



**Statement of the
Alliance of Community Health Plans
for the Record**

**U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Health**

**Re: Medicare Advantage Hearing on Promoting Integrated and
Coordinated Care for Medicare Beneficiaries**

June 7, 2017

MAKING HEALTH CARE BETTER

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The Alliance of Community Health Plans (ACHP) appreciates the importance which the Committee places on the Medicare Advantage (MA) program and its attention to the challenge of improving the integration and coordination of care in MA, particularly for those Americans with chronic conditions. ACHP's non-profit, community-based plans partner with the government to provide MA coverage at the highest quality levels, consistently achieving 4- and 5-star ratings.

ACHP brings together innovative health plans and provider groups leading the nation towards a value-based health care and integrated delivery system. Our members are integrated, provider-aligned health plans providing coverage and care for more than 18 million Americans across 27 states and the District of Columbia, including 2.4 million Medicare beneficiaries.

We hope that the Committee will act on legislation that encourages innovative and cost effective approaches to caring for Americans receiving Medicare benefits, with the goal of improving health outcomes. Among the significant issues requiring attention are reauthorization of Special Needs Plans (SNPs), expansion of telehealth in Medicare Advantage, restoring quality payments under the MA benchmark cap, and flexibility to offer coverage using Value-Based Insurance Design (VBID).

Special Needs Plans

Given their long record of serving more than two million of the most vulnerable Medicare beneficiaries, ACHP encourages the committee to permanently reauthorize Special Needs Plans.

Congress has consistently recognized the value of SNPs, as it has regularly extended the program over the past 14 years. We hope that the Committee will provide the more than 500 SNPs operating nationwide, including SNPs offered by ACHP member plans to tens of thousands of Medicare enrollees, the assurance that they can continue to serve Americans with chronic conditions, disabilities and other special needs without the fear that the program will be terminated.

The individualized nature of SNP coverage means that beneficiaries enrolling in the program receive better tailored and more coordinated services than they might otherwise have access to in fee-for-service Medicare or the broader Medicare Advantage program. Coverage and care under the SNP program can be further enhanced with new provisions, such as those in legislation reported by the Senate Finance Committee, that promote integration of services but also recognize that states may not take the same approach, or move at the same pace, to fully integrate regulatory, financial, and delivery system structures between Medicare and Medicaid.

Permanent authority for SNPs will encourage both states and health plans to devote necessary resources to special populations served by the program and move further towards integrated approaches and

innovative delivery designs – steps ACHP’s plans have taken for years. ACHP urges Congress to provide such authority.

Telehealth

The Committee can take important steps to modernize Medicare by allowing Medicare Advantage plans to offer clinically appropriate, telehealth benefits in their annual bid amounts beyond the services that currently receive payment under Part B. ACHP members increasingly utilize remote access technologies to provide clinical care and strengthen coordination of services across settings – the latter an especially important aspect of caring for chronically ill seniors or enrollees in rural and difficult to reach areas. These efforts are enhanced by our members’ reliance on electronic medical records.

Initial evidence from ACHP member plans indicates that the use of telehealth does not increase costs and may, in fact, lower them. For example, in its [testimony](#) to the Senate Finance Committee on May 16, 2017, UPMC Health Plan states that a 2014 analysis of its e-visit program, “Anywhere Care,” found no evidence that e-visits or other telehealth initiatives added to costs. In fact, “data indicated that members who utilized an e-visit had a lower overall cost of care for the conditions treated than members who sought the same care in an emergency room, urgent care center, primary care office, or retail clinic.”

While CMS has modestly expanded use of telehealth-based services as supplemental benefits through administrative action, that approach limits expansion of effective and efficient technologies. **ACHP urges the committee to enact legislation authorizing services provided by remote access technologies to be considered covered services under basic benefits and therefore part of the MA bid.** Medicare leadership and support for innovative clinical approaches relying on remote access technologies would have a substantial impact on the entire delivery system.

If the Committee moves forward on the telehealth issue, we hope that statutory language will not be unnecessarily limiting, given the pace of technological change. An approach that is overly prescriptive in listing specific services that are permitted and not permitted, or directing the Secretary to develop such a list, is not likely to keep up with changing technology and innovations that improve care and patient access.

Medicare Advantage Benchmark Cap

ACHP urges the Committee to pass H.R. 908, the *Medicare Advantage Quality Payment Relief Act of 2017*, introduced by Representatives Mike Kelly and Ron Kind. Their bipartisan legislation would finally correct the substantial losses affecting 2.5 million seniors due to the so-called “benchmark cap” that has reduced or eliminated quality incentive payments in Medicare Advantage. The unintended consequence of the benchmark cap provision has been to undermine value-based care and diminish benefits to seniors worth tens of millions of dollars.

The Centers for Medicare and Medicaid Services (CMS) under the previous administration interpreted Medicare law in a way that is contrary to Congressional intent, denying Medicare benefits to seniors who enrolled in high quality plans specifically so they could take advantage of enhanced benefits. CMS’ decision has reduced or eliminated quality payments to plans in about half the nation’s counties. In some areas, 4- and 5-star MA plans may receive the same payment as a 3-star plan, contrary to Congress’ goal of paying for quality. According to MedPAC’s [March 2016 Report to Congress](#), the cap reduces county benchmarks by an average of \$480 annually – and that figure will be higher for 2018. The benchmark cap interpretation has also limited the effects of CMS’ laudable initiative to account for the effects of high

enrollment of dual eligible beneficiaries on star ratings; even if they achieve a 4-star rating, plans with high numbers of dual eligibles will not receive a quality incentive payment in capped counties.

While we have argued, with supporting legal analysis, that CMS has discretionary authority to resolve this problem, to date the counsel's office has reaffirmed the agency's interpretation. The clearest solution would be statutory language that leaves the benchmark cap in place – *we do not advocate elimination of the cap* – but directs the Secretary to exclude the quality payments from the benchmark cap calculation, similarly to how quality payments are made in other areas of Medicare. Fixing this problem will provide seniors with enhanced care as any savings gleaned by MA plans, by statute, must be returned to seniors in the form of reduced premiums or cost-sharing and enhanced benefits.

Value-Based Insurance Design

ACHP encourages the Committee to enact provisions granting Medicare Advantage plans flexibility to establish benefit structures that vary based on chronic conditions of individual enrollees. Similar value-based insurance designs (VBID) have been used in the commercial market with promising results.

We believe that MA plans should be allowed to develop, and beneficiaries to choose, coverage options designed specifically to improve care for their chronic conditions and prevent further progression of the disease. Value-based designs would allow MA plans to offer enhanced benefits, reduce cost-sharing for effective services, adjust provider networks to promote treatment by high quality and efficient providers, and offer care improvement and wellness programs tailored to specific chronic conditions.

ACHP believes there are several principles that should be considered in developing legislation that will expand use of VBID in managing chronic conditions while preserving options for, and protecting the interests of, all beneficiaries. These include:

- *Beneficiary engagement and protections:* Active and informed beneficiary engagement is critical to the success of VBID. For example, beneficiary participation in health risk assessments and shared decision-making will help plans better understand the needs of the patient, and the patient will have a more informed understanding of evidence-based practices to manage his or her conditions.
- *Benefit design based on clinical information:* Value-based design to meet the needs of chronically ill MA enrollees moves away from Medicare's "one size fits all" approach under which cost sharing for certain services must be uniform across beneficiaries. Criteria will be necessary to assure that there is sound clinical evidence and demonstration of provider quality for promoting certain services and providers. Criteria based on clinical information are also important in discouraging use of services and providers considered to be less effective and efficient in treating patients with chronic conditions. An appropriate exceptions process should be included as a further beneficiary protection.
- *Careful measurement and evaluation:* Expansion of VBID will require metrics to carefully assess beneficiary understanding, access, quality, and service of tailored benefit structures.

We appreciate the Committee's commitment to improve the Medicare Advantage program. MA plans have become a valued choice for beneficiaries. The steady rise in the percentage of seniors choosing an MA plan year after year is evidence these plans offer attractive, affordable, high quality benefits. ACHP member plans welcome the opportunity to work with you and members of both parties to develop market-tested solutions based on many years of experience improving the health of communities across the nation and the American health care system as a whole.