Commonwealth Care Alliance

June 22, 2015

The Honorable Johnny Isakson
United States Senate
Washington, DC 20510

The Honorable Mark Warner
United States Senate
Washington, DC 20510

Dear Senators Isakson and Warner:

Commonwealth Care Alliance is an integrated health care system serving the comprehensive health care needs of dual eligible beneficiaries in Massachusetts, with a particular focus on the most complex cases and hardest to serve members. We have been serving the over age 65 dual eligible population in the Senior Care Options program, a D-SNP, since 2004. We have been serving the under age 65 disabled dual eligibles since October 2013 in One Care, Massachusetts' financial alignment demonstration. We applaud the Committee's initiative to find better ways to meet the health care needs of Medicare beneficiaries with chronic conditions. Commonwealth Care Alliance and the programs we provide were created with the same drive to do better for those who need health care the most.

Of our almost 7000 seniors, fully half have 3 or more chronic conditions, and 25% have 6 or more chronic conditions, as defined by the Medicare HCCs. By definition all of our One Care members have a disability; 30% have 3 or more chronic conditions and 8% have 6 more or more chronic conditions, which we know to be under counted by the Medicare rules. In addition, roughly two thirds of our One Care members are living with mental illness, which research has shown greatly compounds their physical health needs and the cost associated with effective treatment.

Our approach to serving these populations is to not only coordinate their Medicare and Medicaid benefits through a care manager, but to provide greatly enhanced primary care that is transforming the way health care is provided to high need beneficiaries. We get to know our patients individually, usually in their homes, so that we can personalize their care plans, and we invest heavily in long term services and supports to prevent the need for more acute services. This approach has enabled us to reduce hospitalizations for our senior members by 50% and to rank in the top 4% of Medicare Advantage plans for quality. While the under age 65 population has proved more transient and in many ways harder to serve, our model of care is starting to yield results for those members as well. We have members who are trusting health care providers for the first time in their lives, others whose unmet health needs are being met for the first time in decades and many whom we have been able to serve in less expensive, more appropriate and effective psychiatric settings.

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Our experience with the populations whose care you are seeking to improve and made more cost efficient has taught us some important lessons which we would like to share with you. These recommendations are also vital to the sustainability of programs such as ours in the relatively short term under Medicare rules.

Far and away the most important consideration in promoting effective care management for these populations is to ensure appropriate risk adjustment in Medicare Advantage. In order to make assuming the care and risk for these populations sustainable, CMS' risk adjustment model needs to better reimburse plans for patients with multiple chronic conditions, patients with mental health conditions, particularly the interaction of a mental health diagnosis and chronic medical conditions and the challenges associated with poverty for fully Medicaid eligible members. Our recommendations for moving toward appropriate risk adjustment for our populations in Medicare Advantage are laid out in more detail in the attached letter to Sean Cavanaugh.

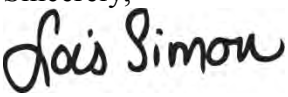
The second most important factor in improving outcomes for Medicare patients with chronic conditions is the integration of long term services and supports. The disconnect between long term services and supports, typically reimbursed by Medicaid, and the acute services funded by Medicare has led to unnecessary costs and poor quality of life through the duration of both programs. Only by integrating long term services and supports into the care plan can you hope to reduce unnecessary acute expenditures. This is what we have been doing very effectively in our Senior D-SNP for the past 10 years, which has reduced hospitalizations for our members by 50%. Of course, the financing structure needs to flexible enough to allow plans to make these kinds of investments in keeping patients healthy.

Finally, and perhaps most interestingly, our experience in Massachusetts has taught us that there need to be policies in place that support small, mission-driven organizations providing personalized care. Otherwise, the market will continue to be dominated by large insurers that are not built to provide the kind of personalized attention that patients with multiple chronic conditions need. For example, there need to be funds available for the necessary administrative investments in a new program. You cannot expect savings in these very complex cases without investing in a robust clinical structure to provide, manage and coordinate care. Similarly, we have learned that passive enrollment is antithetical to the kind of care that patients with chronic conditions need. Not only can large waves of auto enrollment swamp a small plan's commitment to personalized attention in the short term, as was the case for us, but they do not align with the robust patient engagement that is needed to produce optimal outcomes.

Another example of a policy that does not support small, mission-oriented plans is the Part D reimbursement methodology. Our monthly Part D prospective payments, based on a typical Medicare member's pharmacy needs, only cover about half of the pharmacy costs of our disabled, under-65 population. We have to rely on risk share and LICS and reinsurance settlement dollars to cover the rest over a year later, and roughly 3% is never reimbursed. With pharmacy making up over 25% of our health care costs in One Care, that means that we are waiting over a year for over 12% of health care costs to be reimbursed by Medicare. It is extremely challenging for a plan like ours, who has had to invest most of our reserves in starting

up the new program to also float the federal government 12% of our medical costs for over a year.
In conclusion, we are grateful for the questions you are asking. The opportunities to improve care for Medicare members whose care is not already well coordinated and managed are enormous. At the same time comprehensive, integrated care programs such as ours are at a crossroads today where our sustainability is in jeopardy at the very time that policy makers such as you would like to see approaches like our replicated. We hope that you will take the suggestions we have made seriously with those considerations in mind. We would welcome the opportunity to elaborate further on our recommendations in person if that would be helpful to you.

Sincerely,



Lois Simon
President

Enclosure (1)

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