

**Statement  
of the  
American Hospital Association  
before the  
Committee on Ways and Means  
of the  
U.S. House of Representatives**

**“Medicare Advantage Hearing on Promoting Integrated and Coordinated Care for  
Medicare Beneficiaries”**

**June 7, 2017**

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations (approximately 100 of which sponsor health plans), and our 43,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to submit for the record our comments on the importance of promoting integrated and coordinated care for Medicare beneficiaries served through the Medicare Advantage (MA) program.

The MA program is an important source of coverage for approximately a third of Medicare beneficiaries. More than 60 AHA members sponsor MA plans, and nearly all AHA members contract with such plans to provide services to enrolled Medicare beneficiaries.

The MA program is a success when measured on metrics such as marketplace competition, consumer satisfaction and quality of care. However, there are a number of areas where the program can be improved as part of continuous efforts to advance health care quality, health outcomes and health system efficiency, particularly through better integration and coordination of care.

**RECOMMENDED APPROACHES TO IMPROVING INTEGRATED AND COORDINATED CARE FOR  
MEDICARE BENEFICIARIES**

Below are several priority recommendations for improving the integration and coordination of care for beneficiaries enrolled in the MA program. The Committee specifically sought input on the role of Special Needs Plans (SNPs), which we address in our first recommendation below.



We also propose several changes to the MA program that would apply to all models of MA plans, not just SNPs. Finally, the Committee expressed interest in recommendations for improving the Program of All-Inclusive Care for the Elderly (PACE). We do not include specific recommendations for Congressional action here but rather point the Committee to comments the AHA submitted to the Centers for Medicare & Medicaid Services (CMS) related to the [PACE Innovation Act](#) and a [2016 proposed rule](#), and we encourage Congress to work with the agency to pursue their implementation.

- **Providing Continued Access to MA Special Needs Plans (SNPs) for Vulnerable Populations.** SNPs offer certain Medicare beneficiaries more tailored benefit plans to address their special needs. Currently, the SNP program is set to expire on December 31, 2018. **We encourage Congress to extend or make permanent the SNP program while incorporating program reforms consistent with the other recommendations that follow, particularly related to the ability to further tailor benefit packages based on individual need.**
- **Adapting Benefits to Meet the Needs of MA Enrollees.** In most instances, insurers must provide all plan enrollees with the same set and scope of benefits. We recognize that such a policy is intended to prevent discrimination and ensure access to care for all enrollees. However, this requirement has the negative consequence of preventing plans from addressing the unique needs of some enrollees. In some cases, a small subset of enrollees would benefit from a certain specialized service, but plans are unable to offer it due to the resources required to make such a service available to everyone. **We encourage Congress to give plans the flexibility to tailor their products to better meet the needs of subsets of enrollees, such as by expanding the concept of value-based insurance design nationally.** Consistent with existing oversight mechanisms, CMS could continue to monitor that all beneficiaries are receiving the care that they need and that such policies are not unintentionally resulting in adverse outcomes.
- **Increasing Quality of Care and Convenience for MA Enrollees through Telehealth.** Innovation in technology has the potential to increase Medicare beneficiaries' timely access to services, which may increase the quality of care, improve patient satisfaction and reduce costs for the health care system. **Congress should pursue all avenues to expand access to services via telehealth, including removing barriers caused by the geographic location and practice setting "originating site" requirements and restrictions on covered services and technologies. MA plans also should be permitted to submit costs associated with telehealth as part of their bid amounts.**
- **Permitting for Holistic Care through Coverage of Certain Social Services.** Many social, economic and demographic factors contribute to an individual's health status, such as secure and safe housing, employment status, support system to assist with activities of daily living, and adequate nutrition. These factors often cannot be addressed by medical services alone, yet may be the primary drivers of health status and outcomes, as well as health care utilization and total spending by Medicare and other payers. MA plans currently have limited options for providing non-medical social services to help address these underlying social determinants of health. **We encourage Congress to allow plans**

**to offer non-medical social services and include the costs associated with these services in their bid amounts.**

As part of this, we strongly encourage Congress to allow plans to provide services that facilitate keeping individuals in their homes. Two examples include personal care services for beneficiaries who do not have a need for skilled care and remote patient monitoring. Such services have a number of benefits: patients typically prefer staying in their homes, the home can be the most efficient site of care, and providers can often detect new or deteriorating conditions earlier in the disease progression, thus resulting in more efficient use of health care resources and better outcomes.

- **Ensuring Accurate Payment. The AHA strongly urges Congress to direct CMS to refine the Hierarchical Condition Categories (HCC) risk-adjustment model to further account for socioeconomic and demographic status.** We applaud CMS for recent changes to the HCC risk adjustment model that better account for socioeconomic status by considering whether an individual is a full or partial Medicare/Medicaid dual-eligible. However, these changes do not go far enough. There is a strong and growing body of evidence that a number of patient characteristics impact health outcomes, health care utilization and cost of care. The National Academies of Medicine recently identified five social – not medical – factors that influence access to care, health care use, health outcomes and cost:
  - 1) socioeconomic position;
  - 2) race, ethnicity and cultural context;
  - 3) gender;
  - 4) social relationships; and
  - 5) residential and community context.<sup>1</sup>

These factors are not fully accounted for in the HCC risk-adjustment model and should be considered for future adjustments. Better accounting of sociodemographic information, where appropriate, will ensure that plans are adequately reimbursed for more complex patients. Failing to account for these factors when establishing reimbursement rates can harm patients and worsen health care disparities by diverting resources away from plans serving large proportions of disadvantaged patients and their network providers.

- **Providing MA Enrollees with Hospice Benefits. The AHA supports the integration of hospice services into the MA benefit package.** Today, hospice benefits for MA enrollees are coordinated and delivered through the fee-for-service Medicare program while other covered, but “unrelated,” services are managed separately by the MA plan. Integrating these two care coordination streams may enhance the quality and efficiency of care, as well as the patient and family experience.

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<sup>1</sup>National Academies of Sciences, Engineering, and Medicine. 2016. Accounting for Social Risk Factors in Medicare Payment: Identifying Social Risk Factors. Washington, DC: The National Academies Press. <https://doi.org/10.17226/21858>

In pursuing this change, however, adequate beneficiary safeguards must be put in place. Plan rates will need to be adjusted to incorporate costs associated with the hospice benefit. Additionally, nothing in the integration of these services or in the development of the plan rates should disrupt or dismantle the important interdisciplinary structure of hospice services, which includes social work, chaplaincy and family bereavement services in addition to the management of pain and other symptoms. Moreover, given the unique nature of this benefit, plans should be required to implement instant coverage determinations and expedited appeals processes for coverage denials.

## **CONCLUSION**

We appreciate the opportunity to provide these comments and support the Committee's efforts and attention to examining the issues concerning the quality and efficiency of care delivery to Medicare beneficiaries. We remain deeply committed to working with Congress, the Administration, Medicare beneficiaries and other health care stakeholders to ensure a high-performing MA program for the millions of seniors who rely on the program today and in the years to come.