Testimony

for

House Ways & Means Committee
Subcommittee on Health

The Future of Medicare Advantage Health Plans

by
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I. Introduction

Chairman Brady, Ranking Member McDermott, and members of the subcommittee, I am Chris Wing, Chief Executive Officer of SCAN Health Plan (SCAN). SCAN is the fourth largest not-for-profit Medicare Advantage Prescription Drug (MAPD) plan in the United States, serving approximately 170,000 members in California and Arizona. While most of SCAN's members are over the age of 65, we also provide care to some younger, disabled individuals who are dually-eligible for Medicare and Medicaid benefits ("dual eligibles").

We appreciate this opportunity to testify on the successes and benefits of the Medicare Advantage (MA) program. MA plans have pioneered successful strategies to manage the care of seniors with complex health needs. By emphasizing prevention and wellness through primary care, MA plans help beneficiaries achieve better health outcomes. Medicare fee-for-service (FFS) lacks the infrastructure necessary to support the coordination across provider networks that MA plans use to address beneficiaries' unique needs. In fact, a recent *American Journal of Managed Care* study found that MA plans outperformed FFS in 9 out of 11 clinical quality measures.[1] This means that MA beneficiaries received the level of care recommended by a physician with greater frequency than patients in FFS, for 9 of the 11 procedures studied.

Our testimony includes the following:

- An introduction to SCAN and the people we serve;
- Examples of how MA increases the value proposition of Medicare;
- An explanation of how MA program flexibility enables plans to more holistically serve Medicare beneficiaries;
- Evidence that MA exceeds FFS on quality of care;
- A discussion of how the alignment of incentives is encouraging plan and provider collaboration; and
- Recommendations to encourage the continued success of the program.

II. SCAN Health Plan

SCAN has a long history of serving older adults with complex health situations. SCAN was founded in 1977 by a group of Long Beach, California senior citizen activists who were frustrated by a lack of access to health and social services that addressed their unique needs. They specifically wanted assurance that they could continue living in their own homes, even if their declining health qualified them for a nursing home. SCAN's mission today is the same as it was then: to develop innovative ways to help our members manage their health and live independently. For more than two decades, SCAN participated in Medicare's Social HMO Demonstration, incorporating long-term services and supports (LTSS) with a comprehensive program of assessment and care management. It was through our experience as a Social HMO that SCAN developed an expertise in crafting benefits and services of particular importance to persons with special care requirements.

Because of the complex nature of our members' health conditions, SCAN has created a care management model that emphasizes prevention and early intervention, with a keen focus on medication management. Our model spans the continuum of a beneficiary's health status. Our disease management programs focus on recognizing disease-specific symptoms and actions to take, when to call the doctor or seek urgent/emergent care, nutrition, self-

[1] Brennan N., Shepard M. (2010) "Comparing Quality of Care in the Medicare Program," The American Journal of Managed Care, 16(11): 841-848.

management and healthy behaviors, advance care planning, and medication management. Highly-trained care teams address the complex needs of the chronically ill population, and each program is coordinated with all others to ensure safe and effective care transitions between all levels of care and providers. All those involved work together in offering a person-centered, holistic approach for persons with multiple, complex, and ongoing care needs. The *New England Journal of Medicine* has cited SCAN's model as an example of a successful investment in primary care to provide better care at reduced costs through reductions in the use of hospitals and emergency rooms.[2]

III. Medicare Advantage as a Value-Add Proposition

The MA program has seen exponential growth and increased popularity over the last few years. As of March 2014, 30 percent of the Medicare population resides in MA, a total of 15.7 million beneficiaries.[3] That is a year-over-year increase of 10 percent, and a 41 percent increase since March 2010.[4] In my home state of California, about 38 percent of Medicare beneficiaries are currently enrolled in MA.[5] Perhaps most notable is the percentage of newly-eligible Medicare beneficiaries who are choosing MA – more than half, according to a January 2014 Health Affairs article.[6] It is clear that beneficiaries, especially younger beneficiaries, are voting with their feet for the benefits, the flexibility, and the comprehensive coverage that MA plans offer. It is expected that MA will only gain popularity as the Baby Boom generation – who are accustomed to the benefits and infrastructure of managed care organizations – continues to age into Medicare.

There are specific reasons for this significant growth. Medicare Advantage plans provide extra benefits and services that are not included in the Medicare FFS program, such as:

- Case management services
- Disease management programs
- Coordinated care programs
- Wellness and prevention programs
- Enriched Part D benefits
- Vision, hearing, and dental benefits coordinated with medical service

Many plans now offer personal health records to afford beneficiaries greater control over their health information. In addition, many Medicare Advantage plans offer all these additional benefits with either zero or low premium, making the program even more attractive to potential enrollees. In fact, in 2013, 55 percent of MA beneficiaries nationwide were enrolled in plans with zero premiums.[7] Nearly 90 percent of SCAN's members do not pay a premium as part of their plans, and over 80 percent pay $0 copays for visits with their primary care physicians. This is important not only because it saves seniors money, but also because of the benefits it brings

[2] Bodenheimer T., Berry-Millet R. (2009) "Follow the Money – Controlling Expenditures by Improving Care for Patients Needing Costly Services," New England Journal of Medicine, 361:1521-1523.
[3] Gold, M., Jacobson, G., Damico, A., Neuman, T. "Medicare Advantage 2014 Spotlight: Enrollment Market Update," Kaiser Family Foundation, April 2014.
[4] Ibid.
[5] "Medicare Advantage / Part D Contract and Enrollment Data," Centers for Medicare & Medicaid Services, February 15, 2013.
[6] Martin, A., Hartman, M., Whittle, L., Carlin, A., and the National Health Expenditure Accounts Team (2014) "National Health Spending in 2012: Rate of Health Spending Growth Remained Low for the Fourth Consecutive Year," Health Affairs, 33(1): 67-77.
[7] MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment and landscape files, 2013.

to both the patient and the health system as a whole. A study published in the *New England Journal of Medicine* observed that as copayments for ambulatory care increased, elderly patients made fewer outpatient visits and experienced more hospital admissions.[8]

MA plans continue to be a vital source of coverage for low-income and minority beneficiaries. In 2011, 31 percent of African-American Medicare beneficiaries and 38 percent of Hispanic beneficiaries were enrolled in Medicare Advantage plans.[9] Forty-one (41) percent of Medicare beneficiaries with Medicare Advantage plans had incomes below $20,000; for comparison, 37 percent of all Medicare beneficiaries had incomes below $20,000.[10]

IV. Greater Flexibility for Beneficiaries

With the availability of such additional benefits tied to lower out-of-pocket costs, it is no surprise that beneficiaries are increasingly opting to receive their care through MA instead of through FFS, which was designed in the mid-20th century.

Perhaps most notably, Medicare Advantage allows plans to develop coordinated programs focused on individuals with particularly complex health conditions. These "Special Needs Plans" (SNPs), established by the Medicare Modernization Act of 2003, exclusively serve one of three types of special needs individuals: (1) institutionalized beneficiaries, or individuals living in the community who require an equivalent level of care (I-SNP); (2) dual eligibles (D-SNP); and/or (3) beneficiaries with severe chronic conditions (C-SNP).[11]

Because SNPs target their enrollments to particular patient populations, they can design programs that meet a group's unique health care needs and successfully reduce hospitalizations and institutionalizations. SNPs are subject to strict requirements and oversight from CMS and the National Council on Quality Assurance to evaluate quality of care. The advantages of SNPs to beneficiaries and public payors alike are evident in the results of the SNP Alliance's Annual Member Profile. The most recent profile shows that the SNPs profiled serve significantly more complex, high-needs beneficiaries than those in Medicare FFS. For example, while the average risk score, as calculated by CMS through its Hierarchical Condition Category system, for FFS beneficiaries living in institutions was 1.84, SNP Alliance members' median risk score for I-SNPs was 2.23, with an upper range of 2.45. The average risk score for SNP Alliance fully-integrated D-SNPs was 1.49 compared to 1.27 for dual eligibles in FFS. SNP Alliance plans also serve a higher percentage of people with what the National Quality Forum defines as "high-impact conditions." Despite these significantly higher risk levels, SNP Alliance members have been highly effective in reducing hospital utilization, readmissions, and emergency room visits.

Because SCAN's members are, overall, older and frailer than the average Medicare beneficiary, the availability of targeted, coordinated care options is particularly important. SCAN offers I-SNPs, D-SNPs, and C-SNPs to our members, with a total SNP enrollment of approximately 30,000 individuals. A host of case management services is available to enrollees in a SCAN SNP, including the creation of a personal care plan, assistance transitioning safely home after a

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[8] Trivedi, A., Moloo, H., and Mor, V. (2010) "Increased Ambulatory Care Copayments and Hospitalizations among the Elderly," The New England Journal of Medicine, 362(4): 320-328.
[9] "Low-Income & Minority Beneficiaries in Medicare Advantage Plans, 2011," AHIP Center for Policy and Research, February 2013.
[10] Ibid.
[11] "Special Needs Plans – Fact Sheet & Data Summary," Centers for Medicare and Medicaid Services. *Available at* http://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/downloads/FSNPFACT.pdf.

hospitalization, disease management, and medication therapy management. Approximately 10,000 of our members are dual eligibles enrolled in one of SCAN's D-SNPs. In addition to the case management services available to other SNP members, D-SNP enrollees have access to a Personal Assistance Line (PAL) Unit. SCAN provides these dual eligibles with a "PAL," a member services representative who speaks their language and provides additional assistance in navigating the complexities of the Medicare and Medicaid programs. PALs act as liaisons between the member and SCAN staff, medical groups, providers, and community-based organizations, ensuring that the member has access to the services and supports that he or she needs.

This unique care management model has proven effective in improving patient health outcomes. A March 2012 study conducted by Avalere Health found:

- Comparing HEDIS 30-day All-Cause Readmissions Rates between dual eligibles enrolled in a SCAN Health Plan D-SNP versus Medicare FFS dual eligibles, SCAN's dual eligibles had a **hospital readmission rate** that was **25 percent lower** than a similar cohort of California FFS dual eligibles.

- SCAN also scored better than Medicare FFS on ARHQ's Prevention Quality Indicator (PQI) Overall Composite, demonstrating a **14 percent lower hospital inpatient admission rate** for conditions that compose the composite measure, including chronic obstructive pulmonary disease (COPD), congestive heart failure, and bacterial pneumonia.

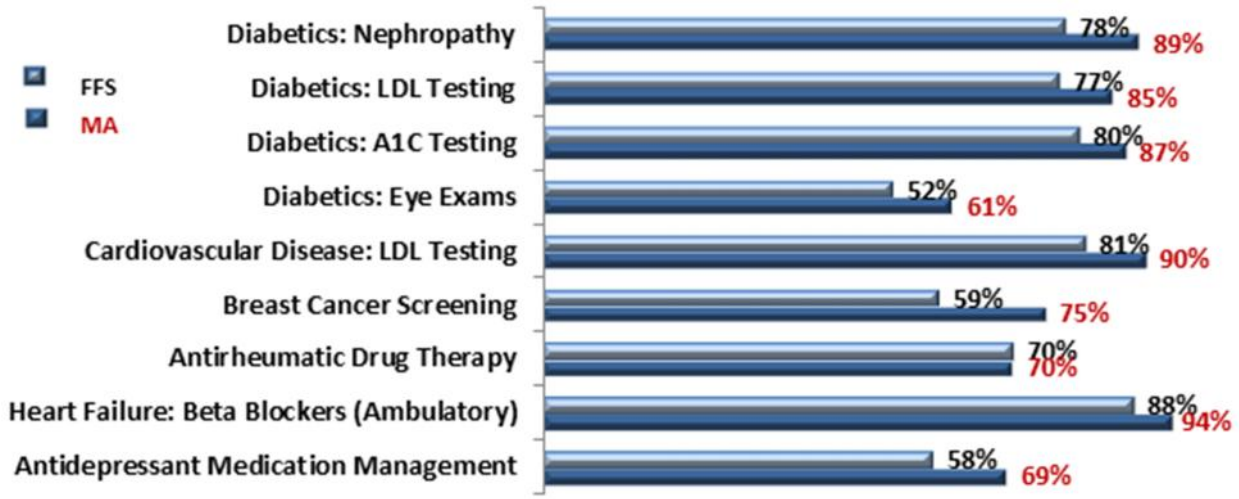
The study also found a potential for significant cost savings tied to the improvement in health status of SCAN's D-SNP enrollees. Based on the results of a matched cohort analysis, if California FFS duals had the same hospitalizations and readmissions rates as SCAN's duals, this would result in at least $50 million in annual savings to Medicare FFS in California.[12] Avalere based the calculation on expected reduced hospitalizations and re-hospitalizations for the 5,500 FFS dual members it examined in the CMS five percent sample, multiplied by 20 to approximate the impact to the full California FFS duals population. Avalere has said that savings could be greater across the entire California duals population if additional FFS duals matched the SCAN members' conditions.

V. Quality

The additional benefits and emphasis on care coordination found in Medicare Advantage translate into much more effective care compared to traditional Medicare. As mentioned above, a recent study in the *American Journal of Managed Care* discovered that MA plans outperformed FFS Medicare in 9 out of 11 clinical quality measures.

[12] "Dual Eligible Population Analysis for SCAN Health Plan: Hospitalizations and Readmissions," Avalere Health LLC, March 2012.

***American Journal of Managed Care:* HEDIS measures**



The findings of this study reveal that breast cancer screening rates were approximately 15 percentage points higher in MA than in FFS. The quality of diabetes care received by beneficiaries was approximately four to 10 percentage points higher in MA across the four measures studied [rates of eye exams, A1C testing, LDL (cholesterol) testing, and nephropathy (kidney) screening or ongoing treatment]. Antidepressant medication management rates were 13 to 14 percentage points higher in MA. Receipt of beta-blockers prescription after discharge for AMI (heart attack) was nearly seven percentage points higher in MA, and LDL (cholesterol) testing for patients with cardiovascular disease was 7 to 8 points higher as well.

The positive effects of MA care coordination programs transcend specific episodes of care. Analysis of a large sample of administrative claims data found that the 30-day readmission rate for hospitalized MA patients was about 14.5 percent in the 2006-2008 period, about 22 percent lower than that for FFS.[13] Taking into account adjustments for readmission risk and disability entitlement status, the MA readmission rate was about still 13 to 20 percent lower than FFS.

SCAN and other MA plans take such benchmarking very seriously. We are constantly measuring ourselves to see how we are fulfilling the Triple Aim: improving the individual experience of care, improving the health of populations, and reducing the per capita cost of care. At SCAN, we actually reward our executives and other employees financially based on metrics that represent these goals. That is one reason why we are seeing high levels of patient satisfaction (97 percent among duals, for example), quality improvement going from 3.5 to 4.5 Stars in one year, and cost savings translating into higher benefits vs. FFS (for example, a $59 additional actuarial value per member per month in Part D benefits).

VI. Encouraging Creative Collaboration

One aspect of the Affordable Care Act that has not received enough attention is the Medicare Advantage Quality Bonus Program, which rewards plans that meet quality benchmarks of 4 Stars and higher. For the first time, CMS has begun paying plans based on quality of care as measured through HEDIS, HOS, and CAHPS. Plans and beneficiaries are responding to this incentive. In 2014, more than a third of MA contracts are now 4+ Stars, compared to 14

[13] Lemieux, J., Sennett, C., Wang, R., Mulligan, T., Bumbaugh, J. (2012) "Hospital Readmission Rates in Medicare Advantage Plans," The American Journal of Managed Care, 18(2): 96-104.

percent in 2011.[14] Even more impressive, 53 percent of Medicare Advantage beneficiaries are now enrolled in plans with four or more stars, compared to just 24 percent in 2011, according to the Department of Health and Human Services.[15]

The Quality Bonus Program has encouraged plans and providers to work together to hit quality benchmarks, especially in California where they frequently share financial risk for beneficiaries. Under the California Model, as it is called, plans pay providers a capitated amount of the premium to manage beneficiaries' medical benefits. Physicians and other providers have a natural incentive to provide efficient care under capitation. However, new developments are making closer collaboration between plans and providers essential to survival. A series of financial challenges – sequestration, rate cuts, an across-the-board penalty on coding intensity, the new HCC model, and specialty drug trends – are financially squeezing both plans and providers. Achieving 4 Stars and above to earn that bonus payment and mitigate at least some of the cuts is driving plans and providers to hit CMS' metrics and provide optimal care.

To give you some idea of the growing level of Physician/Plan collaboration, SCAN invited the leadership of 14 independent physician groups and health systems that serve SCAN's membership to test their interest in forming a joint effort to improve systems of care for the chronically ill population we collectively serve. We created a forum that would enable us to learn from each other and possibly make joint, cross-organizational investments to support improvement.

Given that the 5 Star Quality Bonus is earned by SCAN across its membership, it would not be enough for a best practice to focus on one or another of our contracted provider groups. Rather, we recognize that all boats must rise together if the SCAN network is to be rewarded by the Quality Bonus Program. The fact that SCAN and the 14 providers operate in markets where we compete against Kaiser Permanente, a well-respected 5 Star Medicare Advantage plan that uses the staff model Permanente Medical Group as their exclusive physician group, also provided us with a focal point to get the community-based physician group leaders' competitive juices flowing.

With the Quality Bonus Program providing the impetus to come together, the SCAN Provider Integration Steering Committee was formed and articulated the following goals:

- SCAN will achieve at least 4 Star results in the CMS Quality Bonus Program and strive for 5 Stars, seeking improvement in clinical quality measures and member satisfaction;

- Continue to grow the SCAN product by offering the communities we serve affordable products that meet the needs of Medicare beneficiaries, including those that are healthy and active as well as those living with multiple chronic conditions and becoming increasingly frail;

- Research, encourage and support geriatric best practices across all physician groups to improve care and then make the findings publicly available, and

- Improve administrative efficiencies between SCAN and our provider partners, with a particular focus on data exchange that can support better systems of care and service for our mutual customers.

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[14] "The Medicare Advantage Program in 2014," ASPE. April 7, 2014. *Available at* http://aspe.hhs.gov/health/reports/2014/MedicareAdvantage/ib_MedicareAdvantage.pdf.
[15] Ibid.

VII. Recommendations

Medicare Advantage is an excellent program, but it is far from perfect. There are actions that Congress and CMS could take to make it better. At the same time, Congress and CMS should be on guard that they do not take actions that undermine the stability and effectiveness of the program. Here are a few items that are top of mind:

- ***Rate stability*****:** Over the past few years, the MA program has sustained a series of significant, statutorily-mandated funding reductions. These include a $2.5 billion cut as part of the American Tax Relief Act of 2012, a two percent funding reduction via Sequestration mandated by the Budget Control Act of 2013, and over $200 billion worth of cuts from the Affordable Care Act (ACA). Seniors have begun to feel the impact of these cuts in higher out-of-pocket costs, reduced benefits, and winnowing choice. The impact will likely become more manifest as the vast majority (80 percent) of the ACA-mandated cuts take effect in the future. As plans work to optimize coverage in an environment of diminishing resources, CMS must keep payment rates to MA plans stable. A February 2014 report from Oliver Wyman predicted that cuts of the magnitude proposed in CMS' 2015 advance notice would result in a "high degree of disruption in the MA market," including the "potential for plan exits, reductions in service areas, reduced benefits, provider network changes, and MA plan disenrollment."[16] Thankfully, beneficiary outcry and strong bipartisan, bicameral opposition mitigated some of those cuts. But payments to the program should, at the very least, be held stable to prevent disruption and ensure that the programs upon which seniors have come to rely remain viable.

- ***CMS Stars stability*****:** The CMS 5 Star ratings program is a powerful incentive for plans to adapt their practices to meet specific quality metrics. However, the lag between experience, reporting, and quality rating presents a challenge for plans, particularly given the dynamic nature of the Star ratings criteria year to year. Stars-based payments for a given year are based on data collected three years earlier. For example, a plan's payment in 2015 will reflect its 2014 Star rating, which is based on data collected between January 2012 and June 2013 (estimated). Because CMS makes changes to the criteria, as well as to the weighting of the criteria, each year, plans may make certain investments to comply with measures that cease to exist before those investments are realized. To ensure that Star ratings reflect plans' actual performance on those measures, CMS should hold the criteria as stable as possible.

  Part D benefit flexibility**:** We are coming upon a time when emerging medications can actually cure a patient's disease, not simply make life bearable for a few more months or years. The challenge for government and the health care community will be: how can we afford these miracle drugs which may help one population without financially undermining the rest of the health system? Much of this responsibility falls on the ability of health plans and pharmaceutical companies to negotiate affordable pricing, and rightly so. The market, if structured rationally, is always the best way to bring about reasonable pricing and therapeutic innovation. What we ask is that government officials be responsive to this developing situation and permit maximum flexibility within Part D to

[16] Oliver Wyman, "2015 Advance Notice: Changes to Medicare Advantage Payment Methodology and the Potential Effect on Medicare Advantage Organizations and Beneficiaries," February 2014.

accomplish that goal. CMS should also look at whether the current risk adjustment models should be updated to better predict the costs of high risk patients.

- ***Focus on the "near duals"*:** Under current policy, Medicare does not cover the community-based long-term services and supports (LTSS) that play an essential role in keeping chronically ill beneficiaries from going into a nursing home. Once a person enters a nursing home, he or she stands a greater than 20 percent chance of spending down his or her assets and going on Medicaid.[17] Dual eligibles are some of the most expensive and ill-served beneficiaries in our health care system. To intervene in this downward spiral, Congress should support the creation of a "Community-Based Institutional Special Needs Plan" (CBI-SNP) demonstration, a concept advanced in Section 250 of S. 1871, the Senate Finance Committee's December 2013 SGR legislation. The CBI-SNP demonstration would provide LTSS to low-income Medicare beneficiaries (150 percent FPL) with two or more activities of daily living limitations – those who are euphemistically called the "near duals." Expanding the availability of these benefits to a lower income, Medicare-only population would improve quality of life for individuals and reduce Medicaid long-term care costs as well as Medicare acute and post-acute care costs. The demonstration would also contribute to the evidence base on how to most effectively target specific services to at-risk individuals. The National Governor's Association Health Care Sustainability Task Force has recently advocated for a similar solution to prevent the growth of the duals population. This is an issue that's time has come, and we recommend that this Committee embrace it.

VIII. Conclusion

The MA program continues to grow in popularity. It gives seniors and other eligible individuals what they want: choice, coordination of care, affordability. It has begun to put the incentives in place for constant quality improvement by rewarding collaboration between providers and plans. Congress should have a strong interest in seeing the continued advancement of Medicare Advantage. We stand ready to work with you toward that goal.

Thank you for this opportunity.

[17] Adams, E.K., Meiners, M., Burwell, B. "A Synthesis and Critique of Studies on Medicaid Asset Spend-Down," Report for the Office of the Assistant Secretary for Planning and Evaluation, DHHS, January, 1992. *Available at* http://aspe.hhs.gov/daltcp/reports/syncri.pdf .