***Statement for the Record***
**Subcommittee on Health**
**Committee on Ways and Means**
**U.S. House of Representatives**
**July 24, 2014**

The Alliance of Community Health Plans (ACHP) appreciates the opportunity to submit a statement for the record for a hearing on the Medicare Advantage program conducted by the Health Subcommittee of the House Ways and Means Committee.

ACHP is a national leadership organization representing community-based and regional health plans and provider organizations. ACHP members provide coverage and care for more than 18 million Americans in the commercial market, for newly insured families through the exchanges, and for Medicare, Medicaid, and federal, state, and local public employees. Our members are not-for-profit health plans or subsidiaries of not-for-profit health systems. They share longstanding commitments to their communities, close partnerships with providers, and substantial investments in the innovative approaches and infrastructure necessary to provide health care that is coordinated, affordable and high quality.

**Summary**

ACHP would like to bring two issues to the Committee's attention: First, a statutory cap on Medicare Advantage (MA) benchmarks that are used to set payment rates undermines an important Congressional policy decision that Medicare payment should promote high quality performance. We urge the Committee to amend the statute so that the benchmark cap does not act as a disincentive to achieving high quality care. Second, restrictions on Medicare payment for telehealth-based services increasingly limit the gains that beneficiaries could realize in maintenance of good health, treatment of disease, patient convenience and satisfaction, and access to care. The Committee should consider changes that would promote use of electronic technologies in Medicare.

**Medicare Advantage Benchmark Cap**

ACHP strongly supports the Medicare Advantage program. Our member plans provide coverage to 2.2 million Medicare beneficiaries –14 percent of enrollees in private health plans. Beneficiaries across the country are embracing the program. Contrary to projections, there has been a remarkable growth of about one million beneficiaries per year, so that MA now constitutes 30



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percent of Medicare enrollment. Most observers believe that MA will continue to expand, as new retirees are more comfortable with a managed approach to their care. They are likely to be attracted as well to the idea of receiving services for a fixed monthly premium, rather than incurring the greater financial exposure of fee-for-service payments in the traditional program.

Congress adopted a policy change of great significance when it decided that Medicare should adopt value-based purchasing – or "pay for performance" – in the MA program. Building on the 5-star rating system, which had been developed to enable consumers to compare plans in their area, Congress authorized Quality Incentive Payments (QIP) to be made to MA plans at 4 stars and above. Congress has also authorized value-based payment in the fee-for-service segments of the program.

The 5-star rating system and the quality payments are based on widely accepted measures of clinical quality and patient satisfaction, with the addition of measures of customer service and compliance with CMS administrative requirements. This system is refreshed each year with modifications to measures, introduction of new measures, or the retirement of measures on which plans have achieved uniformly high levels of performance. The Quality Incentive Payment system has worked as Congress intended: performance has improved so that approximately half of all MA enrollees are now in plans rated at 4 stars and above. ACHP members have long been committed to quality as a core element of their mission, and 7 of the 11 Medicare 5-star plans nationally are ACHP members. Eighty-seven percent of Medicare enrollees in plans offered by ACHP members are in 4.5 and 5 star plans.

The capitated payments to MA plans are determined by calculating a benchmark level for every county and comparing the bids from each plan to the benchmark. If a plan is eligible for a quality payment, it essentially raises the benchmark by 5 percent. The additional revenue available to the 4-star plans and above must be used to increase the benefits to enrollees.

We think it is unlikely that Congress would want to undermine the important step it took towards value-based purchasing, but a separate provision of Medicare law could have that effect. In adopting a new system of calculating the county benchmarks, Congress mandated that benchmarks under the new methodology could not be greater than they would be if calculated under the old methodology. This is called the benchmark "cap." The crux of the problem that we want to call to your attention is that the new Quality Incentive Payments were included in the comparison of new v. old benchmarks for calculating the cap, even though they were not part of the old methodology.

The goal of reducing MA benchmarks to be more in line with local fee-for-service costs, as Congress mandated, is being achieved. However, *the benchmark cap, in some areas, reduces or even eliminates the quality payment made for achieving a rating of 4 stars or above*. As we noted,

because the quality payment is simply an increase in the benchmark, reducing the benchmark under the cap reduces or eliminates the increment achieved for a 4 star quality rating. In other words, the cap weakens the incentive to achieve 4 stars and go beyond that. We do not think that Congress intended to take away with one provision the significant policy change towards paying for value that it enacted in another provision.

The impact of the cap is felt particularly in rural counties and counties which received "floor" payments under the old methodology. Without going into details, these are counties that Congress previously determined would need a minimum payment level in order for MA plans to be viable in those areas. The impact on ACHP member plans is substantial. For example:

- Priority Health, based in Grand Rapids, MI expects a revenue loss of $28 million due to the revised benchmark calculation. Of that amount, $5.2 million, or 19 percent, is attributable to the effects of the cap. Further, of the $5.2 million reduction from the cap, Priority Health loses $4.2 million that it otherwise would have achieved for its rating as a 4.5 star Medicare plan. To reiterate, that loss is a loss in the value of benefits that Priority can offer to its beneficiaries.
- Security Health Plan, serving beneficiaries in Wisconsin, expects a revenue loss of $18.5 million due to the revised benchmark calculation. Of that amount, $7.6 million, or 41 percent, is attributable to the effects of the cap. Further, of that $7.6 million, Security loses $5.7 million that it otherwise would have achieved for its rating as a 4.5 star Medicare plan.
- Geisinger Health Plan, serving beneficiaries in Pennsylvania, expects a revenue loss of $32 million under the revised benchmark calculation. Of that amount, $14.3 million, or about 45 percent, represents the effects of the cap. And of that amount, Geisinger loses $8.6 million that it otherwise would have achieved as a 4.5 star plan and would have had available for benefits to Medicare enrollees.

The effects of the benchmark cap are exacerbated by the cumulative impact of a series of MA payment reductions mandated over the past several years. Reductions in the benchmarks, negative annual percentage updates to the capitated payment, significant negative adjustments for "coding intensity," and certain changes to the risk adjustment model all have a substantial effect on revenue available to provide benefits. MA plans are committed to reducing costs where they are able to do so, but the magnitude and cumulative effect of these Medicare policy changes put plans in the position of considering reductions in benefits, available plan options, and service areas.

ACHP urges the Committee to amend the statute in order to mitigate the negative effects of the benchmark cap and the inclusion of the Quality Incentive Payments in the calculation.

**Telehealth-Based Services**

The second issue we would raise for Committee consideration is Medicare coverage for telehealth-based services, which some refer to as remote access technologies. A combination of statutory and regulatory restrictions currently inhibits the use of these technologies in both the traditional Medicare program and in MA. We believe there would be a benefit to a Committee hearing and further study of the issue, with the goal of making appropriate changes that enable Medicare enrollees to benefit from significant new strides in the use of telehealth.

ACHP members and many other health plans increasingly utilize remote access mechanisms to provide clinical care and strengthen coordination of services across settings; these efforts are enhanced by our members' reliance on an electronic medical record. Health plans are using electronic visits, video technology, and remote monitoring to provide maintenance and preventive care for their enrollees, as well as diagnosis and treatment when it is clinically appropriate. Our members are finding very high enrollee satisfaction with this approach and no degradation in the quality of care; in fact, remote technologies provide the opportunity for improvements in the quality of care because they increase the amount of interaction between the patient and health care team and the information available on the patient's health status.

ACHP believes that the appropriate approach for Medicare is to consider remote access technologies to be an alternative modality or complementary means of providing clinical services, and not a service itself. *T elehealth is a different way of delivering an already covered service*, whether that is a physician visit or preventive service. In other words, telehealth should not be seen as simply a supplement or complement to face-to-face encounters. Patients increasingly expect their health plans to provide the access to services and convenience that remote technologies facilitate. State Medicaid programs have recognized the advantages of telehealth-based services, providing at least some level of reimbursement , particularly for real- time interactive video visits. Many states also require commercial health plans to provide reimbursement for services provided via telehealth, although not necessarily at parity with services provided in person.

A key question for Committee consideration is whether the Medicare statute limits covered services to those provided in a physical location or prohibits covering services when the provider is remote from the patient. Another question is the extent to which requirements for traditional Medicare apply to the MA program. We believe that the MA program provides an ideal environment for testing how Medicare enrollees can benefit from telehealth-based services, because the capitated MA payment provides no incentive for overutilization of services.

Dramatic changes in the use of visits via email and video link, clinical advice lines, remote consultation by specialists, electronic medical records, monitoring devices, and other aspects of telehealth hold the promise of improving access to and timeliness of needed care, increasing communication between providers and patients, enhancing care coordination, maintaining health and treating many medical conditions. ACHP urges the Committee to consider appropriate changes that will position Medicare as a leader in promoting innovative clinical approaches using remote access technologies; that leadership would have a substantial impact on the entire delivery system.

ACHP thanks the Committee for considering our views and would be happy to provide additional information on these issues.