

Statement for the Record

Hearing on “MedPAC’s June Report to Congress”

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Subcommittee on Health
House Committee on Ways and Means

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Chairman Herger, Ranking Member Stark, and other distinguished members of the Subcommittee on Health of the House Committee on Ways and Means, I am submitting this Statement for the Record on behalf of the Medicaid Health Plans of America (MHPA) for the Hearing on the Medicare Payment Advisory Commission's (MedPAC) June Report to Congress conducted by the Subcommittee on June 19, 2012. My comments are focused on the chapter of the June report entitled "Care coordination programs for dual-eligible beneficiaries" and specific concerns raised by MedPAC about the integrated care demonstration programs that CMS is developing and implementing with states.

MHPA is the leading association solely focused on representing the common interests of Medicaid health plans. Our 113 member plans serve more than 14 million beneficiaries in 34 states and the District of Columbia. MHPA represents both non-profit and for-profit plans, ranging from large multi-state insurance corporations to small community-based plans. We believe that Medicaid managed care has proven to be a highly successful model for coordinating care for low-income and culturally diverse populations and our plans are eager to expand this model to include dual eligible beneficiaries, whom CMS now refers to as "Medicare-Medicaid enrollees."

MHPA strongly supports the unprecedented efforts of the U.S. Department of Health and Human Services (HHS) to strengthen health care services and improve the quality of life for close to 10 million Americans dually eligible for both Medicaid and Medicare. We also believe that the Capitated Financial Alignment Demonstration (CFAD) initiative is an integral part of the overall strategy of HHS for better integrating care and improving health outcomes for Medicare-Medicaid enrollees (MMEs).

In its June 2012 report, MedPAC expressed support for the goals of both the capitated and managed fee-for-service (FFS) demonstrations being undertaken by CMS and recognized the potential to learn from them about improving the quality of care and reducing Medicare spending. MedPAC also acknowledged that the current FFS

Medicare and Medicaid systems have conflicting incentives that can discourage care coordination and lead to poor outcomes and higher spending.

MHPA in fact believes the existing payment silos and fragmented FFS delivery systems are failing Medicare-Medicaid enrollees and are fiscally unsustainable for both the federal and state governments. According to an analysis by the Urban Institute, the combined cost of Medicare and Medicaid care for this population in 2007 exceeded total Medicare expenditures for all other Medicare beneficiaries, a group four times as large.

Today, less than 10% of Medicare-Medicaid enrollees receive Medicaid coverage through Medicaid managed care plans, while only about 120,000 are in programs that fully integrate Medicare and Medicaid services. The vast majority are left to navigate two separate health systems and obtain other social supports with little or no care coordination. Most of their health care and related services – primary, acute, prescription drugs, long-term care, behavioral health, and social supports – are delivered separately. Few if any of their providers have access to claims data or complete health records. According to a recent CMS study, over a quarter of hospital admissions for Medicare-Medicaid enrollees could have been avoided by prevention of the condition causing hospitalization, or treatment in a less costly or more appropriate setting.

Medicare-Medicaid enrollees are sicker and poorer than the general Medicare or Medicaid populations. According to reports done by the Kaiser Commission on Medicaid during the last several years, 86% of Medicare-Medicaid enrollees in 2008 had annual incomes below 150% of the federal poverty level, compared to 22% of non-dual Medicare beneficiaries. Almost half have difficulty with a least one instrumental activity of daily living, or ADL (such as dressing or bathing). They are three times more likely to have a disability and have higher rates of diabetes, pulmonary disease, strokes, Alzheimer's disease, and mental illness. The population served by Medicare and Medicaid most in need of care coordination currently has the least access.

As noted in MedPAC's June report, as of 2011, Medicaid-Medicare enrollees represented just 15% of the Medicaid population, but accounted for 40% of total Medicaid spending. In Medicare, they represented 18% of Medicare FFS enrollment, but about 27% of total FFS spending. Total federal and state spending on this population now exceeds \$300 billion. Almost two-thirds of Medicaid spending for this population is for long-term care. While nursing home care is a Medicaid entitlement benefit for individuals meeting state income eligibility criteria, in most states access to home and community-based services, which is an optional service, is generally more restricted. An Urban Institute analysis of 2007 data also showed that total per capita Medicare and Medicaid spending on Medicare-Medicaid enrollees averaged \$29,868, more than four times per capita spending on other Medicare beneficiaries. As a society, we can and must do a better job of providing elderly and disabled Medicare-Medicaid enrollees higher quality and more cost-effective health care.

Scope of Demonstrations

In its report, MedPAC raised concerns about the scope of the integrated care demonstrations CMS is developing and implementing with states. Specifically, MedPAC believes the scope of the demonstrations are too large for an approach that hasn't been proven and that inclusion of most Medicare-Medicaid enrollees will make it difficult to compare outcomes with a FFS population. We do not share these concerns.

Through the Medicare-Medicaid Coordination Office (MMCO), and in partnership with the Center for Medicare and Medicaid Innovation (CMMI), HHS is seeking to better integrate Medicare and Medicaid services, to align administrative requirements, quality measures and consumer protections, and to improve health outcomes for Medicare-Medicaid enrollees. The capitated demonstrations represent one of two models MMCO is testing – three-way contracts between CMS, states and health plans will provide a single, blended capitation payment to fully cover all Medicare and Medicaid services, including prescription drugs and long-term care services and supports.

Under this model, person-centered plans and interdisciplinary teams of providers will be used to provide the most appropriate set of services in the most appropriate settings, which will allow more Medicare-Medicaid enrollees to receive care in their homes and communities. Health plans will also be expected to coordinate non-medical supports offered through separate programs and providers. Payment incentives will be shifted away from volume of services to quality of care as outcome measurements are put in place to assess performance, including new measures for evaluating the quality of long-term care. In addition, incentives for payers and providers to cost-shift between the two programs will be eliminated by making a single entity accountable for costs across all services.

MHPA believes that the demonstrations should include as many Medicare-Medicaid enrollees as possible. Participation will allow each beneficiary to receive a baseline health risk assessment and further risk appraisals, a person-centered care plan, and coordinated Medicare and Medicaid services. We feel strongly that Medicare-Medicaid enrollees should not be forced to forego care coordination in demonstration states and reject the notion that the status quo is adequately meeting the health care needs of this population. We also note that while the 20 states proposing capitated demonstrations hope to include just over 2 million individuals in integrated care plans by 2014, another 1.2 million Medicare-Medicaid enrollees in these states will not be served through the demonstrations, at least immediately. In addition, each participant will have the opportunity to “opt out” of a demonstration, so every state will continue to maintain a FFS population, which can serve as a control group for comparison.

Plan Experience

MedPAC also expressed concern about whether health plans that may be selected by states to participate in demonstrations have sufficient experience working with different subgroups of Medicare-Medicaid enrollees and sufficient capacity to deliver a full range of Medicare and Medicaid services.

Medicaid health plans have developed an infrastructure for care coordination, access and quality improvement that results in improved outcomes for beneficiaries. This includes information systems capable of integrating large volumes of information used to identify members in need and programs such as utilization management, disease management, and health risk appraisals, as well as care management personnel dedicated to coordinating health and other services for members.

Medicaid managed care health plans are accredited by The National Committee for Quality Assurance (NCQA) and URAC, which evaluate them on rigorous standards relating to network management, access, quality and beneficiary rights. Medicaid health plans report on care quality using standard Healthcare Effectiveness Data and Information Set (HEDIS) metrics that enable states to evaluate quality improvement over time. For example, in 2011, Colorado health plans improved in 17 of 24 performance measures required by the state, addressing topics ranging from chronic disease medication monitoring to increasing use of prenatal care monitoring. Some states also use Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys to evaluate health plan performance and beneficiaries' satisfaction. In its June 2011 report to Congress, the Medicaid and CHIP Payment and Access Commission (MACPAC) noted that data from the 2010 CAHPS survey showed that Medicaid enrollees gave their plans higher marks than patients in privately insured or Medicare plans. No such comprehensive quality measures or surveys exist in FFS Medicaid.

Health plans serving the Medicaid population already serve large numbers of elderly and disabled persons. MHPA member companies operate Medicare Advantage plans serving close to 4.7 million Medicare recipients. Another 567,000 Medicare beneficiaries are enrolled in their Medicare Special Needs Plans, with three quarters participating in Dual Eligible-Special Needs Plans, or D-SNPs. MACPAC's March 2012 report to Congress report also included an analysis of Medicaid Statistical Information System (MSIS) data that showed that approximately 2.6 million disabled persons were already enrolled in comprehensive, risk-based Medicaid managed care plans as of 2008.

Our plans understand that under the capitated demonstration program they will be held to high performance standards. They expect no less, but welcome the challenge of applying experience and experience acquired by serving low-income, culturally diverse populations in Medicaid to improve the quality of care for Medicare-Medicaid enrollees.

MMCO has given states the flexibility to contract with plans they believe are best given their experience with the aged, blind, and disabled (ABD) population and their local insurance markets. MHPA believes this flexibility is an important aspect of the CFAD program.

Passive Enrollment

While acknowledging that low beneficiary enrollment is a barrier to expansion of integrated care programs, MedPAC questions whether states have the capacity to assign Medicare-Medicaid enrollees to plans that will best meet their needs and whether every plan will provide high-quality care and appropriate care management models.

CMS is allowing states to use passive enrollment for their capitated integrated care demonstrations, but is also requiring them to allow individuals to opt out of the integrated program either prior to enrollment or anytime afterward. MHPA recognizes that many Medicare-Medicaid enrollees have complex medical and behavioral conditions and agrees that states should be careful to ensure that participating health plans have sufficient capacity to meet the particular needs of every included subgroup and that rates paid to plans are sufficient to cover the cost of all necessary services. MHPA also strongly believes that extensive outreach and education will be required to ensure that Medicare-Medicaid enrollees are fully aware of their options and rights. However, we also believe that once a person chooses to enroll, a state should generally be able to require participation for some reasonable period of time before enrollees can make an informed decision about whether to stay in the plan, switch to another plan, or opt back into the FFS system.

We also think states and plans should be able to provide additional supports and services beyond those already available through Medicare and Medicaid as incentives for participation, as well as non-nominal incentives such as coupons for over-the-counter drugs to encourage enrollees' participation in care management activities or to reward desired behaviors (e.g., getting screening tests).

Pharmacy benefits are a critical aspect of care management and we believe must be included in the integrated demonstration plans, as they currently are, in order for them to work. MMCO has been careful to ensure Part D protections apply to pharmacy benefits within the demonstration, and that savings attributable to Part D are retained in the Part D benefit and not the demonstration. Part D-covered pharmaceuticals provided within the demonstrations will not be subject to Medicaid formularies or the Medicaid Drug Rebate Program.

In closing, we believe that the integrated care demonstrations will greatly improve outcomes for Medicare-Medicaid enrollees. We know that this population is more likely to be institutionalized and is subject to higher rates of hospitalization and re-admissions, as well as emergency room visits. Many lack family support to help them navigate between programs and providers. Without a major change in policy, this population will continue to get sicker and will continue to drive a disproportionately high share of Medicaid and Medicare spending.

Thank you for the opportunity to submit a Statement for the Record on behalf of MHPA.