UCare

January 26, 2016

The Honorable Orrin 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 provide comments about the *Policy Options* document from December 2015. UCare, a nonprofit health plan in Minnesota, is particularly interested in the topics you present in this paper because just over 92,000 of our approximately 150,000 members are enrolled in our Medicare Advantage or Special Needs Plans (SNPs). Since 1997, UCare has offered a fully integrated plan to beneficiaries ages 65 and over that includes Medicare and Medicaid financing and acute, primary and long term care services. We also offered a fully integrated plan for people under age 65 with disabilities from 2001 - 2011. Based on our experience and strong belief in integrated financing and care models, we continue to be involved in numerous public policy opportunities to identify innovative and cost effective services for seniors and people with disabilities.

You will be receiving comments from several trade associations with whom UCare partners, including the SNP Alliance and the Alliance of Community Health Plans (ACHP). We encourage the committee to grant significant weight to those comments. We briefly highlight below a few items of particular importance to UCare.

1. **Permanent SNP authorization and CMS support for development of SNPs** – An overarching policy principle we would like to see immediate action on is the permanent authorization of SNPs. We believe it is well understood that models integrating Medicare and Medicaid services and funding lead to better beneficiary experience and outcomes and are, overall, a better purchasing and care delivery model. However, the ongoing lack of permanent authority for these "best in class" models hinders a health plan's ability to continue to develop and optimize these products because so much effort is expended on yearly authorization.

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Along with permanent authorization of SNPs, we believe the following actions would further allow integrated Medicare-Medicaid offerings to flourish and improve the health of this group of beneficiaries:

- Designate an area within CMS, e.g., the Medicare-Medicaid Coordination Office (MMCO), as the official CMS entity for development of SNP policy, and grant authority for this entity to work through the barriers to integration stemming from mismatch with existing federal Medicare and Medicaid policies.
- Grant authority and funding that would allow CMS MMCO to support states' efforts to continue development of SNP plans such as start-up grants to states to develop integrated products, technical resources from CMS and other states, and creation of a CMS-State working group focused on development of SNPs, etc.
- Ensure that any flexibility granted to general Medicare Advantage plans is also given to SNPs.
- Allow greater authority for states to "passively" enroll beneficiaries into SNP plans but include, on an ongoing basis, the beneficiary protection of the opportunity to opt-out of integrated plans and back to Original Medicare (fee-for-service).

2. **Improvements in Medicare Advantage Risk Adjustment** – To grow what we consider "best practice" integrated SNP models, there need to be meaningful improvements to the Medicare Advantage (MA) Risk Adjustment payment system that recognize the higher costs associated with serving members with complex needs. One of the largest barriers to starting certain types of SNPS (e.g., for people with disabilities), and to maintaining existing SNPs (e.g., for people eligible for both Medicare and Medicaid or "dual eligibles") is the lack of the current risk adjustment system to properly account for the cost of services needed to maintain and/or improve a member's health and help them live independently and outside of an institutional setting.

   UCare has direct experience and understanding of the shortcomings of the current Medicare risk adjustment payment system, especially for people with disabilities. In 2011, inadequate Medicare Advantage payments forced UCare to make a business decision to "disintegrate" (discontinue integrating Medicare financing and services) our product for people under age 65 with disabilities. We were keenly aware that this decision was not in the best of interest of our members and their overall health, but discontinuing the Medicare integration was what UCare needed to do in order to keep the product we offered financially viable. Since this happened, we have been weighing-in, whenever possible, with the goal to re-integrate. We now are closely analyzing the new Medicare Risk Adjustment methodology for dual eligibles, including people with disabilities, that was just finalized/released by CMS in order to assess the ability to once again move toward an integrated financing and service delivery model, and what we consider best practice.

3. We are intrigued by the proposals starting on page 8 relating to Advancing Team-Based Care. Given the changes being proposed to hospice benefits and ESRD, we believe that a process should be established that allows for adequate modeling and financial planning before implementing the proposed changes.

4. We generally support the proposals on page 14 related to supplemental benefits and permitting the plans to have additional flexibility in how we serve people with chronic conditions. We currently serve a large number of Somali elders through our SNP and this is a great example where we need to tailor our programs and services to best meet their cultural needs through our care coordination model. More flexibility for offering supplemental benefits can also help support people to remain living in community settings longer, which can decrease future need for more costly institutional services that are covered by Medicaid (funded by federal and state funds). At the same time, we would need to better understand the details of this proposal in order to fully understand the impact on our members and our health plan.

5. We support the statement at the top of page 17 relating to telehealth that it is not necessarily an additional benefit, but rather a mode of delivery. We agree with this statement and hope the committee will continue to look at telemedicine proposals from that perspective.

6. We support the proposal on page 27 to expand access to digital coaching. We see this as an opportunity to improve the health literacy of our members. We hope the committee will also consider methods to ensure these efforts are culturally competent to best meet the needs of all the members served.

Once again, thank you for the opportunity to provide comment and let us know if we can partner with the committee in any way as you move forward with this proposal.

Sincerely,

Ghita Worcester
Senior Vice President, Public Affairs and Chief Marketing Officer