

June 22, 2015

## **Ideas to Improve the Health of Medicare Patients with Chronic Conditions**

UnitedHealth Group is pleased to offer input for the Finance Committee's consideration on solutions and policies to improve health outcomes for Medicare patients with chronic conditions. We commend the Committee for establishing a working group to focus on this topic. It is an important step toward reducing the overall incidence of and mitigating the significant costs associated with chronic illness. UnitedHealth Group shares the Committee's goal of developing policies that will allow our health care system to better serve those with chronic illness.

UnitedHealth Group serves many of the country's most respected employers, and we are also the nation's largest Medicare health plan - serving nearly one in five seniors nationwide - and one of the largest Medicaid health plans, supporting underserved communities in 24 states and the District of Columbia. Our workforce of 185,000 employees serves the health care needs of more than 100 million individuals worldwide.

During the past thirty years, Medicare Advantage (MA) has consistently delivered better benefits, innovation, choice, and affordability to America's seniors while advancing our health care system at large. In spite of the MA program's sustained successes in improving health outcomes and reducing costs, its 17 million beneficiaries are feeling the impacts of double digit MA funding cuts that have been implemented over the past several years. It is critical Congress and the Centers for Medicare and Medicaid Services ensure reasonable and transparent MA funding levels in order to build upon MA's great legacy of bringing innovations to the Medicare population that improve health outcomes and reduce costs in the system.

UnitedHealth Group offers the following ideas for the Committee's consideration.

### **Improvements to Medicare Advantage for patients living with multiple chronic conditions**

All of today's efforts to build more integrated, coordinated, value-based models and leverage clinical innovations and technologies to improve the care and health of Medicare patients with chronic conditions, grew out of the extensive experience of the MA program. The solutions that are needed to help Medicare patients with chronic conditions better manage and improve their health are already largely available through MA.

For over 30 years, MA has been developing solutions to help Medicare patients with chronic conditions receive more coordinated health care services. MA continues to serve as a guidepost for Medicare FFS, showing how more flexibility in benefits design, care delivery and payment strategies can elevate the quality and performance of health care for seniors. Despite these important contributions toward improving health care, MA has experienced severe and repeated funding cuts that are harming seniors. While 2016 MA rates will help provide much needed stability for seniors, these rates do not reflect current medical costs. In order to protect the program for future beneficiaries, MA funding should reflect the true cost of care while meeting

the needs of the nation's growing senior population. Instead of cutting a program that works well, lessons from MA should be applied more broadly for the entire Medicare population. Seniors should continue to have the ability to choose MA in their local area to receive innovative health care services that are proven to lead to better health outcomes than what is offered through Medicare fee-for-service (FFS).

Our experience with Medicare beneficiaries includes understanding the needs of unique populations, such as the dual-eligible and chronically ill populations, through both special needs plans and Medicare Advantage plans. As of April 2015, MA special needs plans for chronic conditions provided tailored benefits to approximately 300,000 beneficiaries with specific chronic illnesses.<sup>1</sup> Seniors in dual-eligible MA special needs plans had a 31% lower discharge rate, 43% lower rate of days spent in the hospital, 19% lower average length of stay, 9% lower rate of emergency visits, and a 21% lower readmission rate compared to dual-eligibles in Medicare FFS.<sup>2</sup>

CMS's Star Rating methodology makes it difficult for plans serving seniors who are dual-eligible, to receive bonuses. MA helps seniors enrolled in the program – some of whom are dual-eligibles – improve their health through higher quality services that are more comprehensive, personalized and affordable. While CMS is undertaking efforts to learn about the challenges of measuring the quality performance of plans serving dual-eligibles, it is time to comprehensively evaluate the Star Ratings system as it currently creates a disincentive to serve this complex population.

**Transformative policies that improve outcomes for patients living with chronic diseases either through modifications to the current Medicare Shared Savings ACO Program, piloted alternative payment models (APMs) currently underway at CMS, or by proposing new APM structures**

Through a variety of partnerships with providers and other stakeholders, MA continues to innovate and transform the health care system and UnitedHealth Group is bringing capabilities, tools and programs at scale to MA enrollees. While efforts are underway to accelerate the adoption of alternative payment models and transition the health care system to value-based care, many chronically ill Medicare patients are choosing access to care coordination, innovative care delivery models and coverage for services that original Medicare FFS does not provide through a MA plan. Innovative delivery models, such as UHG's HouseCalls program, provides important health benefits to our members, fills a need for in-depth encounters with licensed clinicians, improves the continuity and management of care and, in many cases, saves lives. A key component of the treatment plan resulting from a HouseCall includes educating and counseling members on managing chronic conditions, identifying signs and symptoms of disease exacerbation, mitigating risk factors and preventative measures through screenings and recommended vaccinations. Members are provided with materials to support education that occurs throughout the clinical visit. Examples of treatment options and counseling provided include advance care planning, diabetic foot care, exercise plans, healthy diets, mitigating fall risk, bladder control measures and pain control strategies. Policymakers should support the

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<sup>1</sup> MedPAC, 2015

<sup>2</sup> Avalere, 2012

continued advancement of MA as a foundational model to guide the transition to integrated, high-quality, and value-based care for seniors.

### **Reforms to Medicare’s current FFS program that incentivize providers to coordinate care for patients living with chronic conditions**

Health care is in the midst of a transformation. Consistent with what policy-makers, consumers and stakeholders have called for, health care delivery in the United States is moving to a system where physicians, hospitals and other health care providers that demonstrate the highest quality at the greatest value will be rewarded for their efforts. MA plans are collaborating with primary care physicians and other health care providers in order to offer higher quality and more affordable health care coverage. With more than 33% of America’s seniors enrolled in MA plans today, funding of the program is not keeping pace with the growth in health care costs. For example, CMS recently finalized risk adjustment changes that will negatively impact 2016 MA payment. These changes undermine the purposes of risk adjustment, which are to 1) assure appropriate funding for health care services for each beneficiary based on the collective risk of a Plan’s membership, and 2) provide MA Plans with a stable financial platform to serve beneficiaries. Risk adjustment, properly implemented, eliminates potential negative financial impacts on Plans that enroll beneficiaries with more complex healthcare needs and thereby eliminates incentives for adverse selection or “cherry-picking.” The recalibrated risk adjustment model has a particularly negative impact on these most vulnerable beneficiaries, potentially increasing their premiums and other out-of-pocket costs, reducing the scope of their benefits, and thereby reducing access to care and access to coverage. As CMS does for Star Ratings, CMS should establish a separate risk adjustment comment period in advance of the annual rate notice which would improve transparency into and the accuracy of the risk adjustment model.

Today’s FFS environment does not incent quality, collaboration and coordination in health care. It is also administratively inefficient. Medicare FFS is a “one-size-fits-all” program, whereas MA plans are tailored to seniors’ health and economic needs. Recognizing that the transition to value-based payments is an intensive process, care coordination can be significantly improved in the interim by designing benefits and care management programs in ways that take cues from MA. Further, MA innovations such as in-home care and nurse help hotlines outpace FFS Medicare at providing seniors with access to the right care, at the right time, in the right setting. For example, we estimate that incorporating intensive programs that focus on lifestyle changes for Medicare patients with pre-diabetes can reduce diabetes prevalence in this population and save over \$150 billion. Further, increasing administrative efficiencies in FFS could generate potential savings of over \$300 billion by shifting to a model that allows Medicare to contract out claims processing and other services, as well as wellness programs and care management.

### **The effective use, coordination, and cost of prescription drugs**

MA plans are integrated and designed to be comprehensive, with over 80% of MA plans including prescription drug coverage. All MA-PD plans coordinate prescription drug benefits and use Medication Therapy Management and comprehensive reviews to ensure patients are receiving clinically appropriate treatments, informed about their medications, and understand how to use medications most effectively. We optimize medication therapy management by

leveraging data and analytic tools to better target those who need medication management or adjustments to their current therapies.

However, CMS constrains MA programs by setting requirements that limit innovative benefits designs. Additional flexibility would allow MA plans to offer seniors more choices to accommodate their personal preferences. Given the choice, some seniors might opt for a broader drug formulary and higher inpatient cost-sharing, whereas others seek low cost-sharing for inpatient stays and a more limited formulary. Unfortunately, CMS tries to apply a “one size fits all” approach to benefits design by preventing plans in the same service areas from offering two options with similar average benefit levels. Also, bidding rules prohibit us from offering low or zero cost-sharing for drugs managing chronic conditions, unless this cost-sharing is offered to the entire tier for those drugs. CMS could change these policies within the current regulatory framework to increase innovation in MA and help seniors have the choice to select plans that best meets their needs.

MA plans can develop additional clinical programs to close gaps in care and offer, as part of the programs, services like transportation. With added flexibility, MA plans could offer services or gift cards for routine transportation to or from home in nonemergency situations to help seniors who lack transportation get needed medical care. This would help optimize available health care resources in rural and frontier areas by leveraging programs that extend the accessibility of providers, caregivers and community support networks for seniors.

### **Ideas to effectively use or improve the use of telehealth and remote monitoring technology**

We currently offer Remote Patient Monitoring (RPM) for MA members with Congestive Heart Failure, as well as patients dually eligible for Medicare and Medicaid in special needs plans. Based on clinical evidence, other Medicare patients with chronic conditions who would also benefit from RPM include those who are at risk for diabetic retinal disease or peripheral vascular disease. RPM and audio-video telemedicine provides critical education and home training related to comorbidity management. Secure, real-time feedback through RPM technology also helps inform patients’ health choices throughout their day. RPM delivers that knowledge wirelessly through scales, blood pressure monitors, pulse oxymeters, thermometers and user-friendly health questions. We have achieved significant reduction in hospital readmissions through the use of RPM for those with Congestive Heart Failure – pilots in NY and AZ reduced readmissions to 4.3% and 8.3 % respectively, from a baseline of 20.6%. In this instance, RPM looked for weight gain, changes in blood pressure and pulse rate, all which indicate that more intensive treatment may be needed.

### **Strategies to increase chronic care coordination in rural and frontier areas**

MA plans combine a patient-centered care model with robust benefits and services to meet patients in their home or community. However, CMS continues to impose funding cuts and restrictions on MA program requirements that impede innovative benefits designs, undermining the intent and purpose of the capitated payment approach that many MA plans utilize to optimize value and quality. With stable funding and additional flexibility, MA plans are well-positioned to tailor benefits, clinical models and value-based designs that focus on improving care and health

outcomes for Medicare patients in rural and frontier areas. MA plans can develop additional clinical programs to close gaps in care and offer, as part of the programs, services like transportation. With added flexibility, MA plans could offer services or gift cards for routine transportation to or from home in nonemergency situations to help seniors who lack transportation get needed medical care. This would help optimize available health care resources in rural and frontier areas by leveraging programs that extend the accessibility of providers, caregivers and community support networks for seniors.

### **Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers**

Our MA plans are helping patients navigate an increasingly complicated health care system through innovative care coordination programs. Low motivation, personal barriers, and sparse community resources are all key challenges to empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their care providers. To address these issues, MA plans include greater attention to clinical design, patient experience, connectivity to providers and other supports – leading to high rates of member satisfaction. In fact, 91% of seniors in MA report they are satisfied with their coverage.<sup>3</sup> MA Plans are utilizing the latest technology to identify gaps in care and target potentially at-risk patients for support and intervention.

Personal barriers to empowering seniors include limited financial resources. MA seniors spend about \$2,200 annually on health care coverage, while those in Medicare FFS spend around \$4,000 for Medicare and supplemental coverage that do not match the MA program's robust benefits.<sup>4</sup> With 41% of seniors in MA having annual incomes of \$20,000 or less, affordability is a critical aspect of empowering seniors to play a greater role in managing their health.<sup>5</sup> While MA helps seniors afford the care they need to improve their health, the MA program has been cut by 14% since 2010 and there has been nearly a four-fold increase in the number of U.S. counties that no longer have MA as an option for seniors in 2015 compared to 2012.

MA plans leverage data and analytic capabilities to understand and identify opportunities for deploying care management tools that are specifically tailored to local health needs. Our technologies provide a comprehensive look at trends in population health, health care spend, and decision making metrics, with the capacity to concentrate into specific data segments to target solutions. These capabilities allow us to identify populations at risk of or currently facing significant health challenges, as well as confounding social and economic factors. This informs the development of health care solutions that are more personalized, helpful and relevant to a patient's needs.

### **Ways to more effectively utilize primary care providers and care coordination teams in order to meet the goal of maximizing health care outcomes for Medicare patients living with chronic conditions.**

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<sup>3</sup> Mellman and Winston, 2015.

<sup>4</sup> HealthPocket, 2014.

<sup>5</sup> CMS data, 2014.

Multi-disciplinary primary care teams are at the foundation of MA care delivery models, helping seniors realize better health outcomes. Compared to seniors in FFS Medicare, MA seniors have shorter hospital stays, fewer hospital admissions, 13-20% lower re-admission rates, and are more likely to receive primary care and preventive services - mammography screening, blood sugar tests, retinal exams and flu vaccines.<sup>6,7,8</sup> The average readmission costs about \$14,000, and Medicare has the opportunity to save more than \$17 billion in potentially avoidable costs.<sup>9</sup>

One way we lower readmissions is through transitional, post-acute and high-risk case management services which connects highly trained nurse coordinators with patients, care givers, facilities and other care-team members. Patients are considered high-risk for a readmission based on co-morbidities, functional status, social needs or frequent use of high-cost services. Through timely engagement and a collaborative process, patients are educated, empowered and supported during the post-hospitalization recovery process. We also offer programs through MA to improve care coordination for those with complex conditions like end-stage renal disease. Nurse advocates identify and work to close gaps in care we offer to lower readmissions is for MA members with advanced illness. The model focuses on improving quality of life by honoring and supporting the individual's unique traditions, attitudes, beliefs, and addressing issues of physical, emotional, and spiritual comfort.

Because Medicare patients are unlikely to return to their communities after 60 days of being admitted to an institutional setting and average Medicare spending being two times greater for patients living in these setting, there is reason to encourage community-living when possible.<sup>10</sup> In MA, we have combined in-home care with care-management technology to serve medically complex patients, resulting in a more than 60% reduction in admissions and a per-member-per-month cost reduction of 51%.<sup>11</sup> These outcomes can be attributed to 24/7 availability of a member's care team and telephonic care support, in addition to in-person visits by physicians, nurse practitioners or physicians assistants to manage changes in a patient's condition and treat them in place. Providers are trained specifically for chronically ill, high-risk patient care. An electronic medical record allows all providers involved in a member's care to have access to the care plan. Further, any changes, updates, interventions or home visit notes are automatically uploaded and distributed to the member's primary care provider.

## **Conclusion**

Thank you for the opportunity to share our experience, ideas and recommendations as the Finance Committee considers solutions and policies to improve health outcomes for Medicare patients with chronic conditions. 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 innovative delivery models, the growing body of research finds that Medicare Advantage is enhancing seniors' health and well-being, while driving systemic

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<sup>6</sup> Health Affairs, 2013.

<sup>7</sup> American Journal of Managed Care, 2012.

<sup>8</sup> Health Affairs, 2012.

<sup>9</sup> Robert Wood Johnson, 2013.

<sup>10</sup> Kaiser Family Foundation, 2010.

<sup>11</sup> UHG analysis.

improvements in care delivery. Supporting the Medicare Advantage program through stable and predictable funding continues to be the most reasonable and balanced pathway to advancing the health care of Medicare patients living with chronic conditions.