Medicare Advantage Briefing

What is Medicare Advantage? Who is enrolled? How does it work? If these are questions you would like answered, please join us. Come hear from a provider, a practicing physician, and a special needs plan, as well as a patient perspective on what is myth and what is fact when it comes to Medicare Advantage.

Friday, February 6
12:00 pm
Rayburn House Office Building B-318

Agenda

Welcome
Mary R. Grealy, President, Healthcare Leadership Council

Panel Presentations:
Romilla Batra, MD, MBA, Corporate Medical Director, SCAN Health Plan
Diane Laird, MPH, Chief Strategy Officer, MemorialCare Health System and CEO, Greater Newport Physicians
Bart Barrett, MD, Family Physician
Allen Gutierrez, National Executive Director, The Latino Coalition

Questions & Answers

Closing Remarks
Mary R. Grealy
Mary R. Grealy
President
Healthcare Leadership Council

Mary R. Grealy is president of the Healthcare Leadership Council, a coalition of chief executives of the nation’s leading healthcare companies and organizations. HLC advocates consumer-centered healthcare reform, emphasizing the value of private sector innovation. It is the only health policy advocacy group that represents all sectors of the healthcare industry. She was appointed to the position in August 1999.

Ms. Grealy has an extensive background in healthcare policy. She has led important initiatives on the uninsured, improving patient safety and quality, protecting the privacy of patient medical information, and reforming the medical liability laws. She testifies regularly before Congress and federal regulatory agencies. She is a frequent public speaker on health issues and has been ranked many times by Modern Healthcare as one of the 100 Most Powerful People in Healthcare and has been named to Modern Healthcare’s list of the Top 25 Women in Healthcare for 2009.

Romilla A Batra, MD, MBA
Corporate Medical Director
SCAN Health Plan

Dr. Romilla Batra currently serves as the Corporate Medical Director of SCAN Health Plan. In her current role, she is responsible for SCAN’s clinical programs including disease management, ambulatory, and complex case management. In addition, Dr. Batra helps design clinical initiatives to boost SCAN’s 5 star performance. She also oversees SCAN’s CME based provider performance improvement education to engage and educate provider partners.

Dr. Batra has over 12 years of experience in leading organizational efforts to create innovative programs focused on chronic disease management and quality improvement, both on the health plan side as well as the provider group side. She has a diverse clinical background and has managed physician practices in both community-based health centers as well as academic centers. Dr. Batra has in-depth experience in managing strategic planning activities, developing and evaluating patient centric clinical programs. She is a board-certified internist and prior to joining SCAN had worked as a Medical Director at University of California Irvine (UCI) School of Medicine. She continues to volunteer at UCI as an Associate Professor of Medicine and also serves as a faculty member for the Paul Merage School of Business at UCI. Dr. Batra finished her internal medicine training at UCLA and received her MBA with health care focus from Paul Merage School of Business. Dr. Batra has presented at national meetings and recently won the prestigious “Golden Apple Award” for teaching at UCI Medical School.
Diane Laird, MPH  
Chief Strategy Officer, MemorialCare Health System, and  
CEO, Greater Newport Physicians

As the founding CEO of Greater Newport Physicians (GNP), a prominent Medical Group in Southern California, Diane Laird provided the vision and leadership to establish and build an award winning independent practice association (IPA) in partnership with more than 500 local physicians. In 2012, GNP affiliated with MemorialCare Health System and Ms. Laird assumed the role leading the IPA division of the MemorialCare Medical Foundation. Following the affiliation, the IPA division doubled its network of physicians and more than doubled its geographic reach in partnership with MemorialCare.

In January 2014, Ms. Laird also assumed the role of Chief Strategy Officer for the fully integrated System and is leading the organization’s strategic discussions, focusing on the growth and expansion of MemorialCare through unique partnerships and affiliations. Ms. Laird brings more than three decades of senior leadership experience holding a variety of healthcare executive positions with responsibilities including strategic planning, marketing, business development, managed care contracting, real estate, practice management, physician recruiting and group purchasing.

Ms. Laird earned her bachelor’s degree in Biological Sciences from University of California, Irvine and her master’s degree in Public Health from University of California, Los Angeles. She is an active Board Member of CAPG, a trade association which represents more than 150 physician groups in California who care for more than 13 million California residents.

Bart Barrett, MD  
Family Physician  
MemorialCare Health System

Dr. Barrett has been serving Medicare Advantage (MA) patients as a private physician with Greater Newport Physicians since 1994 and is the Medical Director for GNP’s Home Visit Program. He has been an innovator in patient centered care, including the creation of a program to visit MA patients in their homes as part of a comprehensive care strategy. Additionally, Dr. Barrett has been a leader in using technology to improve patient care, using Electronic Records and secure communications to reach out to patients and encourage preventative care. Dr. Barrett piloted a program using this technology that ultimately resulted in an outreach to over 10,000 women. Dr. Barrett is currently exploring ways to improve patient access to care utilizing mobile video on smartphones and tablets.
Allen Gutierrez serves as the National Executive Director of The Latino Coalition, a national organization that represents Latino interests with senior executives of many Fortune 500 companies and both federal and local government agencies.

He is also the founder of The MCA Group based out of Maryland with emphasis on federal and private sector procurement, special events management and multicultural marketing. Prior to joining the entrepreneurial world and starting his own company he was the Chief Operating Officer of the United States Hispanic Chamber of Commerce (USHCC), a national organization that represents the interests of over three million Hispanic Owned Businesses.

Prior to joining USHCC, Mr. Gutierrez previously served as Senior Advisor to the Chief Operating Officer for the U.S. Small Business Administration as well as the Senior Advisor to the Office of International Trade. Additionally, Mr. Gutierrez has previous insurance industry experience as the regional director for Aetna Financial Services in the Emerging Markets Division and as an account manager/sales representative for Great West Life & Annuity.

Mr. Gutierrez earned his Bachelor of Arts degree in political science with a minor in business administration from the University of Southern California, the first in his family to be accepted and graduate from an accredited four-year college.
Medicare Advantage and Lessons for Healthcare’s Future

February 05, 2015
3:08 pm

(The following post is co-authored by Mary Grealy, President of the Healthcare Leadership Council, and Don Crane, President and CEO of CAPG)

As healthcare policymakers continue to seek to incentivize value in Medicare, the successes of the Medicare Advantage program cannot be ignored.

The Healthcare Leadership Council and CAPG are strong supporters of Medicare Advantage, believing that beneficiaries will gravitate toward health coverage plans that provide them with high-quality healthcare at the most affordable costs. A recent column in Forbes highlighted how the growing preponderance of evidence shows this to be the case, pointing out that the number of beneficiaries in Medicare Advantage plans has now hit 17 million and the monthly growth rate in new enrollments is almost double what it was two years ago. As Dr. Scott Gottlieb wrote in the column, “(Medicare Advantage) plans offer a more comprehensive set of benefits than traditional Medicare, often plugging gaps in coverage or helping to offset out-of-pocket costs. Seniors also prefer a network that plans offer, and their ease of use.”

(Of note, the Healthcare Leadership Council will be sponsoring a Capitol Hill briefing on Medicare Advantage on Friday, February 6, featuring experts from SCAN Health Plan, MemorialCare Health System and The Latino Coalition. The briefing is at noon, ET and interested individuals can attend by contacting Amanda Uherek at auherek@hlc.org.)

The impact on the healthcare system as a whole from the growing popularity of private Medicare Advantage plans is a positive one. A study published in Health Affairs examined the rate at which different types of Medicare beneficiaries accessed preventive care services. Just over one in four enrolled in traditional Medicare fee-for-service had annual preventive doctor visits. For those in private Medicare plans, however, was 44 percent. The more we can increase adherence to preventive care, the more we can reduce costs associated with hospitalizations, emergency room visits and acute care services.

Given the evidence, it seems odd that there is still controversy surrounding Medicare Advantage. This is the case, though. Despite the popularity of this program with seniors, Medicare Advantage has been the subject of repeated year over year cuts. These cuts have come from a variety of sources – legislative and regulatory – and more cuts are on the horizon.

The facts are clear. Medicare Advantage is growing in popularity among seniors who choose private plan options over traditional fee-for-service coverage. And, most importantly, Medicare Advantage is getting results in terms of keeping people healthier and reducing the need for more expensive healthcare interventions. There are answers here that can help address the challenges facing our nation’s healthcare system.
Medicare Advantage: A Plan’s Perspective

Romilla Batra, MD, MBA
Corporate Medical Director
SCAN Health Plan
February 6, 2015
Three in 10 Medicare beneficiaries are enrolled in Medicare Advantage plans.
Medicare Advantage enrollment has increased rapidly and is projected to continue to rise

Medicare Advantage Enrollment (in millions), 2005-2024

NOTE: Includes cost plans, MSAs, demonstrations, and Special Needs Plans, as well as other Medicare Advantage Plans.
Medicare Advantage Penetration

The share of Medicare beneficiaries in Medicare Advantage plans varies greatly across the country.

U.S. Average Medicare Advantage Penetration = 30%

NOTE: Includes cost plans, MSAs, demonstrations, and Special Needs Plans, as well as other Medicare Advantage Plans.
Medicare Advantage: Special Needs Plans

Number of Beneficiaries in Special Needs Plans, by Type, 2006 – 2014

Number of Beneficiaries in SNPs, in thousands

<table>
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<th>Year</th>
<th>Chronic Conditions</th>
<th>Institutional</th>
<th>Dual Eligibles</th>
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<td>1,081</td>
<td>184</td>
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<tr>
<td>2013</td>
<td>1,868</td>
<td>282</td>
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NOTE: Numbers may not sum to the total due to rounding. Includes enrollment in Puerto Rico and other territories.

Care Coordination

- Providers
- Pharmacies
- Hospitals
- Skilled facilities
Our Approach

- Younger
- Healthier

Care Coordination

- Sicker
- Frailer

Complex Care Management

Health Promotion & Care Navigation
Assisting members with access to benefits, community resources and health information through 34,108 inbound calls

Care Transitions
Post-hospitalization coaching of more than 5,205 members to help avoid unnecessary readmissions

Disease Management
RN support for 1,135 members with CHF or COPD

Care Management
Interdisciplinary case management for 7,000 members with many conditions
Our Approach: Collaboration with Provider Partners

Monarch HealthCare and HealthCare Partners
Honored by SCAN and UCLA with “Better Way to Care” Award

(LONG BEACH, Calif. — Dec. 3, 2014) — Two of Southern California’s largest medical groups – Monarch HealthCare and HealthCare Partners – were honored this week with “Better Way to Care” awards by SCAN Health Plan and the UCLA Multicampus Program in Geriatric Medicine and Gerontology. The awards were presented at the SCAN-UCLA Best Practices Summit, which brought together physician groups from across the state to share best practices in two main areas: multiple chronic disease management and end-of-life care.

Orange County-based Monarch HealthCare was recognized for its Outpatient Palliative Care Program. “Medicine is more than the art of healing,” said Nancy Boerner, MD, chief medical officer at Monarch HealthCare. “It is a vehicle for hope and quality of life as patients travel through the final stage of life’s journey.”

Monarch’s Outpatient Palliative Care Program, implemented in 2011, consists of a multidisciplinary team that makes home visits to patients who have declined hospice and are deemed to be in their last year of life. Unlike hospice, palliative care allows patients to continue curative therapy while providing an “extra layer of support” to patients, families and physicians. The program has resulted in a 57 percent decrease in hospital admissions while enabling care to
Member Satisfaction

SCAN members who rate their plan...
“the best plan for me”

2015: 91%
2014: 90%
Clinical Outcomes

Comparison of SCAN’s PQI Overall Composite with CA-MFFS, 2010

SCAN’s hospitalization rate is 14 percent lower.
Quality

SCAN HEALTH PLAN

2015

4-STAR QUALITY RATING
Value = \uparrow (Clinical outcomes) \uparrow (Member experience) \\
\downarrow Cost
Six Nationally-Recognized Hospitals

- Long Beach Memorial
- Miller Children’s & Women’s Hospital
- Long Beach Community Hospital
- Orange Coast Memorial
- Saddleback Memorial Laguna Hills
- Saddleback Memorial San Clemente
Two Award-Winning Physician Groups

GREATER NEWPORT PHYSICIANS
An Affiliate of MemorialCare Health System

MEMORIALCARE MEDICAL GROUP®
<table>
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<tr>
<th>Category</th>
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Medicare Advantage Cuts Impact on Care

MemorialCare Medical Foundation
– 28,000 Medicare Advantage Members

2015 PY Advance Notice
– 5% Revenue Cut

Impact to MCMF
– $9.3M Reduction
MA Funds Coordinated Care

- **Wellness & Prevention**
  - Health Coaching
  - Preventive Screenings
  - Vaccination Outreach

- **Ambulatory Care Management**
  - 24/7 Telephone Advice Nurse
  - Primary Care Case Mgmt.
  - Specialized Clinics
    - Anti-coagulation
    - Discharge Clinic
    - ACTIVE Diabetes
    - Back pain

- **Specialty Care Management**
  - Complex & High Risk Care Management
  - Virtual Care Conference

- **Hospital Care Management**
  - 24/7 Hospitalists
  - After hours RN Triage
  - Repatriation/Concurrent Review
  - Care Transitions

- **Disease Management Programs**
  - COPD
  - CHF
  - Diabetes
  - Palliative Care
  - Medication Reconciliation
Coordinated Care Outcomes

50% reduction in 30 day readmission rates*

HbA1c 9.8% → 7.7%
- 1% decrease in HbA1c = 40% decrease in microvascular complications

Time in Therapeutic Range (TTR) 70%**
- 41% decrease in ER admissions
- 53% decrease in hospital admissions

*Compared to usual care
**Gold standard is 63%
A Physician’s Perspective
Bart Barrett, MD

- Value of Medicare Advantage
- Patient Stories
  1. The Invisible Man
  2. Diabetic and Disengaged
- Conclusion and Request
HLC Chair
Susan DeVore
President & CEO
Premier healthcare alliance

Mark Bertolini
Chair, President & CEO
Aetna

Todd Ebert
CEO
Amerinet

Steven Collis
President & CEO
AmerisourceBergen

Rolf Hoffmann
SVP, U.S. Commercial Operations
Amgen

Joseph Swedish
President & CEO
Anthem

Anthony Tersigni, EdD, FACHE
President & CEO
Ascension

Jonathan Bush
President & CEO
athenahealth, Inc.

Joel Allison
CEO
Baylor Scott & White Health

Marc Grodman, M.D.
Chairman, President & CEO
Bio-Reference Laboratories, Inc.

William Gracey
President & CEO
BlueCross BlueShield of Tennessee

Everett Hoekstra
Sr. Vice President & CFO
Boehringer Ingelheim USA

George Barrett
Chairman & CEO
Cardinal Health

Toby Cosgrove, M.D.
CEO & President
Cleveland Clinic Foundation

Tim Ring
Chairman & CEO
C. R. Bard

Michael A. Mussallem
Chairman & CEO
Edwards Lifesciences

Alex Azar
President, Lilly USA
Eli Lilly and Company

Neil de Crescenzo
CEO
Emdeon

John Finan, Jr.
President & CEO
Franciscan Missionaries of Our Lady Health System, Inc.

Patricia Hemingway Hall
President & CEO
Health Care Service Corporation

Daniel Tassé
Chairman & CEO
Ikaria

Daniel Evans, Jr.
President & CEO
Indiana University Health
Paul Meister  
Chairman & CEO  
inVentiv Health

Jennifer Taubert  
Company Group Chairman, North American Pharmaceuticals  
Johnson & Johnson

Susan Turney, M.D.  
CEO  
Marshfield Clinic Health System

John Noseworthy, M.D.  
President & CEO  
Mayo Clinic

John Hammergren  
Chairman & CEO  
McKesson Corporation

Chris O'Connell  
EVP & President, Restorative Therapies Group  
Medtronic

Barry Arbuckle, Ph.D.  
President & CEO  
MemorialCare Health System

Robert McMahon  
President, U.S. Market  
Merck

Steven Corwin, M.D.  
CEO  
NewYork-Presbyterian Hospital

Mark Neaman  
President & CEO  
NorthShore University HealthSystem

Christi Shaw  
US Country Head, President  
Novartis Pharmaceuticals

Jesper Hoiland  
President  
Novo Nordisk, Inc.

Craig Smith  
Executive Chairman  
Owens & Minor

Greg Irace  
President & CEO  
Sanofi US

Chris Wing  
President & CEO  
SCAN Health Plan

Tim Scannell  
Group President, MedSurg & Neurotechnology  
Stryker

Tom Skelton  
CEO  
Surescripts

Doug Cole  
President  
Takeda Pharmaceuticals U.S.A.

Barclay Berdan  
CEO  
Texas Health Resources

Curt Nonomaque  
President & CEO  
VHA Inc.

Gregory Wasson  
President & CEO  
Walgreens

James Chambers  
President & CEO  
Weight Watchers International

Jaideep Bajaj  
Chairman  
ZS Associates
SCAN Health Plan

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”).

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-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 transitions between all levels of care and providers. 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.
ABOUT MEMORIALCARE HEALTH SYSTEM

MemorialCare Health System is a leading Southern California nonprofit integrated delivery system with more than 11,500 employees and 2,600 physicians. Hospitals include Long Beach Memorial Medical Center, the West’s second largest academic-community hospital campus; Miller Children’s & Women’s Hospital Long Beach, among the nation’s biggest children’s hospitals; Community Hospital Long Beach, the city’s landmark hilltop hospital; Orange Coast Memorial Medical Center-Fountain Valley, the region’s fastest growing hospital; Saddleback Memorial Medical Center in Laguna Hills and San Clemente, voted the number one hospital in the 2014 Best of Orange County awards.

The health system includes leading medical groups – MemorialCare Medical Group and Greater Newport Physicians; numerous outpatient surgery centers, imaging centers and labs throughout the Southland.

MemorialCare has gained widespread recognition for our unique approach to health care.
• Among the top 100 integrated systems nationwide (IMS) for nine years.
• Long Beach Memorial, Orange Coast Memorial and Saddleback Memorial were honored by the Leapfrog Group with an “A” Hospital Safety Score™.
• Both MemorialCare Medical Group and Greater Newport Physicians were honored by CAPG with Elite Status of four stars.
• One of the best governed hospital systems in the U.S. (The Governance Institute).
• As having the top leadership team in the nation (HealthLeaders).

We’re particularly proud to be honored by the Gallup organization with their prestigious Gallup Great Workplace Award for four consecutive years. MemorialCare is one of only 36 organizations worldwide to be honored in 2014 with this award.

MemorialCare Medical Foundation includes leading physician groups: MemorialCare Medical Group and Greater Newport Physicians.

memorialcare.org
Building Communities and Partnerships for a Stronger America

Founded in 1995 by a group of Hispanic business owners from across the country, The Latino Coalition today is a robust and growing network of business owners and corporate partners.

Coalition members work together toward the shared goals of increasing economic and social opportunities for the Hispanic community.

With an active database of over 1.2 million Hispanic business owners and over 70 coalition partners – including Hispanic Chambers, faith-based groups, health and education organizations, immigration advocacy groups and international trade organizations – TLC’s network reaches into Hispanic communities across the country.

It is no wonder that TLC is increasingly recognized as a leading voice for the Latino business community, attracting strategic alliances with groups like the U.S. Chamber of Commerce, The Reagan foundation, Score, WIPP, U.S. Pan Asian Chamber of Commerce, Black Chamber of Commerce and Indian business groups.

Advocacy

Lawmakers know that the Hispanic community is a critical – and growing – part of their constituency, but they often don’t know where to turn for the truth about what issues matter most to Latinos. TLC is providing lawmakers at the local, state and national levels with the research and policy positions they need to know to help Hispanic business owners succeed.

Policy Goals

TLC seeks to reduce the cost – and increase the opportunities – of doing business through a sensible approach to the taxation and regulation of business, including access to affordable health insurance and energy.

Benefits of Membership

TLC membership offers access to small business benefits, legislative updates on the issues business owners care about, networking and policy summits, advanced notice of procurement matchmaking events and facilitation of one-on-one appointments between business owners and contracting leaders.

TLC is a nonprofit 501(c) (6) membership organization with offices in Washington, D.C., Southern California and Mexico.
Healthcare Leaders Form New Medicare Advantage Coalition

WASHINGTON – A broad range of healthcare stakeholders has come together to create a new organization dedicated to strengthening Medicare Advantage and demonstrating the program’s value.

The Better Medicare Alliance (BMA) unites providers, beneficiaries and advocates who believe Medicare Advantage is better for seniors and better for the healthcare system as a whole.

Also known as Medicare Part C, Medicare Advantage is the part of Medicare that provides high quality, more affordable healthcare coverage. More than 16 million Medicare beneficiaries rely on Medicare Advantage for their health and financial security, including medical, prescription drugs, vision, dental, fitness and wellness benefits.

Medicare Advantage focuses on prevention, coordinated care, better management of chronic conditions, and new provider payment models that reward value over volume. As a result of these innovations, Medicare Advantage is enhancing seniors’ health and well-being, while driving systemic improvements in care delivery.

“AMGA and its multispecialty medical group members fully support the Medicare Advantage program,” said Don Fisher, Ph.D., President and CEO of the American Medical Group Association (AMGA). “MA incentives align with the goals of medical groups: improved care and reduced cost. MA plans help to improve care coordination by providing incentives for the effective management of chronic conditions and they enable multispecialty medical groups to offer innovative services to their patients. AMGA member groups work with MA plans to focus on high risk patients and use technology and care management strategies to help reduce readmissions for Medicare Advantage patients. We are very pleased to join the Better Medicare Alliance.”

Building on the growing body of research showing that Medicare Advantage is improving health outcomes for seniors, the new group will commission research on the value proposition of Medicare Advantage. BMA will also rally support among seniors and stakeholders to preserve and strengthen this critically important coverage option that one-third of Medicare beneficiaries have chosen. BMA allies will work together to:

- Build on Medicare Advantage’s approach to care coordination.
- Ensure that Medicare Advantage funding is stabilized, predictable and consistent to protect beneficiaries.
- Learn from innovation in Medicare Advantage

As a new organization, the Better Medicare Alliance (BMA) is conducting a search for an Executive Director. BMA is initially being led by Interim Executive Director Krista Drobac, a veteran health policy advocate who has 20 years of experience at the federal and state levels. Ms.
Drobac previously served in key health policy roles at the National Governors Association, the Centers for Medicare and Medicaid Services, the Illinois Department of Healthcare and Family Services, and in the offices of Senator Dick Durbin (D-IL) and Senator Debbie Stabenow (D-MI).

“I have seen firsthand that Medicare Advantage is working to achieve many of the goals we are striving for in improving quality and care coordination for seniors. I am honored to be helping to kick off an effort with such a distinguished group of organizations in that will provide a much-needed new voice for Medicare Advantage in our nation’s health policy conversation,” Drobac said.

BMA’s founding allies are: Aetna, American Medical Group Association, Healthcare Leadership Council, Healthways, Humana, The Latino Coalition, The National Caucus and Center on Black Aging, National Hispanic Medical Association, National Association of Manufacturers, National Retail Federation, Population Health Alliance, UnitedHealth Group, and the US Chamber.

www.bettermedicarealliance.org
www.twitter.com/bmalliance
www.facebook.com/BetterMedicareAlliance
It’s Time to Focus on the Value of Medicare Advantage  
Krista Drobac, Interim Executive Director  
December 8, 2014

As a Democratic staffer in the Senate during the debate and passage of the Medicare Modernization Act in 2003, I was concerned about private plans getting more involved in Medicare. Why were we going to pay commercial plans to do what Medicare does? Would favorable risk be taken out of the Medicare risk pool? Would seniors really receive additional benefits?

What I have come to realize is that Medicare Advantage does not do what traditional fee for service does, it does more and it does it better. And, Medicare Advantage plans are serving a very diverse group of beneficiaries, many of whom suffer from chronic disease. With 16 million seniors and people with disabilities in Medicare Advantage plans today it is time that we focus on what the program is doing for people and how it is contributing to our collective desire to achieve higher quality and greater efficiency.

I have seen firsthand the positive impact of Medicare Advantage with my 71 year-old mother. She has chronic conditions, so coordinating care across providers and settings is somewhat complex and especially important. Her Medicare Advantage plan coordinates her care while containing out-of-pocket costs to her. She receives additional benefits as well. In fact, when she had knee replacement recently, she came home with a remote monitor that allowed her doctors to monitor her progress from home. Remote patient monitoring is supplemental benefit in Medicare Advantage.

We can answer the questions that gave me pause back in 2003 by looking at the value proposition of Medicare Advantage today.

Quality is Better
Medicare Advantage plans have huge incentives to provide high quality care not only because they want to keep their customers, but because their payments are tied to quality. Many of the studies looking at quality in Medicare Advantage used data that pre-dated the new quality incentives put in place by the Affordable Care Act. Even so, the data shows higher quality in Medicare Advantage plans. One study compared the quality of ambulatory care from 2003 through 2009 between beneficiaries enrolled in Medicare Advantage HMOs and those enrolled in traditional Medicare. The authors looked at how the performance of various types of Medicare HMOs differed from that of traditional Medicare for these same measures. They found that beneficiaries in Medicare HMOs were consistently more likely than those in traditional Medicare to receive appropriate breast cancer screening, diabetes care, and cholesterol testing for cardiovascular disease.[1] In the first review of literature on Medicare
Advantage in 10 years, the Kaiser Family Foundation looked at 45 studies that focus on Medicare. They found that Medicare Advantage, on average, scores more highly than traditional Medicare on subsets of Medicare HEDIS indicators – primarily those pertaining to use of preventive care services. Medicare beneficiaries in HMOs were less likely to be hospitalized for potentially avoidable hospitalizations than beneficiaries in traditional Medicare.

The Better Medicare Alliance will be investing in new research that uses more recent data so we can better understand the impact of the inclusion of new quality initiatives in the Affordable Care Act.

**Services & Affordability**
On the questions of services and affordability, the answers are definitively yes, seniors are seeing additional benefits and feeling the impact of lower and more predictable cost sharing. Medicare Advantage plans are not just offering supplemental benefits such as vision, hearing, dental, enhanced coverage of home infusion and personal care. Plans are also offering care management and population health management (PHM). In addition to promoting wellness, PHM requires monitoring of population risk and designing and implementing programs that manage sub-populations based on their risk... For patients identified as being at risk for chronic conditions, common interventions include targeted health education or outreach to engage members in activities intended to reduce risk factors, enrollment in care management programs, and working with nurses in health education.” A recent study of 72 health plans with more than 100,000 enrollees found “the MA experience reveals that population health management involves design and implementation of both extensive and intensive services to manage the needs of a complex population.... Plans reported extensive activities directly for members, including smoking cessation, wellness discounts, and the promotion of healthy lifestyles (exercise and nutrition). [2] This kind of benefit design cannot be done in a fee for service environment.

**Program Structure Incentivizes Value over Volume**
Medicare Advantage contributes to the goals health policy experts have been advising for decades: better care coordination, more opportunities for population health management, more meaningful interventions for people with chronic disease, and lower cost sharing for beneficiaries. Fee for service will always create incentives for overuse of services that don’t necessarily improve quality. The current structure of the Medicare Advantage program with capitation and quality metrics at its core, creates the exact incentives we need to manage care better. In one of the large Medicare Advantage plans, 50 percent of providers are in value-based contracts. A recent study examining Medicare Advantage data from 2003-2009 found that “overall, Medicare Advantage HMO enrollees might use fewer services and be experiencing more appropriate use of services than enrollees in traditional Medicare.” [3] Another study found, “the available measures, while limited, suggest that, on average, MA plans offer care of equal or higher quality and for less cost than [traditional] Medicare. [4]
Plan Payment
There has been much made of plan payment, but a closer look at the data demonstrates the relative efficiency of Medicare Advantage compared to fee for service. According to MedPAC, in 2014, plans of all types submitted premium bids that came in at 98 percent of fee for service. When you look at HMOs specifically, the percentage goes down to 95. [5] Medicare also adjusts plan payments based on quality performance. That is a clear check on payments. The benchmarks are also designed to ensure access for beneficiaries in all geographic areas.

As the Better Medicare Alliance moves forward, we will be further examining the impact of Medicare Advantage on the quality of care received by seniors. We must build on the evidence base that is forming and fill the gaps in research. I believe that research will demonstrate the value of this program to seniors, providers, taxpayers and the health care system as a whole.


http://www.bettermedicarealliance.org/perspectives
http://themorningconsult.com/2014/12/time-focus-value-medicare-advantage/
Key Factors Impacting 2015 Final MA Rates and Payments

Introduction

Over 15 million Medicare beneficiaries are enrolled in Medicare Advantage (MA) plans as of May 2014. Since 2010, funding for the MA program has been cut in a number of ways, including the reduction in the Affordable Care Act (ACA), the new health insurer tax, and cuts in the American Tax Relief Act of 2012 (ATRA). While MA plans are committed to providing high quality coordinated care to their enrollees, these year over year cuts create an uncertain environment for 2015 MA plans and the choices available to beneficiaries. The following issue brief describes the factors affecting the 2015 MA payment environment.

CMS Announcement of 2015 Rates and Payments

The Centers for Medicare & Medicaid Services (CMS) released final 2015 Medicare Advantage (MA) county rates on April 7, 2014. The MA payment methodology is complex and includes a number of factors that interact to impact payments to MA organizations (MAO). Several elements included in the CMS Final Rate Notice—including lower growth rates, the continued phase-in of ACA funding cuts, and the end of the Quality Bonus Demonstration Project—reduce county rates compared to 2014. However, CMS also announced key payment policies that are expected to partially mitigate the impact of these cuts. Analysts have estimated the total impact of the CMS 2015 rate and payment policies will be an average payment reduction of -3.0% to -3.5% affecting MAOs and their enrollees. The final impact on the offerings to beneficiaries in 2015 will not be known until the CMS review and approval process for MAO bids has been completed and the agency releases 2015 MA plan premium and benefit information that will be summarized in the “MA Landscape” in the fall.

Key Factors Affecting 2015 County Rates

This section of the issue brief provides an analysis of the policies included in the Final Rate Notice for each of the key factors that affect MA county rates, a description of the role these factors play in the payment methodology, and data estimating the variation in the impact of these factors across the country.
1. MA and FFS Growth Percentages and the MA Growth Rate—The MA Growth Rate is one of the factors used to update the MA rates from year to year. These factors continue to incorporate an assumption that Congress will act to prevent the 24.1% scheduled reduction in Medicare physician payment rates from occurring.

Currently, CMS calculates two growth rates to determine MA county rates due to the phase-in of the new ACA rates occurring from 2012 – 2017. During the phase-in period, the county rate is a combination of amounts determined under the ACA payment system and the system in place prior to enactment of the law. The statutory phase-in schedule calls for rate reductions in counties over a two, four, or six-year period by incrementally increasing the proportion of the rate determined under the ACA methodology.

Differing growth rates apply to the pre-ACA and ACA components of MA rates. CMS announced a -4.07% 2015 National Per Capita MA Growth Percentage (the MA Growth Percentage), which is used in the pre-ACA rate methodology that is phasing out. The FFS Growth Percentage, which is used to calculate rates under the ACA payment system, is -3.3%. The agency stated the combination of these growth percentages, which it has referenced as the “MA Growth Rate”, is -3.4% in 2015. As shown in Exhibit 1 (next column), this is much lower than in previous years and significantly below the preliminary 2015 MA Growth Rate of -1.9% announced in the Advance Notice in February. CMS has stated the decline in the 2015 growth rates is the result of adjustments to growth rates in prior years primarily due to lower utilization of services such as inpatient hospitalizations than previously projected. These factors reflect CMS’ decision to use its existing authority to assume a 0% physician fee schedule increase instead of the reduction in current law when developing MA rates. Before 2014 CMS assumed Congress would implement the scheduled reduction in Medicare physician payment rates through the Sustainable Growth Rate (SGR).

2. Continued Phase-In of the ACA Funding Cuts—The 2015 county rates reflect the continued phase-in of provisions in the ACA that reduce MA funding by more than $200 billion in 2010—2019 according to CBO estimates.

Effective 2012, the ACA established a new blended benchmark as the MA county rate. The blended benchmark is the combination of two components – the “applicable amount” calculated using the pre-ACA methodology and the “specified” amount calculated as required under the ACA. The specified amount is determined by ranking all counties from high to low FFS costs, dividing the counties into quartiles, and assigning a percentage ranging from 95% for areas with the highest FFS costs to 115% for areas with the lowest costs.

The ACA payment system is being phased in over either 2, 4, or 6 years based upon the estimated impact of the ACA changes in the county. Two-year counties were fully phased in starting 2013, meaning county rates in these areas are calculated solely based on the specified (ACA) amount. Rates in 4 and 6-year counties in which 78% of MA enrollees live (Exhibit 2) are continuing the phase-in process. 2015 will be the first year in which rates in 4-year counties will be calculated solely based on the ACA rate. All counties, including 6-year counties, will be fully phased in starting in 2017.
Increased Bonuses: The ACA provides that quality bonuses are applied only to the portion of the county rate calculated under the ACA methodology as counties are phased in to these rates. The Demonstration Project applied quality bonuses to both the pre-ACA and ACA portions of the rate during 2012 – 2014 and increased the amount of the bonus that was applied during the three years of the Demonstration. Application of the bonus to both portions of the rate continues to be important for 6-year phase-in counties that will continue to be paid on a combined pre-ACA/ACA basis through 2016. Due to the end of the Demonstration Project, the 2015 final county rates reflect the continued phase-in of these funding cuts, and approximately $24.5 billion of these cuts, or 12%, are scheduled to go into effect in 2015 alone. At the end of the 2014, 32% of the ACA cuts will have gone into effect.

3. End of the Quality Bonus Demonstration Project – MAOs receiving less than 4 Stars are no longer eligible for quality bonuses, and those receiving 4 Stars and above may be subject to a payment cap that can eliminate the benefit of the ACA bonuses they earn. In addition, MAOs in 6-year phase-in counties will have bonuses applied to only a portion of their rates rather than the entire rate in 2015 and 2016.

The ACA enacted quality bonuses for MA plans receiving 4 Stars and above and established a cap on rates to not exceed pre-ACA levels. In the 2012 Final Rate Notice, CMS announced a nationwide demonstration in effect for 2012 – 2014 to test an alternative method for determining quality bonus payment percentages. The expiration of the three-year Demonstration Project in 2015 will negatively impact county rates in several different ways:

- **Bonuses for 3 and 3.5 Star Plans**: Under the ACA, MA contracts achieving an Overall rating of at least 4 Stars on the CMS Star Ratings System receive an increase in county rates. The Demonstration Project extended bonuses in lower amounts to contracts receiving 3 and 3.5 Stars during 2012 – 2014. The end of the Demonstration Project means these plans, which enroll approximately 48% of all MA enrollees, will no longer receive bonuses starting in 2015. Exhibit 3 shows the percentage of MA enrollment in each state in contracts that currently receive 3 and 3.5 Stars.

### Exhibit 2:

<table>
<thead>
<tr>
<th>State</th>
<th>2-Year Counties</th>
<th>4-Year Counties</th>
<th>6-Year Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>2-Year Counties</td>
<td>2013</td>
<td>54%</td>
<td>22%</td>
</tr>
<tr>
<td>4-Year Counties</td>
<td>2015</td>
<td>24%</td>
<td>46%</td>
</tr>
<tr>
<td>6-Year Counties</td>
<td>2017</td>
<td>21%</td>
<td>32%</td>
</tr>
</tbody>
</table>

### Exhibit 3:

<table>
<thead>
<tr>
<th>State</th>
<th>% of MA Enrollees in 3 &amp; 3.5 Star Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama</td>
<td>97.8%</td>
</tr>
<tr>
<td>Alaska</td>
<td>21.6%</td>
</tr>
<tr>
<td>Arizona</td>
<td>70.2%</td>
</tr>
<tr>
<td>Arkansas</td>
<td>68.1%</td>
</tr>
<tr>
<td>California</td>
<td>15.2%</td>
</tr>
<tr>
<td>Colorado</td>
<td>13.0%</td>
</tr>
<tr>
<td>Connecticut</td>
<td>14.8%</td>
</tr>
<tr>
<td>Delaware</td>
<td>82.8%</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>76.3%</td>
</tr>
<tr>
<td>Florida</td>
<td>48.9%</td>
</tr>
<tr>
<td>Georgia</td>
<td>84.0%</td>
</tr>
<tr>
<td>Hawaii</td>
<td>28.2%</td>
</tr>
<tr>
<td>Idaho</td>
<td>61.7%</td>
</tr>
<tr>
<td>Illinois</td>
<td>55.5%</td>
</tr>
<tr>
<td>Indiana</td>
<td>70.9%</td>
</tr>
<tr>
<td>Iowa</td>
<td>32.3%</td>
</tr>
<tr>
<td>Kansas</td>
<td>48.8%</td>
</tr>
<tr>
<td>Kentucky</td>
<td>48.4%</td>
</tr>
<tr>
<td>Louisiana</td>
<td>17.7%</td>
</tr>
<tr>
<td>Maine</td>
<td>14.3%</td>
</tr>
<tr>
<td>Maryland</td>
<td>86.2%</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>20.5%</td>
</tr>
<tr>
<td>Michigan</td>
<td>10.3%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>12.7%</td>
</tr>
<tr>
<td>Mississippi</td>
<td>82.6%</td>
</tr>
<tr>
<td>Missouri</td>
<td>34.0%</td>
</tr>
<tr>
<td>Montana</td>
<td>13.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State</th>
<th>% of MA Enrollees in 3 &amp; 3.5 Star Plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nebraska</td>
<td>59.0%</td>
</tr>
<tr>
<td>Nevada</td>
<td>51.5%</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>69.0%</td>
</tr>
<tr>
<td>New Jersey</td>
<td>86.4%</td>
</tr>
<tr>
<td>New Mexico</td>
<td>65.9%</td>
</tr>
<tr>
<td>New York</td>
<td>55.6%</td>
</tr>
<tr>
<td>North Carolina</td>
<td>80.0%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>8.8%</td>
</tr>
<tr>
<td>Ohio</td>
<td>44.8%</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>64.0%</td>
</tr>
<tr>
<td>Oregon</td>
<td>16.5%</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>31.3%</td>
</tr>
<tr>
<td>Puerto Rico</td>
<td>93.1%</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>3.8%</td>
</tr>
<tr>
<td>South Carolina</td>
<td>86.8%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>1.5%</td>
</tr>
<tr>
<td>Tennessee</td>
<td>48.2%</td>
</tr>
<tr>
<td>Texas</td>
<td>80.4%</td>
</tr>
<tr>
<td>Utah</td>
<td>50.7%</td>
</tr>
<tr>
<td>Vermont</td>
<td>78.4%</td>
</tr>
<tr>
<td>Virginia</td>
<td>78.9%</td>
</tr>
<tr>
<td>Washington</td>
<td>56.4%</td>
</tr>
<tr>
<td>West Virginia</td>
<td>73.8%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>12.9%</td>
</tr>
<tr>
<td>Wyoming</td>
<td>91.1%</td>
</tr>
<tr>
<td>U.S. TOTAL</td>
<td>47.5%</td>
</tr>
</tbody>
</table>
the Demonstration, bonuses for plans earning at least 4 Stars in these counties will be lower in 2015 than they would have been if the Demonstration Project had been extended.

Suspension of ACA Cap: Pursuant to the ACA, MA rates calculated under the new methodology can be no higher than the rate would have been prior to the ACA. CMS did not apply this “ACA Cap” from 2012 – 2014 under the Demonstration Project. The 2015 final rates implement the ACA Cap for the first time, impacting plans enrolling approximately 2 million beneficiaries in almost 1,500 counties (Exhibit 4) and reducing rates in these areas by an average of $27 per member per month. The ACA cap may affect rates for plans at all Star ratings or only for the higher rate that would have otherwise applied to contracts achieving at least 4 Stars. The application of the ACA Cap to contracts achieving at least 4 Stars negates the opportunity for plans to earn rewards for high quality ratings in these areas.

Key Factors Affecting 2015 MA Plan Payments

Beyond the factors that affect 2015 county rates, payments to MAOs are affected by other key factors that may have both positive and negative impacts as discussed below.

1. FFS Normalization: CMS changed the methodology for calculating the FFS normalization factor, producing a positive impact on payments that partially mitigates the downward trend in the MA rates.

Each year, CMS applies a FFS normalization factor to MA plan risk scores to account for underlying trends in FFS coding practices since the data year on which the risk adjustment model is based. For 2015 normalization factors, CMS adopted a change in how it estimates the annual trend for risk score growth in the FFS program to account for the increasing proportion of baby boomers entering Medicare, who overall tend to be younger and healthier than the general Medicare population. This new methodology results in an average 4.3% increase that applies to plan payments compared to 2014.

Exhibit 4: Counties Affected by the ACA MA Rate Cap, 2015
2. CMS Risk Adjustment Model: CMS revised the phase-in schedule for changes to the MA risk adjustment model that began in 2014. This policy is also expected to result in partial mitigation of the MA rate cut.

For the 2014 payment year, CMS began the phase-in of a clinically revised risk adjustment model that were designed to reduce payments for diagnosis codes for early stages of certain chronic conditions identified to a greater extent by MA plans than under the Medicare FFS program. MA plans raised concerns about the inconsistency of this policy with emphasis under the ACA and broader delivery system reform on early identification of chronic conditions to support systematic approaches to slow their progression. CMS estimated the changes in the 2014 model would reduce payments to plans by an average of 2.5% and decided to mitigate this impact in 2014 by blending risk scores calculated under the new model (75%) with the risk scores calculated under the previous model (25%). For 2015, CMS changed the blending approach by setting the percentages at 33% for the 2014 model and 67% for the previous model. The agency has estimated the change in this blending approach will increase MA payments by an average of 1.1% in 2015.

3. Coding Intensity: CMS is continuing the annual increase in the coding intensity adjustment at the minimum level required by law, which has a negative impact on MAO payments.

The statutorily required coding intensity adjustment is intended to account for differences in coding between the MA and Medicare FFS programs. Under current law, the minimum coding intensity adjustment for 2015 is 5.16%, an increase of 0.25% from 2014. CMS has taken the position that the coding intensity adjustment and the changes to the risk adjustment model are not inappropriately duplicative. MAOs are concerned that the combination of these two adjustments reduces the resources available for focused programs designed to slow the progression of chronic conditions and improve quality of life for beneficiaries.

4. Health Insurance Tax: MAOs will continue to be subject to the broad health insurer tax that increases annually and reduces revenue available to fund benefits and keep premiums affordable for beneficiaries.

IRS collection of the health insurance tax enacted in the ACA begins in 2014 and applies broadly, with some exceptions, to premiums generated by covered entities engaged in the business of providing health insurance. The tax is assessed based upon the premiums of each entity as a proportion of aggregate premiums collected by all covered entities, and Medicare Advantage and Part D premiums are included in the total. The tax liability increases each year as provided in the statute. An actuarial study by Oliver Wyman found that, on average, the tax will increase MAO costs by approximately $80 per enrollee in 2015.

Conclusion

Following issuance of the Final Rate Notice, Wall Street analysts projected payments to MA plans to be 3 – 3.5% less on average in 2015 due to the decisions announced by CMS. (See excerpts from analysts’ reports in Exhibit 5 on the next page.)

The impact of these changes on beneficiaries will not be known until the agency releases the MA Landscape in the fall. In the months prior, as MA plans develop bids for submission by the June 2 deadline, they will be working hard to mitigate the impact of the rate cuts and ensure beneficiaries continue to have access to the care coordination and the additional value these organizations currently provide to the more than 15 million Medicare beneficiaries they serve.
Exhibit 6: Excerpts From Analysts’ Reports

- **JP Morgan**: “Final rates improve 90 bps in our estimates, to -3.4% all-in from our estimate of -4.3% based on February’s Advance Notice.”

- **Morgan Stanley**: “For MCOs, we estimate the initial rate cut was -3.7% excluding HRA adjustments improving +0.6% to a final rate of -3.1%.”

- **Citi**: “All-in, we estimate Medicare Advantage rates will drop around 3.0-3.5% in 2015.”

- **Cowen**: “…we (and we suspect the companies) believe Medicare Advantage rates (on average) are poised to be down 3.55% industry-wide… By our calculations, benchmarks will be down 8.0% industry-wide for all companies in 2015 relative to 2014.”

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1 AHIP analysis of CMS data.
2 AHIP analysis of CMS data.