TESTIMONY BEFORE THE

SPECIAL COMMITTEE ON AGING

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BY

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Chairman Kohl, Senator Corker and other members of the Committee, I am delighted to be with you today to explore ways to improve the quality and efficiency of services for people who need long-term care. My testimony builds on long-term care policy research I've conducted over many years with colleagues at Georgetown University and presents findings from recent work with Harriet Komisar, supported by the SCAN Foundation, [1] to emphasize that

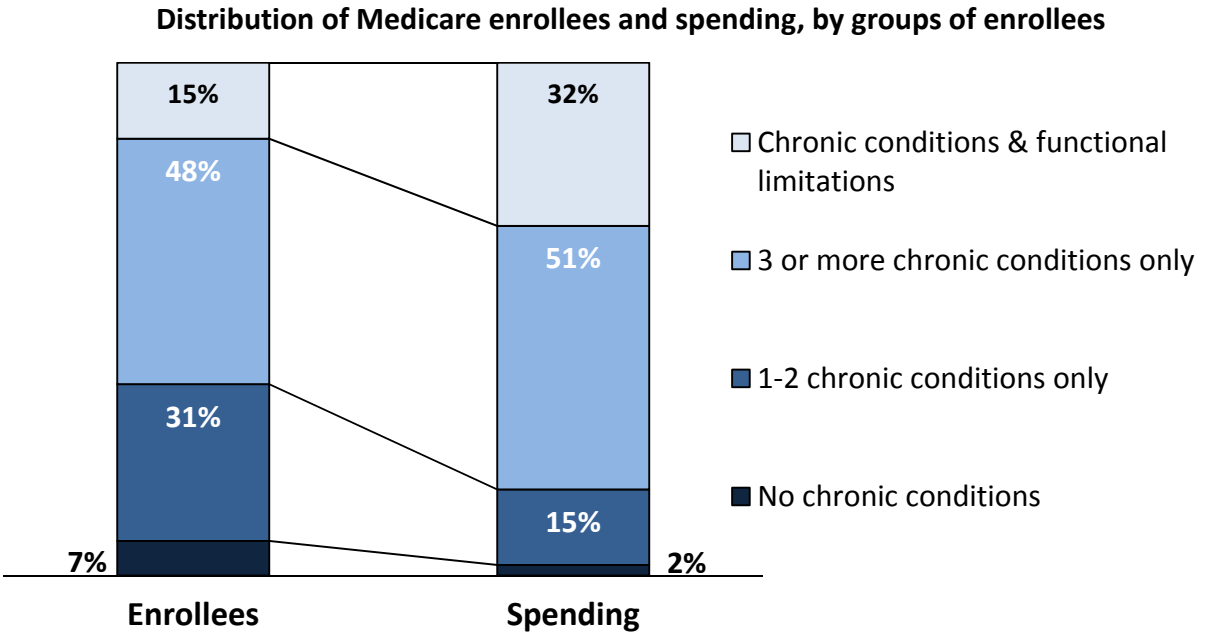
- It is beneficiaries with chronic conditions and functional limitations, not chronic conditions alone, who are disproportionately high Medicare spenders;
- Better coordinating their care—across the spectrum—can achieve significant savings as well as quality improvement; and therefore,
- Medicare should give top priority to delivery reform initiatives that both target beneficiaries with functional impairments and extend care coordination to encompass long-term care.

Although people with chronic conditions are front and center in the movement for delivery reform, that movement risks missing the mark. It is people with chronic conditions and the need for long-term care needs (that is, help with routine activities of life, like bathing and preparing meals), not people with chronic conditions alone, who account for disproportionately high per person Medicare costs. Specifically, the 15% of Medicare beneficiaries who have both chronic illness and long-term care needs account for about a third of all Medicare spending (**Figure 1**). In comparison, enrollees with substantial chronic illness—as indicated by the presence of 3 or more chronic conditions—represent roughly equal shares of the Medicare population and Medicare spending. That means it is the high cost associated with enrollees with the combination of chronic illness and functional limitations—and not the cost of those with

[1] Komisar and Feder, "*Transforming Care for Medicare beneficiaries with Chronic Conditions and Long-term Care Needs: Coordinating Care Across All Services*", The SCAN Foundation, October 2011 http://www.thescanfoundation.org/commissioned-supported-work/transforming-care-medicare-beneficiaries-chronic-conditions-and-long%E2%80%90

multiple chronic conditions alone—that drives the disproportionate share of Medicare spending associated with enrollees with multiple chronic conditions.

Figure 1: Chronic conditions and functional limitations, not chronic conditions alone, explain high per person Medicare costs

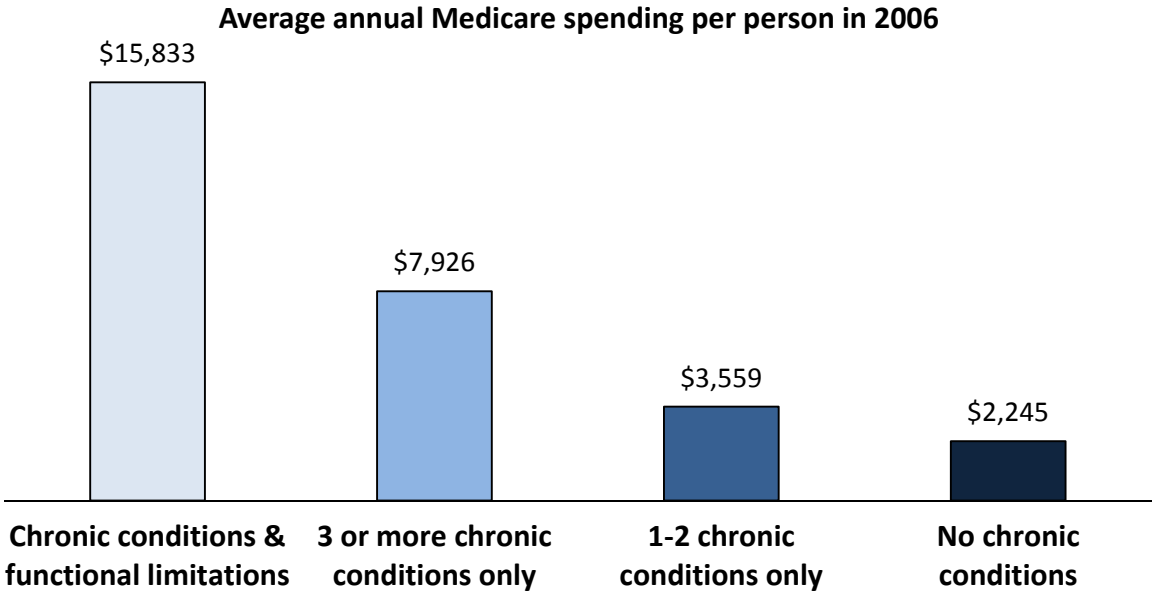


Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

That it is beneficiaries who have functional limitations in conjunction with chronic illness, not chronic illness alone, that explains high spending is apparent from the comparison of average per beneficiary spending (**Figure 2)**. Average Medicare spending for chronically ill beneficiaries with functional limitations is twice as high as for beneficiaries with 3 or more chronic conditions and no functional limitations—about $15,800 compared with $7,900 in 2006. This level is more than four times the average spending for enrollees with 1 or 2 chronic conditions and no functional limitations ($3,600 in 2006). While about a quarter of Medicare beneficiaries with chronic conditions and functional limitations reside in nursing homes, the

majority do not—and for both groups, Medicare spending is significantly higher than for beneficiaries with 3 or more chronic conditions and no functional limitations.

Figure 2: Average per person spending for enrollees with chronic conditions and functional limitations is at least double the average for enrollees with chronic conditions only

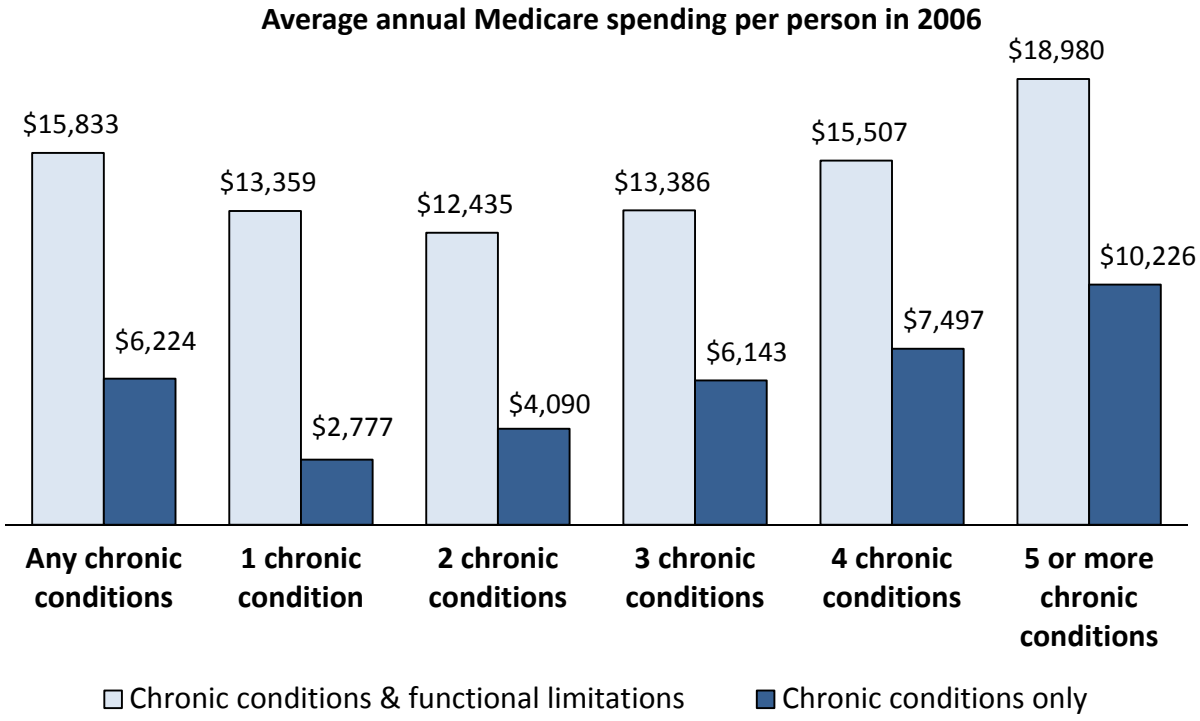


Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

The pattern of higher spending for chronically ill people with limitations than for chronically ill people without holds true no matter what the number of chronic conditions (**Figure 3**). Among enrollees with chronic conditions only (that is, without functional limitations), average annual spending in 2006 ranged from $2,800 (for people with 1 chronic condition) to $10,200 (for those with 5 or more chronic conditions). In comparison, the amount for those with functional limitations ranged from about $13,000 for those with 1 to 3 chronic conditions to nearly $19,000 for those with 5 or more chronic conditions—about (or more than) twice as high as those without functional limitations at every level of chronic illness. Indeed,

average spending for beneficiaries with 5 or more chronic conditions and without functional limitations ($10,200) was lower than average spending for beneficiaries with only one chronic condition who also have functional limitations (about $13,400).

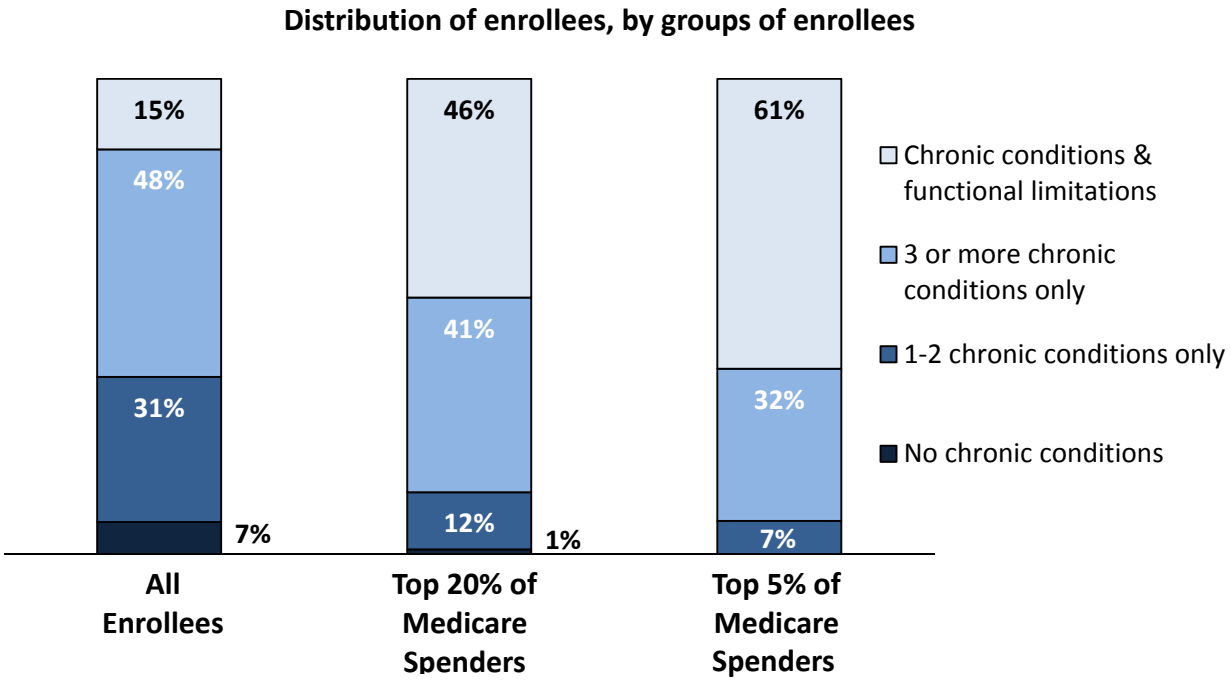
Figure 3: Medicare enrollees with chronic conditions and functional limitations have higher spending per person than enrollees with chronic conditions only



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

Not surprisingly, beneficiaries with long-term care needs rank among Medicare's highest spenders. Nearly half the beneficiaries in the top 20% of Medicare spenders have functional limitations as well as chronic conditions (**Figure 4**). Among Medicare's top 5% of spenders, the proportion is even higher. Three out of five of these highest-cost Medicare beneficiaries are chronically ill people who need long-term care.

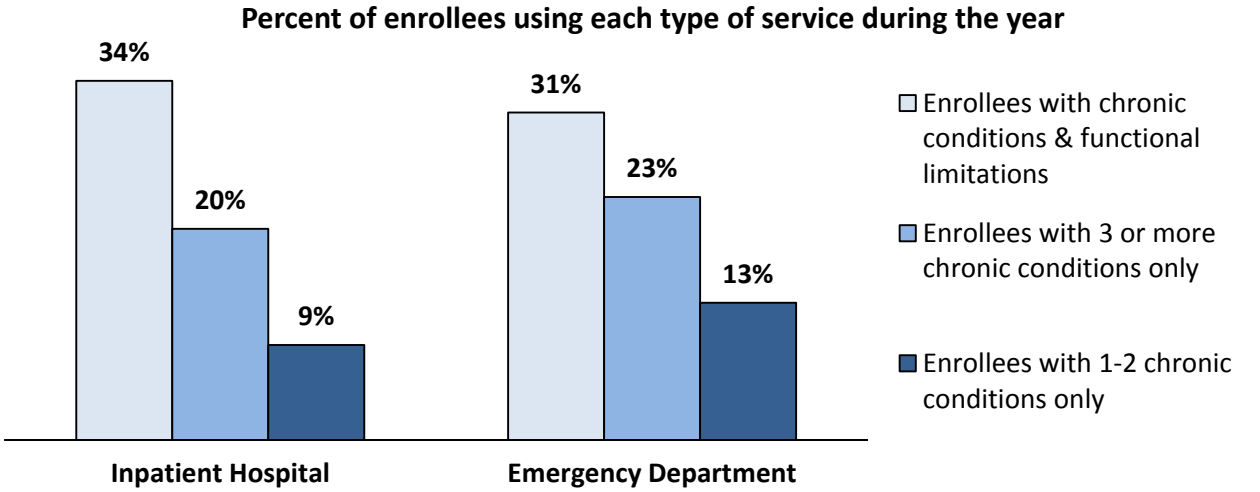
Figure 4: Medicare enrollees with chronic conditions and functional limitations are over half of Medicare's highest spenders



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

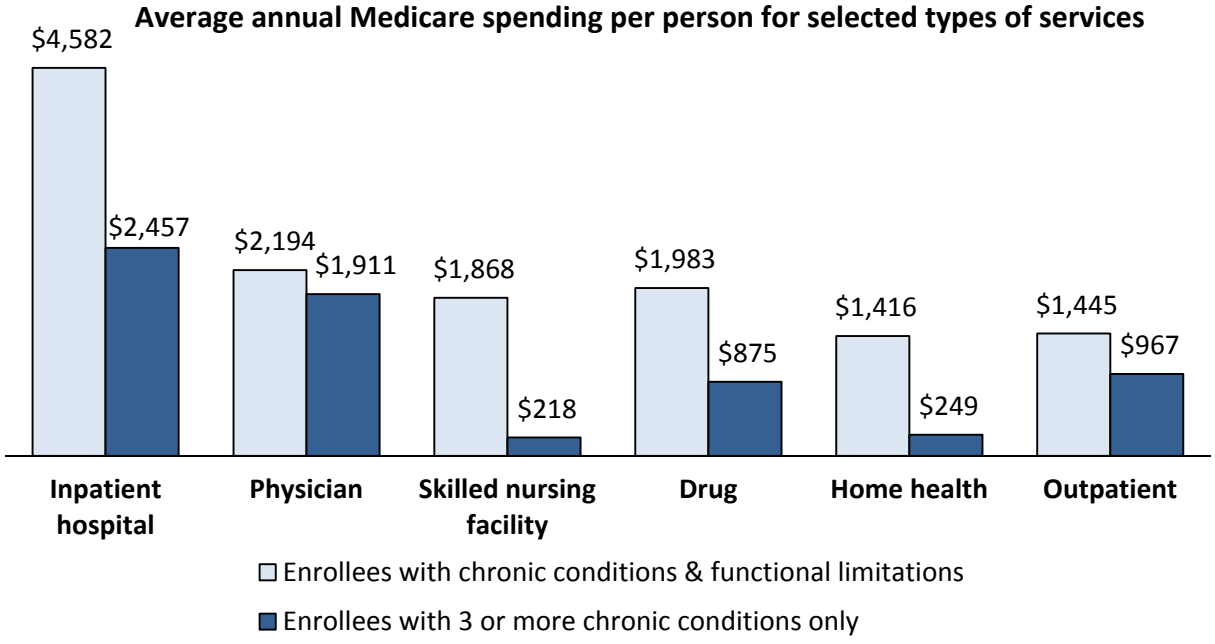
Enrollees with the combination of chronic conditions and long-term care needs are far more likely than other beneficiaries to use both hospital inpatient and emergency department services (**Figure 5)**. One-third had hospital stays in 2006, compared with 20% of enrollees with 3 or more chronic conditions without functional limitations and 9% of enrollees with 1-2 chronic conditions only. As a result, average spending per person on hospital services was nearly double for enrollees with chronic conditions and functional limitations, compared to those with 3 or more chronic conditions only—$4,600 compared with $2,500 in 2006 (**Figure 6**). Higher hospital and post-acute spending are the largest sources of the overall difference in average spending between these groups.

Figure 5: Enrollees with chronic conditions and functional limitations are more likely to use hospital inpatient and emergency department services



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

Figure 6: Higher hospital and post-acute spending are the largest sources of higher spending for enrollees with chronic conditions and functional limitations



Source: H. Komisar & J. Feder, *Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Service*s, The SCAN Foundation, October 2011.

The Centers for Medicare and Medicaid Services are actively engaged in using new authority for innovation under the Affordable Care Act to promote delivery innovations, aimed largely at reducing unnecessary hospital costs. But past experience tells us that without effective targeting to beneficiaries at high risk of inappropriate and high cost hospital use, care coordination is unlikely to produce significant savings. Targeting innovations to people with chronic conditions and functional limitations—and coordinating the full range of their service needs—offers a path to achieving the cost savings and quality improvements that policymakers aim to achieve.

Although limited in number, programs with these characteristics exist and have shown promise in reducing hospital use, nursing home admissions and costs for selected patient groups while improving quality of care. Key elements of these models include:

- A core of comprehensive primary medical care;
- Assessment of patients' long-term service and support needs, plus caregiver assessment;
- Coordination of long-term care as well as medical care (same person or team involved in coordinating both);
- Ongoing collaboration between care coordinators and primary care physicians;
- An ongoing relationship between care coordinators and patients and families;
- Attention to supporting patients during transitions between care settings;
- Commitment to "person-centered" care; and
- Monthly per-person payments to cover coordination costs Medicare does not cover.

CMS can build on these organizations' experience by encouraging delivery innovations that focus on people who need long-term care and coordinate services across the continuum to take account of their long-term care needs along with their medical needs. And CMS can

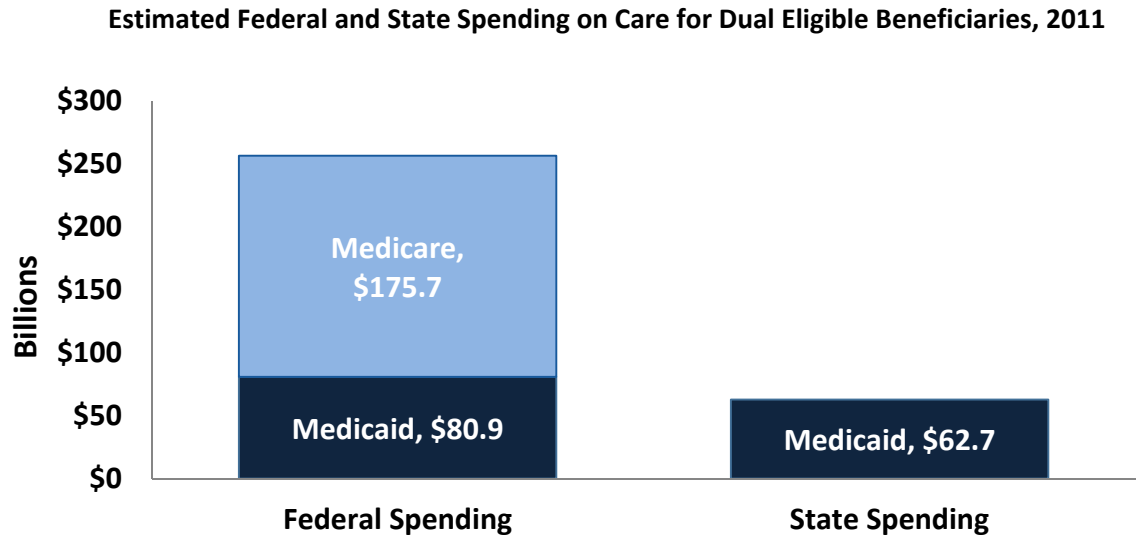
facilitate adoption of these practices by encouraging interventions that accommodate the varied size and capacity of primary care physician practices and improve upon, but do not replace, the fee-for-service payment system. These interventions would:

- Zero in on people most at risk of preventable hospital use, in order to maximize impact on reducing unnecessary and costly care;
- Allow different approaches—both networks that hire and manage care coordinators and coordinators employed by physicians' practices—in order to maximize provider participation;
- Pay monthly amounts per enrolled patient, sufficient to support coordinators and other currently uncovered care management services;
- Hold participating providers accountable for savings that offset these care coordination payments and pay providers—who satisfy quality standards—a share of savings if spending is less than projected; and
- Encourage state participation for dual eligibles provided states, like participating providers, actually invest in delivery improvement.

About half (48%) of the beneficiaries who would benefit from interventions like these are "dual eligibles"—beneficiaries of both Medicare and Medicaid. At 40% of Medicare's and of Medicaid's costs, the 9 million dual eligibles are a focus of efforts to slow growth in spending. But to date policy-makers have focused on states and Medicaid, rather than Medicare, as primarily responsible for improving care delivery to this vulnerable and expensive population. The absence of Medicare leadership is particularly odd, given that the dollars spent on dual eligibles are overwhelmingly federal. Of the $319 billion estimated as spent on dual eligibles in 2011, 80% ($256.6 billion) are federal dollars, more than two-thirds of which flowed through Medicare (**Figure 7).** Further, it is Medicare, not Medicaid, that finances dual eligibles' medical care, including the inappropriate hospital use that is the target of coordination efforts and the expected source of savings from delivery reform. Medicaid's role for dual eligibles focuses

overwhelmingly on long-term care and states lack experience in managing dual eligibles' medical care.

Figure 7: Federal government finances 80 percent of spending on dual eligibles



Source: Feder et al. 2011. "Refocusing Responsibility For Dual Eligibles: Why Medicare Should Take The Lead." Washington, DC: The Urban Institute, http://www.urban.org/health_policy/url.cfm?ID=412418

To improve care and reduce costs for Medicare-Medicaid beneficiaries, along with the roughly equal number of Medicare-only beneficiaries who need long-term care, it is essential that Medicare exert its leadership rather than simply shift responsibility to the states. Priority in delivery reform that coordinates care for beneficiaries with chronic conditions and long-term care needs is fundamental to Medicare's assuming responsibility for reducing the inappropriate service use that the program is now paying for. And that leadership should extend to other measures likely to reduce costs and improve care for people receiving long-term care—like holding skilled nursing facilities accountable for inappropriate hospital admissions of long-term nursing home residents and holding Special Needs Plans (SNPs) accountable for quality care.

For Medicare-Medicaid beneficiaries and for Medicare-only beneficiaries who need long-term care, fiscal pressure requires, and new legislative authority enables, Medicare to remedy the program's longstanding inattention to the costs and care of people whose chronic conditions create a need for long-term care. By so doing, the Medicare program can not only improve the quality of care to its most vulnerable beneficiaries, but also most effectively pursue the cost savings that are so vital to Medicare's future.