Senate Committee on Finance
U.S. Senator Orrin Hatch (R-UT), Chairman
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Hatch Statement at Finance Hearing on Chronic Care

WASHINGTON – Senate Finance Committee Chairman Orrin Hatch (R-Utah) today delivered the following opening statement at a committee hearing examining how Congress can address the challenges Medicare patients with chronic conditions face:

Today's hearing signals the Finance Committee's first step in a bipartisan process that will continue over the next six months. Ranking Member Wyden, myself, and other members of the committee have expressed strong interest in understanding the impact chronic care coordination programs have on Medicare.

Chronically ill patients account for a large percentage of Medicare spending. In 2010, more than two-thirds of Medicare beneficiaries had multiple chronic conditions, while 14 percent had six or more. Beneficiaries with six or more chronic conditions accounted for 46 percent of all Medicare spending. In fact, fee-for-service Medicare spent an average of more than $32,000 per beneficiary with six or more chronic conditions compared to an average of around $9,000 for all other patients.

Left unresolved this situation will only get worse.

Researchers at the Centers for Disease Control and Prevention found an increasing number of adults between 45 and 64 years old – members of the Baby Boom generation – living with multiple chronic conditions, signaling even higher future spending for the Medicare program.

We have to find ways to provide high quality care at greater value and lower cost – all without adding to the deficit.

The good news is that the successful Medicare Advantage program gives beneficiaries the option to receive covered benefits from private plans that are incentivized to manage care across all settings. That explains why 15.7 million beneficiaries – or 30 percent of Medicare participants – chose a Medicare Advantage plan in 2014. I am concerned that ongoing payment cuts and changes to the risk adjustment and quality measurements may be putting these plans at a disadvantage.

Traditional fee-for-service Medicare still fails to properly incentivize providers who engage in labor and time intensive patient care coordination. While disease management and chronic care coordination have been widely used by private sector health insurers, their application in fee-for-service Medicare has been largely restricted to demonstration programs.

Since Obamacare became law, there has been an increased focus on programs like Accountable Care Organizations and Medical Homes. But for more than a decade, the Centers for Medicare and Medicaid Services, or CMS, has piloted numerous demonstration programs to find out what does and does not work to improve health outcomes for patients with chronic diseases.

These demonstration programs have shown, at best, mixed results.

According to one Congressional Budget Office report, CMS paid 34 programs in six major demonstrations to provide disease management or care coordination services in traditional Medicare. On average, these 34 programs had little to no effect on hospital admissions or Medicare spending.

Now I know that the Obama Administration is actively pursuing new care coordination programs through the Center for Medicare and Medicaid Innovation. My hope is that this research will yield long-term results. By identifying cost-effective, data-driven ways to improve patient health, policymakers can better target scarce federal resources to get more value for the dollars spent.

But developing and implementing new policies designed to improve disease management, streamline care coordination, improve quality, and reduce Medicare costs is a daunting challenge. The lack of success in past demonstration programs underscores the inherent limitations of traditional Medicare's fee-for-service payment system – one that rewards providers for delivering increased volume of services, but doesn't incentivize them to coordinate medical care.

Additionally, programs that try to improve outcomes for patients with chronic conditions struggle to identify successful interventions that motivate individuals to alter their health habits. Beneficiaries often have physical and cognitive challenges that limit their ability to effectively communicate with multiple providers.

So, I think this committee understands that we have a very difficult task in front of us. There are no easy answers. That is why I am looking forward to hearing from our panel of expert witnesses. I want to thank Dr. Conway and Dr. Miller for appearing before us today. They will help us understand which care coordination efforts are most effective, which policies have failed, and explain why.

But the committee is not stopping there. After this hearing, we plan to take two additional steps to address these important issues.

First, today I want to announce that Ranking Member Wyden and I have appointed Senators Johnny Isakson and Mark Warner to form a full Finance Committee chronic care reform working group. We have tasked this bipartisan group with studying these complex issues and producing an in-depth analysis of potential legislative solutions. These recommendations will serve as a foundation to develop bipartisan chronic care legislation.

Second, in the coming days, Senators Isakson and Warner, along with Ranking Member Wyden and I, will issue a formal invitation requesting all interested public and private sector stakeholders submit their ideas on ways to improve outcomes for Medicare patients with chronic conditions. Stakeholder input is critical for this committee to work toward the goal of producing bipartisan legislation that can be introduced and marked up in the Finance Committee later this year.

So, as you can see, today's hearing is just the first step in our efforts to address these issues. But, it is an important step. I look forward to an informative discussion.

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