



MEDICARE 2018

Preparing for 80 Million Seniors by 2030

Medicare and the opioid crisis
Medicare and prescription drug reform
Medicare and Medicare Advantage

MEDICARE 2018:

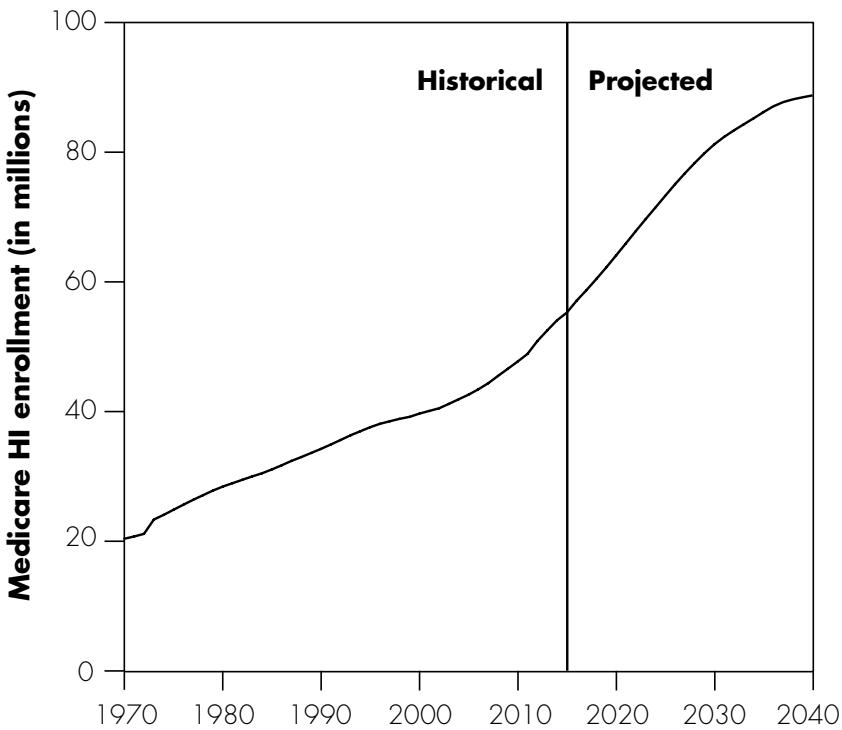
Preparing for 80 million seniors by 2030

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Medicare enrollment is rising

Figure 1-10a. Medicare HI enrollment



Note: HI (Hospital Insurance). Hospital Insurance is also known as Medicare Part A.

Source: 2016 annual report by the Boards of Trustees of the Medicare trust funds. March 2017 Report to Congress: Medicare Payment Policy, Medicare Payment Advisory Commission

Demography is destiny, and in 13 more years, all members of the massive baby boom generation will have reached the age of Medicare eligibility. Medicare enrollment was 59.1 million people as of January 2018, according to the Centers for Medicare and Medicaid Services (cms.gov), which posts national, state and county data on its Medicare Enrollment Dashboard. Medicare enrollment is expected to surge for more than a decade, reaching 80 million by 2030, as shown in a graphic in the March 2017 Report to Congress: Medicare Payment Policy from the Medicare Payment Advisory Commission. (medpac.gov).

Fighting to improve Medicare and patient care by reducing ‘red tape’



By Rep. Peter J. Roskam

One of the clearest ways Congress can directly improve the lives of Americans is by streamlining our healthcare system to maximize patient outcomes, using the newest and most innovative medical practices that provide exemplary patient care in the most cost-effective manner, saving both lives and taxpayer dollars.

With our focus on identifying the

obstacles that impact patient care, the Ways and Means Subcommittee on Health began meeting with physicians, hospitals and other healthcare experts from across the nation to identify the best ways to improve the quality of healthcare.

They brought to our attention duplicative and unnecessary regulations and red tape in the Medicare system that hinder their ability to adequately treat patients. Simply put: Some regulations add cost but don't make patients healthier or safer. To add insult to injury, some of the recordkeeping can only be described as busy work, which wastes the time of professionals who should be able to devote that precious time to their patients.

Many healthcare providers find themselves spending more and more time on documentation, redundant paperwork and regulatory compliance, taking them away from patient care. We've reached the threshold where the regulatory burdens placed on healthcare providers are now coming at the expense of patient care, and we can't allow this to continue.

We're now at a place where we must

find a balance between maintaining a system of accountability for our healthcare providers that makes sense and provides quality care to patients.

In meeting with healthcare professionals from across the country, the Committee continues to hear accounts of outdated regulations that are often du-

seeks to use healthcare providers' input to eliminate outdated regulations, minimize egregious regulatory strain, reduce and streamline paperwork, and expedite life-saving procedures approval for use in the Medicare system.

The Health Subcommittee is focused on finding solutions that balance the

Many healthcare providers find themselves spending more and more time on documentation, redundant paperwork and regulatory compliance, taking them away from patient care.

plicated. The lengthy processes required by the Centers for Medicare and Medicaid Services (CMS) oftentimes becomes an obstacle to quality patient care.

Each day, patient care is sacrificed as a result of an outdated and inefficient system, lives are put in jeopardy, and taxpayer dollars are wasted.

In order to combat the crippling regulatory burdens placed on healthcare providers, the Ways and Means Health Subcommittee has launched the Medicare Red Tape Relief Initiative, which

need for regulations with the cost and quality of care that's being provided. And through the Medicare Red Tape Relief Initiative, I believe we'll be able to find that balance.

Rep. Peter J. Roskam, Illinois Republican, is Chairman of the Ways and Means Subcommittee on Health. He represents Illinois's 6th Congressional District, which spans Chicago's western suburbs.

By 2030, the entire baby-boom generation will be eligible for Medicare

Figure 1-21a: Population by age and sex: 2010

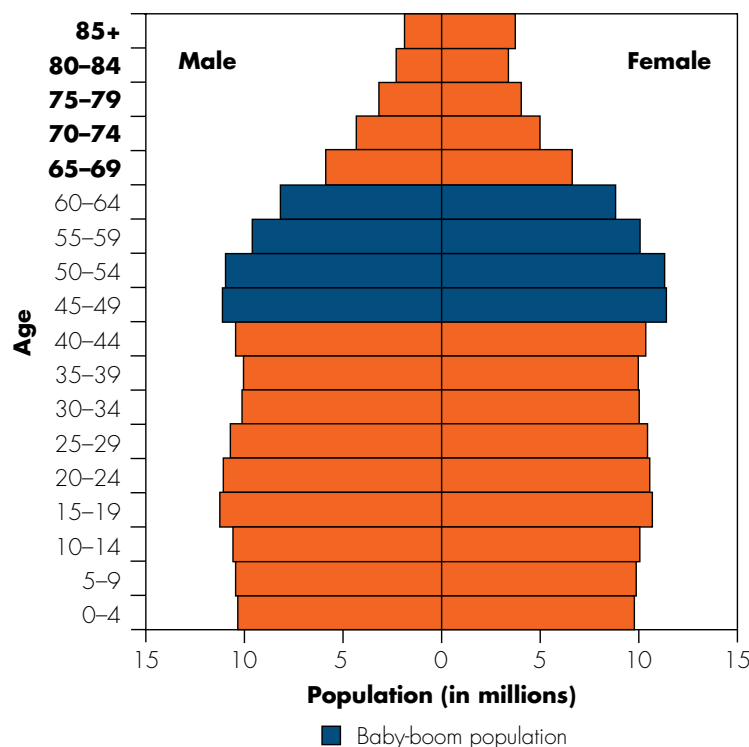
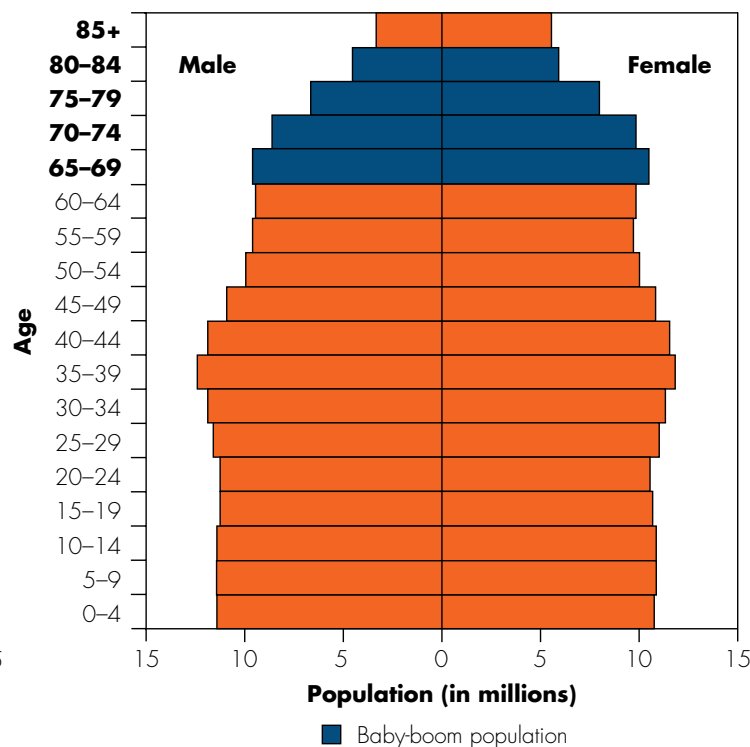


Figure 1-21b: Population by age and sex: 2030



Note: Ranges eligible for Medicare on the basis of age are shown in bold.

Source: Census Bureau, 2010 Census and 2013 National Population Projections, Middle series.
March 2017 Report to Congress: Medicare Payment Policy, Medicare Payment Advisory Commission



By Rep. Sander M. Levin

For more than five decades, Medicare has been the bedrock of health security for tens of millions of Americans. Before the program's creation in 1965, only half of seniors were enrolled in health coverage; today, the uninsured rate among older Americans is 2 percent. Elder poverty has declined by more than two-thirds over that period, and Medicare has been crucial to this historic progress.

As we look to the future of Medicare, many seniors are rightly worried about the direction that the Trump administration and congressional Republicans want to take the program. Just last week, House Republicans unveiled yet another budget resolution that would end Medicare as we know it by instituting a radical voucher scheme, limiting eligibility and cutting more than \$500 billion from the program. This comes on the heels of a recent report by the Medicare Trustees finding that the Republican tax

The future of Medicare — dental, vision and hearing coverage

law and attacks on the Affordable Care Act (ACA) have weakened Medicare's Hospital Insurance Trust Fund.

The ACA showed us that Medicare can be strengthened without cutting benefits — through commonsense efforts to increase revenues and reduce overpayments, while expanding innovative payment models and improving access to preventive benefits. In fact, thanks to the changes made by the ACA, the solvency of the Hospital Insurance Trust Fund was extended by more than a decade, while seniors' benefits were strengthened, not cut.

A continued step in strengthening evidence-backed practices that improve the overall health of seniors would be to include dental, vision and hearing care into Medicare's benefit package.

In 2011, the Institute of Medicine released a landmark report that documented the devastating consequences of inadequate access to dental care on overall health. Finding numerous links between poor oral health and systemic conditions, such as diabetes, cardiovascular disease and malnutrition, the report noted that "there is mounting evidence that oral health complications not only reflect general health conditions but also exacerbate and even initiate them."

Unfortunately, the state of oral health care among the elderly reflects a widespread unmet need. Approximately 70

percent of older Americans suffer from periodontal disease, nearly 20 percent live with untreated tooth decay and one in four are edentulous — meaning they have no teeth at all.

Similarly, lack of access to eye care has placed tremendous burdens on older Americans. Vision impairment is the third leading chronic condition among the elderly in the United States. Untreated vision loss is closely associated with social isolation, depression and cognitive impairments, such as dementia. Moreover, vision loss is a major contributor to falls — a leading cause of costly hospitalizations and preventable death among the elderly.

Yet the majority of older adults lack vision coverage to offset the costs of eye exams, eyeglass frames and lenses, and low-vision magnifying devices to assist with severe vision impairments.

Likewise, numerous studies of the hearing health of older Americans reveal a number of troubling facts. Seniors are disproportionately affected by hearing loss, including nearly two-thirds of individuals over age 70. A 2016 report published by the National Academies of Sciences documented the extensive links between untreated hearing loss and other serious health problems, including poorer mental health, cognitive impairments, balance problems and increased

risk of falls among the elderly.

Unfortunately, of the millions of older Americans who could benefit from hearing aids only 30 percent have ever used one.

As Republicans and the Trump administration continue to call for ideological policies to slash benefits and shift more costs onto patients, they increasingly find themselves on the wrong side of the evidence that tells us that dental, vision and hearing care are closely linked to overall health. Rather than ideological proposals to end Medicare as we know it, we should work to strengthen program benefits to meet these needs.

To that end, I and a number of my Democratic colleagues at the Committee on Ways and Means have introduced legislation that would provide comprehensive dental, vision and hearing coverage to all beneficiaries as part of the basic Part B benefit package.

This is a long-overdue reform backed by evidence, not ideology. It will expand access to necessary care, improve overall health and make Medicare a stronger program for generations to come.

Rep. Sander M. Levin, Michigan Democrat, is Ranking Member on the House Ways and Means Subcommittee on Health.



By Rep. Debbie Dingell

With all of the debate and discussion about health care policy this year, it is important that we take a step back and remember that sometimes the easiest and most impactful improvements we can make to our health care system are sitting right in front of us. Today, Medicare provides quality health coverage to millions of seniors across the country, and the program is as American as baseball or apple pie. Yet, many would be shocked to learn that the program does not cover care for the entire senior population and many gaps remain, including

Listen to seniors: Hearing aids vital to health

coverage for hearing aids.

When taking John to a doctor appointment, a senior shared his desperation in losing his hearing and not being able to afford his hearing aid. I was shocked to learn that Medicare does not cover the cost of hearing aids, which leaves millions of seniors at a loss to pay for often-expensive services that are crucial to maintaining a healthy, independent lifestyle.

That is why I led efforts in Congress to allow Medicare to cover hearing aids and exams with the introduction of the Medicare Hearing Aid Coverage Act. Having a hearing aid isn't a luxury that should only be available to a select few; it is a quality-of-life issue that has a significant impact on cognitive health and by covering it could reduce health care costs in the long run.

More than 9 million American seniors suffer from hearing loss, which is the third most prevalent chronic health condition facing older adults. But more than 70 percent of all older Americans who need a hearing aid do not get one, mostly because they cannot afford it. Hearing

loss can lead to frustration, embarrassment, social isolation and increased safety risks for things such as inability to hear oncoming cars, smoke alarms or the phone ringing.

No one should feel isolated, confused or shut out from the world because they cannot afford the treatment they need. A study by the National Council on Aging found that those with untreated hearing loss were more likely to experience depression, anxiety, paranoia and were less likely to participate in organized social activities compared with those who wear hearing aids.

And now, a growing number of studies have shown a link between hearing loss and increased hospitalization, depression and cognitive decline. A 10-year longitudinal study of patients in Baltimore found that those with hearing loss had a higher probability of developing dementia, with the probability rising as the severity of the hearing loss increased. Dr. Frank Lin of Johns Hopkins University School of Medicine found that as the brain becomes smaller with age, the shrinkage seems to be accelerated in

older adults with hearing loss.

The relationship between hearing loss and the development of dementia is "convincing and striking" according to researchers. We have to take heed of these warnings. The time to act is now.

It is time for Medicare to cover treatments for the whole senior and not just bits and pieces. An ounce of prevention is worth a pound of cure.

We must start this conversation now. With 10,000 people turning 65 every day, it is essential that the next wave of seniors who enter the Medicare program have the benefits they need to ensure they live healthy and productive lives well into the future. Having good hearing coverage is part of that, and expanding Medicare to cover the cost of hearing aids should be something we all can support.

Rep. Debbie Dingell, Michigan Democrat, serves on the House Energy & Commerce Committee, where she works to grow manufacturing, improve access to quality affordable health care, support seniors and veterans and protect the Great Lakes.

Medicare Advantage is solution to health care policy crisis



By Allyson Y. Schwartz

Health care policy continues to be a serious debate for us, as individuals, families, employers, retirees, and as a nation. Cost, benefits, access, and who is responsible for these decisions is confusing for most Americans. This is particularly true for older adults who are aging into Medicare.

Today, over 40 million individuals rely on Medicare, and that number is projected to double in the next decade. Given that it is the federal government that is the largest payor, it is also a significant discussion for federal policymakers.

As a Member of Congress, I engaged in this debate and sought answers that would drive value over volume in financing health care. This meant a renewed focus on primary care as essential to a more integrated health delivery system, public accountability and incentives for quality of care. The goal was to improve health outcomes and contain the rate of growth in cost.

I am more than pleased to see that today, we are seeing a transformation in health care delivery, particularly for older adults, that is taking advantage of this policy shift. It is called Medicare Advantage. It is the private-public option in Medicare that offers managed care and has climbed to 20 million individuals — over a third of Medicare beneficiaries.

Imagine a Medicare that uses meaningful data to identify high need individuals and seeks them out for care, which provides smart benefits flexible enough to address social determinants and aligns strategic goals between payors, providers, and government to increase cost efficiencies

and achieve better outcomes for the patient. That is what Medicare Advantage is doing, as plans and providers implement new ways to meet the needs of complex patients at a cost we can afford.

Here is an important indication of how far we have come in the last few years, taken from Better Medicare Alliance's new "State of Medicare Advantage" report:

- Over the past five years, Medicare Advantage enrollment has grown by nearly 50 percent. They are choosing Medicare Advantage for its affordability, simplicity, additional benefits, and integrated system of care.
- In 2017, 99 percent of Medicare beneficiaries had access to Medicare Advantage plans, 84 percent had access to a plan with Part D benefits, and most choose these MA-PD plans. Forty-five percent of beneficiaries were in plans with \$0 premium plans.
- Most Medicare Advantage plans include additional benefits, like vision, dental, wellness programs.

Over 50 percent offer three or more of these extra benefits.

- The diversity of enrollees has grown in Medicare Advantage — outpacing diversity in Traditional Medicare. Over 20 percent of Medicare Advantage enrollees are minorities, compared with 17 percent in Traditional Medicare. Forty-six percent of Hispanic Medicare beneficiaries and over 35 percent of African-American enrollees choose Medicare Advantage. Nearly half of Medicare Advantage beneficiaries have annual incomes of less than \$20,000.

And beneficiaries are highly satisfied. At Better Medicare Alliance, where I am now President and CEO, we interact with older adults who have chosen Medicare Advantage as their preferred option to manage their health care and achieve healthy lives. Some of our staunchest senior advocates are Medicare Advantage beneficiaries living with complex, multiple chronic conditions that would have been otherwise costly.

Pat, an Arizona beneficiary, lives

with chronic obstructive pulmonary disease (COPD) and relies on the excellent preventive care and affordable over-the-counter medications she receives with her Medicare Advantage plan, which are critical to managing her disease. She is not alone. Evidence shows in many cases out-of-pocket costs are lower for beneficiaries in Medicare Advantage compared with those enrolled in Traditional Medicare. The Centers for Medicare & Medicaid Services reported that the average monthly premiums in Medicare Advantage have decreased to an average of \$30/month.

Cost to government has also gone down. MedPAC in 2016 noted that Medicare Advantage is now essentially equivalent to Traditional Medicare. In addition, evidence shows the emphasis on primary care and care coordination, as well as innovations in care delivery — including home-based care, risk stratification to identify high need patients, wellness programs, and telemedicine — lead to improved outcomes, reduced costs, and cost savings.

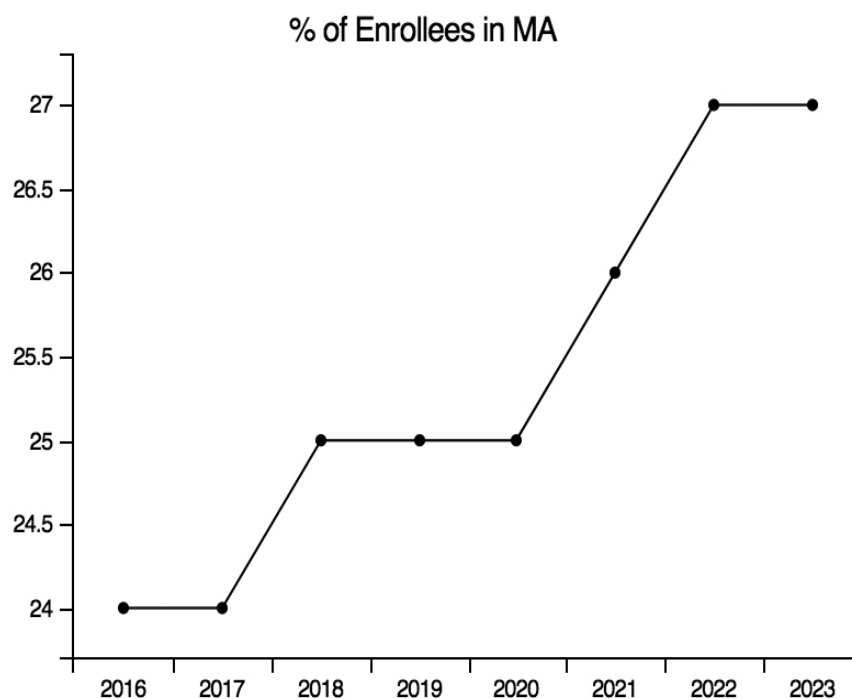
A recent study found value-based contracting in Medicare Advantage generated costs savings and 32 percent lower risk of death. Another study showed emergency room visits were 25 percent lower and rates of annual preventive care were 25 percent higher in Medicare Advantage than in Traditional Medicare for some of the most vulnerable seniors. Plans and providers in Medicare Advantage are providing answers to the question of how best to achieve improved outcomes at lower cost for millions of Medicare beneficiaries. Fortunately, policymakers have not only noticed but supported stability and new flexibility to enable Medicare Advantage to innovate ways to meet the needs of older Americans.

Together, policymakers, beneficiaries, and those who care for them may just be creating the future that means healthier lives and lower costs for everyone.

To read more studies on Medicare Advantage, visit <http://bettermedicarealliance.org/state-of-ma>

Allyson Y. Schwartz is President and Chief Executive Officer of the Better Medicare Alliance and is a former U.S. Representative from Pennsylvania.

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Source: Better Medicare Alliance

'Change is coming' in American healthcare



By Health and Human Services Secretary Alex M. Azar II

Before closing, I want to touch on the role your organizations can play in another of our top priorities at HHS: combating the opioid crisis. ... I'm not sure many caregivers for the elderly ever expected to have to tangle with drug addiction.

For instance, one of the most common causes of hospitalization for seniors in America is a hip fracture, and hip fractures are extraordinarily painful. In many cases, treating them with opioid painkillers is appropriate and necessary. But discharging patients from a post-acute care facility while on an opioid regimen can be risky.

Opioids are often not the best

long-term pain management option and they carry the risk of creating dependence or addiction. For elderly patients, there is also a real risk of these pills being diverted for others to abuse. We have to do our very best to ensure seniors receive appropriate, effective pain management throughout the continuum of care, and in many cases that means appropriately tapering opioids treatment before discharge....

The opioid crisis has been a top priority for President Trump. Advancing the practice of pain management, in fact, is one of the five pillars of the HHS strategy for the opioid crisis we unveiled under this administration.

Developing new, effective pain treatments, which are such an important priority for an aging population, is going to be a focus of a new public-private partnership at the National Institutes of Health, funded thanks to the 2018 government funding bill signed by President Trump earlier this year.

This is just part of a much broader set of accomplishments we have seen under President Trump that will benefit the older Americans you serve.

In the first 500 days of this administration, which we marked yesterday, President Trump has taken significant steps to make American healthcare more affordable and our government more accountable.

Last month, the President rolled out the most ambitious plan for reforming drug pricing of any president — a

sweeping agenda for boosting competition, expanding and improving Medicare negotiation, creating new incentives for lower list prices for drugs, and bringing down seniors' out-of-pocket costs. We are proud to have already taken action since then, with the FDA taking new steps to promote generic competition and CMS putting pharmacy benefit managers on notice about gag clauses that could be driving up costs for Medicare Part D patients. These actions follow a record-breaking year for generic approvals at the FDA, as well as a change to how Medicare pays for Part B drugs that will save our seniors hundreds of millions of dollars in out-of-pocket costs each year.

Meanwhile, CMS has been taking action on the broader value-based agenda I've described today, putting patients first, reducing paperwork burdens, and promoting transparency. We've also proposed to open up new options for more affordable insurance in the individual market. We have taken new steps to protect the conscience rights of religious health providers, so many of whom play an important role in our long-term care system.

I want to conclude today by laying out why I'm so optimistic that there is much more positive change to come.

I believe we will look back on this presidency as an inflection point in the journey toward a system that delivers better, cheaper healthcare, by paying

for value rather than procedures.

Why is that? First, the status quo cannot hold. With the demographic shifts our country is undergoing, the way we do business in American healthcare has to change.

We also have a president who is unafraid to drive the changes we need. The President has seen and heard how the high cost of healthcare is burdening so many Americans, especially our seniors, and he has given us a mandate to do something about it.

Some of the necessary changes won't be so comfortable for entrenched players. But those who are interested in working with us to build a new system will have unprecedented opportunities at hand.

As I said earlier, the changes we are seeing in our country's demographics represent an opportunity. The same is true of this President's reform agenda. So I exhort all of you to engage with us on the issues I've discussed today and take advantage of the opportunities they represent. Because under this President, in American healthcare, change is coming.

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These remarks are excerpted from Secretary Azar's June 5, 2018 speech to the American Health Care Association/National Center for Assisted Living in Washington, D.C.

New hope for seniors: Medicare-covered opioid treatment programs



By Rep. George Holding

We are all familiar with the devastating effects the opioid epidemic is having on our country — tens of thousands of lives lost each year, untold burdens on our health care system and billions of dollars in lost economic potential.

This epidemic has pervaded all populations, including our seniors. Medicare beneficiaries have among the highest and fastest growing rates of opioid use disorder, yet they do not currently

have coverage for the most effective treatment.

The SUPPORT Act, specifically section 207 which I helped author, would change that. This bill, which recently passed the House, provides for a fully coordinated, bundled care model that will help patients in their entire continuum of care in receiving the best current treatment for opioid addiction.

It does so by expanding Medicare coverage to include Opioid Treatment Programs (OTPs) for the purposes of delivering Medication Assisted Treatment (MAT), which combines the use of medication with counseling, group therapy and drug testing.

Currently, OTPs are not recognized as Medicare providers. This means Medicare beneficiaries receiving MAT at OTPs for their opioid use disorders must pay out of pocket. In 13 states, the highest rate of opioid-related inpatient stays is

in the 65-and-over population. That is alarming. However, under this new law, Medicare will be able to cover life-saving Medication Assisted Treatment for our seniors.

Just this month, the National Institutes of Health released a study that found delivering Medication Assisted Treatment to patients following an opioid overdose dropped the death rate by 59 percent.

President Trump's Commission on Combating Drug Addiction and the Opioid Crisis summed up the value of Medication Assisted Treatment, finding that this treatment option has proven "to reduce overdose deaths, retain persons in treatment, decrease use of heroin, reduce relapse, and prevent spread of infectious disease."

But the best evidence for MAT comes from the stories on the ground. For example, Jeff from my home state of North

Carolina became dependent on opioids after a difficult back surgery. He initially tried to stop cold but went into withdrawal and relapsed. Fortunately, Jeff was able to receive treatment from the Goldsboro Comprehensive Treatment Center, where he went through counseling, his progress was monitored, and monthly drug screens kept him accountable. He now says his life has changed for the better 100 percent.

Every Member of the House has constituents just like Jeff who have struggled with addiction but can regain their life with the right treatment.

While there is no silver bullet to this crisis, we need to ensure patients and doctors have all options at their disposal to combat the opioid epidemic.

.....
Rep. George Holding, North Carolina Republican, serves on the House Ways & Means Committee.

Protecting Medicare Advantage



By Rep. Brett Guthrie

In town halls over the past several weeks and months throughout my congressional district, Kentucky's Second, one thing I have heard from constituents at every event is the need to protect Medicare. I couldn't agree more. As 10,000 new seniors become eligible for Medicare services every day, we must protect the program's viability for generations to come. One way to achieve this is to strengthen the Medicare Advantage program.

Medicare Advantage is grounded in the principle that not everyone who uses Medicare services is going to have the same health care needs. When seniors opt for Medicare Advantage, they are able to receive their Medicare benefits through a private insurer that contracts directly with Medicare. Many seniors still choose to use traditional Medicare plans, but for almost 19 million seniors and individuals with disabilities, Medicare Advantage provides the flexibility to choose a health insurance plan that works for them.

Medicare Advantage plans may also offer services that are not provided by traditional Medicare, such as vision and dental coverage. These plans can include care coordination, disease management programs, out-of-pocket spending limits and access to community-based programs. Medicare Advantage allows for health care plans to be tailored to the individual patient, ultimately helping American seniors receive the care they need.

Imagine a senior who recently became eligible for Medicare and is thinking about retiring from her company, where she was receiving employer-sponsored health benefits. Say she recently had surgery and wants to continue seeing the same doctor. This senior should not have to forfeit care because she is retiring. A Medicare Advantage plan might be able to offer a smoother transition into retirement and provide more services than traditional Medicare. She would

still be enrolled in Medicare but with additional options that may allow her to see a greater number of providers. Another example might be a person with disabilities who needs a very specific, personalized treatment. Medicare Advantage could give her the opportunity to continue that treatment into retirement, whereas traditional Medicare plans might not cover that particular service.

Giving seniors more flexibility in how they use Medicare benefits through Medicare Advantage programs not only provides seniors with the opportunity to receive their preferred care — it also saves money and helps preserve Medicare services for future generations. Medicare Advantage plans streamline tailored Medicare services for users, so the government does not end up paying for unnecessary

services that a patient might not want. The Medicare Advantage plans put seniors in control of determining the health care services and providers that they want.

As vice chair of the House Energy and Commerce Committee's Health Subcommittee, I have proudly supported all Medicare plans. Earlier this year, I worked with Reps. Tony Cardenas (D-CA), Erik Paulsen (R-MN) and Earl Blumenauer (D-OR) to send a letter to the Centers for Medicare and Medicaid Services (CMS) to urge support for the Medicare Advantage program. Our letter was signed by a whopping 298 members of the House of Representatives. Members from both parties across the country recognize the value of Medicare Advantage plans.

I was also pleased to work with

my colleagues to secure a permanent extension of the authority for Special Needs Plans in Medicare Advantage — these are specialized plans serving some of our most vulnerable seniors, including many who are enrolled in Medicaid.

As more and more people begin using Medicare services, we must ensure that they can get the full range of care that they need. To do this, we must protect the Medicare Advantage program. I will continue to work with my colleagues to strengthen this important program.

Republican Rep. Brett Guthrie represents Kentucky's 2nd Congressional District in the U.S. House of Representatives. He serves as Vice Chair of the House Energy and Commerce Committee's Subcommittee on Health.

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SonoSpine®: An optimal choice for a Medicare pilot program

By Seth Wade

Disbelief filled my mind as I passed by my co-worker's office door. My friend had complained about neck and back pain for as long as I had known him. He had decided to get something done about it not long after we completed a business review of an innovative spine surgery called SonoSpine®.

The review had revealed the amazing story of SonoSpine®'s founder and ultrasonic technology, but I had never imagined the surgery would be this effective. Here was a co-worker of mine whose quality of life and productivity had suffered greatly for the last few years and now, just days after getting the SonoSpine® procedure, he was ear-to-ear smiles. He was working joyfully for the first time in a long time!

He even told me how the tractor on his hobby farm was "calling his name." "Wow," I said. "I am so happy for you and what a difference SonoSpine® has made in your quality of life!"

After making my way down the hall to my office, I sat in my chair and began to think.

SonoSpine®'s team of people and medical innovation had greatly improved this man's life. More than that, our team had received the added benefit of his quick return to work, plus added productivity now that he is pain-free. SonoSpine® is such a good thing, and good deserves attention.

Insurance was a key issue, though. The technology SonoSpine® uses is FDA-approved, but the procedure does not have a Medicare procedure code allowing for broad insurance coverage at this time. My friend was able to afford an out-of-network service that he believed would provide him with superior care. But this lack of insurance coverage seemed to be an injustice. Our whole office should have been able to take advantage of this care option.

Fortunately, not long after I witnessed this mini-miracle, an opportunity presented itself for me to contribute as the Chief Development Officer to the "good work" they were doing at SonoSpine®. A sense of service to something greater overwhelmed me, and I said yes, but on one condition — that we find a way to help more people. Dr. Dilan Ellegala, SonoSpine®'s founder and chief surgeon, smiled and said, "SonoSpine®'s fusion avoidance spine surgery as the standard of care is our goal, so welcome to the team!"

As we considered the best ways to



AVERAGE COST
SONOSCUPT
\$32.9K
TYPICAL SPINAL FUSION
\$80K-120K

NORMAL ACTIVITY RECOVERY TIME
SONOSCUPT
4-6 WEEKS
TYPICAL FUSION
4-6 MONTHS

PATIENT PAIN ELIMINATION
88% EXCELLENT
SONOSCUPT @ 4 WEEKS
FUSION PROCEDURES @ 4 WEEKS
56% EXCELLENT

PATIENT COMPLICATION
SONOSPINE®
1.54%
FUSION NATIONAL AVERAGE
10-18%

reach new patients, we saw that self-insured employers have an optimal insurance-coverage path for their employees who are suffering from chronic back and neck conditions.

Some 90 million workers and dependents were covered by their employers' self-funded insurance plans in 2011, according to the Self-Insurance Institute of America (SIIA). More than half of employers in industries — such as transportation, manufacturing, finance, retail, healthcare and wholesale — self-insure, SIIA said.

While commercial insurance will surely one day cover SonoSpine® procedures, self-insured employers already have advantages, as they can determine what procedures their insurance will cover. This means self-insured employers

can simply include SonoSpine® as a covered procedure for their employees.

Our medical outcomes and the bundled benefits approach show a clear win-win-win for providers, patients and employers:

Employers/payors have significant cost savings, realized first from the lower initial cost of the SonoSpine® procedure compared with traditional surgical spinal fusion, and secondly from savings derived from a patient's speedy return to work and community after a SonoSpine® procedure.

Patients benefit from a higher level of care (and far fewer complications) and ultimately have excellent quality of life due to the fusion-avoidance focus of the SonoSpine®.

We here at SonoSpine® believe we are

so fortunate to assist with patients' pain alleviation. Surgery is NOT the goal, but if it is clearly the best option, we should do it in as minimally disruptive a method as possible.

Our desire to push ourselves further in patient care creates a ripple effect in their communities and organizations: Patients' ability to enjoy their days pain-free is so impactful to others around them. For us, that never gets old.


We are asking others to join us in the effort to expand the coverage for SonoSpine®'s procedure.

We see clearly that this technology, which evolved out of DARPA-funded programs, would greatly benefit veterans and U.S. service members with TRI-CARE, Tri-West and Healthnet benefits.

Please contact us as we would love to band together with others who are blazing healthcare paths — such as the Center for Medicare and Medicaid Innovation and the VA Center for Innovation in the Department of Veterans Affairs — and supporting the country's ability to utilize better outcomes and cost-saving procedures such as SonoSpine®.

Ultimately, America is what you make it! The 18 percent of the nation's GDP that is represented by healthcare expenses can be something that unites us in heart. We can tackle this if only we are willing to take the risk to stop for a moment and help where possible.

Seth Wade is the Chief Development Officer for SonoSpine® and a proud U.S. Army veteran. Contact Seth at swade@sonospinesurgery.com.



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'Patients must be at the center' of cost, quality decisions



By Centers for Medicare and Medicaid Services Administrator Seema Verma

Increasing quality, improving outcomes, and lowering costs aren't new concepts. Prior administrations have talked about the need to move towards a more sustainable system, one that pays for value and not merely volume. And some progress has been made — but, if we are going to take the final steps, we must activate the most powerful force in our healthcare

system for creating value: the patient.

Patients must be at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families.

This means that we must be completely transparent when it comes to price and quality, and the patient should be the primary controller of their health records, so that they can take those

control of their health records. We made it crystal clear that the days of finding creative ways to trap patient data in closed systems must come to an end. It no longer will be acceptable to limit patient records or to prevent them and their doctors from seeing their complete history.

We have proposed payment consequences for hospitals that don't give patients access to their health records,

We made it crystal clear that the days of finding creative ways to trap patient data in closed systems must come to an end. It no longer will be acceptable to limit patient records or to prevent them and their doctors from seeing their complete history.

records to whatever provider can deliver value. Through this empowerment, there will be a competitive advantage for providers that deliver coordinated, quality care, at the best value, to attract patients who are shopping for high quality care.

In March, along with the White House Office of Innovation, we launched the MyHealthEData initiative to empower patients by giving them

and have asked for feedback on making it a requirement that all providers share health records with patients as a condition of participating in Medicare.

With all of this data sharing, however, protecting the privacy of patient information is even more paramount, so we are requiring that hospitals also take every action necessary to protect patient records. We aren't just telling providers what to do, we are also leading by

example. Earlier this year we announced Blue Button 2.0, a developer-friendly, standards based API, which will allow a majority of Medicare beneficiaries to connect their claims data to third party applications, services, and research programs.

This will unleash innovation to create new cures, evidence based treatments, and increase the quality of patient care in ways we can't even predict. Take a moment and imagine the potential imagine a world in which every treatment your doctor gives you is informed by data from similar patients from all over the world, reducing medical errors and increasing the effectiveness of treating whatever condition you have. Imagine a world in which all of the health data we produce, whether it's through doctor's visits, diet, sleep patterns, or the dozens of data points we produce from wearable devices was compiled to not only make us better aware of our health, but to also prevent serious health conditions. These advancements are within our grasp, but the key is empowering the patient.

We are also empowering the patient by working to advance price transparency. In virtually every sector of the economy, you are aware of the cost of services before you purchase them, except for healthcare. Patients deserve, and need to know cost of services, if they are going to be empowered to shop for value. To this end, we are proposing to require that hospitals post their charges online. We know that that won't fully address patient needs, but we are just getting started and have asked the public for ideas about what additional information patients need to make informed decisions about their care. I look forward to working with many of you on this important initiative.

Times have changed and as our health care costs go up, consumers' demands have changed. And the expectations of CMS have changed. And I understand that some of our initiatives might require providers to change the way they do business. I know it may not be easy, but we owe it to patients. This isn't about provider needs, but about patient needs — and sooner or later, that will be each and every one of us.

These remarks are excerpted from Centers for Medicare and Medicaid Services (CMS) Administrator Seema Verma's May 7, 2018 speech at the American Hospital Association Annual Membership Meeting in Washington, D.C.

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Current Medicare Card

1-800-MEDICARE (1-800-633-4222)

NAME OF BENEFICIARY
JANE DOE

MEDICARE CLAIM NUMBER
000-00-0000-A

SEX
FEMALE

IS ENTITLED TO
HOSPITAL (PART A)

EFFECTIVE DATE
07-01-2016

SIGN HERE → *Jane Doe*

NEW Medicare Card

MEDICARE HEALTH INSURANCE

Name/Nombre
JOHN L SMITH

Medicare Number/Número de Medicare
1EG4-TE5-MK72

Entitled to/Con derecho a
HOSPITAL (PART A)

Coverage starts/Cobertura empieza
03-01-2016

MEDICAL (PART B)

03-01-2016

Medicare.gov

Since April, new Medicare cards are being mailed to all people with Medicare. The new cards have a new, unique Medicare Number — which replaces his or her Social Security Number — to prevent identity fraud. For more information, including a way to see when cards are scheduled to be mailed to a ZIP code, please visit Medicare.gov/newcard.

Medicare should ‘pay it forward’ on clinical trials



By Susan Peschin, MHS

“Innovation,” particularly in health, is a policy buzzword these days. Former House Speaker Newt Gingrich penned an opinion piece over the weekend that called on Republicans to include health care innovation as the third pillar in their political platform to spur medical breakthroughs. Recently, the Department of Health and Human Services put out a request for information on a proposed workgroup to facilitate dialogue between HHS leadership and health care industry innovators and investors to “have a more significant impact on the health and well-being of Americans.”

There is a low-hanging fruit opportunity in Medicare that would accelerate health innovation: incentivize providers to counsel older adult beneficiaries about clinical trials.

Clinical trials are required to determine whether an experimental medicine, treatment or device is safe and effective. For trials involving treatments for aging-related diseases and conditions, such as Alzheimer’s, participation by older people is important not only because they are more representative of the target population but because it allows the treatment to be fine-tuned for older people.

Unfortunately, clinical trial volunteers of any age are scarce. According to the Food and Drug Administration’s 2015-2016 Global Participation in Clinical Trials Report, only 3.4 percent of Americans participated in a clinical trial in 2016. The Tufts Center for the Study of Drug Development report from January 2013 found that 37 percent of clinical trials fail to meet enrollment goals — and 11 percent never enroll a single patient.

Under-enrollment in clinical trials is an especially significant problem for geriatric conditions. A 2017 study in the *Journal of the American Geriatrics Society* reviewed 839 trials for ischemic heart disease and found that 53 percent explicitly excluded older adults. Looking

at oncology, more than 60 percent of all cancer cases are diagnosed in people ages 65 and older but only 25 percent of clinical trial enrollees are from that age group, according to a study in the *Journal of Clinical Oncology*. Older adults are often excluded because they have comorbidities that complicate assessment of trial outcomes, mobility issues or supportive care needs, or they take multiple medications that can confound research results.

Ironically, the recent public funding increases for Alzheimer’s disease and related dementias over the last several years have brought the issue

Aging has partnered with a wide range of stakeholders to develop a comprehensive National Strategy for Alzheimer’s Disease Clinical Trial Recruitment and Participation.

Aside from eligibility issues, the most significant barrier to older adults’ participation in research is that medical providers are not discussing clinical trials or recommending participation with their patients. In 2017, the Center for Information and Study on Clinical Research Participation performed a survey showing that 90 percent of patients want to hear about clinical research during visits with their primary physician, yet only 15

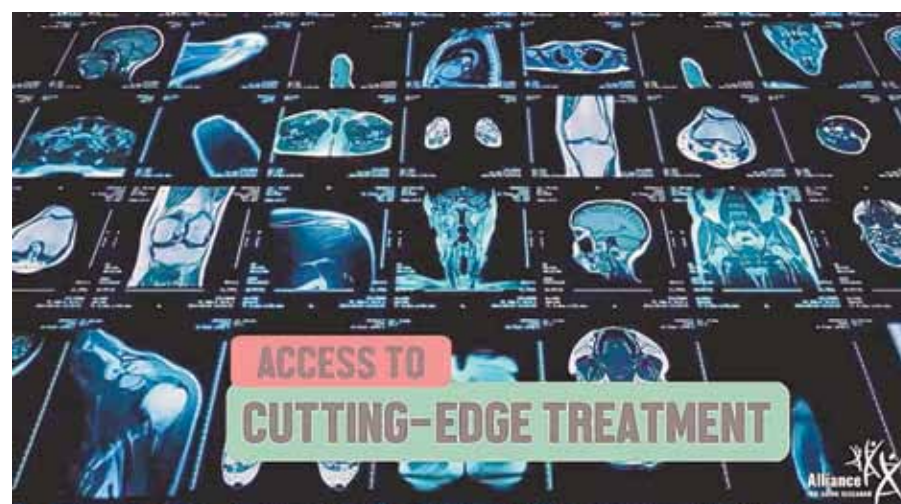
current reimbursement policies. In a 2010 Institute of Medicine report exploring issues in U.S. clinical research, physicians stated they would enroll more patients if there were stronger financial incentives to help offset administrative burdens. A 2015 statement by the American Society for Clinical Oncology published in their journal calls on the American Medical Association to establish new procedural terminology billing codes for providers’ time and effort when they educate older adults about clinical trials, enroll them and conduct management and follow-up of these patients; it also calls for Medicare, Medicaid and private insurance to provide subsequent reimbursement.

Another provider incentive under Medicare could be the new Quality Payment Program (QPP). Under QPP, Medicare payments to physicians will be adjusted based on the provider’s performance on measures in quality, advancing care information, cost and clinical improvement activities. Medicare will use composite performance scores to adjust the physician fee schedule payment rates up or down for providers participating in the QPP. A new clinical practice improvement activity related to counseling about clinical trial participation would create an opportunity for physicians to improve their QPP performance by working with beneficiaries to identify appropriate clinical trials and potentially assist in enrolling them. This activity could also address Centers for Medicare and Medicaid Services’ (CMS) priorities to increase incorporation of patient preferences and shared decision-making. Our organization, the Alliance for Aging Research, submitted a public comment to CMS in early March on this topic.

Low patient accrual rates slow the advancement of scientific discoveries, resulting in delays of life-changing — and potentially cost-saving — new treatments. In an effort to raise awareness about clinical trial under-enrollment and the value of participation, we released a short video, “Pay it Forward: Volunteering for Clinical Trials,” which gives an overview of how clinical trials work; why they are important for individuals, family members and society; how to find a trial; and what to expect when volunteering.

Discussions about clinical trials need to be a standard part of older adult patient care, and Medicare providers should be reimbursed for this time. Medicare should pay it forward, and put these simple policies in place to accelerate innovation.

Susan Peschin, MHS, is President and CEO of the Alliance for Aging Research in Washington, D.C.



There is a low-hanging fruit opportunity in Medicare that would accelerate health innovation: incentivize providers to counsel older adult beneficiaries about clinical trials.

of trial recruitment to a critical point. We are seeing in real time that more federal research dollars do not necessarily translate to more people enrolling in research studies. To address this pressing issue, the National Institute on

percent report being asked to participate in a clinical trial.

Physician-related challenges to enrolling patients in clinical trials include time-consuming burdensome paperwork — which is not accounted for in

Technology, innovation key to Medicare solvency



By Rep. Glenn Thompson

Second to Social Security, Medicare is the largest social program in the United States, with more than 58 million beneficiaries. The majority of this population is 65 or older. About 10 percent of beneficiaries are in the program because they are facing life-changing disease or disability. As such, Medicare remains a critical lifeline for many Americans around the nation and must be sustained into the future. My commitment is to save Medicare.

Prior to being elected to Congress, I spent nearly 30 years as a therapist, rehabilitation services manager and a licensed nursing home administrator. I provided care for patients struggling with illness or injury and equally struggling to understand their benefits from the complex maze of regulations created by the Centers for Medicare and Medicaid Services, more commonly known as

CMS. During my professional career, I was honored to be asked to serve on two Medicare Technical Expert Panels.

I have also been on the payee side of the Medicare equation. Most providers want the best care for their patients but recognize that Medicare's reimbursement rates are much lower than private-market health insurers. This becomes increasingly concerning when coupled with findings from the recently released annual report on the fiscal solvency of the Medicare hospital program, which indicates that it will not be able to pay full benefits beginning in 2026, three years earlier than predicted last year.

Medicare spent \$710 billion in 2017 and projections show increased spending at a faster rate than the overall economy through nearly the remainder of the 21st century. Recognizing the budgetary constraints on the program and the fact that 10,000 baby boomers are enrolling in Medicare every day — and will for the next 13 years — it is essential to find ways to innovate for the prolonged solvency of the program.

Anyone can tell you there is a simple answer: Spend less from the program than incoming revenues and it will remain solvent. However, we need to recognize that beneficiaries are not a simple calculation but rather individuals with

unique healthcare needs and histories. And as a former healthcare provider, I know firsthand that when a benefit is underutilized or denied, outcomes are almost certain to be negative for the patient and have an additional effect of increasing costs through hospitalization or long-term care. Rationing is simply not the answer. The American people deserve better.

It also needs to be understood that raising Medicare payroll taxes is not a viable solution. Raising payroll taxes would only equate to putting more cost burden on the beneficiary, many of whom have already witnessed his or her out-of-pocket healthcare costs drastically increase as a percentage of their income over the past decade.

So where does that leave us?

Simply put, we must begin to look at the equation through a different lens. While there is more than enough room for the reduction of waste, fraud, abuse and limiting overregulation, we must utilize innovation and technology to promote better outcomes and in turn create savings for the Medicare program, so it will remain viable well into the future.

Innovation starts with better case management of those beneficiaries who require the most care due to intensive chronic conditions. The aim would be

to reduce avoidable hospital admissions, which become costly for the program and difficult for the patient.

According to CMS data, the prevalence of Type II diabetes in Medicare beneficiaries 65 and older is approaching 19 percent. These beneficiaries experience a much higher prevalence of hospital admissions than those without diabetes, and those living with diabetes have 2.3 times the cost of care than the average American.

We must continue to focus efforts on compliance with the beneficiary's medical plan and encourage community-based approaches and best practices into chronic care management. Without question, this is certainly a two-way street and not enough can be said in praise for individuals stepping up and taking control of their own health.

Today, we have access to technologies that our grandparents only read about in science fiction novels. Telemedicine, which utilizes the internet, video and voice, has been able to remove geographical barriers that would otherwise add time and out-of-pocket travel costs for beneficiaries. This is especially true in rural America, which faces higher prevalence of chronic conditions, sometimes-inconsistent delivery systems, and challenges with the recruiting and retention of healthcare professionals.

I was exceptionally pleased when CMS announced its first Rural Health Strategy in May, which seeks to expand the prevalence of telehealth and telemedicine to provide better outcomes to Medicare beneficiaries and generate overall program savings. Moving forward, utilization of these technologies should be looked at as an avenue to reduce significant healthcare expenditures and improve the overall patient experience.

Now is not the time to turn a blind eye. We understand the challenges that face our country when it comes to preserving Medicare for future generations. We must continue to empower America's unique ability to adapt, innovate and utilize technology to improve the lives of our citizens. And we must always uphold the promise of Medicare and make certain it is there for those who need it. Americans deserve no less, and it is the leaders of today who will ensure that.

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Rep. Glenn "GT" Thompson, Pennsylvania Republican, is Vice Chairman of the House Agriculture Committee and Chairman of the Subcommittee on Nutrition. He also serves on the House Education and the Workforce Committee and House Natural Resources Committee.

According to CMS data, the prevalence of Type II diabetes in Medicare beneficiaries 65 and older is approaching 19 percent.... We must continue to focus efforts on compliance with the beneficiary's medical plan and encourage community-based approaches and best practices into chronic care management.



Seniors deserve the ‘gold standard’ of care for opioid addiction



By Rep. Raul Ruiz M.D.

Our seniors deserve the highest quality care for opioid dependency, but currently, Medicare does not provide the comprehensive care they need.

That is wrong. I introduced H.R. 5605, the Advancing High Quality Treatment for Opioid Use Disorders in Medicare Act, to give older Americans across our nation more access to comprehensive addiction treatment services through Medicare.

Seniors are frequently prescribed opioids to treat chronic illnesses with constant, lasting pain issues, such as arthritis and other issues related to the musculoskeletal system. The frequency and chronicity of this prescribing makes them acutely at risk of developing a dependence, which is even more dangerous for them. That's because as you get older, your physiology changes, which makes seniors less able to deal with the side effects of opioids and more prone to respiratory depression, the leading cause of opioid-related death.

And so, when you consider that roughly one-third of Medicare beneficiaries received an opioid prescription in 2016, with over half a million receiving a high dose, it makes sense that the hospitalization rate related to opioid misuse in patients over 65 has increased by 500 percent in the past two decades.

Despite these heightened risk factors, many seniors still do not have access to comprehensive, evidence-based treatment under traditional Medicare. We cannot leave our seniors behind as we work to address this national crisis. Our seniors deserve access to the gold standard of care for treating opioid addiction. It's that simple.

My bill does this by creating an Alternative Payment Model demonstration program through Medicare for comprehensive treatment and care programs

for opioid misuse disorder — which will establish quality measures that reward comprehensive treatment programs that actually produce the best patient outcomes.

It works by giving providers and institutions that choose to participate a case management payment, which they would use to provide wraparound services for Medicare beneficiaries. Teams with an addiction specialist would also receive a higher incentive. Seniors participating in this program will receive Medication Assisted Treatment alongside psychosocial support, such as psychotherapy, treatment planning and appropriate social services.

This coordinated care approach is considered the gold standard of care, and if we want to successfully address this crisis, we need to ensure that individuals have access to treatments that will result in successful outcomes.

I have seen firsthand the importance of this with my own patients in the

emergency department. Getting Medication Assisted Treatment is important, and the success of that treatment is enhanced if that patient is also participating in psychotherapy and receiving the appropriate social services. That's why this demo is supported by the American Society of Addiction Medicine and the California Medical Association, among others.

Also included in this bill is H.R. 3528, the Every Prescription Conveyed Securely Act, introduced by Rep. Katherine Clark from Massachusetts. Her legislation will direct providers to use — by 2021 — electronic prescribing for controlled substances (EPCS) technology for Medicare Part D to cut down on opioid prescription fraud and illicit use of prescription opioids. Already, seven states have implemented this system to combat this crisis and keep illicit opioids off the streets. According to the Department of Justice, most fraudulent prescription opiates are obtained

either through doctor shopping, forged prescriptions or theft, all of which can be addressed by an effective electronic prescribing for controlled substances system.

It is critical that all Americans — regardless of their age or how much money they make — have access to high-quality, comprehensive treatment. I am honored to have secured House passage of my bill, H.R. 5605, which will strengthen Medicare by giving older Americans access to gold-standard comprehensive care, including mental health counseling, addiction specialists, treatment planning and social services. Our seniors deserve no less. I will continue fighting to get this critical bill signed into law by the President.

.....
Rep. Raul Ruiz, M.D., California Democrat, serves on the House Energy and Commerce Committee.

We cannot leave our seniors behind as we work to address this national crisis. Our seniors deserve access to the gold standard of care for treating opioid addiction. It's that simple.



Addressing the opioid crisis: More information for seniors and their doctors



By Rep. John J. Faso

Nearly one in three seniors enrolled in the Medicare Part D program was prescribed an opioid during 2016. This fact underlines just how pervasive opioids have become for seniors, who often are dealing with issues stemming from chronic pain. In New York's 19th Congressional District, which I represent, almost half the population is eligible or nearing the age of eligibility for Medicare. We must ensure that seniors have access to better information about the dangers of opioids and potential alternatives.

For years, opioids have been used as popular treatments for all sorts of ailments, not limited to following surgeries to heal broken bones, but also for after surgeries to pull wisdom teeth or to treat chronic pain. In an investigation by the Department of Health and Human Services Office of Inspector General, it was found that more than half a million Medicare beneficiaries received opioid dosages that exceeded the amounts that the manufacturers recommend for these drugs, and also exceeded the level that the Centers for Disease Control and Prevention recommends avoiding for patients with chronic pain. These figures are unacceptable.

Earlier this month, the House considered over 50 bills to address the opioid crisis in the areas of prevention, education, enforcement and treatment. We must tackle every element of this problem and develop a wide range of solutions to protect our families and communities.

One of those proposals passed by the House is a bill that I introduced — H.R. 5685, the Medicare Opioid Safety Education Act of 2018. This bill will help better educate seniors enrolled in the Medicare Part D program on the effects of opioid medications by updating the

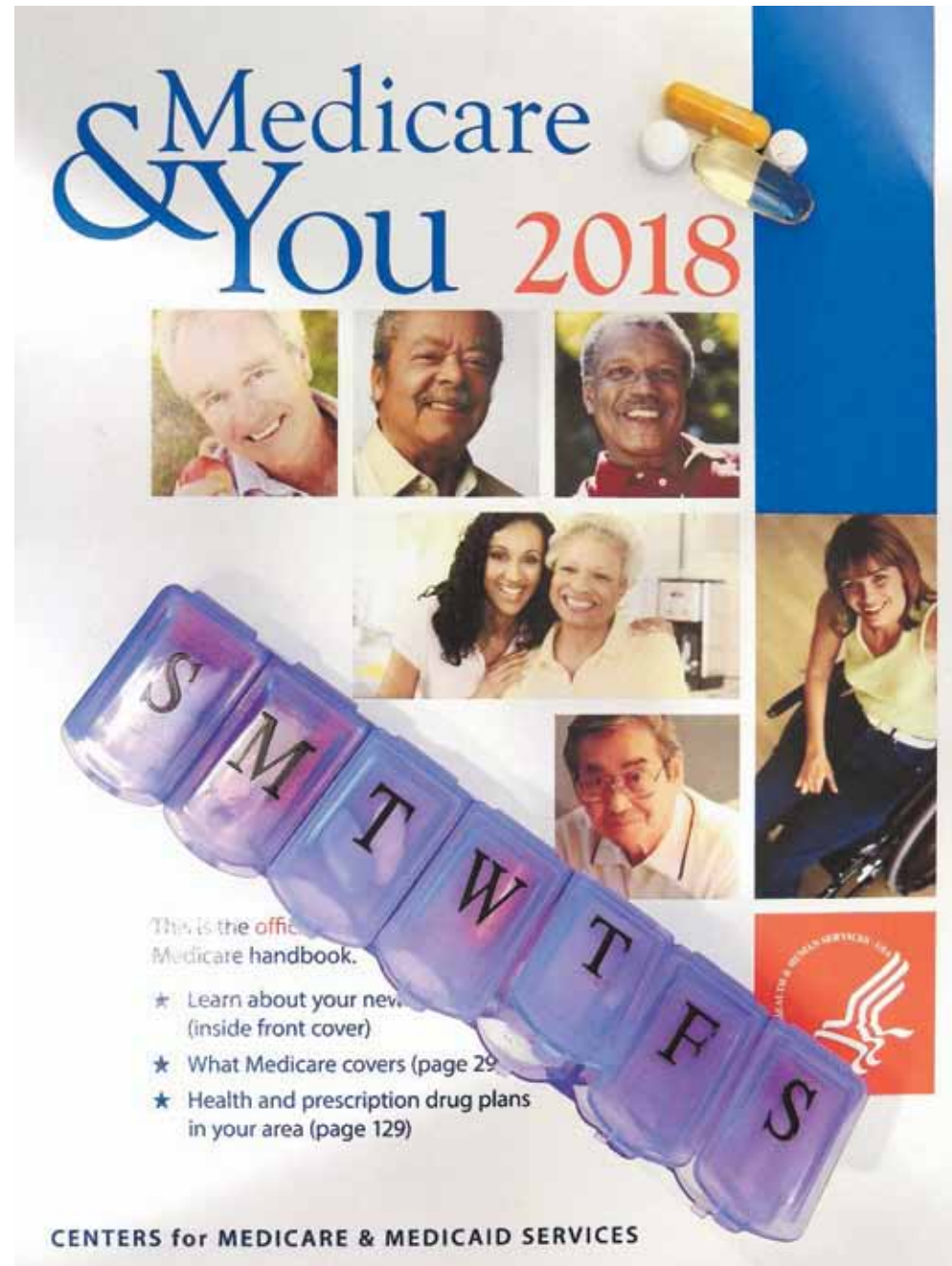


PHOTO BY DOUG WETZSTEIN/SPECIAL TO THE WASHINGTON TIMES.

The “Medicare & You” booklet is given to every senior that is enrolling in the Medicare program. Currently, the word “opioid” is used just once in the booklet, which is woefully too little given the addictive nature of opioids and the ongoing nationwide opioid abuse crisis.

“Medicare & You” informational booklet. This booklet is given to every senior that is enrolling in the Medicare program. Currently, the word “opioid” is used just once in the booklet, which is woefully too little given the addictive nature of opioids and the ongoing nationwide opioid abuse crisis.

My legislation will fix this issue and improve the educational material in the “Medicare & You” booklet by including new information about not only the

risks of opioids but also information regarding alternative treatments. This change will be an essential step forward in helping to make sure seniors and their doctors are able to thoroughly discuss treatment options and fully understand that there are alternatives to opioid medications.

While it may be a simple change, education is an irreplaceable aspect of prevention, and it is never too late to learn more about safe and sustainable

treatment options. This new information will go a long way towards keeping seniors informed of all of their options and ensure they receive the high-quality care they both need and deserve.

.....
Rep. John J. Faso, New York Republican, serves on the House Agriculture Committee, House Budget Committee and House Transportation and Infrastructure Committee.

Medicare and mental health



By Andrew Sperling

2018 marks the 53rd anniversary of the Medicare program. While Congress and the U.S. Centers for Medicare and Medicaid Services, the federal agency that runs Medicare, continue to refine the program, the basic structure of the program has remained in place since 1965.

How is Medicare serving people living with mental health conditions?

Medicare is more than a “health program for older adults.” Few Americans know that more than 10 million non-elderly people with disabilities are served by the program. People become eligible for Medicare two years after receiving Social Security Disability Insurance (SSDI). As many as one in four people are eligible for SSDI because of their mental illness.

How is the program meeting their needs?

Medicare provides important health coverage for people with mental illness, but also has significant gaps and inequities that compromise care for people with mental illness.

- When Congress passed the landmark Mental Health Parity and Addiction Equity Act (MHPAEA) in 2008 — a law requiring health plans to cover mental illness and substance use treatment on the same terms and conditions as other health care — it did not apply the law to Medicare. Medicare remains the only major health plan in America that is *not* required to cover mental illness the same as diabetes and heart disease.
- Medicare imposes a limit of 190 days for inpatient psychiatric care in a person's lifetime, but it does not have the same limit for other hospitalizations. Because mental illness typically strikes when people are young, it is common for Medicare enrollees with mental illness, such as schizophrenia, to reach this limit and no longer have coverage for inpatient care.
- With few exceptions, Medicare does not cover many of the long-term supports and services that people living

with mental illness need, such as peer supports and Assertive Community Treatment (ACT), an intensive, team-based intervention that helps people with mental illness who are at high risk of hospitalization.

There is, however, good news.

- Since 2006, Medicare beneficiaries have had access to prescription drugs through the Medicare Part D program. Monthly premiums for the Part D program have been stable over the past decade and consumer satisfaction remains high.
 - The Medicare Part D program has subsidies for people with very low incomes or who are eligible for both Medicare and Medicaid — many of whom live with mental illness — that allow for \$0 monthly premiums and affordable cost-sharing at the pharmacy counter.
 - Prescription Drug Plans (PDPs) in the Part D program are required to include “all or substantially all” antipsychotics and antidepressants approved by the Food and Drug Administration to treat mental illness on their lists of covered drugs, or formularies.
- In addition, the Affordable Care Act

(ACA) expanded the Medicare prescription drug benefit to eventually close the “donut hole” gap in coverage. The ACA also expanded coverage to include important preventive services in Medicare, such as diabetes screening, that are particularly vital for people with mental illness.

Finally, in recent years, the market of Medicare Advantage (MA) plans has resulted in many plans that offer better coverage of treatment for mental illness than the Medicare Fee-For-Service (FFS) program — plus the advantage of provider networks that help people find mental health professionals. Importantly, many MA plans do cover mental illness and substance use treatment at a level equivalent to treatment for other health conditions.

For over 50 years, Medicare has helped protect the health and well-being of millions of American families. But aligning Medicare with the needs of beneficiaries living with mental illness is long overdue. Congress should address discriminatory limits on inpatient psychiatric care, require equivalent coverage of mental health and substance use conditions and cover effective services, while maintaining existing protections in the Medicare Part D and Medicare Advantage programs that are helping people with mental illness access the care they need.

For over 50 years, Medicare has helped protect the health and well-being of millions of American families. But aligning Medicare with the needs of beneficiaries living with mental illness is long overdue.

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Andrew Sperling is Director of Legislative and Policy Advocacy at the National Alliance on Mental Illness. Learn more at NAMI.org and [@NAMICommunicate](https://twitter.com/NAMICommunicate).



HHS IG: Medicare drug spending rose despite fewer prescriptions

By **TOM HOWELL JR.**
THE WASHINGTON TIMES

Medicare recipients used fewer brand-name drugs but the program still saw its drug costs rise, according to a federal report Monday that says skyrocketing prices set by manufacturers are taking a toll on taxpayers and seniors.

Total reimbursements under Medicare's drug benefit increased 77 percent, from \$58 billion to \$102 billion, even as prescriptions dropped by 17 percent from 2011 to 2015, the Health and Human Services Department's inspector general said.

Unit costs for brand-name drugs rose six times faster than inflation, according to the report.

The investigation comes as Republicans and Democrats on Capitol Hill have questioned pricing decisions by major pharmaceutical companies, and as President Trump has vowed a pressure campaign to get manufacturers to voluntarily lower their prices.

Manufacturers argue the list prices for their drugs are often misleading, saying they have special programs and rebates in place for many customers.

But the investigation found even taking rebates into account, spending on name-brand drugs still rose by 62 percent over the four-year span.

Seniors also had to hand over more of their own money. Beneficiaries paid an average of \$161 out-of-pocket for brand-name drugs in 2011, yet spent an average of \$225 for those same drugs in 2015.

"We conclude that increases in unit prices for brand-name drugs resulted in Medicare and its beneficiaries' paying more for these drugs," the inspector general said.

Medicare didn't cover prescription drugs until a new benefit, Medicare Part D, was added in 2003 by Congress and President George W. Bush. The Kaiser Family Foundation says as of 2017, more than 42 million Medicare beneficiaries were enrolled in Part D.

Taxpayers subsidize the plans, which are administered by private plans that negotiate better deals for beneficiaries.

The program's costs were initially lower than projected as fewer name-brand drugs hit the market, but prices have since spiked.

While members of Congress have singled out companies for selling specialty drugs at eye-popping prices that can exceed \$100,000, Monday's report focused on "maintenance" drugs that

address chronic conditions — things like insulin for diabetes or inhalers for asthma sufferers — over long periods.

If nothing is done, Part D beneficiaries are "likely to continue to be affected for

reverse a trend that's been festering for nearly two decades.

"What we're seeing in the brand space is a rapid increase in prices, really from about 2000 to the current day," said

inspector's report shows that "the government is very concerned about it, and is concerned about it with data," Dr. Anderson said. "That's the contribution."

Mr. Trump's health secretary, Alex



years to come," the inspector general said.

Mr. Trump has acknowledged that drug prices are too high. He released a multipoint plan to bring costs down and, at a recent bill signing, predicted companies will announce "voluntary, massive drops in prices" within weeks.

He didn't provide specifics, leaving consumers to wait and see if he can

Gerard Anderson, a professor at the Bloomberg School of Public Health at Johns Hopkins University. "We are still seeing these rapid increases in prices, and there has been no ability of states, insurers or the American public to essentially be able to come up with an approach to control those prices."

Though it's not a new problem, the

Azar, says list prices and out-of-pocket costs are, indeed, too high and that his agency is taking steps to bring them down. That includes strengthening negotiating powers to bring down the price of drugs in "protected classes" under Medicare Part D and preventing brand manufacturers from "gaming" the system by locking out generic competitors.

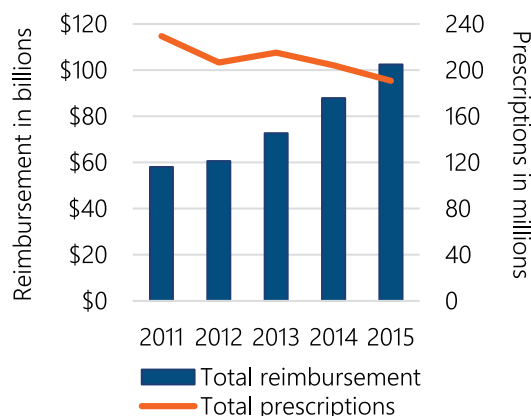
Mr. Azar also says pharmacy benefit managers (PBMs) who negotiate rebates from drug companies should get fixed discounts instead of a percentage of rebates on covered drugs, so PBMs don't just pocket more money whenever list prices go up.

The administration resisted calls for more dramatic action, such as having the government directly negotiate down prices or allowing the importation of drugs from Canada, leaving Washington divided and experts wondering if federal stakeholders can deliver lower costs.

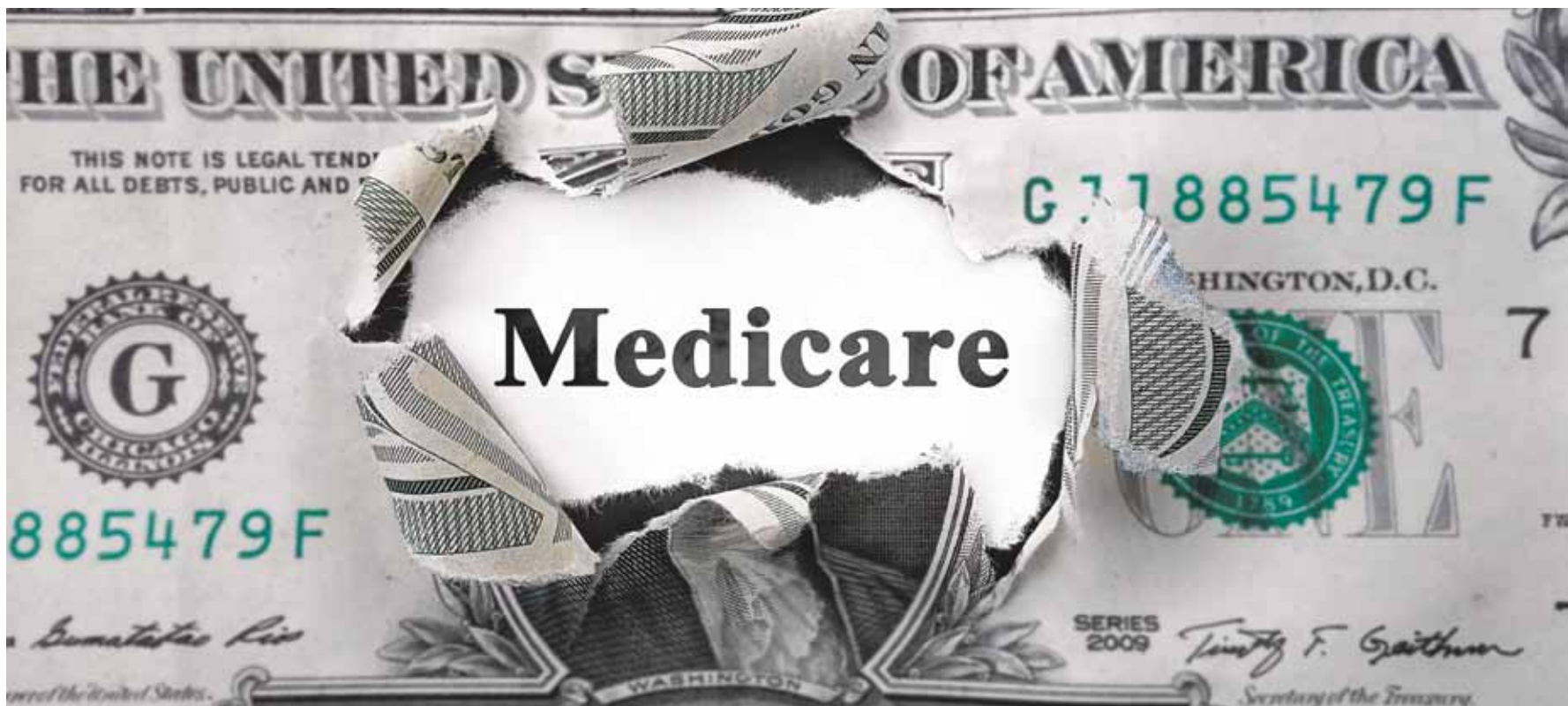
"I don't see that we have a consensus on how to deal with these high-priced drugs," Dr. Anderson said.

This news story first published online on June 4, 2018.

Exhibit 1: Total reimbursement for brand-name drugs in Part D increased as utilization for these drugs declined from 2011 to 2015



Source: OIG analysis of Medicare Part D data, 2011 to 2015.



Social Security now running a deficit; insolvency set at 2034

By **STEPHEN DINAN**

THE WASHINGTON TIMES

Social Security will spend more than it collects this year, the program's trustees said Tuesday, marking the first time in more than 35 years that it will run an annual deficit as it slides toward insolvency by 2034.

Medicare's main trust fund is in even worse shape, scheduled to hit insolvency in 2026 — three years earlier than last year's estimate, the trustees said.

The twin warnings add even more pressure to a budget already strained by last year's tax cuts and this year's deal to boost spending on defense and basic domestic needs, leaving few bright spots in the federal fiscal picture.

The news also produced the usual finger-pointing among Democrats and Republicans, but budget watchdogs said the news was so grim that it should cut through the bipartisan bickering.

"It would be a nice change if this year Congress and the president actually took these warnings seriously enough to do something," said Robert L. Bixby, executive director of the Concord Coalition.

Social Security has been struggling for years and turned cash-negative this decade, meaning the government paid out more in benefits each year than it collected from the payroll tax.

But some analysts had said it was still

running a surplus because of interest on the money credited to the trust fund. Now, even that crutch is gone, as even with interest revenue included the program will pay out more this year than it collects.

It's the first time since 1982 that the program has shown an overall annual deficit.

"This is deeply troubling and should serve as a reality check for anyone concerned about the future of this important program," said Rep. Sam Johnson, Texas Republican and chairman of the House subcommittee that oversees Social Security.

The program is slated to take in \$828.2 billion this year, with most of that coming from payroll taxes. It will pay out \$853.6 billion in benefits and administrative costs. That will cut the cumulative trust fund from \$2.820 trillion to \$2.795 trillion — a small but symbolic slide.

The Old-Age and Survivors Insurance program, the main part of the trust fund, will have its assets depleted in 2034, at which point benefits will have to be cut by more than 20 percent, the trustees said.

Rep. John B. Larson of Connecticut, the ranking Democrat on the key Social Security subcommittee, cautioned against overreacting to those numbers. He said the program "is stable financially for now" — though there are longer-term challenges.

Rather than cut benefits, he has proposed increasing the program's payout. The higher costs would be covered by an immediate tax hike on higher-income

Americans and a phased-in rate hike on everyone.

"Congress must act now because Social Security is not an entitlement; it is the insurance that they have paid for and earned," he said.

The trustees said Social Security's fiscal position deteriorated slightly from last year's report. The Republican tax-cut law is sapping revenue, and President Trump's phaseout of the Obama-era Deferred Action for Childhood Arrivals deportation amnesty for illegal immigrant "Dreamers" will also cost the system workers who would pay in benefits in the short term without being able to collect on them.

Combined, those changes bumped up the insolvency date by months.

For Medicare, the change was a three-year jump in insolvency for the hospital fund, advancing from 2029 to 2026. The trustees blamed a number of changes, including the 2017 tax cuts, which also repealed the Obamacare mandate requiring Americans to hold insurance. That will boost Medicare payouts, the trustees predicted.

"This report should eliminate any doubt that Trump's tax law yanked Medicare closer to insolvency," said Sen. Ron Wyden of Oregon, the top Democrat on the Finance Committee.

Republicans, meanwhile, pointed to longer-term forces: the aging population and a relatively smaller share of people in the workforce to support those seniors.

"Lackluster economic growth in

previous years, coupled with an aging population, has contributed to the projected shortages for both Social Security and Medicare," said Treasury Secretary Steven T. Mnuchin, one of the trustees.

Conservatives said the trustee reports should spur Congress to get to work on solving the imbalance.

But that means either tax increases to cover current costs — seemingly impossible after Republicans spent so much political capital passing the tax cuts — or trims to benefits. And there, the roadblock is Mr. Trump.

He vowed during the 2016 campaign not to reduce future Social Security or Medicare benefits and has repeated those instructions to his budget office now that he is president.

The longer Congress and the president wait, the rougher the changes will be. If nothing is done until the 2034 insolvency date for Social Security, benefits will be cut by 23 percent or the payroll tax will have to be raised nearly 4 percent — a massive hike that would have deep repercussions throughout the economy.

Social Security covers 62 million people, split among retired workers and their dependents, survivors of workers who have died and disabled people.

Medicare, a federal health insurance program, covers nearly 60 million Americans, mostly seniors but some disabled Americans.

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Healthy aging linked to Medicare coverage of ‘social factors’



By Sandy Markwood

Taking a bath, doing the dishes, fixing breakfast, shopping for groceries, making the bed, folding the laundry — these are just some of the tasks that many of us take for granted.

But, as we age, these seemingly mundane yet essential responsibilities can become cumbersome and, for some, impossible.

At some point, nearly 70 percent of Americans will require long-term services and supports to manage the basics of day-to-day life, such as bathing, dressing and cooking. As the national association representing agencies that do

but the least on the social services that might make it easier for older adults to continue living at home. This gap presents an unforeseen obstacle for older adults and caregivers as they navigate the winding, and sometimes rocky, road of maintaining independence and health as they age.

Researchers and many in the health care community are increasingly recognizing that supportive services, like those provided by Area Agencies on Aging, that address social factors — safe housing, access to healthy meals, the availability of transportation options, to name a few — can play a tremendous role in improving older adults’ health and quality of life.

Unfortunately, most adults are either insufficiently prepared to pay for these services or mistakenly think that these supports will automatically kick in at age 65 when they join the ranks of the more than 56 million Medicare beneficiaries. But Medicare — the flagship federal health care program providing hospital and medical benefits to people 65 and older — essentially does not cover long-term services and supports. This leaves far too many families struggling to support their older loved ones’ health and daily needs, resulting in caregiver burnout, financial strain and unnecessary health care costs — plus



empty refrigerator, no heat or no transportation to get to a follow-up visit.

Fortunately, there are opportunities to fill in these gaps for millions of older Americans and their caregivers. For one, our government and health care leaders

outcomes for millions of older Americans. The Aging Network and local Area Agencies on Aging are ideal partners in current and future initiatives to ensure these needs are met.

Fortunately, we are beginning to

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must recognize that addressing the social factors that can influence health and well-being, called the social determinants of health, will result in improved health outcomes.

The good news is that we already have an established and trusted national network of home and community-based supports and services that is committed to boosting the health, independence and dignity of older adults, people with disabilities and their caregivers. This Aging Network has a 50-year history of helping individuals successfully age at home and in the community. But, for the most part, our current health care system hasn’t provided funding that would enable the Aging Network and other community organizations to provide many of the critical support services older adults need.

Policymakers are starting to recognize, however, that since Medicare is the primary provider of health care to older Americans, it should be allowed to cover some of the social services — such as nutrition, transportation and assistance in the home — that could address the social determinants of health, reduce taxpayer costs and improve health

make strides toward expanding Medicare policy to address the health needs that happen at home and in the community — but we have a long way to go. Two recent changes to Medicare have expanded the ability of some Medicare insurance companies to provide limited amounts of health-related social services and supports for some beneficiaries with complex health conditions. While a step in the right direction, access to these services must be significantly expanded to adequately meet the increasing need.

The country’s aging population and the need for long-term care are growing faster than the country can implement solutions. Now is the time for policy leaders, lawmakers and advocates to insist on expanding Medicare to address the social determinants of health and the critical social services needs that enable people to age successfully where they want to — at home and in the community.

Sandy Markwood is CEO of the National Association of Area Agencies on Aging. For more information, please visit n4a.org and [@n4aACTION](https://twitter.com/n4aACTION).



the important work of connecting older adults and their caregivers to many of these vital services, we are well aware of the fact that most Americans want to age in their homes and communities with health, dignity and independence. But our country has a long way to go toward realizing that goal for older adults who can no longer manage life’s core tasks without support.

Among developed nations, the United States spends the most on health care

not enough funding for community supports that could ease those burdens. The only health program that pays for social supports to some degree is Medicaid — which requires older adults to spend down their assets to be eligible for this vital coverage.

It’s said that health happens at home — and we agree. The best patient care possible in the doctor’s office won’t matter if an older adult with multiple chronic conditions goes home to an

Accountable Health Communities model launches in South Jersey with a new advisory board

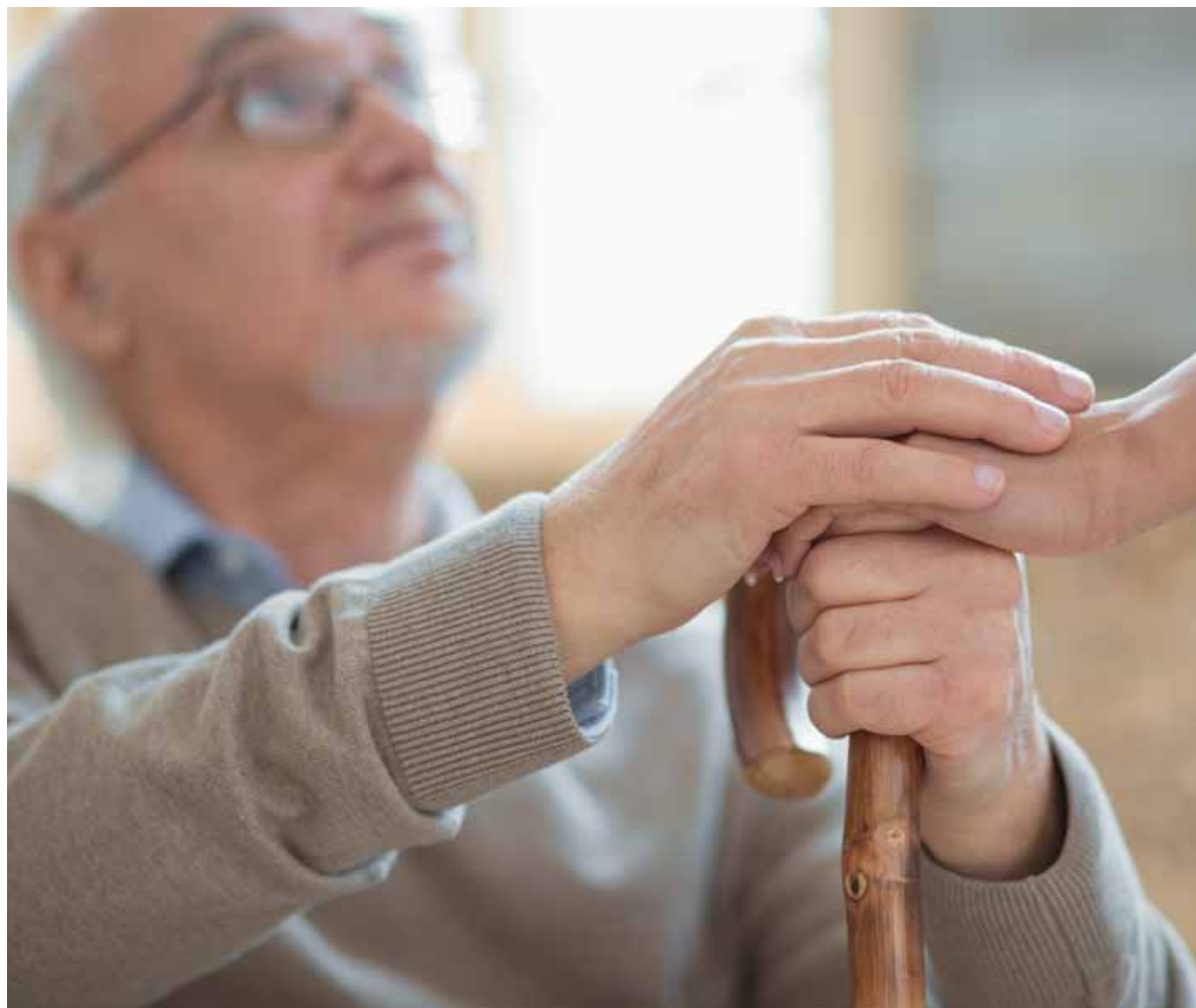


By Amy Yuen

Last year, the Camden Coalition was selected as one of 32 organizations in the country to implement the Accountable Health Communities (AHC) model, which screens Medicare and Medicaid beneficiaries for a range of health-related social needs and provides them with health and social service navigation. Since then, we've been partnering with clinical delivery sites and community service providers serving Camden, Burlington, and Gloucester counties to help us launch our AHC model this coming August. To gear up for the kickoff, we've convened an advisory board that will oversee this ambitious effort to transform how whole person care is accessed and delivered in our region.

Accountable Health Communities is a five-year national initiative of the Center for Medicare & Medicaid Innovation that aims to bridge the gap between clinical and community service providers. The AHC model is designed to address a range of health-related social needs among Medicare and Medicaid beneficiaries: housing instability, food instability, utility needs, interpersonal violence, and transportation. A growing body of evidence has shown that unmet social needs prevent individuals from living the healthiest life possible. By enhancing community partnerships across these counties through this model, we seek to improve health outcomes, cut healthcare costs, and decrease high rates of hospitalization and emergency room visits among patients with complex needs in South Jersey.

"Our healthcare system is not set up for providers to address the social service needs that can lead to poor health," said our CEO Kathleen Noonan. "The Accountable Health Communities model bridges the gap for many Medicare and Medicaid beneficiaries in South Jersey by connecting clinical and social service providers, and training providers



As a community of caregivers, we can systematically address interrelated medical and social needs in the region and fulfill our responsibility to treat the whole person.

to screen for social factors that can affect health. As a community of caregivers, we can systematically address interrelated medical and social needs in the region and fulfill our responsibility to treat the whole person."

As strategic advisers for our implementation of the AHC model, members of the new advisory board will analyze gaps in services annually to assess and prioritize community needs and develop a quality improvement plan. They will serve as ambassadors of our model and will have an opportunity to share best practices, align their organizational goals, and coordinate their resources with other providers to address service gaps in the region. The advisory board, which began its quarterly meetings in late May, is comprised of representatives

from the New Jersey Medicaid office, local government, clinical delivery sites, beneficiaries and their caregivers, and at least one community service provider from each of the core health-related social needs categories.

A diverse group of organizations serving South Jersey participate on the advisory board, including CAMcare, Cooper University Health Care, Food Bank of New Jersey, Jefferson Health, Logisticare, New Jersey Medicaid, Oaks Integrated Care, Robin's Nest, Rowan University/Rutgers-Camden Board of Directors, Virtua Health, and Volunteers of America-Delaware Valley.

Priscilla Davis Martin, Program Support Specialist of the New Jersey Medicaid office, said she's excited about the Camden Coalition's AHC model and

its potential impact.

"Our goal is to identify and address regional barriers of care across our three counties," said Priscilla. "We believe if we can connect healthcare with agencies providing housing, transportation, food, utilities, and safety, we can really assess what patients need and connect them to those resources. We're looking to address both the needs of individuals and communities in this process."

Amy Yuen is staff writer at the Camden Coalition of Healthcare Providers, a New Jersey nonprofit healthcare innovator. This article first published June 13, 2018 on the Camden Coalition's website (camden-health.org) and is reprinted with permission. The contents provided are solely the responsibility of the authors and do not necessarily represent the official views of HHS or any of its agencies. The project described was supported by Funding Opportunity Number CMS IPI-17-001 from the U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services.

Better Information. Better Decisions. Better Care.

The Centers for Medicare and Medicaid Services
release their 2019 Medicare & You Handbook.



Thousands of Americans age into Medicare each day, yet many are unaware of or do not understand the option of Medicare Advantage. Better communication, outreach, and education on Medicare Advantage – the high-value, integrated care option under Medicare – is essential.

As the leading voice for Medicare Advantage, Better Medicare Alliance is grateful to CMS for recent efforts to support older adults and people with disabilities in making the right choice for themselves.

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