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January 25, 2016

The Honorable Orrin G. Hatch
Chairman
U.S. Senate Finance Committee

The Honorable Ron Wyden
Ranking Member
U.S. Senate Finance Committee

The Honorable Johnny Isakson
U.S. Senate Finance Committee

The Honorable Mark R. Warner
U.S. Senate Finance Committee

RE: Comments to Bipartisan Chronic Care Working Group Policy Options Document

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson and Senator Warner:

The Center on Budget and Policy Priorities is a nonpartisan research and policy organization based in Washington, D.C. Founded in 1981, the Center conducts research and analysis to inform public debates and policymakers about a range of budget, tax and programmatic issues affecting individuals and families with low or moderate incomes.

We strongly support your goal of improving care for Medicare beneficiaries with chronic illnesses, particularly those with multiple conditions. Increased care coordination, for example, may enhance health outcomes by ensuring that patients receive needed care while avoiding costly interventions such as hospitalization.

We appreciate the opportunity to provide these comments to the Bipartisan Chronic Care Working Group Policy Options Document. Our comments focus on two options on pages 13 to 16 in the Expanding Innovation and Technology section:

- Adapting Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees
- Expanding Supplemental Benefits to Meet the Needs of Chronically Ill Medicare Advantage Enrollees.

Under these options, Medicare Advantage plans could be permitted to offer additional supplemental benefits, reduced cost-sharing, different provider networks and/or care improvement and wellness programs for enrollees with chronic conditions. The rationale for these options is that

they could allow Medicare Advantage plans to provide more tailored benefits that would improve care or prevent the progression of chronic conditions among their enrollees with chronic conditions.

These options, however, raise significant concerns. They need to be carefully designed and limited in scope. Otherwise, we believe they would likely result in serious problems similar to those that have arisen in the past related to discriminatory Medicare Advantage benefit designs and Chronic Condition Special Needs Plans (C-SNPs).

Some Medicare Advantage plans have previously used their flexibility on Part A and Part B benefits to vary cost-sharing and utilization limits in ways that discriminated against certain high cost-enrollees, as a way to deter sicker beneficiaries from enrolling. While Congressional and administrative actions have since curtailed these problems to some extent, if Medicare Advantage plans can now vary their benefits and cost-sharing for enrollees with chronic conditions, there would be a substantial risk that plans would design their benefits in ways that do not meet the needs of the full spectrum of enrollees with chronic illnesses, particularly those with higher costs, those in the poorest health and those with multiple chronic conditions, cognitive impairments and problems with activities of daily living. Under these two options, benefits could be designed in ways that “cherry-pick” and attract beneficiaries with chronic conditions who are relatively lower cost and easier to treat, while discouraging enrollment by those whose care is the most difficult to provide and coordinate. In addition, large differences in what Part A and Part B benefits are provided by Medicare Advantage plans could also undermine the accuracy of the Medicare Advantage risk adjustment system by making it more difficult to directly compare the claims costs of like beneficiaries in Medicare Advantage and fee-for-service. Also, if plans are able to cherry-pick among chronically ill beneficiaries, they may be able to raise their “risk scores,” which would result in higher risk-adjusted payments, without taking on enrollees whose conditions are difficult to treat.

For much of the existence of C-SNPs, the chronic conditions allowing eligibility for enrollment have not been clearly and narrowly defined. For example, a C-SNP was once approved for beneficiaries with high cholesterol even though the Medicare Payment Advisory Commission (MedPAC) noted in 2008 that the condition was so common that all Medicare Advantage plans should be expected to manage care for that condition. (Congressional and administrative actions subsequently narrowed the scope of C-SNPs.) Moreover, MedPAC found that some C-SNPs were not sufficiently specialized or expert to provide targeted service delivery and disease management strategies for those with chronic illnesses.¹ And in 2013, MedPAC stated that C-SNPs tended to perform no better, and often worse, than other SNPs and Medicare Advantage plans.²

As the Bipartisan Chronic Care Working Group assesses all of the options in the Document, we recommend that it consider these two options only if they include the following elements:

1. **Define narrowly the chronic conditions eligible for greater benefits flexibility.** Roughly 9 in 10 Medicare beneficiaries have at least one chronic condition and about two-thirds have more than one chronic condition.³ Those percentages will rise considerably as

¹ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2008.

² Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2013.

³ See, for example, Kimberly Lochner, Richard Goodman, Samuel Posner and Anand Parekh, “Multiple Chronic Conditions Among Medicare Beneficiaries: State-Level Variations in Prevalence, Utilization and Cost, 2011,” *Medicare*

the Medicare population continues to become older, on average.⁴ Merely basing eligibility on having a chronic condition could encompass nearly all Medicare Advantage enrollees. Eligibility should be limited to a very small number of discrete high-cost chronic conditions and/or to individuals with multiple, specific conditions that have high costs and whose care is difficult to coordinate.

For example, the options could be made available only to individuals with more than six chronic conditions, of which at least one is an eligible high-cost condition. According to the Centers for Medicare and Medicaid Services, in 2010, individuals with six or more chronic conditions constituted 14 percent of Medicare fee-for-service beneficiaries but accounted for 46 percent of total Medicare spending. They incurred, on average, about \$32,600 in Medicare costs — nearly 3.4 times that of the average beneficiary — which was likely driven by the need for hospital care. Of such individuals, 63 percent had at least one hospital admission over the course of the year.⁵ (Alternatively, eligibility could be limited to those with four or more chronic conditions, of which one is an eligible high-cost condition. But that would make these options far less targeted. It would result in roughly 37 percent of beneficiaries being eligible. And individuals with 4-5 chronic conditions incur much less in Medicare costs: their average spending in 2010 was only 37 percent of the average spending of those with six or more chronic conditions.)

2. **Establish specific evidence-based benefit designs.** Similar to what MedPAC has recommended, the Centers for Medicare and Medicaid Services could be directed to establish a small number of specific benefit and cost-sharing designs that would better meet the medical needs of individuals with certain chronic or disabling conditions.⁶ Such designs should be first documented to significantly improve care and health outcomes before being approved. This would help ensure that any greater benefit flexibility is not inappropriately used by Medicare Advantage plans for risk selection purposes and that the benefit designs cover the full spectrum of individuals with specific conditions, particularly those in the poorest health and with the greatest needs.
3. **Require Medicare Advantage plans to be certified that they have sufficient expertise and experience.** To avoid the problems that have beset C-SNPs, Medicare Advantage plans should have to demonstrate that they are capable of improving care for

and Medicaid Research Review, Vol. 3 No. 3, 2013, https://www.cms.gov/mmrr/Downloads/MMRR2013_003_03_b02.pdf and Harriet Komisar and Judith Feder, “Transforming Care for Medicare Beneficiaries with Chronic Conditions and Long-Term Care Needs: Coordinating Care Across All Services,” Scan Foundation, October 2011, www.thescanfoundation.org/sites/.../Georgetown_Trnsfrming_Care.pdf.

⁴ See, for example, Etienne Gaudette, Bryan Tysinger, Alwyn Cassil and Dana Goldman, “Health and Healthcare of Medicare Beneficiaries in 2030,” *Forum for Health Economics and Policy*, December 2015, [http://www.degruyter.com/dg/viewarticle.fullcontentlink:pdfeventlink/\\$002f\\$002ffhep.2015.18.issue-2\\$002ffhep-2015-0037\\$002ffhep-2015-0037.pdf?format=INT&t:ac=j\\$002ffhep.2015.18.issue-2\\$002ffhep-2015-0037\\$002ffhep-2015-0037.xml](http://www.degruyter.com/dg/viewarticle.fullcontentlink:pdfeventlink/$002f$002ffhep.2015.18.issue-2$002ffhep-2015-0037$002ffhep-2015-0037.pdf?format=INT&t:ac=j$002ffhep.2015.18.issue-2$002ffhep-2015-0037$002ffhep-2015-0037.xml).

⁵ Centers for Medicare and Medicaid Services, “Chronic Conditions Among Medicare Beneficiaries, Chartbook: 2012 Edition,” 2012, <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Chronic-Conditions/Downloads/2012Chartbook.pdf>.

⁶ Medicare Payment Advisory Commission, “Report to the Congress: Medicare Payment Policy,” March 2013.

enrollees with the specific, eligible chronic conditions and can fully take advantage of the opportunity that the targeted benefit designs provide.

4. **Require Medicare Advantage plans electing these options to meet specific performance measures related to the chronic conditions.** CMS should be required to develop specific measures related to the particular, eligible chronic condition being addressed and Medicare Advantage plans should be required to report on those measures. This would ensure that the specific benefit designs are working as intended and that the plans adopting them are capable of taking advantage of them in order to improve the health of their chronically ill enrollees.
5. **Provide similar flexibility in the traditional Medicare program.** The same evidence-based benefit and cost-sharing designs should be made available to fee-for-service beneficiaries, including but not limited to those receiving care through accountable care organizations. This would ensure a level playing field between Medicare Advantage and traditional Medicare, while improving care and care coordination and better health outcomes for all Medicare beneficiaries, not just those enrolled in Medicare Advantage plans.
6. **Make these options a limited demonstration project.** To test whether these options are working as intended and are not resulting in problems like risk selection or beneficiary confusion, these options should initially be made available only on a limited basis. For example, beneficiary enrollment and/or participation by plans in these options could be capped and time-limited until such time as CMS or Congress can evaluate whether these options are achieving their goal of improving care for those with chronic illnesses.

Thank you again for this opportunity to provide comments to the Bipartisan Chronic Care Working Group Policy Options Document. Please let us know if you have questions or if we can be of any further assistance.

Sincerely,



Edwin Park
Vice President for Health Policy
Center on Budget and Policy Priorities