U.S. Senate Special Committee on Aging
"Examining Medicare and Medicaid Coordination for Dual-Eligibles"
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Chairman Kohl, Ranking Member Corker, thank you for the opportunity to appear today before the U.S. Senate Special Committee on Aging to discuss improving care for dual eligible beneficiaries. My name is Shawn Morris and I am President of Development and Innovation at HealthSpring, a Cigna company. HealthSpring is one of the largest Medicare Advantage (MA) coordinated care plans in the United States with more than 400,000 Medicare Advantage and 1.2 million Prescription Drug Plan (PDP) members. More than 122,000 of these HealthSpring members are dual eligible beneficiaries enrolled in one of our traditional MA plans or a HealthSpring Special Needs Plan (SNPs). Cigna and HealthSpring have been serving Medicare beneficiaries for 20 years, and our concentration on the big picture of improving beneficiaries' overall health and improving their quality of life has allowed us to develop a unique approach to health care coverage for our members. This approach is particularly beneficial to vulnerable dual eligible beneficiaries with complex health care needs.

At HealthSpring we develop a partnership that provides what our members want – more access to higher-quality preventive care – while giving physicians the tools and incentives they need to deliver that care. Specifically, HealthSpring develops focused, data-driven networks; pays physicians for quality over quantity of care; and provides our physicians the resources they need so they can devote more time and attention to their patients. The result of this approach is healthier members with lower medical costs. It is a common-sense model, but an uncommon practice.

Through long-term initiatives, like our *Living Well Health Centers* and *Partnership for Quality*, we are able to focus on our member's overall health and on improving their experience of care and quality of life.

HealthSpring's *Living Well Health Centers*, for example, provide additional clinical support, adding health plan care coordinators, nurse practitioners, pharmacists, and behavioral health specialists to the interdisciplinary care team. This integrated point-of-care approach increases patient satisfaction and improves adherence to evidence-based treatment plans.

Our *Partnership for Quality* program is also a clear win-win-win. Beneficiaries receive better care and stay healthier; participating physicians are paid more through quality bonuses; and HealthSpring spends less overall on delivering care. For example, members enrolled with *Partnership for Quality* physicians saw an 8% reduction in hospital admissions over a four-year period, and significant increases in preventive health services – such as a 73 percent increase in breast cancer screenings and an 83 percent increase in colorectal screenings. *Partnership for Quality* turns the inefficient, volume-driven model of healthcare on its head, and everyone benefits. Physicians are empowered to devote themselves to their patients and our members receive better care and stay healthier.

As I noted earlier, the HealthSpring members that often benefit the most from our dedication to comprehensive care-coordination and higher quality are our 122,000 dual eligible members. That is why we strongly support the Centers for Medicare and Medicaid Services' (CMS) recent efforts to improve care for this vulnerable population. The new *Capitated Financial Alignment Model* demonstration program, which allows states to integrate Medicare and Medicaid services and financing for dual eligible beneficiaries, offers a real opportunity to improve the quality of care these long-underserved beneficiaries receive and as a fortunate byproduct, generate considerable budgetary savings. HealthSpring is looking forward to the opportunity

to participate in this demonstration and is currently working with states and CMS to make sure the initiative is able to achieve its intended results.

We believe that in order for these demonstrations to succeed in identifying the best, long-term solutions for these patients, great care needs to be taken when selecting the participating plans. As MedPAC noted in its June 2012 report, "plan participation standards should be transparent and should at least consider quality ranking, provider networks, plan capacity, and experience with Medicaid and Medicare services for dual-eligible enrollees." We completely agree. We believe all plans that meet CMS-designated quality and access standards – including Medicaid managed care plans and Medicare Advantage plans – ought to be eligible to participate in the demos. Frail, dual eligible beneficiaries deserve nothing less.

That said, it is also important to recognize that when Congress created Medicare and Medicaid nearly a half century ago, it established Medicare as the primary source of financing of medical care for seniors, regardless of their eligibility for Medicaid.

Indigent seniors have the same Medicare coverage and the same broad access to physicians as more affluent ones, with Medicaid supplementing that coverage. In carrying out the *Capitated Financial Alignment Model*, we should not overturn this structure by preventing Medicare Advantage plans from participating or by requiring beneficiaries to relinquish the current coverage that they have actively chosen. Requiring dual eligibles to abandon trusted, high-quality plans with expertise in coordinating care for dual eligible beneficiaries and forcing them into a plan with a less specialized care coordination model and network of doctors and hospitals could end up undermining the intent of the demonstrations.

It is also important to note that Medicare plans already manage the bulk of services provided to the dual eligibles. Of the $319.5 billion estimated as being spent on duals in 2011, 80 percent are federal dollars, more than two-thirds of which flowed through Medicare. State expenditures on dual eligibles focus overwhelmingly on

long-term care, not medical or acute care where savings and quality improvement are most readily achievable.

Lastly, by maintaining Medicare as the primary source of care for vulnerable dual eligible beneficiaries, we will ensure that they are able to benefit from the variety of new delivery system reforms focused on the Medicare program that the dual eligible population so desperately needs.

Dual eligible beneficiaries represent the greatest need and best opportunity for improving quality and lowering costs. We strongly support these goals and look forward to working with this Committee and other federal policymakers to achieve these results.

Thank you again for the opportunity to testify today and I welcome any questions you may have.

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