary in the BCP model because care coordination is at the heart of the global, capitated payment qualified BCPs receive for as part of their participation.
ACO Attribution	Providers participating in ACOs are subject to the attribution rule which prevents them from actively targeting and enrolling the sickest patients.	There are no attribution rules for BCPs.
Patient Engagement & Benefit Design	There is nothing that limits where a patient can seek care outside the ACO and few, if any, incentives that encourage beneficiaries to actively engage in their care with the ACO.	BCPs have the ability to lower cost-sharing on services that provide the most value for an enrollee's conditions. With this flexibility, plus an actively engaged care team, beneficiaries have the incentive to seek high-value care from their BCP providers.
Individual Care Plan	ACOs <u>are not required</u> to create an individual care plan for every beneficiary.	Every beneficiary enrolled in a BCP receives an individual care plan tailored to their unique needs and conditions.
Targeted Enrollment	The ACO model's "attribution rule" doesn't differentiate between beneficiaries who may have more complex care needs and those who may only need an annual checkup. This prevents specialization and focus on the chronically ill since an ACO may not seek out patients to enroll and must take all who are assigned.	BCPs are specifically designed to target chronically ill beneficiaries with the aim of preventing, delaying, and minimizing the progression of disease and disability.
Payment	ACOs continue to operate under a FFS system and may be eligible for shared savings after a three year period.	BCP payment is no longer tied to the volume driven FFS payment system. Instead, BCPs are paid a set amount for each enrolled beneficiary.

Wyden-Isakson-Paulsen-Welch *Better Care, Lower Cost Act*

Chronic Care: By the Numbers

In 2010, 68% of Medicare beneficiaries had at least two or more chronic conditions. The below figures from 2010 help to explain the story behind this high spending, and provide some insight as to why it is important to the future of Medicare to ensure these individuals have access to high quality care[1].

Account for nearly all Medicare spending:

- Beneficiaries with at least 2 or more chronic conditions accounted for *ninety-three* of Medicare spending, or roughly $487 billion

Hospitalizations:

- *Four percent* of beneficiaries with 0-1 chronic condition were hospitalized at least once
- *Thirty percent* of beneficiaries with 4-5 chronic conditions were hospitalized at least once
- *Sixty-three percent* of beneficiaries with 6 or more chronic conditions were hospitalized at least once

Trips to the ER:

- *Fourteen percent* of beneficiaries with 0-1 chronic condition had an ER visit, and only two percent had 3+ visits
- *Forty-one percent* of beneficiaries with 4-5 chronic conditions had an ER visit, and eight percent had 3+ visits
- *Seventy percent* of beneficiaries with 6 or more chronic conditions had an ER visit, and twenty-seven percent had 3+ visits

Home health:

- *One percent* of beneficiaries with 0-1 chronic condition received at least one home health visit
- *Fourteen percent* of beneficiaries with 4-5 chronic conditions received at least one home health visit, and nine percent received 13+ visits
- *Thirty-six percent* of beneficiaries with 6 or more chronic conditions received at least one home health visit, and twenty-seven percent had 13+ visits

Readmissions:

- *Ninety-eight* percent of all hospital readmissions involved beneficiaries with multiple chronic conditions

Spending per beneficiary:

- Average spending per Medicare FFS beneficiary was *$9,738*
- Average spending per Medicare FFS beneficiary with 4-5 chronic conditions was *$12,174*
- Average spending per Medicare FFS beneficiary with 6+ chronic conditions was *$32,658*

[1] All data is from the Centers for Medicare and Medicaid Services, "Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition," (2013).

What Experts Say About Chronic Disease

"While a range of public policies have helped individuals with chronic illness, it is important to design and implement new public policies or explore promising approaches to further promote living well with chronic illnesses," ***Living Well with Chronic Illness: A Call for Public Action,*** **Institute of Medicine (1/31/12)**

"A system designed (and reimbursed) to take care of acute care needs on an episode of illness basis is not well-structured to provide for the chronic care needs of an aging population. And we have not created a framework that allows well-thought out decisions to be made balancing the benefits of new technology with its costs," ***Making Medicare Sustainable,*** **New America Foundation's Health Policy Program (3/19/09)**

"There is a gap between the care provided to persons with chronic illness and the optimal care that medicine can provide. Physicians innately desire that all patients receive the best of care, but physicians are constrained by a lack of resources and by our health system's current focus on acute illness," **Michael O'Dell, M.D., M.S.H.A., F.A.A.F.P., Associate Chief Medical Officer, Truman Medical Center Lakewood (2007)**

"Lowering total health care expenses requires addressing the factors that drive those high-cost cases. For the most part, they involve chronic conditions like diabetes, hypertension and congestive heart failure, whose treatment varies much more than you'd think from doctor to doctor," **Peter Orszag, Former Director of the Congressional Budget Office and of the White House Office of Management and Budget (11/3/10)**

"An emerging array of studies indicate that payment and care system changes that rely on teams, including nurses and primary care physicians, and engage and support patients and their families have the potential to improve chronic care outcomes and patient experiences and lower annual costs of care for these populations," ***The Potential Savings from Enhanced Chronic Care Management Policies,*** **Urban Institute Health Policy Center (11/2011)**

"It appears that models that models that involve interdisciplinary primary care teams have promise and represent a different approach — by actively involving the patient's own physician and practice team in the chronic care endeavor, rather than simply supplementing the usual care provided by mainstream practitioners," ***Making Medicare Sustainable,*** **New America Foundation's Health Policy Program (3/19/09)**

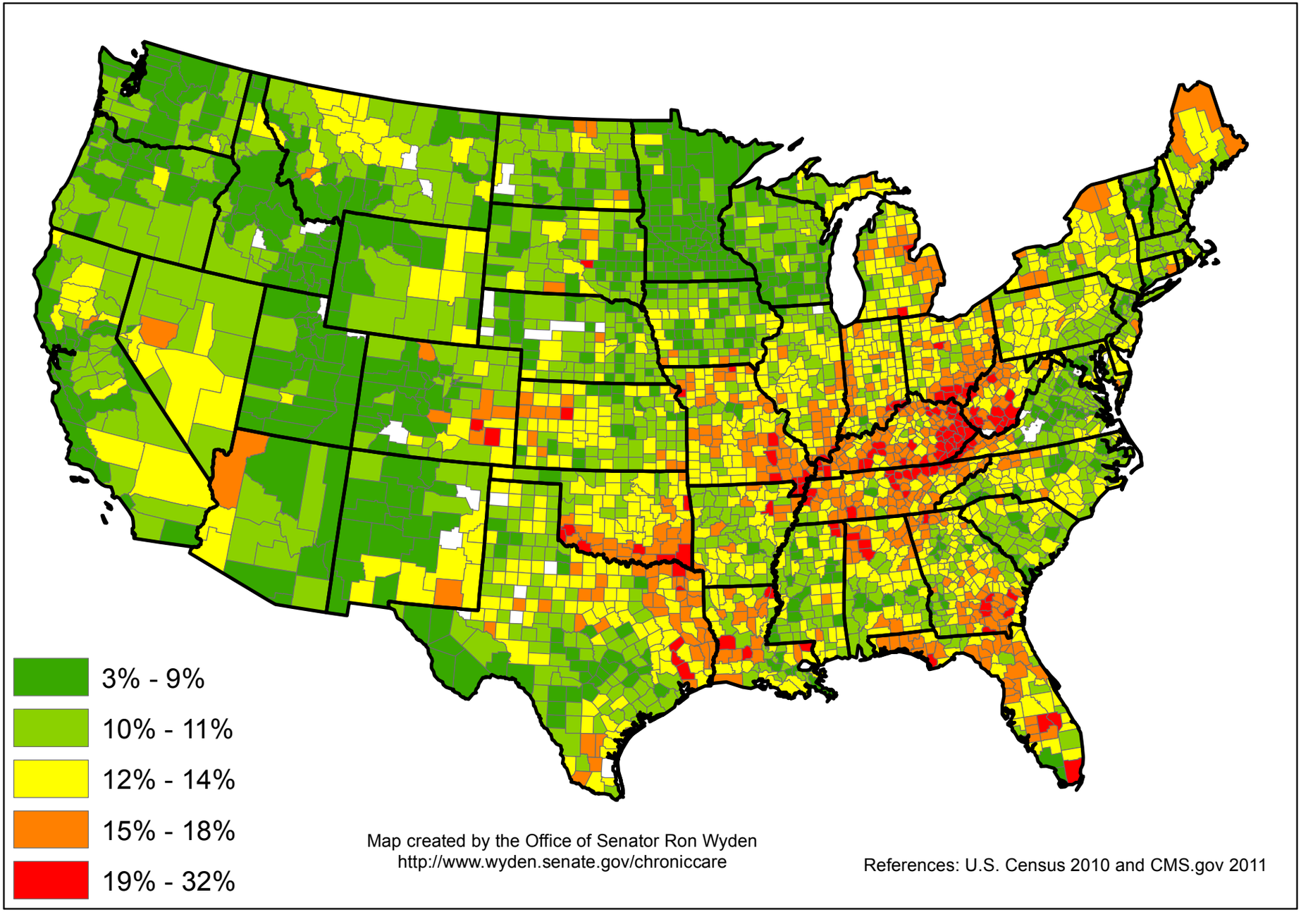
"Americans are living longer than ever with chronic conditions that were virtually untreatable 50 years ago. With more and more Americans affected by chronic illness, our goal is to design and implement comprehensive programs that meet the full spectrum of individual patient needs, improving their quality of life and enabling them to maintain the highest level of self-sufficiency," **Carmella A. Bocchino, Executive Vice President, Clinical Affairs & Strategic Planning, America's Health Insurance Plans (2007)**

"Transformation of chronic care design, delivery, policy and finance is the key to having a healthcare delivery system in America that is healthy, affordable and ethical," **Larry Minnix, President and CEO, LeadingAge (2007)**

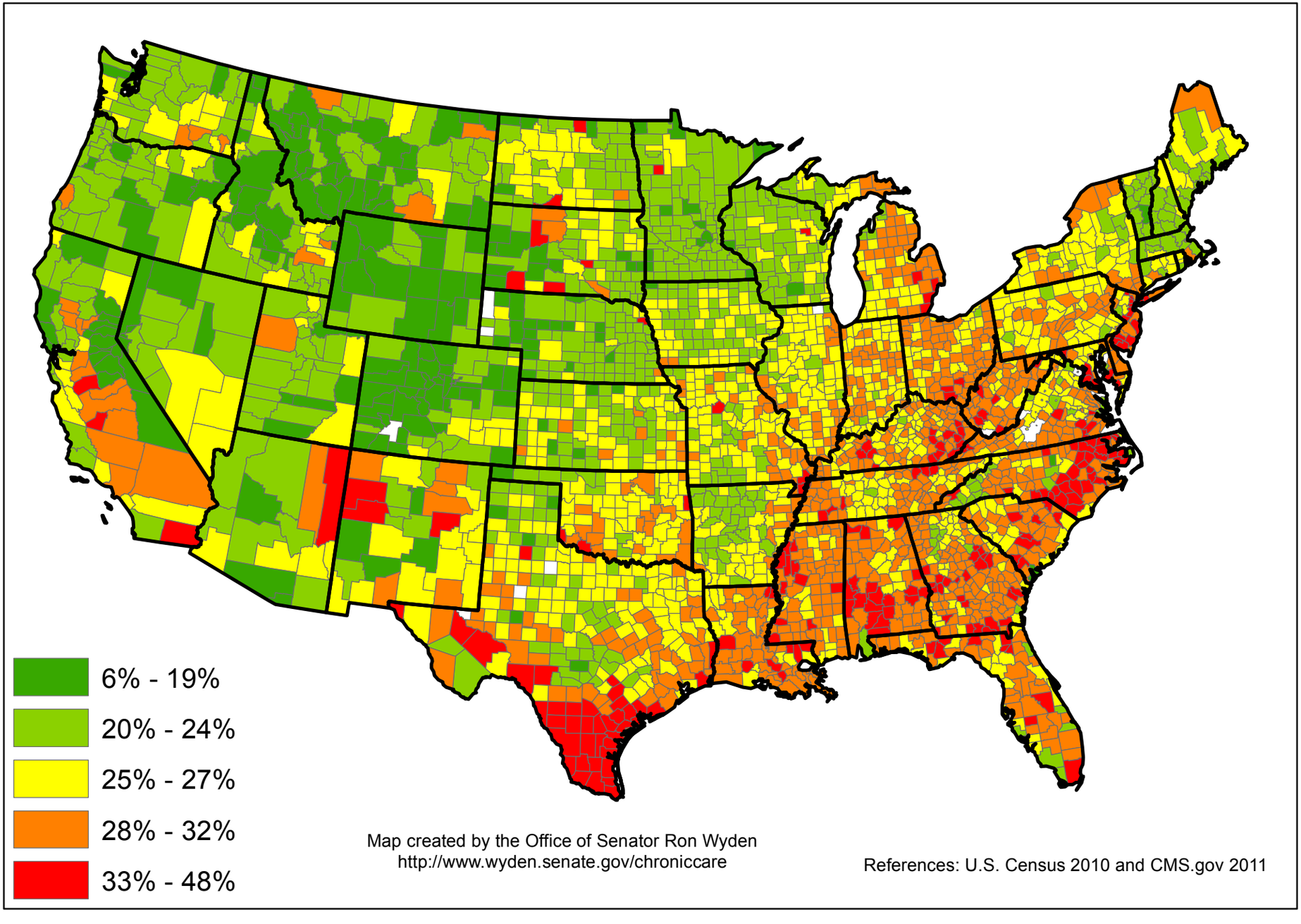
"...Additional savings in Medicare and other healthcare accounts by better coordinating care, especially of the chronically ill. A reasonable target would be $300 billion to $400 billion over the next 10 years," **Former U.S. Senator Kent Conrad, D-N.D. (10/8/13)**

"Use could be reduced from higher quality, e.g., better coordination of care in transitions between hospitals and other settings, including home, or through better ongoing co-management —including patient engagement — of patients with complex and multiple chronic conditions," **Len Nichols, Professor of Health Policy and Director, Center for Health Policy Research and Ethics College of Health and Human Services George Mason University (2/29/12)**

Medicare Beneficiaries (%) with Chronic Obstructive Pulmonary Disease (Emphysema)



Medicare Beneficiaries (%) with Diabetes



Medicare Beneficiaries (%) with Ischemic Heart Disease