



June 22, 2015

The Honorable Johnny Isakson  
Co-Chair  
Chronic Care Working Group  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mark Warner  
Co-Chair  
Chronic Care Working Group  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

Co-Chair Isakson and Co-Chair Warner:

We appreciate the opportunity to provide input to the Finance Committee Working Group as it considers the impact of chronic disease on the Medicare program, and develops improvements to Medicare Advantage for beneficiaries living with chronic disease.

Independent Care Health Plan (*iCare*) offers a unique perspective to improve the lives of beneficiaries dually eligible for Medicare and Medicaid (“Dual Eligibles”). *iCare* serves nearly 6,000 dually-eligible members under CMS Medicare Advantage contract H2237. Predominantly drawing from the disadvantaged, inner-city population of Milwaukee, *iCare* serves only low-income beneficiaries eligible for Medicaid, and does not offer plans for active seniors or commercial populations. The *iCare* Medicare program includes two specialized Medicare Advantage plans: (1) a Dual Eligible Special Needs Plan (D-SNP) and (2) a Fully-Integrated Dual Eligible Special Needs Plan (FIDESNP).

The *iCare* population offers the Working Group a prism in which to see the impact of chronic conditions. Chronic conditions are often the first occurrence on a pathway leading to impoverishment, isolation and behavioral health challenges. Workplace performance is impaired when a person is battling chronic conditions, and a disability determination results if the condition worsens to the point where employment is not feasible. Without employment, income is limited, leading to compromised hygiene, housing and social situations which further impact health status. Depression, substance abuse and other behavioral health conditions are often co-morbid with complex chronic illnesses.

People who traverse this pathway may eventually become dually eligible for Medicare and Medicaid. Their impoverishment qualifies them for Medicaid, while their employment history and disability determination entitle them to Medicare.

The following table shows the prevalence of multiple co-morbid chronic conditions among *iCare*'s population of dual eligibles:

Condition	iCare Members Age 18-44	iCare Members Age 45-64	iCare Members Age 65+	Total Members	Percent of All Members (N= 5,493)
<b>Hypertension</b>	282	1,359	1,210	2,851	<b>52%</b>
<b>Hyperlipidemia</b>	150	902	832	1,884	<b>34%</b>
<b>Diabetes</b>	175	846	802	1,823	<b>33%</b>
<b>Lumbago</b>	208	752	373	1,333	<b>24%</b>
<b>Tobacco use Disorder</b>	241	764	302	1,307	<b>24%</b>
<b>Chest Pain</b>	179	611	468	1,258	<b>23%</b>
<b>Esophageal Reflux</b>	165	619	459	1,243	<b>23%</b>
<b>Depression</b>	223	628	299	1,150	<b>21%</b>
<b>Pain-Limb Soft Tissues</b>	162	601	373	1,136	<b>21%</b>
<b>Chronic Pain</b>	142	557	284	983	<b>18%</b>

Note that most iCare members are younger than age 65, and are entitled to Medicare based on disability, not age. Similarly the table shows that chronic disease is prevalent among the younger disabled population, and is not a function of age alone.

iCare did not anticipate the current state of reimbursement for its SSI/SSDI managed care members, where premium is tied to quality measures and the HCC-impacted rate setting methodology does not adjust properly to member condition. Our members, it seems, are thought to be just like every other Medicare Advantage member, except that they qualify for Medicare and Medicaid because of a disability rather than age. Perhaps disability status should be included in the risk assessment as well as socioeconomic factors. School aid is adjusted for special education students, because the Education Department recognizes that it takes more resources to achieve educational outcomes for students with intellectual, behavioral, and functional challenges.<sup>1</sup> If school aid was distributed based on graduation rates, special education students would receive only average support. We are not certain the Health and Human Services Department is sufficiently sensitive to these challenges and their corresponding impact on health outcomes. We view the counter arguments: i) “this is the lot you’ve chosen as a plan,” ii) “you really want two quality standards,” and similar arguments as irresponsible in the same way that awarding school aid based on graduation rates rather than on degree of disability would be irresponsible. As plans and providers have generally improved their performance under 5-Star and value-based-purchasing measures, those with disabilities have lagged behind; these individuals cannot compete at the same level as regular Medicare Advantage eligibles. They could not compete in school at the same level and they cannot compete in healthcare at the same level.

It is encouraging to note that policy makers at a number of levels are beginning to question the appropriateness of evaluating outcomes for both dual eligibles and traditional Medicare populations using universal star measures. This letter provides iCare’s recommended strategies and procedures related to the following topics requested by the Working Group:

1. Improvements to Medicare Advantage for patients living with multiple chronic conditions;

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<sup>1</sup> Individuals With Disabilities Education Act - Funding Distribution: IDEA Authorized Funding Streams. New America Foundation. (<http://febp.newamerica.net/background-analysis/individuals-disabilities-education-act-funding-distribution>)

2. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions;
3. The effective use, coordination and cost of prescription drugs;
4. Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers; and
5. 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.

The comments provided reflect *iCare's* experience serving consumers with chronic conditions under both Medicare Advantage and Medicaid managed care for the elderly, blind and disabled. While the needs of the populations under each program are essentially identical, Medicare and Medicaid policy differ widely, allowing *iCare* to view the relative strengths and weaknesses of each. As a result, some of our recommendations related to Medicare are transferred from *iCare's* Medicaid experience.

1. **Improvements to Medicare Advantage for patients living with multiple chronic conditions:** The following Medicare Advantage policies place plans serving consumers with multiple chronic conditions at a disadvantage:
  - a. Pay-for-performance measures favoring plans that serve healthy, active seniors. The current 5-Star rating system penalizes plans serving consumers with multiple chronic conditions through a variety of outcome and satisfaction measures designed for a traditional Medicare Advantage population. The March 2015 release by technology company Inovalon of the largest analysis ever performed on dual eligible quality outcomes underscores this disparity. Entitled "An Investigation of Medicare Advantage Dual Eligible Member-Level Performance on the CMS Five-Star Quality Measures," the study evaluated performance on 18 Five-Star quality measures for more than 2.2 million Medicare Advantage members, drawn from 81 separate Medicare Advantage contracts. Results show that disadvantaged beneficiaries have worse health outcomes that cannot be attributed to a plan's quality of service. In fact, eight out of nine HEDIS measures were found to be controlled by socioeconomic status factors.

***Recommendations:***

- a. ***Evaluate D-SNPs based on their peers.*** This recommendation is similar to one made by MedPAC in its June 2013 Report to Congress.<sup>2</sup> The 2013 recommendation called for evaluating hospitals based on their peers, and outlined a method to correct for the problem of hospitals serving poor patients paying disproportionate penalties. MedPAC found that using hospitals' share of low-income patients was a strong and consistent predictor of readmissions. To adjust for income, MedPAC divided hospitals into deciles based on shares of Medicare patients who qualified for Supplemental Security Income (SSI), which is a program for seniors and the disabled with incomes of roughly \$1,000 per month or less. Targets are established for hospitals within each decile, and rankings are computed against other hospitals within the same decile. The same methodology could be used to evaluate

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<sup>2</sup> Medicare Payment Advisory Commission (MedPAC), Report to Congress – Medicare and the Health Care Delivery System, June 2013, Chapter 4. (<http://www.medpac.gov/-documents-/reports>)

health plans, including use of the same deciling variable – proportion of members qualifying for SSI.

- b. ***Incorporate HEDIS Behavioral Health Measures:*** In the same June 2013 Report to Congress, MedPAC noted the high incidence of severe and persistent mental illness (SPMI) among the dual eligible population.<sup>3</sup> In 2009, 20 percent of all dual-eligible beneficiaries enrolled in FFS during the entire year (excluding beneficiaries with ESRD) had at least one SPMI condition. Almost one-third of dual-eligible beneficiaries under the age of 65 had an SPMI condition, compared with 10 percent of dual-eligible beneficiaries age 65 or older.

The National Committee on Quality Assurance (NCQA) recognizes the importance of integrating behavioral and physical health. Accordingly, NCQA issued four new HEDIS behavioral health measures in 2013, and three new HEDIS behavioral health measures in 2014. While this brings the total number of HEDIS behavioral health measures to 11, none are included in the 5-Star rating system.

- c. ***Validate the Growing Body of Evidence through Independent Study:*** As noted earlier the March 2015 study by technology company Inovalon shows that disadvantaged beneficiaries have worse health outcomes that cannot be attributed to a plan's quality of service. However, this study and related works are currently viewed as private studies. MedPAC or another independent public entity must confirm these studies or conduct its own studies of both the quality measurement system and the rate setting methodology. Without this validation, reform will not occur. MedPAC or another independent entity holds the public's trust and silence can be read as agreement with the status quo.
- b. **A Medicare Advantage rate-setting methodology that does not deter plans from serving populations with multiple chronic conditions.** *iCare* recognizes the benefits of the current HCC risk adjustment model, which attempts to adjust capitation rates to more appropriately fit a beneficiary's health status. A 2014 analysis of risk adjustment factors prepared by actuarial firm Milliman showed that the HCC method tends to result in overpayment for the healthiest beneficiaries and underpayment for the sickest beneficiaries (this conclusion has also been drawn by MedPAC). Clearly, this creates a strong disincentive for plans to serve populations with multiple chronic conditions. It also reduces the resources available for plans that do.

***Recommendation:***

- a. ***Require CMS to review and revise the MA risk adjustment model per Section 1853(a)(1)(C)(iii) of the Social Security Act through notice and comment.*** This provision requires CMS to conduct reviews and revisions of the risk model to account for higher medical and care coordination costs associated with "individuals with multiple, co-morbid chronic conditions, individuals with mental illness, and also to account for costs that may be associated with higher concentrations of beneficiaries with those conditions." CMS issued one evaluation report in 2010 pursuant to this provision but has not issued any further reviews or reports.

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<sup>3</sup> *Ibid*, Chapter 6.

- b. ***Incorporate MedPAC's Risk Adjustment Model Revisions:*** On several occasions, MedPAC has noted that the current risk adjustment model under predicts costs for high-cost beneficiaries and over predicts for low-cost beneficiaries. MedPAC has offered several opportunities to fine-tune the model for more accurate reimbursement and to incentivize the best care for individuals with chronic conditions. These options were presented by MedPAC staff to Commissioners during a September 12, 2013 meeting.<sup>4</sup> Adjustments include:
- Adding a factor for the number of conditions for each beneficiary, which would improve payment accuracy for the frailest beneficiaries;
  - An alternative is to use two years of diagnosis data to determine condition categories. This also improves payment accuracy for the frailest beneficiaries, but not as much as adding the number of conditions.
  - Separating dual eligible HCCs into full and partial-dual eligible groups. This would improve payment accuracy for these two groups.
  - Creating a hybrid model that includes concurrent risk adjustment for a few conditions that are chronic, costly, well-defined and easy to verify.
  - Including prior costs or utilization in the risk adjustment model.

While MedPAC acknowledges that any adjustment will create both positive and negative outcomes, the Commission continues to note that the current model works against the interests of those serving people with chronic conditions.

- c. The current excise tax, which creates disparities for plans serving beneficiaries with multiple chronic conditions. The tax penalizes plans, such as D-SNPs, that serve a high proportion of individuals with chronic conditions. D-SNPs are, by design, for low-income individuals, and cannot charge a premium to consumers. Without the ability to charge a premium, D-SNPs cannot pass the tax along to consumers, and are forced to divert Medicare funding into the tax payment. This places D-SNPs at a disadvantage to other plans, creating a disparity that reduces resources for consumers with the greatest needs.

*iCare* will pay over \$2 million in excise taxes for 2014 with \$200 million in revenue. About 50% of this revenue amount is Medicaid; and ironically, CMS has encouraged Medicaid to cover the tax on Medicaid revenue, but not on Medicare revenue. The irony is heightened by the fact that a dually-eligible consumer is by definition covered by both Medicare and Medicaid; CMS recognizes the need to cover the tax on the consumer's Medicaid services but not the Medicare services. Were *iCare* a non-profit plan, no tax would be applied to either Medicare or Medicaid premiums. Because *iCare* is for-profit in status, the tax is required even though on the Medicare side it has no way to adjust for actuarial soundness. We believe this Medicare policy runs counter to federal actuarial soundness rules and is inconsistent with CMS practice in Medicaid coverage of the tax. The policy also disadvantages plans designed to serve individuals with multiple chronic conditions.

***Recommendation:*** Bring congressional attention to Medicare rates for for-profit D-SNP plans that are made actuarially unsound by unfair application of the excise tax.

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<sup>4</sup> Medicare Payment Advisory Commission (MedPAC), Issues for Risk Adjustment in Medicare; presentation by Dan Zabinski during September 12, 2013 Public Meeting. (<http://www.medpac.gov/documents/september-2013-meeting-presentation-issues-for-risk-adjustment-in-medicare-advantage.pdf?sfvrsn=0>)

- d. The current lesser-of logic reduces provider access for consumers with multiple chronic conditions. This issue centers on a 2007 Medicaid statutory allowance for states to pay less than the full Medicare cost-sharing amount if it would lead a provider to receive more than the state's Medicaid rate for the same service. In its March 2015 Report to Congress on Medicaid and CHIP, MACPAC expressed concern over this policy, noting that it reduces access to care for dually eligible beneficiaries.<sup>5</sup> This conclusion is consistent with iCare's experience, where provider contracts have been difficult to negotiate based on the limited or nonexistent reimbursement for Medicaid cost-sharing amounts.

**Recommendation:** Repeal the statutory language allowing for "lesser of" logic. Require Medicaid programs to pay cost sharing amounts at Medicare levels, not Medicaid levels.

- e. An Absence of Regulations Encouraging Free Web-Based Exchange of Information Between Providers and Plans. A "model of care" healthcare revolution has already occurred in this country. Plans are held accountable for provider outcomes. One of the 5-Star measures applied to iCare has to do with the number of members with HbA1c tests less than 9; iCare must make sure that our members receive HbA1c tests and then that test results show diabetes control. The results of HbA1c tests are not part of the claims stream; iCare must send a nurse to the physician's office to review his/her medical records to obtain the results. Of course, current electronic connectivity could otherwise allow us to obtain those results directly through the Internet, avoiding the disruption and added cost in time and money that is associated with visiting the provider's office. Federal Meaningful Use regulations could have encouraged provider-plan connectivity; it did not. The federal IMPACT Act of 2014 could have included provider-plan connectivity in managing post-acute care episodes; it did not. The barriers are political, not technical. The federal government itself seems conflicted in its encouragement of information interconnectivity, even though everyone seems to agree on the cost and quality-of-care advantages of doing.

Access to and completeness of healthcare information needs to be strengthened and protected. Some providers do not understand that plans need access to the results of laboratory tests to achieve their measured outcomes; access is granted only if plans pay for access. This information is held hostage when it should be shared freely. Fee-for-service providers are not required to document a patient's complete diagnosis in order to receive payment. Diagnoses that are not contained in the claims stream result in reduced reimbursements for Medicare plans. When a diagnosis is known to be incomplete, plans generally request providers to complete the diagnosis in the medical record and attest to its presence. These follow-up completions are sometimes done only if the plan reimburses the provider for the adjustment; again, the information is held hostage. Some providers are using the 5-Star programs and the HCC diagnosis programs to leverage additional payments from plans, increasing costs to Medicare and depleting care resources for patients.

**Recommendation:** Prepare legislation, through revised Meaningful Use regulations or other instrument, to encourage and protect the electronic exchange of information with penalties for withholding performance sensitive data.

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<sup>5</sup> Medicaid Payment Advisory Commission, Report to Congress on Medicaid and CHIP, March 2015, Chapter 6. (<https://www.macpac.gov/publication/effects-of-medicaid-coverage-of-medicare-cost-sharing-on-access-to-care/>)

- 2. Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions:** We are very much aware that MedPAC has recommended that CMS reduce the number of measures applied to providers and plans. We are also aware that MedPAC has recommended a decile scale for hospitals and home health agencies; hopefully this same decile scale would be appropriate for plans as well. We were pleased to learn during our meeting that MedPAC has recommended to CMS that the rate setting methodology become more refined in examining the costs associated with the SSI/SSDI classifications, chronic disease classification, and related sub-groups.

Additionally the 5-Star program isolates plans and providers from each other by adopting measures that are not common between them. Each is pursuing its own interests, whereas each could be working together as a team toward the same end; in military terms, the value of this collective impact is well understood and is sometimes called "force multiplication."<sup>6</sup>

**Recommendation:** Encouraging the alignment of healthcare resources through the use of stable, common (multiplier effect) measures across the care delivery and care plan system.

- 3. The effective use, coordination and cost of prescription drugs:** Prescription drugs can optimize wellness and reduce treatment costs if appropriately managed. However, drugs can also diminish health and lead to costly acute care episodes if poorly managed. The key to achieving the former is to enhance the role of pharmacists, who today function largely in a medication dispensing role. Given the level of education, clinical knowledge and patient interaction of pharmacists, a broader and more beneficial role for these professionals is possible.

As the United States experiences a growing shortage of primary care physicians, new models of care must be allowed to evolve to fill this gap. However, greater use of pharmacists as a mid-level provider is challenging under Medicare, as pharmacists are not recognized as providers under the Social Security Act. This constrains pharmacists from providing and billing beneficial services under Part B.

Currently, the following non-physician providers are recognized in the Social Security Act: audiologists, certified nurse midwives, certified registered nurse practitioners, certified registered nurse anesthetists, physicians' assistants, licensed clinical psychologists, licensed clinical social workers, physical and occupational therapists, and registered dietitians/nutrition professionals. The requirements to become a pharmacist include as much, if not more, training as each of these healthcare providers.

Two areas that beg for greater coordination by pharmacists are medication adherence and Medicare reconciliation, particularly following an inpatient discharge. In Milwaukee, iCare works with an innovative community-based pharmacy chain that sends individuals into member homes following every hospital discharge. Since medication regimens often change post-discharge, the pharmacist performs the valuable function of ensuring compliance with the treatment plan and avoiding adverse drug interactions caused by treatment plan confusion.

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<sup>6</sup> Collective Impact Forum, Collective Impact Shared Resources, May 2015.  
(<http://collectiveimpactforum.org/resources/collective-impact-shared-resources>)

In addition, the pharmacist can visually assess the member's living conditions to determine if physicians should be alerted to any health issues or medication needs. In one example, a pharmacist saw that an iCare member slept propped up on six pillows. When asked why, the member complained of breathing problems that interfered with sleep. The pharmacist recognized the symptoms of congestive heart failure, and notified the member's physician of a medication need. The current reimbursement model does not incentivize this level of care by pharmacists.

**Recommendation:** Amend title XVIII of the Social Security Act to provide for coverage under the Medicare Program of pharmacist services.

4. **Options for increasing flexibility in the kinds of services available under Medicare that are less costly but equally beneficial compared to current services.** Greater patient engagement can be realized through broader recognition of the role of "In-Lieu-of Services" in the Medicare program. Following are a few of the many examples of beneficial "In-Lieu-of" services that are not recognized expenses under the Medicare program:

- a. Health coaches and peer counselors, who can help activate and train consumers to follow treatment and/or medication regimens. These personnel are inexpensive relative to the cost of physician or skilled nursing care, and affordably deliver the repetitive education, motivation and reinforcement needed for healthy outcomes. The use of certified peer counselors is a recognized expense under the Wisconsin Medicaid program, offering a model for consideration by CMS.
- b. Crisis Recovery Centers (CRCs), which provide sub-acute behavioral health care. In an example of another "in-lieu-of" service recognized by Wisconsin Medicaid, iCare is able to shorten or divert inpatient psychiatric stays through use of contracted CRCs. The cost savings are considerable, with CRC stays costing \$400 per diem vs. inpatient psychiatric stays at \$1,200 per diem.
- c. Traditional provider types can also provide "in-lieu-of" services through adjustments to Medicare payment rules. For example, Medicare covers inpatient skilled nursing facility (SNF) stays following a three-day hospital stay, creating a disincentive for nursing homes to divert hospital admissions. Payment to SNFs for inpatient services in lieu of a hospital stay would lead to fewer inpatient hospital admissions and days.

**Recommendation:** Create a process to evaluate "in-lieu-of" services that promise to offer equal benefit at lower cost to Medicare beneficiaries

5. **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.** Interventions needed for SNP populations require greater investment in non-traditional forms of care coordination and patient engagement – most of which are not covered by Medicare and therefore not reflected in MA payment. Yet, quality performance is graded on a curve including all MA plans. This results in lower 5-Star ratings and often no quality incentive increases in payments to SNPs, thereby reducing the resources available to deliver and improve outcomes for their patients, many of whom live with chronic illness.

This challenge is highlighted at *iCare*, which has proven the effectiveness of a well-managed care coordination model. Yet, current Medicare Advantage reimbursement methods do not account for the cost of any of the following:

- a. Care coordinators employed by *iCare* to help consumers access services appropriately, coordinate and optimize service delivery, and help navigate an increasingly complex healthcare system.
- b. Physician involvement in interdisciplinary teams (IDTs) coordinating care. CMS is applauded for its January 2015 implementation of a new chronic care management code allowing physicians to bill for consulting patients via video. However, interaction with IDTs remains a non-billable service for physicians. This policy merits examination, as an IDT is structured to extend the reach of a physician and maximize implementation of a physician's plan of care. Creating parity between telehealth consults with either consumers or the IDTs serving consumers will lead to better care coordination and reduce costly events associated with unmanaged care.

**Recommendation:** Allow plans to include in the medical portion of their Medicare Advantage bids costs related to care coordination needed to serve chronically ill patients. Plans can coordinate care more extensively than FFS providers to help manage chronic illness. Currently plans must include care coordination as a supplemental benefit or in the administrative portion of their bids. Flexibility to include care coordination in A/B bids could improve access and outcomes for chronically ill patients.

## Conclusion

Thank you for the opportunity to share our recommendations regarding reform of Medicare policies to better serve individuals with chronic conditions. We believe that such reforms will lead to better health outcomes and quality of life for sick, frail and disabled populations, and that cost savings for the Medicare program would result. The work necessary to achieve this vision will take many years, and it is imperative that policymakers act now to begin the transformation to a higher quality, more sustainable health care system.

Sincerely,



Thomas H. Lutzow, PhD, MBA  
President/CEO  
Independent Care Health Plan

C: Carlos Zarabozo, MedPAC Consultant  
Shawn Bishop, Principal, SB Consulting  
Sarah Barth, Dir. of Integrated Health and Long-Term Services, Center for Health Care Strategies