STATEMENT FOR THE RECORD

Submitted to the
House Ways and Means Committee
Subcommittee on Health

*Medicare Advantage:
Promoting Integrated and Coordinated Care for Medicare Beneficiaries*
June 7, 2017

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America’s Health Insurance Plans (AHIP) is the national association whose members provide coverage for health care and related services to millions of Americans every day. Through these offerings, we improve and protect the health and financial security of consumers, families, businesses, communities and the nation. We are committed to market-based solutions and public-private partnerships that improve affordability, value, access and well-being for consumers.

We thank the committee for strongly supporting the Medicare Advantage (MA) program. Many committee members – both Republicans and Democrats – signed letters earlier this year, urging the Centers for Medicare & Medicaid Services (CMS) to avoid further MA payment cuts and maintain stable coverage options for beneficiaries in the 2018 rate setting process. Overall, more than 320 members of Congress addressed letters to CMS, expressing support for the MA program, in the weeks leading up to the April 3 announcement of 2018 MA payment rates.

The reason for this strong, bipartisan support is simple: the MA program is providing better value, better services, and better health. Medicare Advantage delivers real results for the people who depend on the program – and for the hardworking taxpayers who support it.

When MA plans work with providers to deliver more coordinated care, we make meaningful progress to deliver better care, improved health, and lower costs for all patients – not just those in Medicare Advantage.

According to recent research, in areas where penetration is strongest, the MA program has had a “spillover effect” in delivering significant decreases in Medicare fee-for-service (FFS) spending growth. Researchers in Health Affairs found that in counties with high baseline MA penetration rates, each 10 percentage point increase in MA penetration was associated with a decrease in per patient FFS spending of $154 annually.¹

For years, MA bids have been lower than the FFS program on average for delivering basic Medicare benefits. Today, the MA program is more efficient than traditional Medicare at delivering benefits and care to seniors and individuals with disabilities.

These results show the critical role of the private sector and government working together – efficiently and effectively. They show that proven approaches – like coordinated care and a focus on wellness and prevention – deliver real value and are essential to success.

We appreciate that today’s hearing focuses on the role played by the MA program in promoting integrated and coordinated care for seniors and individuals with disabilities. Through their participation in the MA program, our members have a long track record in emphasizing prevention, providing access to disease management services for chronic conditions, implementing value-based care, and offering systems of coordinated care for ensuring that beneficiaries receive the health care services they need.

Our members also have demonstrated strong leadership in sponsoring MA Special Needs Plans (SNPs) that serve as a crucial safety net for approximately 2.4 million of our nation’s most vulnerable seniors. As participants in the SNP program, our members tailor their benefits and services to address the unique needs of individuals who are dually eligible for both Medicare and Medicaid, who have severe or disabling chronic conditions, or who qualify for an institutional level of care.

Medicare-Medicaid Demonstration Plans (MMPs) are another promising model for providing coordinated, integrated health care to vulnerable beneficiaries. These plans currently serve more than 397,000 enrollees in a number of states as part of an initiative to better align the financing of Medicare and Medicaid and to integrate primary care, acute care, behavioral health, and long-term services and supports for dual eligible enrollees.

Programs of All-Inclusive Care for the Elderly (PACE) provide an important option for more than 38,000 older adults and people age 55 and over living with disabilities. PACE organizations provide medical, social, and long-term care services – through a managed care model – to frail, community-dwelling individuals who are eligible for nursing home-level care according to state Medicaid standards. As the elderly population in our country increases, PACE programs can become an increasingly important model of care delivery.

Our statement focuses on two topics: (1) our members’ strong commitment to serving Medicare beneficiaries; and (2) legislative recommendations for expanding on the MA program’s success in delivering coordinated care to Medicare beneficiaries.
Our Members’ Commitment to Serving Medicare Beneficiaries

AHIP’s members are strongly committed to serving Medicare beneficiaries under the MA program and continuing to provide coverage for cost-effective, high quality, and accessible health care.

MA plans offer a different approach to health care delivery than beneficiaries experience under the Medicare FFS program. MA plans have developed systems of coordinated care for ensuring that beneficiaries receive health care services on a timely basis, while also providing access to disease management services for their chronic conditions. These coordinated care systems provide for the seamless delivery of health care services across the continuum of care. Physician services, hospital care, prescription drugs, and other health care services are integrated and delivered through an organized system whose overriding purpose is to prevent illness, manage chronic conditions, improve health status, and employ best practices to swiftly treat medical conditions as they occur, rather than waiting until they have advanced to a more serious stage. MA plans also help to reduce emergency room visits for routine care, ensure prompt access to primary care physicians and specialists when care is needed, and promote communication among treating physicians about the various treatments and medications a patient needs.

As part of their overall strategy for serving Medicare beneficiaries, MA plans also are implementing patient-centered innovations that include:

- Mitigating the harm of chronic diseases by focusing on prevention, early detection, and care management;
- Reducing beneficiary costs;
- Addressing the needs of vulnerable individuals, including low-income beneficiaries; and
- Applying clinical best practices to increase patient safety and limit unnecessary utilization of services.

Today more than 18.6 million Americans – about 32 percent of all Medicare beneficiaries – have chosen to enroll in the MA program, and 16.7 million of them receive drug benefits through their
Since 2010, MA enrollment has increased by 60 percent. While the average payment to MA plans is equivalent to FFS costs, MA bids are 10 percent below FFS costs and MA plans often offer additional benefits to enrollees for no additional premium. Ninety percent of beneficiaries can choose from at least five MA plans.

Research findings consistently demonstrate that the innovative strategies adopted by MA plans translate into better health outcomes for enrollees. For example:

- In January 2017, *Health Affairs* published a study showing that utilization of post-acute care following a hospital discharge was lower for MA enrollees than for FFS enrollees. The authors of this study stated: “Medicare Advantage patients also exhibited better outcomes than their FFS Medicare counterparts, including lower rates of hospital readmission and higher rates of return to the community.”

- According to another study co-authored by AHIP staff and published by the *American Journal of Managed Care*, readmission rates for MA enrollees were found to be about 13 percent to 20 percent lower than FFS.

- Another study in *Health Affairs* found that MA plans had higher rates of annual preventive care visits (53 percent vs. 33 percent in FFS).

To build upon this strong record of success, we support additional steps that would support MA plans as they develop the next generation of innovative programs and services to provide greater value to Medicare beneficiaries. Below we outline our recommendations for addressing this priority.

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Legislative Recommendations for Strengthening MA Program

Permanently Reauthorize Special Needs Plans

SNPs were established by Congress to provide new coverage options to beneficiaries with specific health care challenges. Medicare beneficiaries who enroll in these plans benefit from the coordinated care, disease management, and other initiatives our members have pioneered to ensure that they receive high quality health care across the entire continuum of services they need.

A Health Affairs study found that beneficiaries with diabetes in a Medicare Advantage SNP had “lower admission rates, shorter average lengths-of-stay in the hospital, lower readmission rates, slightly lower rates of hospital outpatient visits, and slightly higher rates of physician office visits than their fee-for-service counterparts.” Specifically, the study indicated that SNP enrollees had 9 percent lower hospital admission rates and 19 percent fewer hospital days, and 7 percent more office visits than beneficiaries in traditional Medicare.6

We encourage Congress to permanently reauthorize all SNPs including plans for beneficiaries who are dually eligible for both Medicare and Medicaid (D-SNPs), those for beneficiaries with specified chronic conditions (C-SNPs), and those for beneficiaries who require an institutional level of care (I-SNPs). Plans have made substantial investments to develop and operate these products, which are demonstrating success in improving beneficiary outcomes in comparison to the FFS program. Short-term reauthorizations create uncertainty and are inconsistent with the continued development of these innovative programs. Permanent reauthorization would alleviate this uncertainty and further our members’ commitment to creating programs tailored to enrollees with special needs.

Allow for Non-Uniform Benefits by Expanding Value-Based Insurance Design

Our members have pioneered innovative benefit designs that use research and clinical guidelines to promote better health, manage chronic conditions, and target populations with specific health needs. These types of value-based insurance design (VBID) features can improve quality of care

by encouraging individuals to access critically needed, high-value services and health improvement activities including preventive care. These strategies align with the national goals of providing patient-centered care, improving patients’ overall health status, and changing financial incentives in a way that drives quality in health care delivery. We urge Congress to expand the use of VBID in the MA program nationally to permit more beneficiaries with chronic conditions to receive customized benefits through these models and to support participation by all MA organizations.

Allow MA Plans to be Considered Alternative Payment Models

The Medicare Access and CHIP Reauthorization Act (MACRA) defines an Alternative Payment Model (APM) as a CMS Innovation Center model, the Shared Savings Program, the Health Care Quality Demonstration, or a federally-required demonstration. MA plans have partnered with providers in developing APMs that contribute to the delivery of care that is of higher quality and lower cost than care delivered through FFS coverage. Accordingly, we believe that either legislative or regulatory action should be taken to allow MA plans to be defined as APMs. This step would level the playing field by providing risk arrangements in MA the same treatment as risk arrangements in traditional Medicare, resulting in more equitable opportunities for physicians. Numerous stakeholders, including physician groups, have addressed letters to the Administration, urging CMS to recognize MA alternative payment models.

Allow MA Plans to Include Telehealth Services in Basic Benefits Package

Health plans have embraced telehealth through the widespread use of nurse hotlines, remote monitoring services, electronic office visits, and other innovative ways of providing value to enrollees. These strategies have been found to increase access to a variety of health care services, including individuals without regular physicians and for Medicare beneficiaries. For example, one Health Affairs study found that access to telemedicine through a large public

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employer plan increased the amount of care delivered to patients who had no previous interaction with a provider\textsuperscript{10}; another study found that off-hours physician services provided to nursing home residents via telemedicine reduced hospitalizations.\textsuperscript{11}

However, current law limits MA plans from incorporating telehealth benefits into their basic benefit package that go beyond the scope of services included in the FFS benefit. As a result, MA plans must use supplemental benefits funded by rebates or premiums to offer expanded coverage of remote access technologies, which has reduced flexibility in plan financing and limited the availability of other additional benefits or buy-downs of Medicare cost sharing. Permitting MA plans to broaden the use of telehealth in delivering basic benefits would be more consistent with modern medical practices and would enhance value and reduce premiums for enrollees.

\textbf{Allow MA Plans to Offer Non-Medical Benefits as Supplemental Benefits}

MA plans should be permitted to offer non-medical benefits as part of the supplemental benefits they provide to their enrollees. This includes housing and nutrition-related services as well as other social services that can help improve the overall well-being and health status of beneficiaries with chronic conditions. Allowing MA plans to offer non-medical benefits would be consistent with the goals of CMS’ Accountable Health Communities Model, which is funding bridge organizations to screen Medicare beneficiaries for health-related social needs and refer them to, or provide them with, services that meet these needs.

\textbf{Establish Unified Grievances and Appeals Process for Individuals Enrolled in D-SNPs}

Currently, grievance and appeals procedures for beneficiaries in D-SNPs (i.e., plans for dual eligibles) are governed by separate state and federal requirements. These redundancies create confusion for beneficiaries and caregivers, and result in decreased efficiency and increased administrative burdens for plans. Enrollees in D-SNP plans would be better served by a unified grievance and appeals process.

\textsuperscript{10} Uscher-Pines, Lori, Mehrotra, Ateev. Analysis of Teladoc use seems to indicate expanded access to care for patients without prior connection to a provider. Health Affairs 33 (2):258-264. February 2014.
\textsuperscript{11} Grabowski, David C., O'Malley, A. James. Use of telemedicine can reduce hospitalizations of nursing home residents and generate savings for Medicare. Health Affairs 33(2): 244-250. February 2014.
Eliminate the MA Benchmark Cap

To the extent that CMS is unable to identify statutory authority to do so, we urge Congress to repeal the benchmark cap that currently prohibits some MA plans from receiving the full bonus payments they have earned under the program’s Star Ratings System. This existing policy continues to be problematic for beneficiaries enrolling in these plans, who are likely to experience additional costs or reduced supplemental benefits as a result, and is inconsistent with the broader health system goals of incentivizing high quality performance. Removing this cap is an important step toward preserving and rewarding the innovative programs and strategies through which MA plans are working to provide value to seniors and individuals with disabilities.

Thank you for considering our recommendations for expanding on the MA program’s success in delivering coordinated care to Medicare beneficiaries. We look forward to working with the committee as you consider legislation addressing these important issues.