CHCS Center for Health Care Strategies, Inc.

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200 American Metro Blvd.
Suite 119
Hamilton, NJ 08619
(609) 528-8400
(609) 586-3679 *fax*
www.chcs.org

Senate Committee on Finance
Chronic Care Working Group
219 Dirksen Senate Office Building
Washington, DC 20510-6200

Subject: Comments on Bipartisan Chronic Care Working Group Policy Options Document

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

The Center for Health Care Strategies (CHCS), a national health policy resource center, appreciates the opportunity to comment on the Senate Committee on Finance's Bipartisan Chronic Care Working Group Policy Options Document that was published on December 18, 2015. Over the past two decades, CHCS has partnered with the majority of states in the country to promote chronic care innovations within publicly financed health care.

Individuals who are dually eligible for Medicare and Medicaid have been a particular focus of our work. CHCS is currently assisting the Centers for Medicare & Medicaid Services' (CMS) Medicare Medicaid Coordination Office (MMCO), 22 states and a subset of health plans working to integrate care for Medicare-Medicaid enrollees through financial alignment demonstrations, Dual Eligible Special Needs Plan (D-SNP) platforms, or Medicaid managed long-term services and supports (MLTSS) programs. The nation's 10 million Medicare-Medicaid enrollees are among the most high-need, high-cost subsets of the Medicare population. They are beset by various combinations of poverty, chronic disease, physical and cognitive disabilities, and social isolation. Given their high utilization of physical and behavioral health and LTSS services, they also account for a disproportionate 39 percent of all Medicaid expenditures and 31 percent of all Medicare costs.

We commented on proposals outlined in the Chronic Care Working Group Policy Options Document that could have the largest impact on Medicare-Medicaid enrollees. Our responses to three policy proposals are informed by our work with states, health plans and the federal government:

- **Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations:** Developing integrated D-SNPs may take several years. The timeframe required varies based on several factors, particularly state and health plan experience with serving this population in a managed care environment and Medicaid MLTSS program.
- **Addressing the Need for Integrating Behavioral Health for Chronically Ill Beneficiaries.** Integrating physical and behavioral health services is important for Medicare-Medicaid enrollees, and states can provide models that may be of interest to Medicare.
- **Ensuring Accurate Payment for Chronically Ill Individuals.** Using functional assessment data may improve accuracy of risk adjustment approaches for Medicare-Medicaid enrollees. However, the best methods for doing this are still being explored.

Below are more detailed comments on these three proposals:

1. **Providing Continued Access to Medicare Advantage Special Needs Plans for Vulnerable Populations.** The Chronic Care Working Group requested feedback on how much time is

needed for states and D-SNPs to successfully integrate all Medicare and Medicaid services. All D-SNPs must have contracts with every state in which they operate that outline how they will coordinate with the state's Medicaid program. Several states with Medicaid MLTSS programs use these programs to increase integration or coordination with D-SNPs by requiring health plans to offer both D-SNP and MLTSS products.

Developing contract requirements that increase coordination of services and administration is a complex undertaking for states and health plans. Depending on existing state and health plan experience with serving this population in a managed care environment and Medicaid MLTSS programs, this process can take several years. CHCS supports several states in their D-SNP contracting efforts, and we have found that states need flexibility in their timelines due to several considerations.

The current level of integration within the contracts varies by state, and therefore the amount of time needed to achieve full integration depends in part on the level of current Medicare and Medicaid integration. A number of states, including Pennsylvania and New Mexico, require only minimal coordination, while other states like Arizona and Minnesota require almost full integration of benefits.

Another consideration is how Medicare Advantage payment and quality rating policies and D-SNP decisions to enter or leave a market impact state efforts to advance integration. For example, Minnesota has integrated Medicare and Medicaid services for dually eligible individuals over the age of 65 through the Minnesota Senior Health Options (MSHO) program. However, Minnesota terminated its MN Disability Health Options (MDHO), an integrated care program for those under age 65, several years ago when most of the participating health plans determined that their participation was not financially viable due to Medicare Advantage payment and risk adjustment policies. New Jersey was slated to develop a fully-integrated D-SNP program in 2014, but a number of health plan-initiated D-SNP closures in 2013 and 2014 created unexpected delays. Closures were due in part to D-SNP and CMS decisions about product offerings in light of potentially low Medicare Stars ratings – another area outside of state control.

Other factors relate to a state's approach to advancing a Medicaid MLTSS program. For example, stakeholder support for the simultaneous implementation of both a new integrated care program and a MLTSS program can vary considerably by state, influencing both state strategies and timelines for D-SNP contracting. Additionally, states launching MLTSS programs need considerable flexibility to decide where potentially limited state oversight resources should be focused. For example, Kansas and Florida have opted to maintain limited D-SNP contracts in early stages of MLTSS program operations until they are ready to integrate benefits more fully. Other states, like Arizona, adopted an incremental approach to bolstering state contracts with D-SNPs under both the AHCCS-Acute Medicaid managed care program and the Arizona Long Term Care System (ALTCS) programs.

States set to launch new MLTSS programs in 2017—such as Pennsylvania and Virginia—plan to eventually integrate all Medicare and Medicaid services. CHCS is assisting both states to use D-SNP contracting as the platform for benefit integration as part of their initial health plan procurement efforts. CHCS expects that state and federal policymakers will learn more about how much time it takes for states to achieve full integration from different starting points from the efforts underway in these two states, as well as in other states that are currently at different points on the integration continuum.

Lastly, a more permanent status for D-SNPs under the Medicare Advantage program would be conducive to greater progress in this area. States need some assurance that the D-SNP platform will remain available into the future if they are going to invest time and resources in this platform as part of their longer-term planning for integration.

2. **Addressing the Need for Integrating Behavioral Health for Chronically Ill Beneficiaries**. The Chronic Care Working Group requested feedback on policy proposals for integrating behavioral health for chronically ill beneficiaries. Such policies could have a significant impact on health status and spending for the dually eligible population. One-quarter of Medicare-Medicaid enrollees aged 65 and older and nearly 40 percent under age 65 have a mental health disorder.[1] Among Medicare beneficiaries, those with serious mental illness (SMI) are more than twice as likely to have three or more chronic, co-morbid conditions.[2] Spending for Medicare-Medicaid enrollees with SMI is at least twice that of individuals without these conditions.[3]

   States can provide models that may be of interest to Medicare. A growing number of states have adopted managed care models in which a single entity is responsible for both behavioral and physical health services. By combining administration of and financing for physical and behavioral health services in a comprehensive managed care arrangement through either a physical or behavioral health plan, state Medicaid programs hope to better align system incentives and increase accountability for managing a more complete range of services, and provide for a more seamless care experience for beneficiaries. Many of these initiatives extend to Medicare-Medicaid enrollees as well, particularly through financial alignment demonstrations and the D-SNP platform.

   Over the last five years, CHCS has examined strategies for effective physical/behavioral health integration in managed care arrangements. Common ingredients for success that can inform similar initiatives for the dually eligible population include:
   (1) Specialized clinical expertise at the health plan level and state capacity for robust oversight and monitoring;
   (2) Federal/state and health plan access to historical and real-time linked Medicare and Medicaid data and information on physical and behavioral health needs to inform care coordination and management;
   (3) Shared financial accountability and aligned performance measures across Medicare and Medicaid services at the health plan level;
   (4) Commitment to recovery-based, person-centered principles to advance whole-person care that address beneficiaries' complex needs;
   (5) State/federal willingness to address administrative conflicts between Medicare and Medicaid (e.g., licensure and credentialing requirements, billing systems) that may impede the development of integrated behavioral health provider networks; and
   (6) Robust stakeholder engagement to strengthen program design and implementation.

3. **Ensuring Accurate Payment for Chronically Ill Individuals**. CHCS would like to commend the Committee's attention to potential differences in costs associated with beneficiaries who are dually eligible for Medicare and Medicaid through different eligibility pathways. CMS has recently proposed to make changes to the CMS-HCC Risk Adjustment Model to account for difference in costs in different eligibility categories, but the intent of this initiative appears to be to adjust rates based on partial or full dual eligible status only. Although broadly speaking Medicare-Medicaid enrollees comprise a high-need group, they are a heterogeneous population. This makes it important to adjust capitation rates paid to

health plans to reflect the characteristics and needs of the enrollees in each plan to ensure access and needed care for higher-cost enrollees.

CHCS also supports the Chronic Care Working Group's interest in a study to examine whether the use of functional status would improve the accuracy of risk-adjustment payments. CHCS is leading the *Medicaid Managed Long-Term Services and Supports (MLTSS) Rate-Setting Initiative*, supported by the West Health Policy Center, which examines similar questions for Medicaid programs. The initiative includes eight states – Arizona, Kansas, Massachusetts, Minnesota, Tennessee, Texas, Virginia, and Wisconsin – and national experts who are working together to develop or refine rate-setting strategies for MLTSS and/or Medicare-Medicaid integrated care programs. Medicare and many state Medicaid programs use risk adjustment systems focused on clinical diagnoses, but payment methodologies and risk-adjustment models for health plans providing LTSS are less established. Below are some early, relevant lessons from participating states:

(1) ***Use of functional status data for risk adjustment is challenging.*** To make effective use of functional assessment data, there should be capacity to link the assessment data to encounter and/or claims data. These challenges may be compounded by the use of different functional assessment tools and data systems, for different population groups, or by different managed care plans.

(2) ***More analysis is needed to identify the key aspects of functional status or individual characteristics that most affect costs***. I.e., what is the predictive power of specific variables? What are the key cost drivers for this population?

(3) ***The need for risk adjustment is affected by factors that may vary in importance in different markets.*** Risk adjustment based on functional status is likely most important when: (a) there are multiple plans competing for the same population; (b) there is clear diversity in predicted costs for the included populations based on functional status; and (c) plans could have the ability to cherry-pick based on this information.

CHCS appreciates the opportunity to comment on the Senate Committee on Finance's Bipartisan Chronic Care Working Group Policy Options Document. We recommend that Congress consider the contribution that state Medicaid programs can make as leaders in advancing value and quality health care for high-need populations. Your Committee's attention to improving chronic care financing and delivery for Medicare beneficiaries could have a tremendous impact on the health of Medicare-Medicaid enrollees who are among this nation's most vulnerable and expensive populations.

Sincerely,

Stephen A. Somers, PhD
President/CEO

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[1] Congressional Budget Office (CBO). 2013. *Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies.* Washington, DC: CBO.

[2] The SCAN Foundation. DataBrief no. 35: *Prevalence of Chronic Conditions Among Seniors with Severe Mental Illness.* February 2013. Available at: http://thescanfoundation.org/sites/thescanfoundation.org/files/1pgdatabrief_no35_prevalence_of_chronic_conditions_among_seniors_with_severe_mental_illness.pdf

[3] Ibid.