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Submitted electronically via chronic_care@finance.senate.gov

The Honorable Orin G. Hatch
Chairman
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Ron Wyden
Ranking Member
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Johnny Isakson
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

The Honorable Mark R. Warner
United States Senator
Committee on Finance
United States Senate
219 Dirksen Senate Office Building
Washington, DC 20510

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

Thank you for the opportunity to submit comments on the Senate Finance Committee's Chronic Care Working Group's Policy Options Document of December 2015.

MJHS is one of the most innovative health systems in the New York City metro region, offering home health, hospice and palliative care, skilled nursing, Medicare Advantage Special Needs Plans and Medicaid managed long term care plans. We have more than a century's experience caring for the frail elderly and for chronically impaired persons of all ages.

MJHS encompasses some of the longest tenured Medicare, Medicaid and integrated managed care plans in New York and the nation (Elderplan/HomeFirst), internationally renowned, culturally sensitive hospice programs through MJHS Hospice and Palliative Care), and a nursing home that consistently achieves top ratings on Nursing Home Compare (Menorah Center for Rehabilitation and Nursing Care),

We strongly support the Working Group's goal of facilitating the delivery of high quality services designed to improve the health and well-being of Medicare beneficiaries living with chronic illness.

We especially appreciate your consideration of permanency for Medicare Advantage Special Needs Plans, which provide the type of care coordination across all care settings and services tailored to beneficiaries' individual needs that the Working Group seeks to ensure is available to all Medicare beneficiaries. Likewise, we especially appreciate your consideration of improving the CMS-HCC Risk Adjustment Model.
We also hope that the Working Group will support providing all SNPs at least as much flexibility as provided to general MA plans for the populations being targeted and the same permanency status as exists for general MA plans.

Based on our deep and broad history and experience, we offer the following specific comments:

Make SNPs permanent. MJHS offers a Dual- and Chronic-SNPs as well as a FIDESNP. All provide the care and care coordination that is crucial for chronically ill beneficiaries, most of whom have multiple chronic conditions. By definition, chronic illness is ongoing and our members will need care tailored to their needs and abilities over their lifetimes. Permanent SNP authority would:

- Create stability for these beneficiaries and their families by ensuring that the SNPs they chose will not sunset.

- Enable us and our network providers to make appropriate investments in chronic care systems and services.

- Reduce the administrative expense of constantly having to develop a Plan B whenever the continuation of SNP authority is in question.

If general MA plans are allowed greater flexibility in their benefit design to treat chronically ill beneficiaries, SNPs should be given similar flexibility – and funding. Existing SNPs have invested millions of dollars in developing programs carefully calibrated to the needs of their members; it seems unlikely that even the most well-intentioned general MA plans can catch up. Therefore, we believe emphasis should be placed on enhancing the ability of the proven SNP model. Moreover, implementing this proposal might lead to confusion among new enrollees over which approach – the SNP versus the general MA – has the experience and ability to meet their needs.

However, if general MA plans are given more flexibility, so should SNPs. With the exception of FIDESNPs, SNPs currently cannot use supplemental benefits.

If general MA plans are allowed to include certain telehealth services in their annual bid amounts and if Accountable Care Organizations are allowed to use telehealth and be reimbursed for it, SNPs should be also be allowed to use and be reimbursed for telehealth. Furthermore, telehealth should be allowed to count toward network adequacy for specialists with limited availability in the plan's service area and for behavioral health. More than 95% of Elderplan's and HomeFirst's members live in their own homes, but even with the support of aide and transportation services may find it difficult to go to multiple physician visits. Being able to offer needed services through telehealth would be a boon to these members.

Change the CMS-HCC Risk Adjustment Model to take into consideration a beneficiary's total number of conditions, the interaction between behavioral/mental health conditions with physical health conditions, dual eligible status and use of more than one year of data. Plans such as Elderplan/HomeFirst are currently adversely affected by the CMS-HCC model's inability to fully account for the costs of serving high-risk, high-need, chronically ill beneficiaries and especially for dual eligible beneficiaries. Many of these beneficiaries have multiple physical and behavioral health problems. The CMS-HCC especially under-accounts for behavioral health issues. For example, the HCC currently accounts for the impact of depression but not for anxiety. Yet anxiety can limit the beneficiary's ability to maintain mobility, independence and physical health treatment resulting in the person being homebound, needing longer aide hours and more assistance with Activities of Daily Living.

We also urge the Chronic Care Working Group and Senate Finance Committee to reject proposals to ignore diagnoses found in home risk assessments unless and until they are followed by treatment. Studies have clearly demonstrated that co-morbid conditions complicate care and treatment of many chronic illnesses. While not all co-morbidities may require specific treatment in any one month or year, they may increase the complexity of care and medication management needed to treat the primary chronic condition.

More fully account for the influences of multiple diagnoses, behavioral health issues, disability, and social factors in quality measures, particularly within the Star Ratings system. This is in line with our comments above. We also urge Congress to press CMS to measure SNPs against like SNPs. In September 2015, CMS released findings from a RAND study that provides scientific evidence that dual eligibility significantly lowers outcomes on 12 of 16 Star Rating measures examined, while disability status significantly lowers outcomes on 11 of the 16 measures. It is misleading to dual eligible beneficiaries seeking a plan and patently unfair to D-SNPs and other SNPs to be compared with general MA plans.

In a similar vein, we urge Congress to press CMS to compare plans participating in the Financial Alignment Demonstration only with those plans operating in the same state. There is significant variation between the populations served by the various states' demonstrations and the benefit packages offered.

Do not carve hospice into Medicare Advantage. Both MJHS' plans and hospice organization believe that the Medicare hospice benefit should remain outside of MA. In 2013, New York began requiring Medicaid plans to provide the Medicaid hospice benefit and to pay at the fee-for-service rate. The contracting, billing and payment issues involved have been a struggle for both plans and providers and have added to the administrative expense and complexity of both. Rather than a single claims process, New York hospices and plans now have to negotiate, manage and process Medicaid hospice claims with multiple entities. The change has also added to the State Department of Health's workload, as they continue to issue guidance on contracting and claims issues. We urge the Working Group not to add more costs and complexity by carving hospice into MA.

Be mindful of overlapping initiatives from the Centers for Medicare and Medicaid Services and ensure alignment between existing and proposed requirements. For example, CMS-3260-P – Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, CMS-2390-P – Medicaid and CHIP Managed Care Proposed Rule, and CMS' Financial Alignment Demonstration program all contain assessment, care management and care transition proposals, some of which are similar and some of which are disparate or duplicative. These proposals and program requirements should be synchronized among themselves and with the Chronic Care Working Group's ultimate recommendations.

Sincerely,

Alexander Balko
President & CEO
MJHS

Cc:
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