healthfirst

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100 Church Street
New York, NY 10007
www.healthfirst.org

United States Senate
Committee on Finance
Chronic Care Working Group
Chronic_care@finance.senate.gov

Dear Senators Isakson and Warner:

Thank you for the opportunity to provide comments to the Senate Finance Committee Chronic Care Working Group regarding chronic care reform in the Medicare program.

Healthfirst is a not-for-profit, provider-sponsored health plan serving New York City, Nassau, Suffolk, and Westchester counties. Our model promotes population health at the provider level by transferring most financial risk to our hospital system sponsors who, with their community-based partners, work with us to align incentives and ensure quality, member satisfaction, and efficiency.

We serve 1.1 million members, including nearly 130,000 Medicare Advantage (MA) beneficiaries. Approximately 65% of our Medicare members are dually eligible for Medicare and Medicaid and 80% receive a Low Income Subsidy. Dual eligible MA beneficiaries face challenges related to low socioeconomic status (low-SES) such as low income and education levels, and are also considerably more likely to have multiple chronic conditions and more than one behavioral health condition.[i] Healthfirst is the largest and the only 4-star Medicare Advantage HMO serving New York City (2015 Stars).

Healthfirst has invested in population health strategies that focus on both our members and providers to address the clinical complexity of our members, while seeking to prevent or slow disease progression for those living with chronic conditions. The following are examples of best practices in the Healthfirst portfolio of targeted programs that improve outcomes for our Medicare beneficiaries and that are directly aligned with the three goals of the Senate Finance Committee Chronic Care Working Group:

(1) <u>Increase care coordination among individual providers across care settings who are treating beneficiaries living with chronic disease</u>

Healthfirst provides timely, actionable summary and detailed reports that strengthen the ability of primary care physicians and practices to implement care coordination processes to improve chronic care management such as outreach and engagement of members needing prevention services, chronic care testing, missing medication refills or those with care transition.

(2) Streamline Medicare's current payment systems to incentivize the appropriate level of care for beneficiaries living with chronic diseases

Healthfirst promotes optimal population health outcomes at the provider level by aligning financial incentives, utilizing financial risk transfer and other value-based methods of payment. The providers accepting risk are engaged in extensive and diverse clinical partnerships across our care delivery system with the goal of close collaboration to promote an optimal patient experience. For example, in our "Care for Older Adults" Advisory workgroup, representatives from every care delivery setting work closely with Healthfirst staff to identify, design and implement best practices to optimize health outcomes for beneficiaries in the setting that best achieves their expressed health goals.

(3) Facilitate the delivery of high quality care, improve care transitions, produce stronger outcomes, increase program efficiency, and contribute to reduction in Medicare spending growth

Healthfirst recognizes the importance of offering evidence based care transition solutions to reduce the likelihood of readmission and clinical deterioration. We partner with primary care practices, specialists and hospital discharge planners by providing daily reports containing numerous indicators that allow identification of beneficiaries who are at high risk for readmission and poor health outcomes. In addition, whenever possible, we promote linkages with house call physicians and providers, community based transition services and in-house care management.

With respect to the eight specific issues areas raised by the Senate Finance Committee for comment, we would like to provide feedback on the first area: *Improvements to Medicare Advantage for patients living with multiple chronic conditions.*

82% of Healthfirst Medicare members have two or more chronic conditions and nearly 52% have four or more chronic conditions.[ii] As such, we appreciate the importance and need to improve Medicare Advantage for these very vulnerable beneficiaries. We recommend three policy changes, outlined below, that will ensure adequate funding to plans serving high proportions of beneficiaries with low socioeconomic status (low-SES), as these beneficiaries are more clinically complex, more likely to have multiple chronic conditions, and more likely to face other challenges such as access to education, housing and personal safety that are not accounted for in clinical coding models.

- **Recommendation 1:** Adjust *Medicare Advantage Star Ratings system to recognize MA plans that serve high proportions of low-SES beneficiaries*

  The Medicare Advantage Star Ratings system does not currently account for differences in education, health literacy, community resources, or experience with the health care system that many low-SES Medicare beneficiaries experience, particularly those who are dually eligible and have higher chronic care needs. As a result, the Star Ratings system undervalues the achievements of plans focused on low-SES beneficiaries. This leads to inaccuracies in the Star Ratings as well in the determination of Quality Bonus Payments.

  We understand that analysis is currently being conducted by CMS as required under the Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014, and that this work

will inform the development of a solution that accounts for SES differences of MA beneficiaries and the MA plans that serve them. However, this solution is years away. In the interim, an immediate short-term solution is required to ensure that the care coordination and higher chronic care needs of low-SES populations are appropriately addressed.

Over the past several months, we have worked with eight other Medicare Advantage plans to carefully evaluate options to address the inequity in the Star Ratings system in the short-term. We support the resulting proposal to provide an adjustment in the Star Ratings based on (1) the proportion of low income members served by the plan and (2) the percentage of clinical measures for which the plan improved significantly year-over-year. The details of this proposal are more fully specified in a separate submission to the Senate Finance Committee Chronic Care Working Group from the group of eight MA plans, including Healthfirst.

We would be pleased to work with the Senate Finance Committee to develop a workable solution to ensure that low income MA beneficiaries receive the care coordination to address their higher chronic care needs.

- **Recommendation 2:** *Apply plan-specific coding intensity adjustments instead of an across-the-board adjustment.*

  Coding - the reporting of beneficiary diagnoses, including chronic conditions, during an encounter – is an integral part of the Medicare Advantage program that impacts payment, the bidding process, and risk-adjusted quality scores. Because of this, there are incentives for MA plans to code more intensively than Fee-For-Service (FFS) providers which has led to a divergence in coding practices between MA and FFS. To account for the differences in coding practices, CMS has applied an across-the-board cut to MA plan risk scores. For 2015, this amounted to a 5.16% cut.

  In a recent study conducted by Milliman, Healthfirst compared our coding intensity to CMS's estimate for the total MA population employing the same methodology that CMS described in the 2010 Advance Notice and Final Rate Announcement. The results show that Healthfirst's coding intensity is only 1.5% higher than that of FFS and considerably lower than the overall MA coding intensity of 5.16%, as indicated by the 2015 MA coding intensity adjustment.

  Application of an across-the-board coding intensity adjustment is increasingly forcing plans like Healthfirst (i.e., with less coding intensity) to offset these large and inequitable cuts with reduced benefits and increased cost shares for members. Because we serve a high proportion of beneficiaries with multiple chronic conditions and low-SES, the impact of reduced benefits and increased cost shares imposes an enormous burden on the vulnerable MA beneficiaries who can least afford it.

  MedPac, in its June 2015 "Report to the Congress: Medicare and the Healthcare Delivery System," notes that "plans are… disadvantaged if they code less intensively than other MA plans because the adjustment is the same for all plans." MedPac suggests that an alternative to the current across-the-board coding adjustment is to have plan-specific coding adjustments, which would remove some of the incentive for plans to increase coding intensity, as well as shift payment rewards to efficient plans with high quality rather than to those with greatest coding intensity.[iii]

We support MedPac's suggestion to apply plan-specific coding adjustments as opposed to the current across-the-board cut. Plan-specific coding adjustments will result in more equitable payment outcomes and reduce the need for MA plans with lower coding intensity to cut benefits and increase cost shares.

- **Recommendation 3:** *Shift the Medicare Advantage HCC Risk Model back to the 2015 blend (67% 2013 model / 33% 2014 model)*

  For the 2014 MA payment year, CMS introduced a new Hierarchical Condition Category (HCC) model. The impact of the 2014 HCC model varied across MA plans; plans with a higher proportion of dual-eligible beneficiaries or with a higher prevalence of chronic kidney disease (CKD) and diabetes experienced larger reductions in payment as a result of the model changes. For payment years 2014 and 2015, risk scores were a blend of the clinically-revised 2014 model and the 2013 model. For 2016, CMS is moving from the current blend of 67% 2013 model / 33% 2014 model to complete use of the 2014 model.

  The 2014 HCC model penalizes beneficiaries with certain chronic conditions (e.g., CKD, diabetes) who benefit from disease and care management programs targeted at addressing their needs and plan efforts to identify the diagnoses important to their care. Furthermore, changes in the weights associated with these conditions suggest a shift away from early interventions aimed at identifying and managing chronic conditions which is counter to the notion that MAOs are a vehicle for transforming the healthcare delivery system through preventive care.

  To ensure adequate funding to MA plans serving a higher proportion of dual-eligible beneficiaries and/or with a higher prevalence of chronic conditions like CKD and diabetes, we recommend that the HCC Risk Model used for 2016 payments be shifted back to the blend used in 2015.

We appreciate this opportunity to share our recommendations with the Senate Finance Committee Chronic Care Working Group in your efforts to improve care for Medicare beneficiaries with chronic conditions. Please do not hesitate to contact me for any additional information at (212) 801-1500 or pwang@healthfirst.org.

Sincerely,

Pat Wang
Chief Executive Officer

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[i] Kasper, J., O'Malley Watts, M., & Lyons, B. (2010, July). Chronic Disease and Co-Morbidity Among Dual Eligibles: Implications for Patterns of Medicaid and Medicare Service Use and Spending. https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8081.pdf. Accessed June 17, 2015

[ii] Medicare Health Outcomes Survey, 2014 Cohort 17 Baseline Report, May 2015, Centers for Medicare and Medicaid Services

[iii] *"Chapter 1 -Synchronizing Medicare policy across payment models."* MedPac Report to the Congress: Medicare and the HealthCare Delivery System. June2015. http://www.medpac.gov/documents/reports/june-2015-report-to-the-congress-medicare-and-the-health-care-delivery-system.pdf?sfvrsn=0. Accessed June 17, 2015.