Statement Submitted for the Record by
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President and CEO
Priority Health

Before the
Subcommittee on Health
Committee on Ways and Means
United States House of Representatives

Hearing on the Future of Medicare Advantage Plans
July 24, 2014

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On behalf of Priority Health, I would like to thank Chairman Brady, Ranking Member McDermott and Members of the Health Subcommittee for holding a hearing on the Future of Medicare Advantage. I am pleased to have the opportunity to submit this statement on behalf of Priority Health. My testimony will include background on Priority Health as part of the Spectrum Health System, examples of how we work with our provider network to deliver high value care to our member beneficiaries, and a few of our concerns about the impact of the Medicare Advantage (MA) payment methodology, particularly the impact of the "benchmark cap" on the MA Quality Improvement ("5 Star") program.

Priority Health is a Michigan-based non-profit health plan nationally recognized for improving the health and lives of its members. It continues to lead in engaging members in their health, delivering effective health and disease management programs and working with physicians to improve health care outcomes and performance. All of our Medicare Advantage plans have earned 4.5 stars from CMS for three consecutive years. Priority Health is one of only 20 health plans nationwide with wellness programs accredited by the National Committee for Quality Assurance, an organization that also rated our Medicare Advantage plans in the top 3% in the nation. Our portfolio of Medicare plans offers quality, affordable options to our more than 97,000 Michigan beneficiaries.

Priority Health is part of Spectrum Health System, the largest not-for-profit health care system in West Michigan. Our integrated health care system is dedicated to evidence-based, patient-centered medicine and patient safety. Together our quality is among the nation's best, while our costs are among the nation's lowest. Priority Health's premiums rank in the lowest quartile when benchmarked against regional competitors.

Priority Health understands that health optimization is foundational and requisite to ensuring that our valued beneficiaries live well. We offer services that advance quality care for our members and go above and beyond traditional Medicare Fee-for-Service (FFS) offerings.

Our core purpose of "Improving the health and lives of our members" is brought to life through our medical management programs and systems of care in partnership with our network providers. By transforming the care model and attacking chronic illness, we have demonstrated improvements in population health. Our sophisticated population analytics inform us of subpopulations in need of alternative approaches to care, to more effectively address their unique concerns. Our innovative approaches to transforming care include:

- Home-Based Primary Care - This innovative initiative brings the care team into the homes of our patients who are at the far end of the population health continuum - the advanced chronically ill – and whose multiple medical conditions are complicated by functional and/or cognitive limitations that make it difficult for them to adequately access traditional ambulatory care in a physician's office. We have changed not only how the patient accesses their care, but provided a team-based model of care to meet all the needs of the patient. This is a fundamentally transformative way of delivering care that provides powerful insight into the holistic needs of the patient. This program has served over 200 patients since inception and we are now scaling this program across our network.

- Post-Acute Care Transformation - As the Committee knows, Medicare's payment for services following hospitalization includes a great deal of waste, low-value care and, all too often, lack of coordination of services that result in readmissions. Across the health care landscape, post-acute care is responsible for the greatest degree of variation; a striking conclusion from the Institute of Medicine's[1] recent report on geographic variation in Medicare spending is that post-acute care is the largest driver of overall variation. The real impact of post-acute care reform lies in better coordination and improved evidence-based care. As a result, Priority Health is leveraging a predictive tool, in conjunction with clinical management and patient/family engagement, to ensure the right care in the right setting for the right amount of time. The results are optimized care and outcomes, reduced hospital re-admissions, and reduced avoidable skilled nursing rehab days. Additionally, performance metrics will promote greater clinical decision support to consumers, who will then be able to choose high performing skilled nursing settings based on quality and efficiency metrics—improving their engagement in the management of their care, and reducing the clinical and performance variability that is pervasive in this environment.

- Clinical Decision Support via Advanced Care Planning - Priority Health has been a leader in the advancement of the patient's voice regarding their goals, wishes, and preferences for care at the end of life. Our Plan Care Managers conducted a demonstration of this capability

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[1]Newhouse JP, Garber AM. Geographic variation in Medicare services. N Engl J Med 2013;368:1465-1468

that was recently published in the Journal of Palliative and Supportive Care 'Telephonic advance care planning facilitated by health plan case managers'. Priority Health is working with, and providing incentives for, providers in our networks to promote this much needed conversation with our members, which in turn will promote a person-centered approach to health care decision making that respects the goals, wishes and preferences of our members for end of life care.

- Care Management (CM) competency and alignment with our providers - Although modern medicine has generated evidence-based treatment protocols that have eradicated illness and prolonged life expectancy, far too many people still struggle to live well with complex illness, often complicated by the social determinants of health. We are aligning our CM teams with Accountable Care Networks to build relationships and patient-centered plans of care that are transparent at all touch points. We are engaging our network partners in the design of the ideal model of care, sharing tools and resources to optimize the care experience, and collaborating in the development of a common care plan utilizing common technology platforms. This collaborative approach will permit excellence in care management across all settings and eliminate duplication and/or redundancy, while allowing CM to scale their solution to reach a larger percentage of patients in need.

A critical component in driving clinical value with our network of providers is through better economic alignment. We are transforming the care model by paying for value instead of volume (pay for value), which aligns the payer/provider relationship to advance this new equation. By promoting best practices and identifying waste in the system, we are working together to develop patient management innovations that create value in clinical care and drive quality outcomes at lower cost.

When Congress authorized Quality Incentive Payments for Medicare Advantage plans with 4 stars and above, it created a significant incentive for plans like Priority Health to further invest in the innovative approaches to care delivery and payer/provider alignment that have been critical to advancing care model transformation, much as it is attempting to do in the fee-for-service Medicare program. When an MA plan becomes eligible for a Quality Incentive Payment it can result in a 5% increase to their benchmark, thus incentivizing plans (and their provider partners) to continue to develop programs that result in improved care quality.

Congress also authorized a new methodology for calculating benchmarks, mandating that the benchmarks cannot be greater than what they would have been under the old benchmark methodology (thus creating a "cap"). Unfortunately these two policies are increasingly at odds, with the result that plans' quality incentive payments are being eroded by the cap. The reduction in quality inventive payments makes it more difficult to (1) pass those savings on to our members in the form of lower premiums, (2) to provide more robust benefits and most importantly, (3) to

enhance our ability to make investments in innovations resulting in higher quality care. We don't believe Congress intended the benchmark cap to act as a disincentive to achieving high quality care but that is now increasingly the effect.

We are concerned that the cap on the benchmarks to pre-ACA levels fails to recognize efforts to advance quality. We estimate that almost 60% of the counties in our service area are being capped and that over 25% of the counties in our service area will have no difference in benchmarks between a 5 star plan and a 2.5 star plan. As this is an issue that will be more regional in nature, it will have a more significant impact and cause greater uncertainty for smaller, state-based regional plans than national carriers, and may be more likely to cause disruption in rural areas where options are already limited for members.

Medicare Advantage plans have become a valued choice for beneficiaries. The steady rise in the percentage of beneficiaries that choose an MA plan year after year is evidence that these plans offer attractive, affordable, and high quality benefits. As the Baby Boomer generation ages into Medicare, MA plans will continue to experience significant growth. This generation is better acquainted with the benefits of managed care and has a higher propensity to choose an MA plan. They understand the benefit of having case and disease management, wellness, preventive care, coordination of care and added services like dental and vision care that are unavailable with traditional Medicare.

Medicare Advantage has also put in place incentives that drive quality outcomes by rewarding alignment between provider and plan. By working towards healthier outcomes, reducing costs, increasing satisfaction and promoting quality, MA plans will become the preferred plan of beneficiaries.

We hope this statement provides some valuable feedback on the impact that Medicare payment policy has on our ability to continue to invest in the innovative programs that are transforming the care model, improving care quality, and bolstering the long-term sustainability of both regional health plans like Priority Health and the entire health system. Thank you and we look forward to working together toward the continued advancement of improved care and better value for Medicare beneficiaries.